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CATEGORICAL FACTORS

Policy: The Medicaid eligibility determination process begins with a determination of an applicant’s category. The applicant may be eligible for Medicaid in any one of the following categories:

- receiving Supplemental Security Income (SSI);
- eligible under Low Income Families (LIF);
- eligible under Singles/Childless Couples (S/CC);
- ADC-related;
- receiving Foster Care or Adoption Assistance;
- Federal Poverty Level Programs;
- SSI-related (Aged, certified blind/disabled);
- under age 21;
- pregnant women;
- FNP parents; or
- parents living with their dependent children under age 21.

References:

SSL Sect.	366.1 453(1)(b)
Dept. Reg.	360-3.3 369 369.3(d)(1)
ADMs	OMM/ADM 97-2 94 ADM-12 93 ADM-34 87 ADM-22 82 ADM-24

Interpretation: The federal government participates in the cost of care for all categories except S/CC and FNP parents.

NOTE: New York State is currently providing Medicaid with federal participation to most recipients, regardless of category,

CATEGORICAL FACTORS

including Single Individuals and Childless Couples as a result of the time limited waiver granted to New York State, pursuant to Section 1115 of the Social Security Act.

Certain other persons are eligible for Medicaid as a result of their eligibility remaining in effect from a previous period of time. These persons are listed on **CATEGORICAL FACTORS, MEDICAID EXTENSIONS/ CONTINUATIONS**.

Disposition:

When the proper categorical relationship has been established, financial eligibility is determined according to the guidelines specified in the **INCOME** and **RESOURCE** sections of this manual, in addition to any applicable requirements found in the **OTHER ELIGIBILITY REQUIREMENTS** section.

This section describes the following categorical relationships and requirements:

- Legally recognized same sex marriages,
- Low Income Families (LIF);
- ADC-Related;
- SSI-Related;
- Under age 21;
- Pregnant women;
- Families living with their dependent children under age 21;
- Singles/Childless Couples (S/CC);
- FNP parents; and
- Medicaid Extensions/Continuations.

CATEGORICAL FACTORS**LEGALLY RECOGNIZED SAME SEX MARRIAGES**

Policy: Individuals who declare that they have been legally married in a jurisdiction that recognizes and performs same-sex unions must, regardless of gender, receive full faith, credit and comity as all other legally married persons when a district makes any Medicaid eligibility and case decision in New York State.

References: GIS 08 MA/023

Interpretation: Individuals of the same sex who have been married in a jurisdiction that recognizes and performs same-sex unions must receive equal treatment and recognition of such marriage. Equal treatment means that terms such as “husband”, “wife” and “spouse” are construed in a manner that encompasses legal same-sex marriages. Factors including but not limited to the following must be evaluated in the same manner for all legally performed marriages:

- Required signatures on applications;
- Household composition and size;
- Budgeting methodology;
- Determination of Legally Responsible Relatives;
- Spousal and Child Support issues
- Health insurance premium payments;
- Chronic/long term care budgeting issues, including transfers of resources for SSI-related A/Rs;
- Income from trusts;
- Homestead and resource exemptions for SSI-related A/Rs
- Burial funds;
- Estates; and
- Liens and recoveries.

Disposition: Individuals who have been legally married in a same-sex union will have their eligibility for Medicaid and related programs determined in the same manner as individuals who are legally married that are not of the same sex.

Documentation: Documentation of a legally recognized same-sex marriage is only necessary in the same limited circumstances as documentation of any other marriage (for example, when an individual seeks spousal budgeting for long term care).

CATEGORICAL FACTORS

LOW INCOME FAMILIES (LIF)

Policy: Families with children under age 21, children under age 21 who are not living with caretaker relatives, applying caretaker relatives (including adult only cases) and pregnant women may be eligible for Medicaid under Low Income Families (LIF). (See **CATEGORICAL FACTORS ADC-RELATED LIVING WITH SPECIFIED RELATIVE** for more information on caretaker relatives)

Although for federal reporting purposes, deprivation of parental support or care due to continued absence, death, incapacity, or under/unemployment is recorded, families that do not meet the deprivation criteria are included in the LIF group.

References:

SSL Sect.	366 366-ee 367
ADMs	10 OHIP/ADM-01 OMM/ADM 97-2
GIS	09 MA/ 027

Interpretation: Although the ADC cash category no longer exists, Medicaid cannot be more restrictive than the ADC methodologies that were in effect on July 16, 1996. The LIF category consists of families with a deprivation and families without a deprivation.

Disposition: The financial standards under LIF provisions generally parallel those of the cash program; however, no methodology which is more restrictive than the methodology used in the ADC cash program on July 16, 1996, may apply to LIF. Because Medicaid and cash eligibility are de-linked, future changes made to the cash program will not automatically trigger changes to the Medicaid program.

If an A/R is determined eligible under the LIF criteria, deprivation factors are explored and appropriate WMS categorical codes used for reporting purposes. If the A/R is not eligible under LIF, eligibility must be determined under, Family Health Plus, Family Planning Benefit Program, etc.

Effective for eligibility periods on or after January 1, 2010, there is no resource test for LIF A/Rs. For A/Rs applying for Medicaid coverage for the three month retroactive period prior to January 1, 2010, there is a resource test.

CATEGORICAL FACTORS**ADC-RELATED**

Policy: The ADC program no longer exists as a cash grant program. However, Medicaid continues to have an ADC-related medically needy category. Persons who are members of families with a deprivation may be eligible under the ADC-related category of assistance if they meet the financial and all other eligibility requirements for Medicaid.

References:

SSL Sect.	366 366.1(a)(5) 366-ee
Dept. Reg.	360-3.3 369.2
ADMs	10 OHIP/ADM-01
GISs	09 MA/027 08 MA/022

Interpretation: In order for adult relatives of children to be eligible for Medicaid as ADC-related, the children must meet the appropriate categorical requirements. These include age, relationship, living with a specified relative, and deprivation of parental support and/or care.

NOTE: The A/R's statement of his/her relationship to the child which may or may not indicate a deprivation factor is acceptable unless there is a reason to doubt the validity of the relationship. A signed application indicating the relationship and deprivation factor is generally the only verification required. When the relationship or deprivation factor is questionable other verification is necessary.

Disposition: If an adult A/R and the child s/he cares for meet all the ADC-related requirements, their eligibility is compared to the Medically Needy Income level or the Medicaid Standard (and MBL Living Arrangement Chart as appropriate) whichever is most beneficial.

Effective for eligibility periods on or after January 1, 2010, there is no resource test for ADC A/Rs. For A/Rs applying for Medicaid coverage for the three month retroactive period prior to January 1, 2010, there is a resource test.

NOTE: MEDICAID STANDARD, MBL LIVING ARRANGEMENT CHART is found in REFERENCE.

CATEGORICAL FACTORS**ADC-RELATED**

The following specific topics are considered in this section:

- Age
- Relationship of child to caretaker relative
- Living with specified relative
- Deprivation of parental support or care by:
 - Death
 - Incapacity
 - Continued absence
 - Un/Underemployed Two-parent Households

**CATEGORICAL FACTORS
ADC-RELATED****AGE OF CHILD**

Policy: A child under the age of twenty-one (21) who is deprived of parental support and/or care (See **CATEGORICAL FACTORS DEPRIVATION OF PARENTAL SUPPORT**) is ADC-related when s/he is living with a specified relative (See **CATEGORICAL FACTORS LIVING WITH SPECIFIED RELATIVE**). The A/R and his/her caretaker relative must meet all other requirements to be eligible for Medicaid.

References:

SSL Sect.	366.1(a)(5)(iii)
Dept. Reg.	360-3.3(b)(5)
ADMs	93 ADM-29
GIS	94 MA/015

When to Verify Status: When a child is obviously under the age of twenty-one it is not necessary to verify age. However, since an A/R's date of birth is generally relevant at some point during the eligibility process, it is recommended that date of birth be verified at the first application. Once documented, it is not necessary to re-verify an A/R's date of birth. An application or recertification is never delayed or denied for lack of age verification when the child is obviously under age twenty-one (21).

Verification: The documents used to verify Citizenship/Immigration Status can also be used to verify age.

Documentation: Sufficient to establish an audit trail:

- the date of birth,
- type of document,
- place and filing date of the document,
- any identifying numbers, and
- the name of the official who signed the document.

**CATEGORICAL FACTORS
ADC – RELATED**

RELATIONSHIP OF CHILD TO CARETAKER RELATIVE

Policy: Individuals caring for children who are deprived of parental support (See **CATEGORICAL FACTORS DEPRIVATION OF PARENTAL SUPPORT**) may be eligible for Medicaid as ADC-related. Both the caretaker relative and the child are ADC-related when the caretaker is within a certain degree of relationship to the child.

References: SSL Sect. 366.1(a)(iii)
Dept. Reg. 369.1(b)
ADMs 93 ADM-29

Interpretation: The following is a list of relatives who meet ADC-related criteria. The relationship may be by blood, half blood or adoption.

- (1) The child's father, mother, brother, sister, grandfather, great-grandfather, great-great grandfather, grandmother, great-grandmother, great-great grandmother, uncle, great-uncle, great-great uncle, aunt, great-aunt, great-great aunt, first cousin, nephew or niece.
- (2) The child's stepfather, stepmother, stepbrother, or stepsister, but no other step relative.
- (3) The spouses of any of the relatives listed above, even though the marriage may have been terminated by death, divorce or annulment.
- (4) When a child is born out of wedlock, paternity is adjudicated or acknowledged in writing for a paternal relative to qualify as ADC-related.
- (5) When a child has been surrendered to an authorized agency or adopted, relatives by either blood or adoption may qualify.
- (6) When a child is residing with both parents, both parents may be ADC-related, if a deprivation exists.
- (7) When a child is residing with more than one qualifying relative, other than his/her parents, only one adult relative may be ADC-related due to his/her relationship to the child. For example: a child lives with both grandparents, only one grandparent may be ADC-related through the children.

**CATEGORICAL FACTORS
ADC-RELATED**

RELATIONSHIP OF CHILD TO CARETAKER RELATIVE

(8) Two adults may each qualify as a caretaker relative if there are at least two children in the household that are not siblings.

NOTE: A caretaker relative can be under the age of 21 if s/he assumes a parental role. For example, a teenage parent living with his/her child, or an older brother who is the primary caregiver of younger siblings.

Verification: The A/R's statement of his/her relationship to the child is acceptable unless there is reason to doubt the validity of the relationship. A signed application indicating relationship is generally the only verification required. When the relationship is questionable other verification is necessary.

Examples of acceptable forms of verification are:

birth certificate
baptismal certificate
court papers
adoption papers
marriage certificate
other documentation from schools or social services agencies

Documentation: Sufficient to establish an audit trail:

- (a) signed application; and
- (b) if the living relationship is questionable: type of document; date and place of filing; and identifying numbers of the available document or name of the official signing the document.

**CATEGORICAL FACTORS
ADC - RELATED****LIVING WITH SPECIFIED RELATIVE**

Policy: In order for a child and a caretaker relative to be ADC-related they must be living together.

References: SSL Sect. 366.1(a)(5)(iii)

Dept. Reg. 360-3.3(b)(5)

INFs 07 OHIP/INF-1

Interpretation: The determination of eligibility for ADC-relatedness includes consideration of the living arrangement of the dependent child who has been deprived of parental support. The child must be living with his/her parent or caretaker relative. The child is considered to be living with the parent or other relative as long as the relative takes responsibility for the care and control of the child, even though:

(1) circumstances may require the temporary absence of either the child or relative;

(2) the child has been placed in the home of such relative by a court, except when placement is on a board basis with a plan for supervision and control by the local department of social services through its Child Welfare program.

In situations of equally (50-50) shared (physical and legal) custody, the dependent child is considered to be living with both parents and both parents get the benefit of ADC budgeting. However, when a court order for equally shared custody of the child(ren) is not followed, a determination must be made as to which parent is actually the primary caretaker. Which parent has greater physical custody and responsibility for medical, education, day care and similar needs are factors to consider when making this determination.

Verify Status: (a) When the A/R indicates the presence of a child in the household;

**CATEGORICAL FACTORS
ADC-RELATED**

LIVING WITH SPECIFIED RELATIVE

- (b) When the A/R indicates the absence, incapacity, death or the presence of both parents of the dependent child.

Verification:

A signed application indicating the household composition is generally sufficient to verify the A/R's living arrangement. However, if the living arrangement is questionable other forms of verification are necessary. For example: a non-relative landlord statement or school records.

To determine the primary caretaker of the child(ren) when the court order indicates equally (50-50) shared joint physical and legal custody, but one parent claims the custody is not equally shared, consider which parent has the primary responsibility for:

- Assisting the child with homework or school related tasks
- Paying tuition cost related to the child's education
- Arranging and paying for the cost of day care
- Transporting the child to and from school or day care
- Responding to emergencies at the child's school or day care center or dealing with law enforcement
- Arranging medical and dental care for the child
- Making decisions regarding the child's future
- Paying for food and clothing when the child visits the other parent

Other factors to consider:

- If the parents reside in different school districts, where does the child attend school?
- If one parent is given visitation rights, the other parent is generally the custodial parent.
- Who claims the child on his/her income tax may be an indicator of the primary caretaker.

Only members of the household are included in the case.

**CATEGORICAL FACTORS
ADC-RELATED**

LIVING WITH SPECIFIED RELATIVE

A child is considered to be living with the individual as long as the individual has care and control of the child. The child can then be added to the household count. This policy applies even if the child or parent is temporarily absent.

Documentation: Sufficient to establish an audit trail:

- (a) signed application indicating the household composition; or
- (b) if the living arrangement is questionable: type of document; date and place of filing; and identifying numbers of the available document or name of the official signing the document.

Disposition: When the child has been determined to be living with the A/R, the other categorical requirements detailed in **CATEGORICAL FACTORS ADC-RELATED** are considered in determining eligibility as ADC-related.

NOTE: The A/R's statement of his/her relationship to the child which may or may not indicate a deprivation factor is acceptable unless there is a reason to doubt the validity of the relationship. A signed application indicating the relationship and deprivation factor is generally the only verification required. When the relationship or deprivation factor is questionable other verification is necessary.

**CATEGORICAL FACTORS
ADC-RELATED****DEPRIVATION OF PARENTAL SUPPORT OR CARE**

Policy: An A/R is ADC-related when s/he is the caretaker relative of a child under the age of twenty-one (21) and that child is deprived of parental support and/or care. That child is also ADC-related. The A/R must meet all other requirements to be eligible for Medicaid.

References: SSL Sect. 366.1(a)(5)(iii)
Dept. Reg. 360-3.3(b)(5)
ADM 97 ADM-20

Interpretation: A child is considered deprived of parental support and/or care when any of the following conditions exist:

- death of a parent;
- physical or mental incapacity of a parent;
- continued absence of a parent; or
- un/underemployed two-parent household.

When there are multiple children in a household, there may be multiple deprivation factors. For example: a woman who has two children from a previous marriage remarries and has two children by the second husband. The second husband is in an accident and becomes incapacitated. The children from the second marriage are considered deprived of parental support because of their father's incapacity. The two children from the mother's previous marriage are deprived of parental support/care because of the absence of their birth father.

It is possible for children in a household to be ADC-related based on different deprivation factors. Using the above example, when the father recovers from his accident, returns to work, and is no longer incapacitated, his children are no longer ADC-related based on incapacity. The other two children, from the woman's previous marriage, continue to be deprived of parental support/care, because their father is absent from the home. The mother and her first two children are ADC-related. The second two children and their father must be evaluated for ADC-relatedness based on un/under employment.

**CATEGORICAL FACTORS
ADC-RELATED**

DEPRIVATION OF PARENTAL SUPPORT OR CARE

Deprivation is established for at least one dependent child, in a household, for the caretaker relative to be ADC-related.

When a child is no longer deprived of parental support/care, s/he and his/her caretaker relative remain categorically eligible for ADC-related Medicaid until the end of the third month following the month in which the deprivation ended. This is a categorical extension only. The family must continue to meet all other ADC-related eligibility requirements (See **CATEGORICAL FACTORS ADC-RELATED**). These additional three (3) months of ADC-related categorical eligibility are provided while the household is overcoming the effects of deprivation.

When to Verify:

When the A/R indicates the presence of a child in the household and that the child is deprived of parental support and/or care due to the absence, incapacity, death or a two-parent household with a designated principal wage earner.

NOTE: The A/R's statement of his/her relationship to the child which may or may not indicate a deprivation factor is acceptable unless there is a reason to doubt the validity of the relationship. A signed application indicating the relationship and deprivation factor is generally the only verification required. When the relationship or deprivation factor is questionable other verification is necessary.

**CATEGORICAL FACTORS
ADC-RELATED
DEPRIVATION OF PARENTAL SUPPORT OR CARE**

DEATH OF A PARENT

Policy: When a child under the age of twenty-one (21) is deprived of parental support and/or care due to the death of one or both parents, the child and the remaining parent or other caretaker relative are ADC-related. The A/R must meet all other requirements to be eligible for Medicaid.

References: SSL Sect. 366.1(a)(5)
Dept. Reg. 360-3.3(b)(5)
ADMs 93 ADM-29

Verify Status: When the A/R indicates that a child in the household has a deceased parent.

Verification: When eligibility is based on deprivation of parental support/care due to death, verification of the death of the parent is obtained from the applicant's/recipient's written and/or oral statements.

NOTE: See **CATEGORICAL FACTORS RELATIONSHIP OF CHILD TO CARETAKER RELATIVE** for information on verifying/documenting relationship.

Documentation: Sufficient to establish an audit trail:

- (a) the date of death; and
- (b) relationship to child.

Disposition: When a child is deprived of parental support/care due to the death of a parent, the child and his/her caretaker relative(s) are ADC-related. In addition, the child and/or caretaker relative may be eligible for other survivor benefits from Social Security, Veterans' Administration, employers, etc.

**CATEGORICAL FACTORS
ADC-RELATED
DEPRIVATION OF PARENTAL SUPPORT OR CARE**

INCAPACITY

Policy: When a child under the age of twenty-one (21) is deprived of parental support and/or care due to the incapacity of one or both parents, the child and the parent or caretaker relative may be ADC-related. The A/R must meet all other requirements to be eligible for Medicaid.

The incapacity results from a medical condition and substantially reduces or eliminates the parent's ability to support/care for his/her child. The incapacity must have existed for at least thirty (30) days or be expected to last at least 30 days.

NOTE: The A/R's statement of his/her relationship to the child which may or may not indicate a deprivation factor is acceptable unless there is a reason to doubt the validity of the relationship. A signed application indicating the relationship and deprivation factor is generally the only verification required. When the relationship or deprivation factor is questionable other verification is necessary.

References: SSL Sect. 366.1(a)(5)(iii)
Dept. Reg. 360-3.3(b)(5)
ADMs 74 ADM-180

Verify Status: When the A/R indicates that a child in the household has an incapacitated parent.

A woman is pregnant or has recently given birth. Pregnancy and/or child birth, by themselves, are not considered incapacitating. There must be additional medical evidence that the mother is incapacitated.

A parent is in, or has recently been released from a hospital, nursing home, or other medical facility.

A parent appears to be or indicates that s/he is blind, sick or disabled.

A parent is in an alcohol or drug treatment program, or indicates that s/he wants treatment.

A parent is in receipt of Workers' Compensation, Veterans' Benefits, N.Y.S. Disability Insurance or RSDI Benefits.

Verification: When eligibility is based upon deprivation of parental support/care due

**CATEGORICAL FACTORS
ADC-RELATED
DEPRIVATION OF PARENTAL SUPPORT OR CARE**

INCAPACITY

to incapacity, the local district verifies and documents the incapacity of the parent and the expected duration of that incapacity through the applicant/recipient's written and/or oral statements.

Documentation: Sufficient to establish an audit trail:

- Receipt of SSI or RSDI Benefits due to disability
- Receipt of Veteran's Disability Benefits
- Receipt of NYS Disability Benefits
- Worker's Compensation
- Other similar benefits
- Disability/Blindness Certificate.
- Receipt of benefits or certification of disability/blindness must be expected to last for at least 30 days.

**CATEGORICAL FACTORS
ADC-RELATED
DEPRIVATION OF PARENTAL SUPPORT OR CARE**

CONTINUED ABSENCE

Policy: When a child is deprived of parental support and/or care due to the continued absence of one or both parents, the child and the remaining parent or caretaker relative are ADC-related. The A/R must meet all other requirements to be eligible for Medicaid.

Generally, when a child is deprived of parental support/care due to the absence of a parent, the A/R is referred to IV-D, to establish paternity and/or secure medical support. (See **OTHER ELIGIBILITY REQUIREMENTS LEGALLY RESPONSIBLE RELATIVES PARENTS AND CHILDREN IV-D REQUIRMENTS**)

References: SSL Sect. 366.1(a)(5)

Dept. Reg. 360-3.3(b)(5)

Interpretation: Continued absence of a parent exists when one or both parents are not living with the child. The absence must interrupt or terminate the parent's ability to function as a provider of maintenance and/or care for the child.

The following are examples of continued absence.

- Imprisonment - A parent is incarcerated.
- Divorce, annulment, or legal separation - Custody of the child, support, alimony and other financial arrangements are usually agreed upon and established by a court.
- Abandonment or desertion - A parent has left or never lived in the child's home. The absent parent may or may not be contributing to the care and maintenance of the child. There is no legal agreement.
- Removal from custody - A child is removed from the custody of his/her parent(s) by court order.

For the purpose of establishing eligibility for Medicaid, continued absence only exists when the duration and/or nature of the parent's absence interrupts or stops the parent from providing maintenance, physical care, and/or guidance to the child.

When the parent's absence is of the duration and/or nature that s/he is still functioning as the A/R's parent, continued absence can

**CATEGORICAL FACTORS
ADC-RELATED
DEPRIVATION OF PARENTAL SUPPORT OR CARE**

CONTINUED ABSENCE

not be used as the deprivation factor. For example: a parent is temporarily absent due to employment in another city, but continues to provide financial support and care to the child.

When to Verify Status: When the A/R indicates that s/he is caring for a child and that the child's parent is not living in the household.

Verification: When eligibility is based upon deprivation of parental support/care due to continued absence, the local district verifies the absence of the parent and, as necessary, the relationship of the parent to the child through the applicant/recipient's written and/or oral statement including the signed application.

When parents share joint custody or are both actively involved with the child, it is determined which parent provides the child's primary home and care. The following are guidelines for joint custody cases and other instances where the child has substantial and continued contact with both parents.

If the parents reside in different school districts, where does the child attend school? Who selects the child's school?

Who assists the child with homework or school related tasks?

Are there any tuition costs related to the child's education? If so, who pays those costs?

If the child is enrolled in day care, who makes the arrangements and pays the costs?

Who is responsible for taking the child to and from school or day care?

Which parent is listed as the contact for emergencies at the child's school or day care centers?

Who arranges medical and dental care for the child?

Who initiates decisions regarding the child's future?

Who responds to emergencies involving the child (i.e., medical or law enforcement emergencies)?

**CATEGORICAL FACTORS
ADC-RELATED
DEPRIVATION OF PARENTAL SUPPORT OR CARE**

CONTINUED ABSENCE

Who provides food and clothing for the child when the child visits the absent parent?

Who has visitation rights? If one parent is given visitation rights, the other parent is the custodial parent.

Who claims the child on his/her income tax may be an indicator of the primary caretaker, but the decision takes into account all the circumstances.

Does one parent pay child support to the other?

When both parents actually share equally in providing for the child, there is no deprivation due to continued absence.

NOTE: If only one parent is applying, the child is included in that parent's household. If both parents apply as separate households, the child is included in the household which results in the most advantageous budgeting for the child.

Documentation: Sufficient to establish an audit trail.

The A/R's statement(s) are acceptable unless there is reason to doubt their validity. In such instances the following documentation should be pursued:

- the address of the absent parent (when obtainable), name and address of person or organization providing information, and date obtained;
- name and address of person or organization verifying that parent is not in home, and date obtained; or
- name of document verifying absence, any identifying numbers and/or dates, and name of the official who signed the document.

**CATEGORICAL FACTORS
ADC-RELATED
DEPRIVATION OF PARENTAL SUPPORT OR CARE**

UN/UNDER EMPLOYED TWO PARENT HOUSEHOLD

Policy: A child (See **CATEGORICAL FACTORS, ADC-RELATED, AGE OF CHILD**), residing with both parents, meets the criteria for ADC-U as long as one of the two parents has been identified as the principal wage earner. This is regardless of whether or not either parent is working, actively seeking employment or has recently been employed. A child whose custody (physical and legal) is evenly shared both parents/households met the categorical eligibility criteria for ADC. Both parents are also considered to be ADC-U.

NOTE: The A/R's statement of his/her relationship to the child which may or may not indicate a deprivation factor is acceptable unless there is a reason to doubt the validity of the relationship. A signed application indicating the relationship and deprivation factor is generally the only verification required. When the relationship or deprivation factor is questionable other verification is necessary.

References:

SSL Sect.	349
ADMs	OMM/ADM 97-2 97 ADM-20
INFs	07 OHIP/INF-1

Interpretation: The principal wage earner may be either parent if neither of the parents is working. If no other deprivation exists, the family is always related to the ADC-U category.

Verify Status: When a child is residing in a two-parent household and neither parent is incapacitated.

Disposition: When a household is determined to be ADC-U-related, the household's income is budgeted using the ADC-related disregards. (See **INCOME ADC-RELATED DISREGARDS**)

If the household is not eligible under ADC budgeting, the A/R is budgeted under FHP; if ineligible under FHP, eligibility is determined for FPBP, etc.

CATEGORICAL FACTORS**SSI-RELATED**

Policy: Persons who are aged (65 and over), certified blind or certified disabled are eligible for Medicaid if they meet financial and other eligibility requirements. These persons are SSI-related.

References:

SSL Sect.	366 366-ee
Dept. Reg	360-3.3(b) 360-5 368
ADMs	10 OHIP/ADM-01 91 ADM-27 87 ADM-41
GIS	09 MA/027 08 MA/022

Medicaid Disability Manual

Interpretation: Eligibility for SSI-related A/Rs is determined by comparing income, after appropriate deductions to the Medically Needy Income level or the Medicaid Standard (and MBL Living Arrangement Chart as appropriate) whichever is most beneficial. Resources are compared to the appropriate resource levels. When an A/R is SSI-related and ADC-related, s/he is offered a choice between SSI-related budgeting and ADC-related budgeting. (See **INCOME BUDGETING**) If the individual's income eligibility is the same under both budget types and the individual is not eligible for, or does not wish to participate in Medicaid Buy-In for Working People with Disabilities (MBI-WPD), the individual must be given the ADC-related category of assistance, since benefits under this category are not limited based on resources.

A certified blind or disabled individual who documents or attests to resources in excess of the Medicaid resource level must have eligibility considered for FHPlus. Resources are not considered in the eligibility determination for FHPlus.

The following sections describe SSI categorical requirements:

- Age (65 and over);
- Blindness; and
- Disability.

**CATEGORICAL FACTORS
SSI-RELATED**

AGE (65 OR OVER)

Policy: All persons 65 years of age and over are eligible to receive Medicaid, if they meet the financial and other eligibility requirements.

References:

SSL Sect.	366 366.1 366-ee
ADMs	10 OHIP/ADM-01
Dept. Reg.	360-3.3(b)(1)
GISs	09 MA/027

Interpretation: When determining eligibility for A/Rs age 65 or over, local districts offer a choice between the SSI-related budgeting and ADC-related budgeting if the A/R also meets the requirements for ADC-related Medicaid. If the individual's income eligibility is the same under both budget types, the individual must be given the ADC-related category of assistance, since benefits under this category are not limited based on resources. (See **INCOME** ADC-RELATED BUDGETING)

When to Verify Status: Verify status when:

- (1) the A/R's birth date indicates that s/he is age 65 or approaching 65.
- (2) the A/R indicates that s/he receives Medicare, Social Security, Railroad Retirement or other pension benefits. These benefits may indicate that the A/R is aged. However, these benefits may be based on disability, early retirement, etc.

Verification Process: The age of a certified blind or certified disabled adult does not affect eligibility, and therefore, verification of age does not delay case processing.

The following documents are used to verify age:

Birth Certificate
Adoption papers or records
Hospital or clinic records
Driver's License

**CATEGORICAL FACTORS
SSI-RELATED**

AGE (65 OR OVER)

Church records
Baptismal Certificate
Vital Records Office of the New York State Department of Health
Municipal Local Registrar Records
U.S. Passport
Census records
Immigration and Naturalization Service Records
Records of birth maintained by SSA
Physician's statement

Documentation: Sufficient to establish an audit trail:

the date of birth,
place and date of filing,
identifying numbers of the available document, and
the name of the official who signed the document.

Disposition: Persons 65 or over are advised of benefits which may be available to them under the Supplemental Security Income (SSI) program. If they appear eligible and express interest they are referred to the local Social Security District Office for a determination of SSI eligibility. Application for SSI is **not** a condition of eligibility for Medicaid.

**CATEGORICAL FACTORS
SSI-RELATED**

BLINDNESS

Policy: Persons of any age are eligible to receive Medicaid when they are certified blind by the Commission for the Blind and Visually Handicapped, providing they meet the financial and other eligibility requirements.

References:

SSL-Sect.	366 366-ee
Dept. Reg.	368
ADMs	10 OHIP/ADM-01 87 ADM-41
GISs	09 MA/027

Medicaid Disability Manual

Interpretation: To be eligible as blind, individuals are certified as legally blind by the Commission for the Blind and Visually Handicapped. Total blindness is not required for such certification and all A/Rs evidencing obvious visual impairments are considered for this category. If a person shows evidence of multiple impairments, a classification of blindness takes precedence over other disabilities.

If an A/R's vision improves to the point that s/he is no longer certified blind, the A/R remains SSI-related for two months following the month his/her blindness is overcome. To be eligible for Medicaid, the A/R must still meet all other requirements.

Exception: Persons who were eligible as Medicaid-only blind persons in December, 1973 **and** who continue to meet the December, 1973 criteria for blindness, continue to have their blindness evaluated by the Commission for the Blind and Visually Handicapped in accordance with the December, 1973 standards for as long as they remain eligible for Medicaid.

When to Verify Status: Verify status when:

- (1) the A/R indicates blindness or a severe vision impairment on the application.
- (2) When the A/R shows evidence of blindness or obvious visual impairment.
- (3) When the A/R indicates present or past employment at a workshop for the visually handicapped.

**CATEGORICAL FACTORS
SSI-RELATED**

BLINDNESS

- (4) When the A/R indicates on the application that s/he is in receipt of Social Security Disability benefits or other disability pension benefits based on his/her visual impairment.

**Verification
Process:**

Verification of legal blindness for the purpose of establishing eligibility for Medicaid is certification from the Commission for the Blind and Visually Handicapped (CBVH). If the A/R is unable to provide his/her certification, the local district submits form LDSS-2353, "Eye Examination Clearance - Blind Applicant for Medicaid" to the Commission to determine if the A/R is registered. If the A/R is unknown to the Commission, a report of an eye examination by an ophthalmologist or an optometrist is submitted on the appropriate form (i.e., LDSS-3377 Rev. 2/82, Mandatory Eye Examination Report, Commission for the Blind and Visually Handicapped) to the Commission for certification.

Documentation: Sufficient to establish an audit trail:

- (a) a copy of the certification of blindness from the Commission for the Blind and Visually Handicapped included in the case record; or
- (b) the date of certification, Commission Registration number and/or name of the official who signed the document.

Disposition:

If the A/R meets the above requirements, s/he is considered SSI-related and his/her income and resources are compared to the medically needy income levels in **REFERENCE MEDICALLY NEEDY INCOME AND FEDERAL POVERTY LEVELS** and the resource levels also found in **REFERENCE MEDICAID RESOURCE LEVELS** to determine eligibility for Medicaid. Such persons are offered a choice between the SSI-related budgeting methodology and the ADC-related budgeting methodology, provided s/he meets the requirements for ADC. If the individual's income eligibility is the same under both budget types and the individual is not eligible for, or does not wish to participate in Medicaid Buy-In for Working People with Disabilities (MBI-WPD), the individual must be given the ADC-related category of assistance, since benefits under this category are not limited based on resources.

The A/R is advised of the benefits available through the SSI program. If s/he is interested, s/he is referred to the local SSA District Office for a determination of his/her SSI eligibility. Application for SSI is **not** a condition of eligibility for Medicaid.

**CATEGORICAL FACTORS
SSI-RELATED**

DISABILITY

Policy: Persons under the age of 65, who are certified disabled by either the Social Security Administration (SSA), the State Medicaid Disability Review Team, or local Medicaid Disability Review Team are eligible to receive Medicaid providing they meet all the financial and other eligibility requirements.

Disability is defined as the inability 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 has lasted or can be expected to last for a continuous period of not less than twelve (12) months.

A child may be determined disabled if s/he has a medically determinable physical or mental impairment that results in marked and severe functional limitations that have lasted or are expected to last for at least 12 months or result in death.

The standards used to determine disability for Medicaid A/Rs are the same as those used by SSA to determine eligibility based on a disability for SSI or Retirement, Survivors' Disability Insurance (RSDI) (See Medicaid Disability Manual). However, for the Medicaid Buy-In program for Working People with Disabilities (MBI-WPD) (See **CATEGORICAL FACTORS MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES**) the first step of the sequential evaluation, known as the SGA test (See **CATEGORICAL FACTORS SUBSTANTIAL GAINFUL ACTIVITY**), is eliminated.

All disability determinations for MBI-WPD are performed by the State Disability Review Team.

References:

SSL Sect.	366 366-ee
Dept. Reg.	360-2.4(a)(2) 360-3.3(b)(2) 360-5
Medicaid Disability Manual	
ADMs	10 OHIP/ADM-4 10 OHIP/ADM-2 10 OHIP/ADM-01 04 OMM/ADM-5

**CATEGORICAL FACTORS
SSI-RELATED**

DISABILITY

	03 OMM/ADM-4
	92 ADM-52
	90 ADM-17
	88 ADM-42
	87 ADM-41
	80 ADM-48
	78 ADM-35
INFs	92 INF-41
	87 INF-4
	05 OMM/INF-1
LCMs	98 OMM/LCM-009
	98 OMM/LCM-003
GISs	10 MA/003
	09 MA/027
	06 MA/005
	05 MA/023
	96 MA/028

Interpretation:

The receipt of SSI or RSDI benefits based on a disability is acceptable proof of disability. Persons in receipt of Railroad Retirement benefits as "totally and permanently" disabled are also considered disabled for Medical Assistance purposes. Workers' Compensation, New York State Disability and Veterans' Administration benefits do not confer automatic disability for Medicaid purposes. A separate disability determination is completed for recipients of these programs. Potentially disabled A/Rs are advised of any benefits that they might qualify for under SSI and/or RSDI and referred to the SSA district office. Application for SSI, however, is not a condition of eligibility for Medicaid. A/Rs for Medicaid, who claim an impairment or unemployability due to sickness or disability that has or is expected to last at least 12 months, are referred to the local or State Medicaid Disability Review Team or the Social Security Administration.

All disability determinations for MBI-WPD as well as determinations for individuals who are age 65 or over and are establishing a pooled trust are performed by the State Disability Review Team.

Medicaid disability reviews are conducted when a determination of disability will yield a Medicaid benefit to the A/R or a financial benefit to the Medicaid program. For example:

CATEGORICAL FACTORS SSI-RELATED

DISABILITY

- More favorable budgeting that would enable a single adult or member of a childless couple (SCC) to obtain Medicaid or Family Health Plus if he/she does not meet the public assistance standard of need;
- Budgeting that would enable an A/R who is otherwise financially ineligible to obtain full Medicaid benefits, with or without a spenddown;
- Exclusion of an asset from a transfer penalty if the A/R has transferred the asset to an adult child who is determined to be disabled;
- Exclusion of funds deposited in a pooled trust.

An example of a financial benefit to the Medicaid program is the placement of an SCC A/R into a federally participating category which assists in meeting the cost neutrality provisions of the 1115 Managed Care Waiver.

Disability determinations are completed for all A/Rs under the age of 65 who are citizens or qualified aliens not in the federal five year ban, and who appear to meet the Social Security Administration disability criteria. The A/R is given an informed choice between SSI-related budgeting and any other appropriate category when s/he is eligible under more than one category.

Disability determinations are completed for Aliessa aliens (qualified aliens in the five year ban and PRUCOL aliens) only if a determination of disability will provide a Medicaid benefit for the A/R. There is no financial benefit to the Medicaid program, as federal financial participation cannot be obtained for these A/Rs, nor are they included in the federal 1115 waiver. Thus, if an Aliessa alien A/R is eligible for full Medicaid coverage without a disability determination, there is no requirement to perform a Medicaid disability review for the A/R.

When a non-SSI-related Medicaid recipient dies, his/her case, medical condition and expenditures are reviewed for referral to the Medicaid Disability Review Team.

The disability review process takes into consideration the severity and extent of the individual's medical condition and resulting functional limitations. It may also take into account the individual's

**CATEGORICAL FACTORS
SSI-RELATED****DISABILITY**

age, education and previous work experience. All A/Rs who are potentially SSI-related as disabled persons or their representatives are informed of the disability category. The information includes, but is not limited to:

- (a) The disability review process;
- (b) The need for the individual to cooperate in securing detailed medical documentation from treating sources and the possible need for the individual to have an examination(s), consultation(s) and/or diagnostic test(s);
- (c) The need for the individual to provide social and functional information, such as education and details of their past work experience;
- (d) The time frames involved in the disability process; and
- (e) The potential benefit(s) to the individual of a disability certification, such as a different budgeting methodology, an increased Food Stamp benefit and the identification of medical and/or social resources that may assist the A/R.

Each A/R who is potentially SSI-related as a disabled individual (or his/her representative) must complete a LDSS-1151 - "Disability Interview." Special emphasis is placed on the individual's education, special training if any, work experience during the past fifteen (15) years, disability related income, medical care received and the individual's functional capacity.

Districts may not require an individual to come to the district for an interview. However, districts may complete the Disability Interview form (LDSS-1151) by telephone.

To initiate the medical evidence packet, districts may mail the LDSS-1151 and the district-specific Release of Medical Information form to the applicant or they may conduct a telephone interview to complete the LDSS-1151 form. If attempting to conduct the interview by telephone districts must make three attempts to contact the individual before resorting to the mail. When the LDSS-1151 form is returned to the district, it is important that the information on the form be reviewed by the district worker for completeness and the form is signed by the worker. If the form is not complete, it is the responsibility of the worker to contact the applicant and obtain the information before submitting the packet for a disability review.

**CATEGORICAL FACTORS
SSI-RELATED**

DISABILITY

Whether the district chooses to obtain completed disability forms by mail or via the telephone, if the individual requests assistance or wishes to have an interview in person, the district must accommodate the request.

Medical evidence is gathered as soon as possible to meet the time frames of the application/recertification process. Medical evidence may include a completed LDSS-486: "Medical Report for Determination of Disability," from a physician, hospital admission and discharge summaries, clinic reports, diagnostic test results and reports from practitioners such as therapists, nurse practitioners, physicians' assistants, optometrists, chiropractors, psychiatric social workers and audiologists.

**CATEGORICAL FACTORS
SSI-RELATED****DISABILITY**

The local or State Medicaid Disability Review Team evaluates the medical evidence, considering such factors as the individual's age, education, work experience and residual functional capacity to determine if the A/R is disabled. The Medicaid Disability Review Team completes the LDSS-639: "Disability Review Team Certificate" for each potentially disabled A/R. The LDSS-639 contains the determination and the regulatory basis for that determination. It documents any request(s) for additional medical and/or social information, the effective date of disability and expiration date of disability, if applicable. The entire disability determination process is completed within 90-days of the initial application/recertification. If the process takes more than 90 days, on the 90th day the A/R is sent a written statement giving the reason for the delay. When the disability process is completed, the A/R is given a written notice of the determination, the reasons for it and the regulatory basis. (See **OTHER ELIGIBILITY REQUIREMENTS DECISION AND NOTIFICATION**)

There are two categories of disability:

Group I includes persons who show no possibility of engaging in any substantial gainful work activity. They have a physical and/or mental impairment(s) which is disabling and considered irreversible. These cases have no disability end date on the LDSS-639 "Disability Review Team Certificate."

Group II includes individuals who have disabling impairments at the time of determination, but are expected to show an improvement in physical and/or mental status, enabling them to become capable of substantial gainful activity. Some reasons for improvement are: the condition is arrested; a remission occurs; therapeutic advances occur; and/or rehabilitation.

NOTE: End dates for all Group II certifications must be tracked through WMS and medical evidence gathered for a continuing disability review prior to the Group II disability end date.

When an individual re-applies after previously being certified disabled, another disability review is not necessary if the disability end date has not yet expired, unless: 12 months or more have elapsed since the date of the last case closing, or the individual has in the interim engaged in a useful occupation, or has had a significant change in treatment such as surgery or rehabilitation.

**CATEGORICAL FACTORS
SSI-RELATED****DISABILITY**

Medicaid is available for recipients who are certified disabled through the second month following the month in which disability ceases. When a recipient's health improves and s/he is no longer certified disabled, the recipient remains SSI-related for two months following the month his/her disability ends. To be eligible for Medicaid, the recipient must still meet all other requirements. (See **REFERENCE MEDICALLY NEEDY INCOME AND FEDERAL POVERTY LEVELS** for medically needy requirements and **REFERENCE MEDICAID RESOURCE LEVELS** for resource requirements)

When to Verify:

- (a) When the A/R indicates that s/he is in or was in receipt of SSI benefits based on disability;
- (b) When the A/R indicates that s/he is in receipt of RSDI benefits based on disability;
- (c) When the A/R indicates that s/he has excessive medical bills;
- (d) When the A/R indicates that s/he is in or has recently been released from a hospital, nursing home or other institution;
- (e) When the A/R indicates that s/he is or was chronically sick, disabled, or mentally impaired;
- (f) Substance abuse (alcoholism or drug abuse) in and of itself is not considered a disability under the Social Security disability criteria. Individuals who have substance abuse disorders are asked about and evaluated for any other co-existing mental or physical impairments they may have that prevent them from working;
- (g) When the A/R indicates that a continuing illness or disability was his/her reason for leaving school or employment;
- (h) When the A/R indicates receipt of benefits based on illness or disability (e.g., Workers' Compensation, Veterans' Benefits, NYS Disability, employer disability pensions, etc.);

**CATEGORICAL FACTORS
SSI-RELATED****DISABILITY**

- (i) When the A/R appears to suffer from a physical and/or mental impairment. Some examples are difficulty walking, standing, breathing, concentrating, following instructions or remembering;
- (j) When the A/R indicates present or past employment at a sheltered workshop or participation in a rehabilitation program;
- (k) When the A/R indicates that s/he has outstanding medical bills during the three-month period prior to the date on which s/he became eligible for SSI;
- (l) When the NYS Department of Health identifies cases with potentially disabling diagnoses that have not previously been reviewed for disability.

Verification:

When the A/R is SSI-related because s/he receives SSI or RSDI, the A/R provides documentation of the Social Security Administration's determination of disability. A copy of the SSA benefit check is sufficient proof of disability since it shows the RSDI claim number. Certain alpha suffixes on the claim number identify the check as a disability payment (See **INCOME SOCIAL SECURITY RETIREMENT, SURVIVORS AND DISABILITY INSURANCE/RAILROAD RETIREMENT AND VETERAN'S BENEFITS**). Local districts contact the SSA office to determine the current alpha suffix for disability checks.

When an A/R loses eligibility for SSI cash for reasons unrelated to his/her medical condition, generally a disability determination is not required. If the A/R lost eligibility prior to the date when SSA was to be reevaluating the A/R's medical condition, the A/R is considered disabled until his/her medical diary reexamination date. The local district contacts the SSA district office to obtain the medical diary reexamination date and the reason why SSI benefits were terminated.

When the determination of disability is made by the local or State Medicaid Review Team, a copy of the most current LDSS-639: "Disability Review Team Certificate" is included in the case record.

NOTE: End dates for all Group II certifications must be tracked through WMS and medical evidence gathered for a continuing disability review prior to the Group II disability end date.

**CATEGORICAL FACTORS
SSI-RELATED**

DISABILITY

Documentation: Sufficient to establish an audit trail:

- (a) A copy of the RSDI award letter, RSDI check or sufficient identifying information (i.e., date of award, name of official signing the document);
- (b) A current LDSS-639 indicating Group I or Group II certificate of disability by the State or local Review Team;
- (c) The code indicating disability on the SDX;
- (d) An SSA 1610 completed by the SSA district office; or
- (e) A copy of the information from the Third Party Query System.

Disposition: When an A/R is certified disabled, s/he is SSI-related. After following the appropriate budgeting procedures (See **INCOME SSI-RELATED BUDGETING METHODOLOGY**), his/her income is compared to the Medically Needy Income level or the Medicaid Standard (and MBL Living Arrangement Chart as appropriate) whichever is most beneficial (See **REFERENCE MEDICALLY NEEDY INCOME AND FEDERAL POVERTY LEVELS, LIVING ARRANGEMENT CHART**). His/her resources are compared to the appropriate Medicaid resource level (See **REFERENCE MEDICAID RESOURCE LEVELS**). SSI-related A/Rs are offered a choice between SSI-related budgeting and ADC-related budgeting methodology, when they also meet ADC categorical requirements. If the individual's income eligibility is the same under both budget types and the individual is not eligible for, or does not wish to participate in Medicaid Buy-In for Working People with Disabilities (MBI-WPD), the individual must be given the ADC-related category of assistance, since benefits under this category are not limited based on resources.

The A/R is advised of benefits which may be available to him/her under the Social Security Disability (SSD) and/or Supplemental Security Income (SSI) programs. If s/he is interested, s/he is referred to the local Social Security District Office for a determination of SSI and/or SSD eligibility.

The A/R is also informed of the possibility of receiving an increased Food Stamp benefit if an individual is certified disabled. When a PA or Medicaid recipient is certified disabled, the cost of his/her medical care and services may be claimed as SSI-related retroactively from the effective date of disability, subject to the two year federal claiming limitations.

**CATEGORICAL FACTORS
SSI-RELATED****SUBSTANTIAL GAINFUL ACTIVITY (SGA)**

Description: Persons who are performing Substantial Gainful Activity (SGA) are not usually considered disabled. However, local districts must refer all such cases to the State Disability Review Team for a disability determination for the Medicaid Buy-In Program for Working People with Disabilities (MBI-WPD).

Policy: SGA is work activity that involves performing significant physical and/or mental activities for pay or profit. Work can be substantial and gainful even if it is performed part-time or requires less responsibility than former work.

Activities such as household tasks, hobbies, club activities or social programs generally are not considered substantial gainful activity.

References: Dept. Reg. 360-5.2

Disability Manual

GISs 06 MA/029
04 MA/031

Interpretation: The amount of gross monthly earnings from work activities (minus appropriate impairment-related work expenses) may establish that the individual is engaging in SGA.

The maximum amount of gross earnings is identified in the **REFERENCE SUBSTANTIAL GAINFUL ACTIVITY**. When an individual's gross earnings from work activities average in excess of the identified monthly amount, this generally demonstrates the ability to engage in SGA in the absence of evidence to the contrary (See **DISABILITY MANUAL**). Federal regulations provide for annual automatic cost of living adjustments to the SGA threshold amount.

NOTE: When evaluating whether or not an individual is performing SGA, consider the nature of the work being done, the adequacy of the performance, any special employment conditions and the amount of time that is spent in work activity.

When to Verify: When a potentially disabled A/R declares that s/he is employed.

**CATEGORICAL FACTORS
SSI-RELATED**

SUBSTANTIAL GAINFUL ACTIVITY (SGA)

Documentation: Sufficient to establish an audit trail:

- Employer statement concerning any subsidy, special condition of employment, performance at work;
- Pay stubs; or
- Impairment-related expense receipts.

**CATEGORICAL FACTORS
SSI-RELATED****TRIAL WORK PERIOD****Policy:**

A trial work period (TWP) is a period during which a certified disabled individual may test his or her ability to work and still maintain disability status. During this trial work period, an individual who is still medically impaired may perform "services" in as many as nine (9), not necessarily consecutive, months. "Services" in this section means any activity in employment or self-employment for pay or profit or the kind of activity normally done for pay or profit.

Effective January 1, 2005, a trial work period month is any calendar month in which the certified disabled recipient earnings exceed the TWP level. The TWP amount changes each year. The current amount can be found in **REFERENCE TRIAL WORK PERIOD**. For self-employed individuals, a calendar month counts as a trial work month when his/her earnings are more than the TWP level or the individual works more than 80 hours per month. Federal regulations provide for annual cost of living adjustments to the trial work threshold amount.

References:

Dept. Reg. 360-5.9

GISs 06MA/029
 04 MA/031

Disability Manual

Interpretation:

For the purpose of calculating the number of months associated with a trial work period, the time spent on certain activities is **NOT** considered if the activity is:

1. Part of a prescribed program of medical therapy;
2. Carried out in a hospital under the supervision of medical and/or administrative staff;
3. Not performed in an employer-employee relationship; or
4. Not normally performed for pay or profit.

**CATEGORICAL FACTORS
SSI-RELATED****TRIAL WORK PERIOD**

During the trial work period the A/R may still be considered disabled even if the earnings exceed the Substantial Gainful Activity (SGA) limit (See **REFERENCE** SUBSTANTIAL GAINFUL ACTIVITY).

At the end of the trial work period, there is an evaluation of the individual's ability to perform SGA. The evaluation may include a medical review to see if the individual still meets the disability criteria.

When to Verify: When a certified disabled A/R indicates potential earnings from employment or indicates s/he would like to work.

Documentation: Sufficient to establish an audit trail:

Pay stubs;

Returned clearance in case record; or

Note indicating duration of employment.

CATEGORICAL FACTORS**EMPLOYMENT SUBSIDIES**

- Description:** An employer may subsidize the earnings of an individual with a disability by paying more in wages than the reasonable value of the actual services performed.
- Policy:** When determining whether or not subsidized employment constitutes Substantial Gainful Activity (SGA), only the real value of the work is considered. When determining financial eligibility for Medicaid, the entire income from subsidized employment is considered.
- References:**
- ADMs 87 ADM-44
 83 ADM-65
- Disability Manual
- GISs 06 MA/029
 99 MA/014
- When to Verify:**
- (a) When an apparently disabled individual is earning over the Substantial Gainful Activity (SGA) figure (See **REFERENCE SUBSTANTIAL GAINFUL ACTIVITY**);
 - (b) When an individual's pay may not reflect the actual level of productivity;
 - (c) When the A/R's employment is sheltered;
 - (d) When a childhood disability is involved; or
 - (e) When a mental impairment is involved.

CATEGORICAL FACTORS

MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES

Policy: Sections 62-69 of Part A of Chapter 1 of the Laws of 2002 extends Medicaid coverage to working disabled applicants/recipients (A/Rs) who have net incomes at or below 250% of the Federal Poverty Level (FPL) and non-exempt resources at or below the appropriate Medicaid Resource Level.

Unlike other Medicaid programs, the Medicaid Buy-In Program for Working People with Disabilities (MBI-WPD) is a work incentive program and work activity is a requirement of eligibility.

SSI-related budgeting, including allocation and deeming, is used for determining net available income and resources. (See **INCOME MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES** for a discussion on budgeting of income and **RESOURCES MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES** for budgeting of resources.)

At application, individuals in the MBI-WPD program may attest to resources other than trusts, burial funds and Third Party Health Insurance, if not requesting Medicaid coverage of long term care services. At renewal/recertification, individuals in the MBI-WPD program may attest to income including interest income, residence, and itemized resources but must document employment.

Managed Care is a voluntary option for MBI-WPD individuals who are income eligible under 150% FPL. Mandatory Managed Care counties cannot require these individuals to enroll in a Managed Care plan. MBI-WPD individuals with income at or above 150% FPL are excluded from Managed Care. Such individuals may voluntarily participate in Managed Long Term Care.

- References:**
- SSL Sect. 366(1)(a)(12) & (13)
 - ADM 11 OHIP/ADM-1
 - 11 OHIP/ADM-7
 - 10 OHIP/ADM-2
 - 04 OMM/ADM-5
 - 03 OMM/ADM-4
 - GISs 11 MA/017
 - 10 MA/003
 - 09 MA/015
 - 08 MA/027
 - 08 MA/004

CATEGORICAL FACTORS**MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES**

Interpretation: The Medicaid Buy-In program for Working People with Disabilities (MBI-WPD) consists of two groups of A/Rs, the Basic Coverage Group and the Medical Improvement Group. For eligibility in either group, work activity must be documented.

CATEGORICAL FACTORS

MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES

A. The Basic Coverage Group

The Basic Coverage Group includes individuals who meet the following requirements:

- The A/R is certified disabled (See **CATEGORICAL FACTORS SSI-RELATED BLINDNESS AND SSI-RELATED DISABILITY AND ACCEPTABLE PROOF OF DISABILITY**).
- The A/R is at least 16 years of age, but under the age of 65.
- The A/R is working and receiving financial compensation. There is no minimum number of hours that an individual must work per month, nor is there a minimum wage requirement. However, there must be work activity in each month that MBI-WPD coverage is sought, unless the individual has been granted a grace period.
- The A/R has a net income at or below 250% of the FPL.
- The A/R has non-exempt resources that do not exceed the appropriate Medicaid Resource Level.

1. Basic Coverage Group Work Requirements

For the MBI-WPD program, work consists of engagement in a work activity for which financial compensation is received. The Basic Group has no minimum number of hours for such work activity.

Proof of work activity includes: current pay stub(s); paycheck(s) or a detailed written statement from an employer. If these documents are not available, the individual's income tax return, W-2 form, or records of bank deposits may be used. If an individual is not required to pay taxes, a sheltered workshop employee, for example, the applicant is not denied eligibility for the MBI-WPD program.

A time-limited activity that prepares an individual for work, such as a training program, does not meet the work requirement because it is preparation for work. Once a training program is completed and employment secured, an individual may be eligible for the MBI-WPD program.

Seasonal work may be considered work for the MBI-WPD program for the duration of the employment. If the work ends, a grace period may be granted if the individual continues to look for employment.

CATEGORICAL FACTORS

MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES

2. Grace Periods for the Basic Coverage Group

Grace periods for the Basic Coverage Group allow for lapses in work activity due to job loss or a change in medical condition that is through no fault of the individual. The Job Loss Grace Period and the Change in Medical Condition Grace Period provide coverage up to six months in a twelve-month period. Multiple grace periods are allowed in the twelve-month period but the sum of the grace periods may not exceed six months. The first day of the grace period starts the twelve-month period. Both types of grace periods require written verification, one from the employer for the job loss grace period and one from an acceptable medical source for the change in medical condition grace period. If the recipient has not secured employment by the end of the grace period, his or her eligibility for MBI-WPD ends and continued eligibility under other Medicaid programs must be evaluated.

B. The Medical Improvement Group

The Medical Improvement Group includes individuals who meet the following requirements:

- The A/R is at least 16 years of age, but under the age of 65.
- The A/R has a net income at or below 250% FPL.
- The A/R has non-exempt resources that do not exceed the appropriate Medicaid resource level.
- The A/R has lost eligibility under the Basic Coverage Group due to the direct and specific result of medical improvement. The A/R is no longer certified disabled, but continues to have a severe medically determined impairment. A recipient can only be added to the Medical Improvement Group by action of the State Disability Review Team at the time of a Continuing Disability Review (CDR).
- The A/R is working and receiving financial compensation. The A/R in the Medical Improvement Group must be employed at least 40 hours per month and earn at least the federally required minimum wage.

1. Medical Improvement Group Work Requirements

For the MBI-WPD program, work consists of engagement in a work activity for which financial compensation is received. For the Medical

CATEGORICAL FACTORS

MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES

Improvement Group, work activity must be at least 40 hours per month and paid at no less than the applicable federal minimum wage.

Proof of work activity includes: current pay stub(s); paycheck(s) or a detailed written statement from an employer. If these documents are not available, the individual's income tax return, W-2 form, or records of bank deposits may be used. If an individual is not required to pay taxes, a sheltered workshop employee, for example, the applicant is not denied eligibility for the MBI-WPD program.

A time-limited activity that prepares an individual for work, such as a training program, does not meet the work requirement because it is preparation for work. Once a training program is completed and employment secured, an individual may be eligible for the MBI-WPD program.

Seasonal work may be considered work for the MBI-WPD program for the duration of the employment. If the work ends, a grace period may be granted if the individual continues to look for employment.

Any working individual who had coverage discontinued under the MBI-WPD Medical Improvement Group and is reapplying for the MBI-WPD program, must meet all of the requirements for the MBI-WPD Basic Coverage Group, including certification of disability, in order to participate in the program again.

2. Grace Periods for the Medical Improvement Group

Grace periods for the Medical Improvement Group allow for lapses in work activity due to job loss or a change in medical condition that is through no fault of the individual. The Job Loss Grace Period and the Change in Medical Condition Grace Period provide coverage up to six months in a twelve-month period. Multiple grace periods are allowed in the twelve-month period but the sum of the grace periods may not exceed six months. The first day of the first grace period starts the twelve-month period. Both types of grace periods require written verification, one from the employer for the job loss grace period and one from an acceptable medical source for the change in medical condition grace period. If the recipient has not secured employment by the end of the grace period, his or her eligibility for MBI-WPD ends and continued eligibility under other Medicaid programs must be evaluated.

CATEGORICAL FACTORS

MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES

NOTE:

- Grace periods may be authorized if the individual's income does not meet the hourly work and/or wage requirement. This may be due to a job loss or change in medical condition. Written verification for either grace period is required.
- If, at the end of a change in medical condition grace period, the individual continues to work less than 40 hours a month, a Continuing Disability Review (CDR) must be performed to determine eligibility for the Basic Coverage Group.
- If an individual is not working at the end of a job loss grace period, Medicaid eligibility must be determined in a non-SSI-related category, as the individual is medically improved, and not disabled. If the individual needs a disability determination, a CDR must be performed for the Aid to the Disabled program.

3. Other Medical Improvement Group Work Issues

- Local districts must review the individual's work activity and wage rate every 6 months.
- If the individual's income does not meet the hourly work and/or wage requirement or has increased or decreased at the time of the 6 month work and wage review, the local district must re-determine eligibility for the MBI-WPD program and/or determine eligibility for other Medicaid programs and take appropriate action. If the individual's work hours fall below the required 40 hours or the minimum wage requirement, the individual may be eligible for a grace period.
- To determine the hourly wage for a self-employed individual in the Medical Improvement Group, gross monthly income is divided by the number of hours worked as attested by the recipient. The result is rounded to the nearest penny and compared to the federal minimum wage.

NOTE: The six-month work and wage check does not eliminate the recipient's responsibility to report any change income within 10 days of the change.

CATEGORICAL FACTORS

MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES

Eligibility under the Medicaid Level

The MBI-WPD program is the most advantageous program for an A/R who is found to meet the eligibility requirements for both Medicaid without a spenddown and the MBI-WPD program. This is because a person in the MBI-WPD program can medically improve without an adverse impact on eligibility while A/Rs who are in receipt of Medicaid under the Aid to Disabled program will lose such eligibility in the event they have medical improvement.

In situations where the A/R is found to be eligible for Medicaid without a spenddown AND the MBI-WPD program, the A/R is encouraged to choose the most advantageous program, and must be given a copy of the *Explanation of the MBI-WPD Program* and have all questions answered regarding the program and its eligibility requirements so that he/she may make an informed choice between the two programs.

Substantial Gainful Activity (SGA) and Transition to MBI-WPD

New Medicaid applicants:

If the gross earnings from work, minus Impairment Related Work Expenses (IRWES) (See **INCOME IMPAIRMENT RELATED WORK EXPENSES**) are greater than the SGA level (See **CATEGORICAL FACTORS SUBSTANTIAL GAINFUL ACTIVITY** and **REFERENCE SUBSTANTIAL GAINFUL ACTIVITY**), and the individual does not have acceptable certification of disability, a disability determination must be performed by the State Disability Review Team for the MBI-WPD program.

If the gross earnings from work minus IRWES are less than the SGA level, the A/R is encouraged to participate in the MBI-WPD program, or the Medicaid Aid to the Disabled program, whichever is most beneficial.

Medicaid renewals:

If a certified disabled Medicaid A/R who is not participating in the MBI-WPD program reports an increase in income and the earnings from work minus IRWEs are greater than SGA, the individual must be transitioned to the MBI-WPD program.

CATEGORICAL FACTORS

MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES

If the gross earnings are less than SGA, the individual is encouraged to participate in the MBI-WPD program, or the Medicaid Aid to the Disabled program, whichever is most beneficial.

Extended Period of Eligibility

A/Rs who have lost SSDI benefits due to substantial work, following a nine-month trial work period, and who are entitled to a 36-month extended period of eligibility (EPE), may be enrolled in the MBI-WPD Basic Coverage Group for the duration of the EPE. IF all other eligibility requirements for the program are met a new disability determination is not necessary. Approximately 2-3 months prior to the end of the EPE, appropriate medical evidence must be obtained and submitted with a complete disability packet to the SDRT for a Continuing Disability Review (CDR). Documentation of the diagnosis(es) for which the applicant was determined disabled by SSA must be obtained in order for the CDR to be performed.

Trial Work Period and Transition to MBI-WPD

A/Rs in the Aid to the Disabled category of Medicaid may be granted a Trial Work Period (See **CATEGORICAL FACTORS TRIAL WORK PERIOD**) of up to 9 months to determine if the A/R can develop a consistent pattern of work. In such instances, care must be taken to transition the recipient to the MBI-WPD program before the Trial Work Period ends or the disability certificate expires. Subsequent Continuing Disability Reviews (CDRs) for these individuals must be performed by the State Disability Review Team (SDRT).

SSI 1619 (b) Program and Transition to MBI-WPD

An A/R who has lost eligibility for 1619 (b) due to excess income and/or resources may be enrolled in the MBI-WPD Basic Coverage Group without a disability determination if the SSI medical diary date has not yet expired and all other eligibility requirements are met. Approximately 2-3 months prior to the medical diary date, appropriate medical evidence from providers must be obtained and submitted to the SDRT for a CDR. Documentation of the diagnosis(es) for which the applicant was determined disabled by SSA must be obtained in order for a CDR to be performed.

CATEGORICAL FACTORS**MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES**

Documentation: Applicants for the MBI-WPD program must provide proof of disability. Acceptable proof of disability includes the following:

- A current disability certification by the State or local Disability Review Team (DRT);
- a verification of receipt of Railroad Retirement benefits due to total and permanent disability;
- A current disability certification by the Social Security Administration (SSA), for SSDI benefits; this may include a current award letter, proof of receipt of SSDI benefits such as a check or bank statement listing the benefit, or a Medicare card;
- A current certification from the Commission for the Blind and Visually Handicapped (CBVH);
- A current letter from SSA placing the individual in a SSDI Extended Period of Eligibility;
- A current SSA letter informing the individual that he/she is no longer eligible for the 1619 (b) program (the SSA medical diary date is required).

NOTE: Districts must track the disability end date for an MBI-WPD program recipient who is in an Social Security Disability Income (SSDI) 36 month Extended Period of Eligibility or who has transitioned to the MBI-WPD program from the SSA 1619(b) program.

NOTE: End dates for all Group II certifications must be tracked through WMS and medical evidence gathered for a continuing disability review prior to the Group II disability end date. The DOH-5029, "Medical Report for MBI-WPD MI CDR" must be used when gathering medical information for a Continuing Disability Review (CDR) for an individual in the MBI-WPD Medical Improvement (MI) Group. One DOH-5029 completed in its entirety, and signed and dated by an acceptable medical source is submitted to the State Disability Review Team for a determination of the individual's continued MI eligibility. To be completed in its entirety, the treating physician must complete Part A of the form filling in all current diagnoses. Parts B, C and D must be completed if indicated (see instructions on the form. Acceptable medical sources are listed in the NYS "Medicaid Disability Manual". If an acceptable medical source does not complete the DOH-5029 in its entirety and sign and date the form, the district must follow the instructions in the NYS "Medicaid Disability Manual" for gathering medical information for the CDR.

CATEGORICAL FACTORS**MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES**

Applicants for the MBI-WPD Program must provide proof of work activity. Acceptable proof of work activity includes the following:

- A current pay stub(s), paychecks, or a written statement from the employer stating the hours worked and the wages paid;
- A current income tax return, W-2 form, or records of bank deposits;
- If the individual is not required to file an income tax return, work activity may be documented by pay stubs or a letter from the employer stating the hours worked and wages paid. If the individual presents a personal check as a “paycheck”, a statement from the employer is needed to document that the check is for work activity. If the recipient is in the Medical Improvement group, the letter must also include the number of hours worked;
- A self-employed individual may present a worksheet of hours worked, for whom, and income earned from each client.

CATEGORICAL FACTORS**UNDER AGE 21**

Policy: Persons under the age of 21 are eligible for Medicaid if they meet all other eligibility requirements. For Medicaid purposes, a person under the age of 21 is a child.

References:

SSL Sect.	366 366.1(a) (5) 366-ee
Dept. Reg.	360-3.3(b) (3)
ADM	10 OHIP/ADM-01 01 OMM/ADM-05
GIS	09 MA/027

Interpretation: All children under age 21 regardless of school attendance, marital status or relationship to other members of the family are potentially eligible for Medicaid. The child's eligibility is first determined using Low Income Families (LIF) budgeting. (See **INCOME LOW INCOME FAMILIES (LIF) BUDGETING METHODOLOGY**) If the child is ineligible under LIF budgeting the child's eligibility is determined using the ADC-related budgeting methodology. (See **INCOME ADC-RELATED DISREGARDS ADC-RELATED BUDGETING**) If the child is ineligible under ADC-related budgeting and under the age of 19, the child's eligibility is determined under the appropriate expanded poverty level programs. If the child is certified blind or certified disabled his/her eligibility may be determined using SSI-related budgeting. (See **INCOME SSI-RELATED BUDGETING METHODOLOGY**) Children between the ages of 19 and 21, who are not determined eligible under the aforementioned categories, must have their eligibility evaluated under Family Health Plus. If the person is not eligible under FHP, eligibility is determined for the Family Planning Benefit Program, etc.

NOTE: Infants under age one (1) or a baby born to a woman in receipt of Medicaid, including FHPLus, FPBP, etc., at the time of birth, is automatically eligible for Medicaid until the end of the month the baby turns one (1). (See **CATEGORICAL FACTORS MEDICAID EXTENSIONS/CONTINUATIONS**)

CATEGORICAL FACTORS

UNDER AGE 21

When to Verify: When a child is obviously under the age of twenty-one it is not necessary to verify age. However, since an A/R's date of birth is generally relevant at some point during the eligibility process, it is recommended that date of birth be verified at the first application. Once documented, it is not necessary to re-verify an A/R's date of birth. An application or recertification is never delayed or denied for lack of age verification when the child is obviously under twenty-one (21). A newborn's first name, sex, and date of birth are added to the case as soon as the district is informed of the birth, with the documentation obtained later.

Verification: The date of the birth (DOB) is acquired only once, preferably at first application for assistance provided by a program [Public Assistance (PA), Medicaid, Food Stamps (FS) or Services], since the information is not subject to change. The WMS inquiry or Clearance Report is sufficient, even if the information is entered by another district, unless there is reason to believe the system information is not correct or the A/R is misrepresenting himself or herself.

Examples of acceptable forms of verification:

When a newborn is entered on WMS by the Newborn System, the information on WMS is sufficient to verify age. The district may request a birth certificate, but if it is not provided the information on WMS is sufficient.

The district attempts to obtain verification from the applicant first.

Examples include:

- | | |
|--|-----------------------|
| Birth Certificate | Baptismal Certificate |
| Adoption papers | Passport |
| Driver's License | Census records |
| Immigration and Naturalization Service (INS) records | Hospital records |
| Bureau of Vital Statistics records | Physician records |
| Church records | Marriage records |
| Employer's records | SSA records |

CATEGORICAL FACTORS**UNDER AGE 21**

Documentation: Sufficient to establish an audit trail:

the date of birth, type of document, place and date of filing, and identifying numbers or the available document or name of the official who signed the document.

Disposition: When determining eligibility for a child under age 21 the net income of the child's household after applying the appropriate budgeting methodology is compared to the income level (Medically Needy level, Medicaid Standard or federal poverty level as appropriate). (See **INCOME MEDICALLY NEEDED LEVELS** for discussion of income level and **REFERENCE MEDICALLY NEEDED INCOME AND FEDERAL POVERTY LEVELS**) Treatment of the household's resources depends on the budgeting methodology used. (See **REFERENCE MEDICAID RESOURCE LEVELS**)

NOTE: Effective for eligibility periods beginning on or after January 1, 2010 FHPlus and non-SSI-related Medicaid A/Rs will not have resources considered in determining eligibility. This change includes the following Medicaid categories: Single/Childless Couples (SCC), Low Income Families (LIF), ADC-related (including adults who spend down excess income to the Medicaid income level), children under 21 years of age when comparing income to the Medicaid income level (under age 21), and parents living with their dependent child(ren) under age 21 with income at or below the Medicaid income level (FNP Parents).

SSI-related individuals residing with children under age 21 may be LIF or ADC-related. If the SSI-related individual, not seeking long-term care services, LTC services, is eligible as LIF or ADC there is no resource test. In determining eligibility, resources are never considered for pregnant women and infants under one year of age. Resources are also not considered for children over age one but under age 19 if income is at or below the appropriate poverty level.

In addition, there is no resource test for applicants for the Family Planning Benefit Program, Medicaid Cancer Treatment Program, the Medicare Savings Program including the Qualified Individual Program (QI), Qualified Medicare Beneficiaries (QMB) and Specified Low Income Medicare Beneficiaries (SLIMB), AIDS Health Insurance Program (AHIP) and policy holders who have utilized the minimum required benefits under a total asset Partnership for Long-Term Care insurance policy. (See **RESOURCES NEW YORK STATE PARTNERSHIP FOR LONG-TERM CARE**)

CATEGORICAL FACTORS**PREGNANCY/NEWBORNS**

Policy: Pregnant women are eligible for Medicaid, if they meet all other eligibility requirements. Infants under age one (1) or a baby born to a woman in receipt of Medicaid, including FHPlus, FPBP, etc., at the time of birth is automatically eligible for Medicaid until the end of the month the baby turns one (1). (See **CATEGORICAL FACTORS MEDICAID EXTENSIONS/CONTINUATIONS**)

References:

SSL Sect.	366 366-ee
Dept. Reg.	360-3.3(b)(4) 360-3.3(c)(5)
ADMs	10 OHIP/ADM-01 01 OMM/ADM-6 OMM/ADM 97-2 95 ADM-21 90 ADM-9 87 ADM-39 85 ADM-33 85 ADM-13 80 ADM-47
INF	00 OMM/INF-01
GISs	10 MA/011 10 MA/006 09 MA/027 00 MA/024 91 MA042

Interpretation: A pregnant woman applying for health insurance is not eligible for Family Health Plus (FHPlus). A woman who becomes pregnant after enrolling in FHPlus is counseled on her options of either remaining in FHPlus until the end of her pregnancy and the 60 day post-partum period or switching to full Medicaid coverage. The counseling includes providing information on the services available under Medicaid compared to FHPlus, and assisting the woman in determining if her current providers also participate in Medicaid fee-for-service or managed care.

Pregnant women with household income equal to or less than 100% of

CATEGORICAL FACTORS**PREGNANCY/NEWBORNS**

the federal poverty level may be eligible for full Medicaid coverage. Pregnant women with household income greater than 100% of the federal poverty level and equal to or less than 200% of the federal poverty level may be eligible for perinatal care and are eligible for enrollment in Medicaid Managed Care. Perinatal care coverage provides most Medicaid covered care and services. (See **OTHER ELIGIBILITY REQUIREMENTS PREGNANT WOMEN** and **REFERENCE COVERED SERVICES FOR PREGNANT WOMEN**)

A woman determined eligible for Medicaid for any day during her pregnancy remains eligible for Medicaid coverage for at least 60 days from the date the pregnancy ends, regardless of any changes in the family's income or household composition. Eligibility continues until the last day of the month in which the 60th day occurs. This eligibility period is granted in all instances where a Medicaid application was made prior to the end of the pregnancy and the pregnant woman was determined eligible for Medicaid. At the end of the 60-day period, the A/R's circumstances are re-evaluated. If the A/R is not found eligible for full Medicaid, the A/R is budgeted under FHP; if ineligible under FHP, eligibility is determined for FPBP, etc.

When to Verify: When an A/R indicates she is pregnant;

When an A/R indicates that she has recently given birth.

Verification: A birth or pregnancy may be verified by:

- (a) Information from the New York State Medicaid New Born System.
- (b) Notification from a Managed Care Organization, Article 28 Prenatal Care Providers, or other medical provider is acceptable; notification can be verbal or written. If notification is verbal, an appropriate notation is made in the case record with the name of the person and the organization providing the information and the date.
- (c) For a woman who has an established case (whether there is an unborn on the case or not), written or verbal notification of the birth from an immediate family member or medical provider, or, in exceptional circumstances, an alternate reliable individual or agency, is acceptable. If notification is verbal, an appropriate notation is made in the case record with the name

CATEGORICAL FACTORS**PREGNANCY/NEWBORNS**

of the person and the organization providing the information and the date.

- (d) Any official government, medical or church record continues to be an acceptable form of documentation of birth.
- (e) Individuals who are initially eligible for Medicaid as a “deemed” newborn are considered to have provided satisfactory documentation of citizenship and identity, by virtue of being born in the United States, and will not be required to further document citizenship or identity at any subsequent Medicaid eligibility redetermination/renewal.

NOTE: Verification is NOT required for name, date of birth, or social security number in order to provide the one-year extension for the newborn.

Disposition:

The eligibility of a pregnant woman is determined first under the LIF budgeting methodology. If ineligible under LIF budgeting, eligibility is determined using ADC-related budgeting methodology. If ineligible under ADC-related budgeting, the poverty levels are used for the pregnant woman and other children residing with her. This includes two-parent families. (See **CATEGORICAL FACTORS UN/UNDEREMPLOYED TWO-PARENT HOUSEHOLDS**) There is no resource test for pregnant women and newborns. Pregnant women are requested to voluntarily provide their social security number. However, pregnant women cannot be denied Medicaid for failure to provide an SSN.

NOTE: Pregnant women have a right to apply for presumptive eligibility (See **OTHER ELIGIBILITY REQUIREMENTS PRESUMPTIVE ELIGIBILITY**) at the site of a provider.

NOTE: When an LDSS is notified via WMS Report WINR 5225 (Upstate) or WINR 0796 (NYC), or through any other means that a baby has been born with a low birth weight designation (weighing less than 1200 grams at birth), and the mother is in a managed care plan, the LDSS must inform the health plan in writing within 5 days. The 5 day clock begins on the day that the district received such notification. Notification to the plan may be made in electronic form.

CATEGORICAL FACTORS**FNP PARENTS**

Policy: Stepparents who reside with their spouse and their spouse's children, but have no other children of their own residing in the household are considered FNP parents.

Fathers of an unborn who reside with the mother of the unborn and have no other children of their own residing in the household are considered FNP parents.

References:

SSL Sect.	366 366-ee
ADMs	10 OHIP/ADM-01 97 OMM/ADM-2
GISs	09 MA/027 01 MA/043 99 MA/028

Interpretation: FNP parents receive LIF budgeting. When they are not eligible under LIF, eligibility is determined under the medically needy standards using ADC-related budgeting.

Effective for eligibility periods on or after January 1, 2010, there is no resource test for FNP Parents. For A/Rs applying for Medicaid requests coverage for the 3-month retroactive period prior to January 1, 2010, there is a resource test.

FNP parents cannot spend down to obtain full Medicaid coverage.

FNP parents who are not eligible for Medicaid have eligibility for Family Health Plus determined by comparing their gross income to the appropriate federal poverty level for a family living with children. When not eligible for Family Health Plus, eligibility is determined for the Family Planning Benefit Program, etc.

CATEGORICAL FACTORS**FAMILIES LIVING WITH DEPENDENT CHILDREN UNDER AGE 21**

Policy: A family including two birth and/or adoptive parents in which their child under age 21 is not deprived of parental support or care due to incapacity, may be eligible for Medicaid if the parents are living with their child and the family meets all other eligibility requirements. The deprivation for the child is considered to be the un/under employment of the parent. Stepparents and fathers of an unborn living with the pregnant woman who have no other children in the household may also be eligible for Medicaid.

References:

SSL Sect.	366 366.1(a) (7) 366-ee 466.1 (a) (5) 366.2 (a) (8) 368-a.1 (j)
Dept. Reg.	360-3.3 (b) (7) 360-3.3 (b) (5)
ADMs	10 OHIP/ADM-01 OMM/ADM 97-2 89 ADM-38
GISs	09 MA/027

Interpretation: A one or two-parent family including a child under the age of 21 may be eligible for Medicaid if the family meets the Low Income Families (LIF) or ADC-related budgeting requirements.

The living arrangement of the child is considered. The child must be living with his/her parents. The child is considered to be living with the parents as long as the parents take responsibility for the care and control of the child, even though circumstances may require the temporary absence of either the child or one or both parents.

When a budget surplus exists, the parents and the child may be eligible with a spenddown or the child may be otherwise eligible under the poverty level budgeting methodology. (See **INCOME MEDICALLY NEEDY INCOME LEVELS**)

Effective for eligibility periods on or after January 1, 2010, there is no resource test for families living with dependent children under age 21. For A/Rs applying for Medicaid coverage for the 3-month retroactive period prior to January 1, 2010, there is a resource test.

CATEGORICAL FACTORS**FAMILIES LIVING WITH DEPENDENT CHILDREN UNDER AGE 21**

Stepparents and fathers of an unborn, with no children of their own, who have income at or below the Medicaid standards may be eligible for Medicaid, but are not eligible with a spenddown.

CATEGORICAL FACTORS

SINGLES/CHILDLESS COUPLES (S/CC)

Policy: Persons between the ages of 21 and 65 who are not living with their child under the age of 21 and do not meet the requirements for any other category of assistance must meet all the Singles/Childless Couples (S/CC) categorical requirements in order to be eligible for coverage under Medicaid.

References:

SSL Sect.	366 366.1(a) 366-ee
Dept. Reg.	360-1.2 360-1.3 360-3.3
ADMs	10 OHIP/ADM-01 97 ADM-21 97 ADM-23 OMM/ADM 97-2
GIS	09 MA/027

Interpretation: When an A/R is not related to any other category for Medicaid, eligibility is determined in accordance with S/CC policy. If the A/R is ineligible using the S/CC budgeting methodologies, eligibility must be considered under Family Health Plus and Family Planning Benefit Program as appropriate.

NOTE: Parents living with their child over the age of 21 are considered a childless couple for S/CC budgeting purposes.

Disposition: The income of S/CC A/Rs are compared to the Medicaid Standard. (See **REFERENCE MEDICALLY NEEDY INCOME LEVELS and FEDERAL POVERTY LEVELS**)

Effective for eligibility periods on or after January 1, 2010, there is no resource test for S/CC A/Rs. For A/Rs applying for Medicaid coverage for the 3-month retroactive period prior to January 1, 2010, there is a resource test.

CATEGORICAL FACTORS**FAMILY PLANNING BENEFIT PROGRAM (FPBP)**

Description: The FPBP provides Medicaid reimbursement for family planning services on a fee-for-service basis. Federal financial participation for such services is 90 percent in accordance with Section 1903(a)(5) of the Social Security Act. There is no local cost for services provided under the FPBP.

Policy: The FPBP provides Medicaid coverage for family planning services only to men and women of childbearing age with incomes at or below 200% of the federal poverty level (FPL). FPBP services are available only to persons who are not otherwise eligible for Medicaid or Family Health Plus, or who have indicated in writing that they want to apply for the FPBP only.

References:

SSL Sect.	366(1)(a)(11)
ADM	02 OMM/ADM-7
GISs	06 MA/028 06 MA/017

Interpretation: Males and females of child-bearing age whose income is at or below 200% of the FPL, may be eligible for the FPBP when they:

- are New York State residents; and
- are citizens or otherwise eligible immigrants with satisfactory immigration status; and are either:
- not otherwise eligible for Medicaid or Family Health Plus (FHPlus) or have indicated in writing that they want to apply for the FPBP only; or
- under age 21 and living with their parents and apply for family planning services and do not have parental financial information. Eligibility is determined by comparing only the income of the person under 21 to 200% of FPL.

There is no resource test for the FPBP.

CATEGORICAL FACTORS

FAMILY PLANNING BENEFIT PROGRAM (FPBP)

Family planning services include:

- Most FDA approved birth-control methods, devices, and supplies (e.g., birth control pills, injectibles, or patches, condoms, diaphragms, IUDs);
- Emergency contraception services and follow-up care;
- Male and female sterilization;
- Pre-conception counseling and preventive screening and family planning options before pregnancy

The following additional services are considered family planning only when provided within the context of a family planning visit and when the service provided is directly related to family planning:

- Pregnancy testing and counseling;
- Comprehensive health history and physical examination, including breast exam and referrals to primary care providers as indicated (mammograms are not covered);
- Screening and treatment for sexually transmitted infections (STIs);
- Screening for cervical cancer and urinary tract or female related infections;
- Screening and related diagnostic laboratory testing for medical conditions that affect the choice of birth control, e.g. a history of diabetes, high blood pressure, smoking, blood clots, etc.;
- HIV counseling and testing;
- Counseling services related to pregnancy, informed consent, and STD/HIV risk counseling;
- Bone density scan (only for women who plan to use or are currently using Depo-Provera); and
- Ultrasound (to assess placement of an intrauterine device).

The FPBP does not cover abortions or treatment for infertility.

The authorization period for FPBP is 12 months and the authorization must begin with the first month of the application. Retroactive coverage is not available under the FPBP. Before the end of the initial 12-month authorization period, the recipient will require a full re-determination of eligibility under all of the applicable eligibility requirements for the FPBP.

CATEGORICAL FACTORS**FAMILY PLANNING BENEFIT PROGRAM (FPBP)**

NOTE: County-specific Family Planning Exclusion Statements must not be used for applicants who apply using the Access NY Health Care application DOH-4220.

CATEGORICAL FACTORS**FAMILY HEALTH PLUS (FHPlus) and FAMILY HEALTH PLUS PREMIUM ASSISTANCE PROGRAM (FHP-PAP)**

Description: FHPlus provides comprehensive managed care health insurance to low-income adults who have income above the current Medicaid levels. With few exceptions, adults cannot have private health insurance. All adults age 19-64 who apply for Medicaid and appear to be ineligible for reasons of excess income are evaluated for their potential eligibility for FHPlus. (See **CATEGORICAL FACTORS PREGNANCY** for treatment of pregnant women).

The prescription drug benefit under the Family Health Plus Program is administered by the Medicaid Program, and not by the health plan. FHPlus recipients must use a NYS Common Benefit Identification Card (CBIC) to obtain pharmacy benefits.

The Family Health Plus Premium Assistance program is available to A/Rs who have or have access to qualified and cost-effective employer sponsored health insurance (ESI) and who are otherwise eligible for Family Health Plus. An A/R with access to ESI is an individual whose employer offers health insurance benefits to its employees, and the individual is eligible for those benefits. For example, an employer may only offer benefits to employees who work full-time. In addition, the ability of the applicant to enroll in those benefits must be reasonable and uncomplicated. For example, if the employer is not cooperative in providing necessary plan information to the applicant or to the district, then the district would be unable to determine if "access" exists.

Individuals in receipt of FHP-PAP shall have available to them health care services including: payment of the recipient's share of the premium, co-insurance, any deductible amount, and the cost sharing obligations for the A/R's employer-sponsored health insurance that exceed the amount of the person's FHPlus co-payment obligations. The A/R will also receive services and supplies otherwise covered by the FHPlus program, but only to the extent that such services and supplies are not covered by the person's employer sponsored health insurance.

NOTE: Although COBRA coverage is not considered employer sponsored insurance, if the health insurance meets the standard benefit package and passes the FHP-PAP cost effectiveness test, such COBRA payments qualify for payment under the FHP-PAP.

CATEGORICAL FACTORS

FAMILY HEALTH PLUS (FHPlus) and FAMILY HEALTH PLUS PREMIUM ASSISTANCE PROGRAM (FHP-PAP)

Policy:

Applicants who meet the following criteria may be eligible for FHPlus:

- are age 19 through 64,
- are New York State residents,
- meet certain citizenship/alien status requirements,
- are ineligible for Medicaid based on income,
- meet certain income requirements, and
- are **not** employees or family members who are federal employees who are eligible for and have access to employer-sponsored health coverage. **NOTE:** Temporary or part-time public employees who are ineligible for employer-sponsored coverage may, if otherwise eligible, receive Family Health Plus.

NOTE: Effective September 1, 2010, otherwise eligible employees of the State, county, municipal governments, as well as public school districts may enroll in Family Health Plus or the Family Health Plus Premium Assistance Program.

The majority of Medicaid eligibility standards and rules apply for FHPlus applicants; however, there are several differences such as a higher income level. Photo ID requirements do not apply to FHPlus.

Before eligibility for Family Health Plus can be established, the A/R must select a health plan. To avoid gaps in coverage in instances when the A/R changes from Medicaid eligibility to Family Health Plus eligibility, a daily benefit-package flip process will be applied in all local departments of social services.

Every month, on the Monday prior to the monthly primary pulldown, a systemic identification of current recipients authorized for Family Health Plus who are not enrolled in a health plan for the following month will be reported to the district on a Potential FHP Auto Assignment Report. On the Wednesday prior to the monthly pulldown, the recipient will be auto-assigned to a FHPlus plan for the first of the following month. Auto-assignments are done based on the following criteria:

- If the recipient has a history of enrollment within the past year with a Medicaid Managed Care or FHPlus quality plan, the individual will be assigned to that plan;
- If only one FHPlus plan operates in the district, the individual will be assigned to that plan;

CATEGORICAL FACTORS

FAMILY HEALTH PLUS (FHPlus) and FAMILY HEALTH PLUS PREMIUM ASSISTANCE PROGRAM (FHP-PAP)

- If more than one FHPlus plan operates in the district, the auto-assignments will be divided first among the quality plans in that district (utilizing the table of quality plans used in the Auto-assignment Algorithm for Medicaid Managed Care); and
- If no quality FHPlus plans operate in the district, assignments will be made among all FHPlus plans in the district that are open to auto-assignment for Medicaid Managed Care.

NOTE: If an adult applying for coverage under Family Health Plus has existing insurance coverage that is not specifically listed below, the adult is not eligible for Family Health Plus, regardless of the limited nature of the coverage:

- Accident-only coverage or disability income insurance;
- Coverage issued as a supplement to liability insurance;
- Liability insurance, including auto insurance;
- Worker’s compensation or similar insurance;
- Automobile medical payment insurance;
- Credit-only insurance;
- Coverage for on-site medical clinics;
- Dental-only, vision only, or long term care insurance;
- Hospital indemnity or other fixed dollar indemnity coverage;
- Specified disease coverage;
- Prescription-only coverage.

References:

SSL Sect.	369-ee
ADMs	10 OHIP/ADM-7 09 OHIP/ADM-1 09 OHIP/ADM-2 08 OHIP/ADM-1 05 OMM/ADM-4 01 OMM/ADM-6
INF	08 OHIP/INF-6
GISs	10 MA/07 09 MA/024 08 MA/034 08 MA/021 08 MA/007 08 MA/003

CATEGORICAL FACTORS**MEDICAID CANCER TREATMENT PROGRAM: BREAST, CERVICAL, COLORECTAL AND PROSTATE CANCER (MCTP)**

Description: The Medicaid Cancer Treatment Program for Breast and/or Cervical Cancer provides full Medicaid coverage to individuals who meet the established criteria to qualify for the Centers for Disease Control and Prevention (CDC) screening under the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). The Medicaid Cancer Treatment Program for Colorectal and/or Prostate Cancer provides full Medicaid coverage for individuals who are screened and/or diagnosed by the Cancer Services Program Partnerships (CSPP) or a CSPP provider and meet established criteria. Individuals must be in need of treatment for these types of cancers or pre-cancerous conditions. Coverage is available for all medically necessary Medicaid services for the period of time the individual needs treatment.

In New York State cancer screening is conducted by the New York State Department of Health's Cancer Services Program (through the Cancer Services Program Partnerships (CSPP)). The income standard for the CDC screening program is 250% of the FPL. There is no resource test.

A list of CSPP is available on the Department of Health's website at <http://www.health.state.ny.us/nysdoh/cancer/center/partnerships.htm>.

or

By calling the Cancer Services Program at 1-866-442-2262.

Policy: Individuals who meet the following criteria are eligible for the Medicaid Treatment Program for Breast and/or Cervical Cancer:

- have been screened by their local CSPP and diagnosed as needing treatment for breast and/or cervical cancer or a precancerous condition;
- are uninsured (no creditable coverage);
- are New York State residents;
- are U.S. citizens or aliens with satisfactory immigration status;
- and
- are ineligible for Medicaid under any of the mandatory categorical groups (i.e., pregnant women, parents of a dependent child, Low Income Families, or the disabled).

CATEGORICAL FACTORS**MEDICAID CANCER TREATMENT PROGRAM: BREAST, CERVICAL, COLORECTAL
AND PROSTATE CANCER (MCTP)**

NOTE: While the federal program restricts eligibility to women under age 65, New York State will cover any males or individuals 65 years of age or older who meet the screening and eligibility requirements.

Individuals who meet the following criteria are eligible for the Medicaid Cancer Treatment Program for Colorectal and/or Prostate Cancer:

- have been screened by their local CSPP or a CSPP provider and found to be in need of treatment for colorectal and/or prostate cancer or pre-cancerous condition;
- have income at or below 250% Federal Poverty Level (FPL);
- are less than 65 years of age;
- are uninsured (no creditable coverage);
- are New York State residents;
- are U.S. citizens or aliens with satisfactory immigration status; and
- are ineligible for Medicaid under any of the mandatory categorical groups (i.e., parents of a dependent child, Low Income Families, or the disabled).

CATEGORICAL FACTORS**THE MEDICAID CANCER TREATMENT PROGRAM: BREAST, CERVICAL,
COLORECTAL AND PROSTATE CANCER (MCTP)**

References: SSL Sect. 366(4)(v)

 GISs 07 MA/026
 05 MA/038

Interpretation: There are specific application forms and unique procedures for the MCTP. If an individual meets the CSPP screening and diagnosis criteria for treatment for breast, cervical, colorectal or prostate cancer, the CSPP assists the individual with completing the MCTP application process. The State Department of Health's Cancer Services Program reviews the application, certifies the need for treatment and submits the application to the State Office of Health Insurance Programs (OHIP).

State OHIP staff review each application and make the final determination of eligibility. If it appears the individual may be eligible for regular Medicaid under any of the mandatory categories, the case will be authorized by State OHIP staff for at least 90 days and the individual will be sent a letter referring him/her to apply for Medicaid at the local district. For an individual to continue on the MCTP past the 90 days, the individual must show a notice of decision by the county or show just cause why they did not apply. State OHIP staff will work with the local district to coordinate the closing of the MCTP case and the opening of the Medicaid case in the district if required. If the individual is not otherwise eligible for Medicaid, State OHIP staff will maintain the case in District 99; this includes undercare and renewal.

Transportation is authorized by local department of social services staff.

NOTE: Individuals eligible for the MCTP are not eligible for managed care.

CATEGORICAL FACTORS
CHILD HEALTH PLUS

Description: The federal Balanced Budget Act (BBA) of 1997 (Public Law 105-33) created the State Children's Health Insurance Program as Title XXI of the Social Security Act (Child Health Plus in New York State).

Policy: Title XXI provides health care coverage to low-income children who are currently uninsured. Pursuant to Title XXI, New York State enhanced its existing Child Health Plus program. Any child who is determined financially ineligible for Medicaid is referred to Child Health Plus (CHPlus).

References: Public Health Law – Title 1-A of Article 25

Dept. Reg. 360-4.8

ADMs 10 OHIP/ADM-4
98 OMM/ADM-8
91 ADM-18
91 ADM-11
89 ADM-40

Interpretation: As part of the process of applying for CHPlus children are screened to ascertain whether they appear to be Medicaid eligible. Any applying children who appear to be Medicaid eligible will be required to apply for Medicaid. This process also applies to children who are currently enrolled in CHPlus and appear potentially Medicaid eligible at the time of annual CHPlus recertification.

State law requires significant outreach efforts for both CHPlus and Medicaid. These efforts include public education campaigns and the designation of community-based enrollers who will assist children applying for and enrolling in CHPlus or Medicaid, whichever is appropriate. The enroller will submit applications to the local department of social services (LDSS).

If an LDSS receives an application for a child who is ineligible for Medicaid due to excess income or immigration status and a plan selection has been made, the LDSS must, on a daily basis, mail the application and documentation, including a copy of the ineligible Medicaid budget for cases denied for excess income, directly to the selected CHPlus plan. If a plan selection has not been made and there is only one CHPlus plan in the county, the application and supporting documentation is mailed directly to that plan. If a plan selection was not made and there are multiple CHPlus plans available in the county, the LDSS must send the application and supporting information to the Corning Tower, Room 1619, Empire State Plaza, Albany, New York 12237.

CATEGORICAL FACTORS

CHILDREN IN FOSTER CARE

Policy: All children in foster care who are in the care and custody of the Office for Children and Family Services commissioner or local district commissioner, and who are citizens or have satisfactory immigration status, are categorically eligible for Medicaid. In addition, children adjudicated as juvenile delinquents pursuant to Article 3 of the Family Court Act and placed into the custody of the Office of Children and Family Services, pursuant to Section 353.3 of the Family Court Act, and who are citizens or have satisfactory immigration status, are categorically eligible for Medicaid.

References: SSL Sect. 366.3(a)
Title 10

Dept. Reg. 360-3.3(a) (4)

GIS 11 MA/006
05MA/041

Chapter 58 of the Laws of 2010, Part F

Interpretation: All children in foster care are categorically eligible for full Medicaid coverage, regardless of their Title IV-E status, as long as they are citizens or have satisfactory immigration status and are otherwise eligible. A separate Medicaid financial determination is not necessary.

All children adjudicated as delinquents under Article 3 of the Family Court Act and placed in the care and custody of the Office of Children and Family Services pursuant to Section 353.3 of the Family Court Act are categorically eligible for full Medicaid coverage, regardless of their Title IV-E status, as long as they are citizens or have satisfactory immigration status and are otherwise eligible. A separate Medicaid financial determination is not necessary.

The district making the foster care payment is responsible for the child's Medicaid, as long as the child remains a resident of New York State. If a child enters certain facilities certified by the Office of Mental Health (OMH) or the Office for People with Developmental Disabilities (OPWDD), the State may be responsible for the child's Medicaid

CATEGORICAL FACTORS

CHILDREN IN FOSTER CARE

coverage while s/he remains in the facility. (See **OTHER ELIGIBILITY REQUIREMENTS STATE AND FEDERAL CHARGES OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES**)

When this situation occurs, it is likely that OMH or OPWDD will contact the local district to request that the child's county Medicaid coverage be terminated so that the State can establish coverage. Districts must cooperate with OMH and/or OPWDD so that appropriate coverage can be established expeditiously.

When a Title IV-E child in foster care moves out of state, the state where the child resides is responsible for providing Medicaid. If a child who is receiving Title IV-E payments from another state resides in New York State, and application for Medicaid is filed with the local district in which the child resides. The child's name, date of birth, social security number, third party health insurance information and verification of Title IV-E is documented in the case record and a New York State Medicaid case is opened.

The provisions of categorical eligibility cease to apply when a child in foster care is placed in permanent absence status in a medical facility as defined in 18NYCRR 360-1.4. For persons in permanent absence status, chronic care budgeting is used to determine eligibility.

IV-D referrals or determinations of good cause must be made as appropriate. Support from parents of a certified blind or disabled child is not sought when the child is expected to be living separate and apart from his/her parents for 30 days or more.

When a child in foster care is discharged, a separate Medicaid eligibility determination must be performed based on the child's living arrangements at discharge (residence in the community). Continuous coverage provisions apply. However, a child who is discharged from foster care who is a citizen or who is in satisfactory immigration status and is in receipt of Title IV-E kinship guardian assistance payments (KinGAP) must be provided with Medicaid without regard to their income and resources. The local social services district making the KinGAP payment is the district of fiscal responsibility.

CATEGORICAL FACTORS

MEDICARE SAVINGS PROGRAM

Policy: Certain A/Rs who receive Medicare may be eligible for Medicaid to pay the Medicare premium, coinsurance and deductible amounts.

References:

SSL Sect.	366 366-ee 367-a(3)a
ADMs	11 OHIP/ADM-2 10 OHIP/ADM-05 10 OHIP/ADM-3 10 OHIP/ADM-01
INFs	10 OHIP/INF-3
GISs	09 MA/027 08 MA/ 016 05 MA/033 05 MA/013

Interpretation: There are four groups that are eligible for payment or part-payment of Medicare premiums, coinsurance and deductibles, through the Medicare Savings Program.

Qualified Medicare Beneficiaries (QMBs)

The A/R must:

1. be entitled to benefits under Part A of Medicare; and
2. have income equal to or less than 100% of the federal poverty level.

If the A/R meets the above criteria, s/he is eligible for Medicaid payment of the Medicare Part A and B premiums, coinsurance and deductible amounts.

Specified Low-Income Medicare Beneficiaries (SLIMBs)

The A/R must:

1. have Part A of Medicare; and
2. have income greater than 100% but less than 120% of the federal poverty level.

CATEGORICAL FACTORS

MEDICARE SAVINGS PROGRAM

If the A/R meets the above criteria s/he is eligible for Medicaid payment of the Medicare Part B premiums.

Qualified Disabled and Working Individuals (QDWIs)

The A/R must:

1. have lost Part A benefits because of return to work;
2. be a disabled worker less than 65 years of age;
3. have income equal to or less than 200% of the federal poverty level;
4. have resources not in excess of twice the SSI limit; therefore, resources cannot exceed \$4,000 for a household of one or \$6,000 for a household of two; and
5. not be otherwise eligible for Medicaid.

If the A/R meets the above five criteria s/he is eligible for Medicaid payment of the Medicare Part A premium, not the Medicare Part B premium.

Qualifying Individuals – (QI)

The A/R must:

1. have Part A of Medicare;
2. have income equal to or greater than 120% and less than 135% of the federal poverty level.

NOTE: There is no resource test for QI. Additionally, individuals cannot be eligible for Medicaid and QI status at the same time.

If the A/R meets the above criteria s/he is eligible for Medicaid payment of the Medicare Part B premiums, each month.

Applicants should use the DOH-4328 when applying for this benefit. The DOH-4220 or the LDSS-2921 may not be required for persons applying for MSP benefits only.

Each state has been given a capped allocation to fund these premium payments.

CATEGORICAL FACTORS

MEDICARE SAVINGS PROGRAM

NOTE: See **REFERENCE MEDICALLY NEEDY INCOME AND FEDERAL POVERTY LEVELS** for a chart displaying the Medicaid Levels and Federal Poverty Levels.

The A/R may spend down income to become eligible for Medicaid. The A/R may also spend down income to become eligible for Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLIMB). However, the Medicare premium cannot be applied in whole or in part to reduce excess income. At the time of application, the applicant is encouraged to make a choice to apply the Medicare Premium to their spenddown to attain Medicaid eligibility **OR** to forego Medicaid eligibility for eligibility in the Medicare Savings Program. The advantages and disadvantages of both programs must be fully explained. An A/R may switch between spenddown and Medicare Savings Program; however, in the interest of accuracy and administrative efficiency, the A/R is encouraged to select and remain in one of the two programs.

Eligibility for the MSPs must be determined even if an applicant does not indicate that he or she is applying for the MSP on the DOH-4220 or LDSS-2921.

NOTE: The ACCESS NY Supplement A does not have to be completed if the person is applying for MSP only.

If applicants are applying for MSP-only they may complete DOH-4328 (Medicare Savings Program Application). There is no resource test for persons applying solely for MSP and who are not Qualified Disabled and Working Individuals (QDWI). However, if they are also applying for Medicaid with a spenddown, or they do not know what program to apply for, they must apply using the DOH-4220.

The Low Income Subsidy (LIS) program, also known as “Extra Help”, is administered by the Social Security Administration (SSA) to help low income Medicare beneficiaries pay for prescription drug costs associated with their Medicare Part D benefits. (See **RESOURCES THIRD PARTY RESOURCES**) Section 113 of the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) states that an application to SSA for the LIS program for Medicare Part D benefits will be used to initiate an application for benefits under the MSP.

CATEGORICAL FACTORS

MEDICARE SAVINGS PROGRAM

To comply with this requirement, eligible applications transmitted from SSA with a net income below 135% of the current Federal Poverty Level (FPL) will be accepted through an automated process.

AUTOMATED APPLICATIONS ACCEPTED:

Eligible applications from SSA that have net income below 135% of the Federal Poverty Level (FPL) will be automatically opened as a Qualifying Individual (QI) case; those with net incomes below 120% of the FPL will be opened as a Specified Low Income Medicare Beneficiary (SLIMB) case and those with net incomes below 100% FPL will be opened as a Qualified Medicare Beneficiary (QMB) case. All cases will be opened with an effective date based on the date of application to SSA.

- The begin date for Medicare Part A and B coverage will be the first day of the month of application to SSA for LIS
- The MSP begin date for SLIMB and QI will be the first day of the month of application to SSA for LIS.
- The MSP begin date for QMB will be the first day of the month following the month of application to SSA for LIS.

All individuals determined eligible through the automated process will be sent an acceptance notice by the State through the Client Notice System (CNS). The acceptance notice will inform the individual of their MSP category and will include the revised "Medicare Savings Program Request for Information" form. This form is designed to: collect additional demographic and financial information not collected on the LIS application; to collect information about other health insurance premiums; report income information; report a change in circumstance; and, request consideration for retroactive MSP coverage as applicable. Individuals found eligible for QMB will be issued a non-photo Common Benefit Identification Card (CBIC). Individuals found eligible for SLIMB and QI are not issued a CBIC.

Financial information provided by the recipient may affect the MSP level of benefits the individual is entitled to receive. In such instances verification of income and/or value of health insurance premiums must be provided and evaluated prior to changing the MSP level.

CATEGORICAL FACTORS

MEDICARE SAVINGS PROGRAM

Retroactive MSP benefits are NOT available to persons eligible for QMB. Retroactive MSP benefits are available to otherwise eligible SLIMB and QI individuals for three months prior to the date of the LIS application. Retroactive MSP benefits for QI cases cannot be provided for a previous calendar year.

Should an individual indicate on the "Medicare Savings Program Request for Information" form that he/she would like to apply for full Medicaid benefits; the district must send the Access NY Health Care application and Supplement A, if applicable, to the MSP recipient. The recipient must comply with all current procedures for applying for Medicaid benefits.

NOTE: Completion of the "Medicare Savings Program Request for Information" form is optional. Failure to complete and return the form will not result in a discontinuance of benefits. LIS application data sent by SSA to the State has been verified by SSA and is sufficient for documentation of identity, income, residence and citizenship.

AUTOMATED APPLICATIONS DENIED

Applications denied through the automated process include: individuals reported on the SSA file as having income in excess of 135% of the FPL; and individuals who have been denied by SSA as not in receipt of Medicare.

These cases will be sent a denial notice by the State through CNS. Such notice will include contact information for the appropriate local district.

AUTOMATED APPLICATION EXCEPTED

Applications that appear on an Exception Report must be reviewed and necessary action taken as appropriate.

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CATEGORICAL FACTORS**MEDICARE BUY-IN**

Description: Certain A/Rs who receive Medicare may be eligible for Medicaid to pay the Medicare premium, coinsurance and deductible amounts.

Policy: Persons eligible to be on the Medicare Buy-In who are not otherwise eligible for one of the Medicare Savings Programs (MSPs) are eligible in what is referred to as the “Original Buy-In”.

References: SSL Sect.

Dept. Reg. NYCRR 360-3.3

ADMs 95 ADM-11
87 ADM-27

Interpretation: The majority of individuals on Medicare Buy-In qualify as MSPs, not the “Original Buy-In”. “Original Buy-In” individuals (those that are not otherwise eligible for the MSP) are:

- Individuals in receipt of SSI cash assistance who do not qualify for the QMB program;
- Individuals eligible for Medicaid under the Pickle Amendment (refer to 87ADM-27);
- Individuals eligible for Medicaid under the Disabled Adult Child (DAC) provision (refer to 95 ADM-11);
- Individuals eligible under Section 1619B of the Social Security Act, which states that any certified blind or certified disabled person who is a qualified severely impaired individual will continue to be eligible for Medicaid despite earnings that demonstrate his or her ability to engage in substantial gainful activity under the SSI program (refer to 18 NYCRR Section 360-3.3); and
- Individuals eligible for Medicaid under 249E of Public Law 92-603, which includes individuals who became ineligible for SSI cash assistance because of the 1972 increase in their OASDI benefit and who would continue to be eligible except for that increase (refer to 18 NYCRR 360-3.3).

CATEGORICAL FACTORS**MEDICAID EXTENSIONS/CONTINUATIONS**

Policy: Medicaid is authorized for certain persons after their eligibility has ceased. These extensions/continuations are based on the A/R's previous eligibility.

References:

SSL Sect.	366.4
Dept. Reg.	360-3.3(c)
ADMs	09OHIP/ADM-1 02 OMM/ADM-7 01 OMM/ADM-6 OMM/ADM 97-2 97 ADM-20 95 ADM-21 90 ADM-42 90 ADM-30 90 ADM-9
INF	90 INF-45
GISs	03 MA/010 02 MA/012 98 MA/041 91 MA/042
LCM	98 OMM LCM-002

Interpretation: The following persons are eligible for Medicaid extensions/continuations:

- (1) A person who was eligible for Medicaid in December, 1973 as the spouse of a recipient of old age assistance, assistance to the blind or aid to the disabled (AABD), if such recipient continues to meet the standards of eligibility for aid to the aged, blind, or disabled in effect at that time, and the person continues to be the spouse of such recipient and resides with the recipient.
- (2) A person who was eligible for Medicaid as an inpatient in a medical facility in December, 1973 and who would have been eligible for Aid to the Aged, Blind or Disabled (AABD) at that time, if s/he had not been in the medical facility, for as long as s/he remains eligible according the AABD standards in effect in December, 1973.

CATEGORICAL FACTORS**MEDICAID EXTENSIONS/CONTINUATIONS**

- (3) A person who was eligible for Medicaid under LIF in at least three of the six months immediately preceding ineligibility, when this ineligibility resulted from the collection or increase in child or spousal support. The person remains eligible for four calendar months, beginning with the month following the month in which s/he became ineligible.
- (4) Any certified blind or certified disabled person who is a qualified severely impaired individual will continue to be eligible for Medicaid despite earnings that demonstrate his or her ability to engage in substantial gainful activity under the SSI program. A person is a qualified severely impaired individual if:
- (i) s/he was eligible for Medicaid and received SSI benefits, State supplementary payments, or benefits under section 1619(a) of the Social Security Act in the month preceding the first month in which the provision of this paragraph are applied; and
 - (ii) the Social Security Administration has determined that:
 - (a) the person continues to be blind or to have a disabling physical or mental impairment;
 - (b) the person continues to meet all other requirements for SSI eligibility except for earnings;
 - (c) the lack of Medicaid coverage would seriously inhibit the person's ability to continue or to obtain employment; and
 - (d) the person's earnings are insufficient to provide a reasonable equivalent of the SSI, Medicaid, and publicly funded attendant care benefits that would be available to the person if s/he were not employed.
- (5) A woman eligible for Medicaid during any month of her pregnancy retains eligibility until at least 60 days after the termination of the pregnancy. The 60-day continuation of Medicaid eligibility begins on the last day of the pregnancy and ends on the last day of the month in which the 60th day occurs. To receive the 60-day post partum extension, the woman must have applied for Medicaid prior to the end of her pregnancy.

CATEGORICAL FACTORS

MEDICAID EXTENSIONS/CONTINUATIONS

(6) A woman eligible for Medicaid during any month of her pregnancy is eligible for 24 months of coverage under the Family Planning Extension Program (FPEP). The 24-month extension is applied at the end of the 60-day postpartum continuation. Women who qualify may receive a full range of family planning services, exclusive of abortions, from one of the participating providers (Title X Clinics) for 26 months after the end of their pregnancy regardless of changes in income. If a woman does not recertify for Medicaid after the 60-day postpartum extension, she is still eligible for FPEP for 24 months. Eligibility for the FPEP is based on the woman's self-declaration of pregnancy and evidence of Medicaid coverage at the time of her pregnancy. Claims payment is made outside of the Medicaid Management and Information System (MMIS). FPEP coverage is not reflected on WMS. All women being considered for FPEP must first be considered for eligibility under the FPBP/MA programs. FPEP is only for the women defined above who are ineligible for FPBP/MA due to unsatisfactory immigration status and/or income in excess of 200%.

(7) An infant, born to a woman eligible for and receiving Medicaid at the time of the infant's birth, is eligible for Medicaid until the end of the month in which the child turns age one. When a woman applies for Medicaid within three months after giving birth and it is determined that she was eligible at the time of the birth, the infant is eligible for this one-year extension.

An infant born to a woman eligible for and receiving FHPlus on the date of the infant's birth is eligible for Medicaid until the end of the month in which the child turns age one.

(8) An infant eligible for Medicaid, based on his/her household income being equal to or below 200% of the poverty level, and receiving medically necessary inpatient care and services on his/her first birthday will remain eligible for inpatient coverage until the end of his/her inpatient stay.

(9) A child eligible for Medicaid, based on his/her household income being equal to or below the poverty level standard for his/her age, and receiving medically necessary inpatient care and services on his/her nineteenth birthday will remain eligible for inpatient coverage until the end of his/her inpatient stay.

CATEGORICAL FACTORS

MEDICAID EXTENSIONS/CONTINUATIONS

- (10) A person overcoming a certified disability or certified blindness remains categorically SSI-related through the second month following the month in which the disability or blindness ends. This is a categorical extension only. These persons must meet the financial eligibility requirements for Medicaid as SSI-related recipients.
- (11) A family overcoming an ADC deprivation factor remains categorically ADC-related for three months following the month in which the deprivation ended. The deprivation can end due to any of the following changes in circumstances: a parent is no longer incapacitated; or b) absent parent returns to the home. This is a categorical extension only. The family must meet the financial eligibility requirements for ADC-related Medicaid recipients.
- (12) An individual under the age of 22, if the individual attained the age of 21 while receiving psychiatric services in a State hospital for the mentally disabled, is entitled to a one year extension.
- (13) A child who was in receipt of SSI on August 22, 1996, and whose SSI payment was discontinued on or after July 1, 1997 due to the change in disability criteria as defined by the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, will continue to be eligible in the SSI-related category until the earliest event occurs:
- a) the child reaches 18 years of age;
 - b) the child no longer meets the income and/or resource levels of the SSI program;
 - c) the child no longer meets the definition of disabled that was in effect prior to the PRWORA; or
 - d) the child fails to meet another Medicaid eligibility requirement.

CATEGORICAL FACTORS

MEDICAID EXTENSIONS/CONTINUATIONS

(14) A refugee or a Cuban-Haitian entrant eligible under the Refugee Assistance Program (RAP) who becomes ineligible as a result of increased earnings from employment remains Medicaid eligible for the duration of the RAP eligibility period (currently eight (8) months from the date of entry into the United States). (See **OTHER ELIGIBILITY REQUIREMENTS STATE AND FEDERAL CHARGES REFUGEES AND CUBAN-HAITIAN ENTRANTS**)

(15) Children under the age of 19 are guaranteed coverage for up to 12 months. Each time eligibility is determined, (i.e., at initial determination, and at every recertification or redetermination), children up to the age of 19 who are found fully eligible for Medicaid will be provided coverage for 12 months from the date of the determination or redetermination or until their 19th birthday, whichever is sooner, regardless of any changes in income or circumstances. This also applies to children in families who are in Public Assistance cases and receiving Medicaid. It does not apply to children whose immigration status entitles them only to coverage for emergency medical treatment, to children eligible with a spenddown; or to children only eligible using the SSI-related budgeting methodology.

IV-E Foster Care children are also eligible for continuous coverage, including children in the custody of the Office of Children and Family Services (OCFS) in IV-E eligible settings. Medicaid for all children in Foster Care should be authorized for 12 months from the initial determination, or 12 months from redetermination. State regulations require that Services review Foster Care cases every 6 months. Medicaid should be re-authorized for 12 months each time a Service case is re-determined and eligibility is confirmed.

(16) An individual enrolled in a Managed Care Organization (MCO) is guaranteed six months of Medicaid coverage for the capitated benefits offered through the MCO even if he or she loses Medicaid eligibility. The six-month period of eligibility starts on the recipient's effective date of enrollment in an MCO and continues through the end of the sixth month. Enrollees who are no longer Medicaid eligible and are in guaranteed eligibility status receive pharmacy services through the fee-for-services program and family planning services through free

CATEGORICAL FACTORS

MEDICAID EXTENSIONS/CONTINUATIONS

access policy which allows recipients to access services on a fee-for-service basis as well as in the plan (if capitated). This guarantee does not apply to a recipient who: is incarcerated; dies; moves out of State or requests that his/her case be closed; is a pregnant woman with a net available income in excess of the medically needy income, but at or below 200% of the poverty level. (See **REFERENCE MEDICALLY NEEDY INCOME LEVELS**) Recipients receiving coverage under a guarantee who have excess income and SSI-related recipients who have resources spend down to gain Medicaid eligibility for services outside of their plans. (See **INCOME EXCESS** and **RESOURCES EXCESS RESOURCES**)

- (17) Children age 18 up to age 21 who are final-discharged from foster care and remain in New York State are eligible for Medicaid until the end of the month in which they turn 21. The Medicaid case for the child must contain necessary documentation including identity, citizenship/immigration status, residency, etc..

If it is determined, based on the address received from the foster care worker, that the child is residing in a different county, the “from district” must authorize Medicaid coverage for an initial 12 month period following the foster care discharge. Once authorized, the child’s case can be transferred to the new district of residence using the provisions outline in 08 OHIP/LCM-1, “Continued Medicaid Eligibility for Recipients Who Change Residency (Luberto v.Daines)”.

If it is beneficial, a child who moves back into the Medicaid household of his/her legally responsible parent(s) after discharge from foster care may be included in the household budget of the other family members. However, if including the child in the household is not beneficial, the child must remain eligible on his/her own case until his/her 21st. birthday.

This section also describes the following Medicaid provisions:

- Separate Medicaid Determinations (Rosenberg/Stenson);
- Section 249E of the Public Health Law 92-603;
- Pickle Eligible (formerly 503 cases);
- Disabled Adult Children (DAC); and
- Transitional Medicaid (TMA).

**CATEGORICAL FACTORS
MEDICAID EXTENSIONS/CONTINUATIONS**

SEPARATE HEALTH CARE COVERAGE DETERMINATIONS

Policy: Recipients of Temporary Assistance (TA) and Medicaid who are closed on Temporary Assistance and who are pregnant, under 21 years of age, parents residing with children under age 21, certified blind/disabled, or age 65 and over, are provided a separate determination for Medicaid /Family Health Plus/Family Planning Benefit Program Benefit eligibility. Single adults/childless couples determined ineligible for Safety Net Assistance based on income and whose income is at or below 100% of the federal poverty level will have Medicaid continued pending a separate determination.

References: Dept. Reg. 360-2.2

ADMs 01 OMM/ADM-6
90 ADM-30
82 ADM-5
80 ADM-84
80 ADM-19

Interpretation: When an SSI recipient loses eligibility, Medicaid is continued until a separate Medicaid determination is made.

When a TA recipient loses eligibility, the reason for the TA closing will:

- (1) Allow Medicaid to continue unchanged if the reason for closing the TA case does not apply to Medicaid;
- (2) Prompt a separate determination of Medicaid eligibility if the reason for the TA closing may affect Medicaid eligibility; or
- (3) Close the Medicaid case if the reason for closing the TA case also applies to Medicaid.

The separate determination for Medicaid is completed by the end of the calendar month following the month in which cash assistance was terminated. A separate statement is made in the Notice of Intent advising the recipient of the action to be taken on his/her Medicaid case, the reasons for the action and the supporting regulations.

When the TA case is closed, the separate determination is made from information in the TA case record. If additional information is required, the district requests it from the recipient (Rosenberg court decision).

**CATEGORICAL FACTORS
MEDICAID EXTENSIONS/CONTINUATIONS**

SEPARATE HEALTH CARE COVERAGE DETERMINATIONS

When a SSI cash benefit is discontinued, a separate determination is made from information provided by the Social Security Administration on the SDX. If additional information is required, the local district requests the information from the recipient (Stenson court decision). (See **OTHER ELIGIBILITY REQUIREMENTS RENEWAL**)

NOTE: When an application for both TA and health care coverage is made and TA is denied, a separate health care coverage determination is completed, unless the reason to deny TA is also a proper basis for the denial of health care coverage.

**CATEGORICAL FACTORS
MEDICAID EXTENSIONS/CONTINUATIONS**

SECTION 249E OF THE PUBLIC LAW 92-603

Description: Under Section 249e of Public Law 92-603 A/Rs are entitled to have the amount of their October 1972 social security increase disregarded in the determination of eligibility if they meet the following criteria:

- (1) in August of 1972, they were entitled to Retirement, Survivors and Disability Insurance (RSDI) benefits and eligible for or in receipt of cash assistance under ADC or AABD; or
- (2) in August of 1972, they were entitled to RSDI benefits and would have been eligible for ADC or AABD, except that they were in a medical institution or intermediate care facility; and
- (3) they currently meet the categorical requirements for SSI (aged, certified blind/disabled) or ADC-related persons.

Policy: To determine if an A/R is eligible under 249e:

- (1) determine the amount of the A/R's RSDI benefit in August 1972. This is done by multiplying the A/R's current RSDI benefit by a figure derived from the present and prior percentage increases in RSDI since August 1972. This figure will change each time there is an RSDI cost of living increase. The figure to use to calculate the amount of A/R's RSDI benefit can be found in **REFERENCE SECTION 249E**.
- (2) using the amount of the August 8, 1972 RSDI benefit and other information provided by the A/R, determine if s/he was eligible for ADC or AABD in August 1972 and was terminated due to the 20% SSA increase of October 1972; if yes,
- (3) determine the A/R's current eligibility, disregarding the 20% Social Security increase received in October 1972. To determine the amount of the current Social Security benefit being considered, multiply the A/R's current RSDI benefit by a figure computed from the present and prior percentage increases in RSDI since 1972. This figure will change each time there is an RSDI cost of living increase. This factor can be found in **REFERENCE SECTION 249E**.

**CATEGORICAL FACTORS
MEDICAID EXTENSIONS/CONTINUATIONS**

SECTION 249E OF THE PUBLIC LAW 92-603

References:	SSL Sect.	366.2(b) 363-b
	Dept. Reg.	360-3.3(c)(14)
	ADMs	04 OMM/ADM-2 85 ADM-3
	GIS	04 MA/031

Disposition: The current year RSDI benefit amount is multiplied by the current year RSDI percentage increase based on cost of living increases since August 1972 (both amounts can be found in **REFERENCE SECTION 249E**) to derive the amount used to determine eligibility for AABD in August 1972. If the person would have been eligible in August 1972, the current RSDI amount is multiplied by the factor representing the increases since August 1972 (factor can be found in **REFERENCE SECTION 249E**) to determine the amount, which is considered as income effective for the current year. This also addresses the need to disregard the 20% Social Security increase of October 1972.

**CATEGORICAL FACTORS
MEDICAID EXTENSIONS/CONTINUATIONS**

PICKLE ELIGIBLE (FORMERLY 503 CASES)

Description: Section 503 of Public Law 94-566, referred to as the Pickle Amendment, protects Medicaid eligibility for all recipients of Retirement Survivors and Disability Insurance (RSDI) who were previously eligible for RSDI and SSI benefits concurrently. These recipients are individuals who would be eligible for SSI, if all RSDI COLAs received since they were last eligible for and receiving RSDI and SSI benefits concurrently, were deducted from their countable income. The RSDI beneficiary may have lost his/her SSI benefit for reasons other than COLAs and still be considered a Pickle eligible.

References:

SSL Sect.	366.2(b) 363-b
Dept. Reg.	360-3.3(c)(10)
ADMs	87 ADM-27 85 ADM-35

Interpretation: To be eligible under the Pickle Amendment, an A/R must meet the following criteria:

- (1) On or after April 1977, were eligible for and receiving SSI and RSDI benefits concurrently;
- (2) is currently eligible for and receiving RSDI;
- (3) is currently ineligible for SSI, and
- (4) would be eligible for SSI, if the RSDI COLAs received by the A/R and his/her spouse, since the last month that the A/R received both RSDI and SSI benefits, are disregarded.

A person eligible under the Pickle amendment must meet the SSI income and resource criteria. An A/R cannot spend down to attain Pickle eligibility.

Eligibility for all individuals who meet the Pickle criteria is initially determined by deducting all COLAs received since SSI eligibility was lost. (See **REFERENCE REDUCTION FACTORS FOR CALCULATING MEDICAID ELIGIBILITY UNDER THE PICKLE AMENDMENT**) If the individual's total income (less COLAs) and resources are below current SSI standards, the individual is eligible under the Pickle Amendment.

**CATEGORICAL FACTORS
MEDICAID EXTENSIONS/CONTINUATIONS**

PICKLE ELIGIBLES (FORMERLY 503 CASES)

A notation is made in the case record to identify potential Pickles for future action. A potential Pickle is someone who:

- (1) concurrently received SSI and RSDI after April 1977;
- (2) loses SSI eligibility; and
- (3) was not found eligible for Pickle treatment at the time SSI eligibility was lost.

Disposition:

Anyone who concurrently receives RSDI and SSI and loses their eligibility for SSI is potentially eligible under the Pickle Amendment, except for persons who:

- (1) currently have a recoupment taken against them by SSI for money incorrectly paid or SSI is in the process of making a recoupment effort, even if no money is recouped;
- (2) are closed because they moved out of New York State; or
- (3) received SSI in error.

**CATEGORICAL FACTORS
MEDICAID EXTENSIONS/CONTINUATIONS**

WIDOWS/WIDOWERS

Policy: There are two separate disregards that can apply to widows/widowers.

- A. A person 60 years of age or older who applies for and receives early widow's or widower's insurance benefits under section 202(e) or (f) of the Social Security Act, or receives other benefits under section 202 of such Act but is eligible for widow's/widower's insurance benefits, and who becomes ineligible for SSI as a result of receiving such benefits, will remain eligible for Medicaid so long as:
- (1) s/he would be eligible for SSI payments if s/he were not receiving such benefits; and
 - (2) s/he is not entitled to Medicare Part A benefits.
- B. Certified disabled widows or widowers who lost SSI and Medicaid benefits due to an actuarial adjustment authorized under the Social Security Amendments of 1983 are eligible for Medicaid providing they meet all of the following criteria:
- (1) in December 1983, the potential eligibles were entitled to monthly insurance benefits under Title II of the Social Security Act;
 - (2) the potential eligibles were entitled to widows' or widowers' benefits based on a disability under Title II for January 1984 and also had SSI benefits paid with respect to them in that month;
 - (3) the potential eligibles lost their SSI Benefits because of the increase in the amount of their widow(er)'s benefits for which they became entitled prior to age 60;
 - (4) the potential eligibles have continued to receive their widow(er)'s benefits since January 1984; and
 - (5) the potential eligibles would continue to be eligible for SSI if the amounts of the January 1984 adjustment and any subsequent cost of living adjustments were disregarded in determining their eligibility.

**CATEGORICAL FACTORS
MEDICAID EXTENSIONS/CONTINUATIONS**

WIDOWS/WIDOWERS

References: SSL Sect. 366
 Dept. Reg. 360-3.3(c)(9)
 ADM 87 ADM-27

**CATEGORICAL FACTORS
MEDICAID EXTENSIONS/CONTINUATIONS**

DISABLED ADULT CHILD (DAC) BENEFICIARIES

Description: Section 6 of Public Law 99-643 (42 U.S.C. 1383c(c)), provides that individuals who lose SSI eligibility because of the receipt of Social Security Disabled Adult Child (DAC) benefits, or because of an increase in the amount of these benefits are eligible for Medicaid if certain criteria are met.

Policy: DAC Social Security benefits are received upon the disability, retirement or death of a parent. An individual is eligible for Medicaid as a DAC beneficiary if all of the following criteria are met:

- (1) the individual is at least 18 years old;
- (2) the individual became certified blind or certified disabled before reaching the age of 22;
- (3) the individual was receiving SSI benefits on the basis of blindness or disability;
- (4) the individual lost SSI benefits on or after July 1, 1987; and
- (5) the individual's loss of SSI benefits was the result of entitlement to a DAC benefit, or an increase in the benefit.

When the criteria are met, and the individual would be eligible for SSI benefits if the amount of the initial entitlement or an increase in the DAC benefit were disregarded, the individual is eligible for Medicaid.

References: ADMs 95 ADM-11

LCMs 92 LCM-41 (February 28, 1992)

Interpretation: For an individual who lost SSI eligibility because of the initial entitlement to a DAC benefit, the entire amount of the DAC benefit is disregarded in the determination of countable income, including any subsequent increases in the benefit. When ineligibility for SSI was due to an increase in the DAC benefit, the amount of DAC benefits received in the month prior to the termination of SSI is the amount of DAC benefits that are counted in determining eligibility. Any subsequent increase(s) in DAC benefits is disregarded. If the

**CATEGORICAL FACTORS
MEDICAID EXTENSIONS/CONTINUATIONS**

DISABLED ADULT CHILD (DAC) BENEFICIARIES

individual would be eligible for SSI (SSI income and resource levels) by disregarding the DAC benefit or increase(s) in the benefit, s/he remains eligible for Medicaid under the DAC provision.

NOTE: When determining Medicaid eligibility for individuals who have been identified as DACs, districts first determine eligibility under the DAC provision, even if the individual appears to have income under the medically needy level. If eligibility cannot be established under the DAC provision, SSI-related budgeting procedures apply.

When a Medicaid recipient eligible under the DAC provision has an increase in either income (other than the DAC benefit) or resources that would have resulted in a loss of SSI eligibility, the recipient will also lose DAC status for Medicaid. By budgeting the DAC benefit, the individual may be subject to a spenddown requirement. If the income and/or resources are reduced to the point where the individual would again be entitled to SSI benefits except for the increase in or entitlement to the DAC benefit, the individual would again become eligible for Medicaid under the DAC provision.

Individuals who are eligible for Medicaid under the DAC provision are evaluated for QMB eligibility. The individual's actual gross income (without disregarding the DAC benefit) is used when determining QMB eligibility (See 89 ADM-7). Regardless of QMB eligibility, individuals who are eligible for Medicaid under the DAC provision are eligible for Medicaid payment of Medicare Part B premiums as is done for the original buy-in groups including SSI recipients and persons qualifying under Sections 503 (Pickles) and 1619(b) of the Social Security Act (Public Law 99-509).

NOTE: In determining the amount of income available for the cost of care under chronic care budgeting, (See **INCOME CHRONIC CARE BUDGETING METHODOLOGY FOR INSTITUTIONALIZED SPOUSES** and **CHRONIC CARE BUDGETING METHODOLOGY FOR INDIVIDUALS**) DAC benefits are considered available income and added to all other sources of available income.

**CATEGORICAL FACTORS
MEDICAID EXTENSIONS/CONTINUATIONS**

TRANSITIONAL MEDICAID (TMA)

Policy:

In order to assist families in making the transition from Medicaid under the Low Income Families (LIF) category of assistance to self-sufficiency as a result of employment, a twelve (12) month extension of Medicaid benefits is mandated under certain circumstances. Twelve (12) months of Transitional Medicaid (TMA) is available if the household: (1) is ineligible under LIF due to new or increased earned income of the parent/caretaker relative, or the loss of an income related disregard; (2) includes a dependent child (under age 21) living in the household; and (3) was receiving Medicaid under LIF in one out of the last six (6) months prior to the termination of eligibility. Earnings may be in combination with unearned income. When the household's income consists solely of unearned income, the household is not eligible for TMA. There is no requirement for continued employment during the TMA authorization period.

NOTE: Members of a household may be eligible for TMA when the parent/caretaker relative is not in receipt of Medicaid under the LIF category of assistance, if all other TMA criteria are met. For example: A mother receives SSI cash assistance and has Medicaid. Her two children receive Medicaid under LIF in a separate case. When she becomes employed, she loses her eligibility for SSI. When the new, earned income is counted, the family becomes ineligible for Medicaid under LIF. However, the children meet the TMA criteria and are authorized for the twelve month TMA extension. The mother's eligibility for Medicaid is determined applying appropriate rules.

References:

SSL Sect.	366
Dept. Reg.	360-3.3(c) 369.1 385.14(d)
ADMs	11 OHIP ADM-05 OMM/ADM 97-2 90 ADM-30
GIS	09 MA/023

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INCOME

Description: Income is any payment received by the A/R from any source. Income may be recurring, a one time payment, earned or unearned.

Policy: All income is reviewed to determine if it is available (See **OTHER ELIGIBILITY REQUIREMENTS OWNERSHIP AND AVAILABILITY**) and countable. Certain types of income are disregarded by statute or regulation.

References:

SSL Sect.	366.2
Dept. Reg.	360-4.3 360-2.3
ADMs	93 ADM-29 91 ADM-27

Interpretation: Income is considered in the month it is received. Disregards are subtracted from gross countable monthly income. Disregards are established by statute or regulation (see the appropriate category). Any remaining net monthly income is compared to the appropriate income level. (See **INCOME INCOME LEVELS**) Income in excess of the level is considered available to meet the cost of medical care. (See **INCOME EXCESS**) Any amounts retained beyond the month of receipt are considered resources. (See **RESOURCES RESOURCES**)

Lump sum payments (benefit awards, bonuses, year end profit sharing, retroactive pay increases, severance pay, etc.) and windfall payments (inheritances, court settlements, lottery winnings, gifts, etc.) may be considered either income or a resource depending on the category of the A/R and the type of payment. (See **INCOME LUMP SUM PAYMENTS**)

NOTE: Mandatory deductions/payments (taxes, FICA, New York State Disability, etc.) are generally not disregarded.

**Verification/
Documentation:** All income and its availability is verified and documented in the case record. When information cannot be verified, the attempts to verify are documented.

INCOME**EARNED**

Description: Earned income is income received as a result of work activity. This includes wages, salaries, tips, commissions and income received from self-employment.

Policy: Gross earned income is determined and a decision made as to its availability. All applicable disregards are deducted. The remaining amount of earned income is added to any other income to determine the available net income.

NOTE: Mandatory deductions/payments (taxes, FICA, New York State Disability, etc.) are generally not disregarded.

The earned income of any child under age 21 who is attending school and who is employed may or may not be disregarded depending on his/her status. For further information regarding student disregards see Income Disregards under the specific categorical methodology.

References:

SSL Sect.	366.2(a)
Dept. Reg.	360-4.3
	360-4.6

INCOME**EARNED**

Interpretation: Gross earned income is determined based upon wage verification from the employer. In determining the effect of earnings on prospective income, a number of factors are considered in addition to the current wage verification. Some of these factors may include permanence of employment or position, permanent increase or reduction in hours worked, permanent change in rate of pay and seasonal variations or additional seasonal employment. Although income tax records are not required, in many cases where much of the income does not appear on the wage verification, it is valuable to see the income tax records of the A/R. This is also valuable when it is suspected that the A/R might have an additional source of income (a second job, an employed spouse, etc.). In these instances, it is often necessary to request income tax records, in addition to verification of wages, salary, etc. which can be obtained from pay stubs or from the employer.

Irregular earnings or income from casual employment may be extremely difficult to verify when the A/R declares that this is the method by which s/he supports him/herself. It is necessary to obtain as clear a picture of his/her income as possible. Determining the type of work, frequency of employment and prevailing wages is necessary if verification from employers is not available. In this manner, a reasonable figure consistent with the maintenance picture can be obtained from any other available source, including the A/R, to be used in determining eligibility for Medicaid.

Disposition: When the gross earned income is determined, disregards are deducted to result in the available net income. This, in addition to any other income, is then compared to the appropriate income level in determining eligibility for Medicaid.

The following types of earned income are considered in this section:

- Wages and Salaries
- Tips
- Commissions, Bonuses and Similar Payments
- Self-Employment or Small Business Income
- Income from Roomers (Lodgers) and Boarders

INCOME EARNED

WAGES, SALARIES AND CONTRACTUAL INCOME

Description: Wages are cash payments, for labor or services. Wages are paid on an hourly, daily, or piecework basis. For example: a factory worker may be paid \$5.00 an hour; a different factory worker may be paid \$.03 for every bolt s/he tightens; a farmer may pay a worker by the day during harvest; or an A/R may clean a house for an agreed upon wage, regardless of how long it takes.

Salaries are fixed cash compensation, paid regularly, for labor or services. Salaries are generally paid weekly, biweekly, or monthly. Salaries do not vary with the amount of labor or services produced. However, a salaried employee's income may vary occasionally due to overtime pay, bonuses, commissions, etc. (See **INCOME LUMP SUM**)

Contractual income is income paid on a contractual basis. The income is intended to cover a specific period of time. This includes, but is not limited to school employees. For all categories, except SSI-related, the income is averaged over the months covered by the contract, regardless of whether the employee chooses to receive/be paid the income in fewer or more months than the contract covers. For example: a school aide is employed under a yearly contract, but only receives a paycheck for the months of September through June. The pay for September through June should be added and divided by 12 to determine the A/R's monthly income.

For SSI-related A/Rs contractual income is budgeted as received.

Policy: All income is reviewed to determine if it is available (See **OTHER ELIGIBILITY REQUIREMENTS OWNERSHIP AND AVAILABILITY**) and countable. Income is generally considered in the month it is received. See above for a description of when to consider contractual income.

References: Dept Reg. 360-2.3
ADM 93 ADM-29

Interpretation: Wages and salaries are verified. State computer matches are reviewed to determine the source of income. When determining eligibility for a retroactive period, the actual income received by the A/R is budgeted.

**INCOME
EARNED****WAGES, SALARIES AND CONTRACTUAL INCOME**

When determining eligibility for a prospective period, the local district estimates the A/R's future income. When the A/R's income is constant or salaried, one (1) pay stub within the past four (4) weeks is acceptable as an overall representation of income. If the A/R's income varies, the A/R's wages for the four (4) weeks immediately preceding the application are averaged. If the A/R received an exceptionally high or low payment during this period, that payment may be disregarded. When the A/R cannot supply documentation, the social services district can accept other forms of information, which it determines will verify the wages earned.

When the A/R is paid a salary for labor or services provided over a period greater than one month, the salary is broken down to determine monthly income.

When to Verify: When the A/R indicates that s/he is employed.

When the A/R indicates that s/he was employed in the recent past.

When the Resource File Integration (RFI) reports indicate that the A/R has income.

If the A/R indicates that he/she lost or changed jobs in the last three months and provides his/her former employer's name, even if this information still appears on the RFI system, the LDSS must accept the information on the application and not require additional documentation (e.g. Employment Verification form, LDSS-3707) from the former employer to prove loss of employment.

Documentation: Sufficient to establish an audit trail:

- The pay stubs; pay checks; or a written statement from the employer;
- In the event the A/R does not have pay stubs or receive pay checks, Attachment IV to 10 OHIP/ADM-05 is used, "Verification of Employment" and is sent to the A/R for him/her to give to his/her employer to complete;
- The A/R's income tax return, W-2 form, or records of bank deposits may be used; or
- When an A/R indicates that he/she is paid in cash because he/she is paid "off the books" and his/her employer refuses to provide a statement of wages, the Self-Declaration of Income form (10 OHIP/ADM-05 Attachment V) must be filled out by the A/R.

**INCOME
EARNED****TIPS**

Description: Tips are a gratuity paid to persons engaged in personal service, based upon a percentage of the price of goods or services, exceptional service or preferred attention.

Policy: Tips received by the A/R and members of his/her household are considered in determining eligibility for Medicaid.

References: SSL Sect. 366.2(a)
Dept. Reg. 360-4.3

Interpretation: Tips given to people working in personal service occupations are often a significant part of their income. Wages and salaries paid to such persons are often quite low because tips are expected to provide a large portion of their income. Tips may vary seasonally or by the quality and type of service rendered. Some occupations for which tips may constitute a substantial portion of earnings are:

- Waiters and waitresses
- Taxi drivers
- Bellhops
- Bus persons
- Bartenders
- Porters
- Shoe shiners
- Delivery persons
- Barbers and beauticians
- Chambermaids
- Checkroom, locker room and washroom attendants
- Masseurs and masseuses
- Caddies
- Vending stand operators
- Entertainers who play in restaurants, bars or nightclubs
- Parking attendants

Since the list is not all inclusive, income from tips is considered for any A/R who is engaged in a personal service occupation.

**INCOME
EARNED****TIPS**

In determining the amount of gross earned income an A/R receives from tips, a reasonable estimate of tips may be obtained if such factors as the number of persons served and the kind of establishment are kept in mind. For example, a person working in the dining room of a major hotel would generally receive larger tips than a person working in a small coffee shop.

When to Verify Status: (a) When the A/R declares income from tips on the application;

(b) When the A/R is employed in one of the occupations listed above or another personal service occupation,

Verification: While there is no standardized method for verifying tips, the following techniques have proven useful:

(a) Seeing the A/R's income tax return;

(b) Obtaining a statement from the employer with an estimate of the A/R's tips earned.

**INCOME
EARNED****COMMISSIONS, BONUSES AND SIMILAR PAYMENTS**

Policy: Commissions, bonuses or other amounts paid on the basis of superior performances, sales made or goals accomplished are considered earned income and the amount paid is verified.

References: SSL Sect. 366.2(a)
Dept. Reg. 360-4.3
ADM 92 ADM-32

Interpretation: The situations in which commissions, bonuses, royalties and other similar payments are made vary considerably. The A/R may be paid under a commission only, salary plus commission, guaranteed minimum commission or draw against future commissions. The commissions may be a percentage of sales price or a flat amount per unit sold.

Royalties are payments such as remuneration to the holder of a patent or copyright for the use of an invention or the duplication of a writing, or to the owner of a mine for the extraction of a product such as oil, gas or minerals.

In the event that the A/R has incurred expenses in generating the commissions or royalties such as promotional literature, samples or costs for transporting customers, the expenses are verified and deducted from the amount of the commissions to obtain the gross earned income.

Some employed persons are paid bonuses based upon individual or group achievement, production, sales goals, or employer profits. These may be paid annually or more frequently. When commissions, bonuses, royalties or similar payments are paid less frequently than monthly, a decision as to how to treat such payments is based on the category of the A/R.

**INCOME
EARNED****COMMISSIONS, BONUSES AND SIMILAR PAYMENTS**

For all categories, royalty payments are treated as earned income in the month received and as a resource thereafter. For SSI related A/Rs, the district must determine whether the royalty will be considered infrequent or irregular income and apply the appropriate policy. (See **INCOME SSI-RELATED DISREGARDS**)

When to Verify Status:

- (a) When the A/R declares in the application that s/he is a salesperson, route person, or employed in another occupation related to selling goods and services;
- (b) When the A/R indicates in the application that s/he has recently been employed as a salesperson (s/he may have residual commissions which are due to be paid to him/her, especially in the field of contract sales);
- (c) When the A/R indicates that s/he receives commissions or bonuses as part of the conditions of employment or is employed by a business which is known to pay bonuses.
- (d) When the A/R indicates that s/he is a writer or has produced another product from which a royalty may be provided as payment.

**INCOME
EARNED****COMMISSIONS, BONUSES AND SIMILAR PAYMENTS**

- Verification:**
- (a) Seeing a statement from the employer stating the criteria for payment of commissions bonuses or royalties and the anticipated earnings;
 - (b) Seeing the income tax return for the previous year;
 - (c) Seeing wage statements; and
 - (d) If applicable, seeing statements of expenses.
- Documentation:** Sufficient to establish an audit trail:
- (a) Employer's statement verifying the amount and pay period of salary, if any, and the amount of past commissions , royalties or bonuses; and
 - (b) Name of the supplier, date, amount and item of business expenses; or.
 - (c) Copies of the A/R's income tax return for the previous year.

**INCOME
EARNED****SELF-EMPLOYMENT OR SMALL BUSINESS INCOME**

Description: Self-employment, small business or farm income is income that results from work activity on the part of the A/R, in which s/he is self-directing and receives compensation directly from the customer.

Policy: After allowable business expenses have been deducted, the remaining income is considered available earned income of the A/R and is subject to the appropriate budgeting methodology based on the category of the A/R.

References: SSL Sect. 366.2(b)
Dept. Reg. 360-4.3(c)
GIS 09 MA/025
01 MA/024

Interpretation: When an individual is self-employed or owns or operates a small business in which s/he is employed, certain costs related to the business or self-employment (e.g. the cost of materials, supplies, and labor) are deducted from the gross income for the purpose of determining eligibility for Medicaid.

Following are some of the items of business expenditures which are generally deductible from gross business income:

- Rental of quarters, equipment, or furniture;
- Salaries and fringe benefits of employees;
- Cost of goods for re-sale;
- Business taxes, licenses and permits;
- Cost of tools, supplies and raw materials;
- Insurance for the business;
- Lights, heat, water, sewage and telephone charges;
- Advertising and travel;
- Taxes and carrying charges on any property used in the business.

NOTE: For SSI-related A/Rs, depreciation costs for buildings, equipment and materials necessary for and directly related to the operation of the business are also deducted from gross income. Depletion, amortization and 179 expenses, which are types of depreciation, may also be deducted for the SSI-related.

INCOME EARNED

SELF-EMPLOYMENT OR SMALL BUSINESS INCOME

Following are some of the items of business expenditures, which are **not** deductible from gross business income:

- Payments on the principal for real property used wholly or partially in the business;
- Any expenses which are not directly related to the operation of the business, (for example, personal expenses such as lunch or transportation for work).

Income and expenses are generally considered on an annual basis. The difference between income and expenses is then divided by 12 to establish the A/R's monthly earned income. The primary source for verifying the A/R's income and expenses is his/her income tax records.

How to Estimate Net Earnings from Self-Employment:

If the A/R has been conducting the same trade or business/farm for several years; has had net earnings which have been fairly constant from year to year; and anticipates no change or gives no satisfactory explanation why net earnings would be substantially lower than in the past, take the net profit from the past year as an estimate for the current year. Divide yearly net profit by 12 to determine monthly income.

If an A/R is engaged in a new trade or business/farm, give the A/R the Financial Status (Farm or Business) Form (DOH-4469) to complete. Divide net profit by 3 to project monthly income for the next year.

NOTE: When using the three-month business record, a loss in one month may be used to offset a profit in another month. If an A/R owns more than one business, and tax returns are not available, a DOH-4469 must be completed for each business. A loss in one business does not offset a gain in another.

**INCOME
EARNED**

SELF-EMPLOYMENT OR SMALL BUSINESS INCOME

Procedure to Determine Net Profit

Income Tax Return

<u>Business Organization</u>	<u>Documentation</u>
Single Owner Business/Farm	tax return including Schedule C or C-EZ or Schedule F (farm) or Financial Status Form (farm or business) DOH- 4469
Partnership	tax return including Schedule E or F (farm) or Form 1065 and Schedule K-1 and W-2 if applicable or partnership agreement or Form 1065, Partnership Return or Schedule K-1 (1065) or Financial Status Form (farm or business) DOH- 4469
S-corporation	Tax return (Form 1120S) and Schedule K-1 and W-2 if applicable, or Financial Status Form (farm or business) DOH- 4469

Take net profit from appropriate lines of schedules, and:

For LIF, Medically Needy (ADC-Related) and S/CC A/Rs, add back any depreciation, depletion, amortization or 179 expenses, deducted;
or

For SSI-related A/Rs, because depreciation, depletion, amortization, 179 expenses are allowed, use net profit as gross income.

NOTE: One-half of self-employment tax as listed under Adjustments to Income on Form 1040, is an allowable deduction for all categories.

**INCOME
EARNED****SELF-EMPLOYMENT OR SMALL BUSINESS INCOME**

Do not allow personal expenses and entertainment, personal transportation, purchase of capital equipment to expand a business*, or payment on the principal of loans or mortgages. Depreciation, depletion, amortization and 179 expenses may be allowed for SSI-related A/Rs.

***NOTE:** The repair or replacement of existing capital equipment is allowed.

Assume that all deductions taken on tax returns or business records are allowed by the IRS, unless there is conclusive evidence to the contrary.

If the **annualized** self-employment income indicates a loss (negative dollar amount), use zero income.

EXCEPTION: Within a single type of business, use zero income only when the tax return or business record indicates a cumulative loss, for example: an A/R has three rental properties; two show a net profit and one shows a net loss; use the loss to off-set the profits, and do not reduce the loss to zero unless the cumulative bottom line for the three properties is a negative dollar amount.

If tax returns are not available because the A/R indicates:

- that the business is new, and no federal tax return has yet been filed; or,
- that last year's tax return is not representative of the current year's earnings; or,
- that s/he does not file a tax return for the business,

then the Financial Status Form (DOH-4469) can be used to document the self-employment income.

**INCOME
EARNED****SELF-EMPLOYMENT OR SMALL BUSINESS INCOME**

Inasmuch as, the DOH-4469 reflects a three-month financial snapshot of a business, it is appropriate to allow a loss in one month to offset a profit in another month. When using an annualized business record such as a tax return a business loss is brought to zero, and cannot be used to reduce income from another source.

A/Rs are not required to supply actual bills and receipts to substantiate the income and expenses recorded on the Financial Status form (DOH-4469). The applicant's certification on the bottom of the form, that the information is true and correct, is sufficient.

Documentation: Sufficient to establish an audit trail.

Disposition: When the gross business income is determined and the business expenses are determined and deducted, the resulting amount is earned income.

NOTE: The A/R's income is evaluated against the maintenance picture of the A/R. (See **OTHER ELIGIBILITY REQUIREMENTS FINANCIAL MAINTENANCE**)

INCOME EARNED

INCOME FROM ROOMERS (LODGERS) AND BOARDERS

Description: Income from roomers (lodgers) and boarders is payment received by the A/R for meals and/or lodging from other individuals residing in the home who are not members of the A/R's Medicaid household.

Roomers (lodgers) rent a room or rooms and receive no meals as part of the rent. Boarders rent a room or rooms and receive meals as part of the rent.

Policy: The treatment of income from roomers and boarders varies depending on the category of the A/R. For all categories of assistance, if the A/R can document that actual expenses incurred in providing the room or board exceed the specified roomer/boarder deduction, the actual expenses are disregarded and any money received in excess of this documented amount is considered available income.

When an SSI-related A/R provides room and/or board as a business rather than as a convenience for relatives or friends, the income is considered to be earned income. Motels, hotels, rooming houses and boarding houses are considered businesses. If the SSI-related A/R does not provide room or board as a business, the income is treated as unearned income. For LIF, S/CC and ADC-related categories of assistance, roomer/boarder income is always treated as earned income.

References:

SSL Sect.	366
Dept. Reg.	352.31(a)(3) 360-4.3 360-4.6(a)(1)(xviii)

Interpretation: To determine countable roomer/boarder income, the following roomer/boarder disregard is to be applied based on the category of the A/R.

\$15 for S/CC and LIF - roomers (meals not included)

\$60 for S/CC and LIF - boarders (meals included)

\$90 for ADC-related and SSI-related roomers or boarders
(meals may or may not be included)

INCOME EARNED

INCOME FROM ROOMERS (LODGERS) AND BOARDERS

For all categories of assistance, if the individual can document that the actual expenses paid in providing room or board are greater than the allowable roomer/boarder disregard, the actual expenses are deducted.

In determining if the actual expenses paid in providing room and/or board exceed the monthly roomer/boarder deduction, the following expenses are deductible:

- property, school, water and sewer taxes;
- utilities;
- interest payments on mortgages;
- cost of essential repairs;
- food (if included in rent)

A person providing room/board as part of a business, may deduct allowable business expenses paid the same taxable year to the extent the expenses are attributable to the rented portion of the property.

The allowable expenses incurred in providing room and board are prorated based on the number of rooms designated for rent compared to the number of rooms (other than bathrooms) in the house.

If income received for room or board is less than the allowable expenses of providing room or board, the excess expenses are deducted from the next month's roomer/boarder income.

- When to Verify:**
- (a) When the A/R declares in the application that s/he has income from roomers or boarders;
 - (b) When the A/R declares in the application that persons live with him/her who are not applying for assistance and who contribute to the support of the household;
 - (c) When the case record indicates that the A/R received income from roomers and/or boarders, but does not currently declare that s/he is receiving it.

**INCOME
EARNED****INCOME FROM ROOMERS (LODGERS) AND BOARDERS**

- Verification:**
- (a) Seeing a statement from the roomer and/or boarder as to the amount and frequency of his/her payment;
 - (b) Seeing any business records that the A/R may have maintained; and/or
 - (c) Seeing records of actual expenses if greater than the categorical standard disregard;
- Documentation:** Sufficient to establish an audit trail:
- (a) Name of the roomer or boarder, plus the amount and frequency of payment; and/or
 - (b) Copies of actual expense listing, if the costs are greater than categorical disregard.

INCOME**UNEARNED**

Description: Unearned income is income which is paid because of a legal or moral obligation rather than for current services performed. It includes pensions, government benefits, dividends, interest, insurance compensation and other types of payments.

Policy: The available net amount of unearned income, in addition to any other countable income, is compared to the appropriate income level.

References: SSL Sect. 366.2
Dept. Reg. 360-4.3

Interpretation: The following types of unearned income are described in detail in this section:

Unemployment Insurance Benefits;
NYS Disability Benefits and Workers' Compensation
Social Security, Railroad Retirement, Veterans' Benefits;
Dividends and interest;
Private pensions/Retirement Funds;
Union benefits;
Support payments (voluntary and court-ordered);
Contributions from relatives and friends;
Income from rental of property;
Military Dependency allotments; and
Reverse Mortgages.

Unearned income is verified as to the amount, type and frequency, and the information is documented in the case record.

Disposition: When the gross unearned income has been determined, disregards are deducted to result in available net unearned income. This, in addition to any other countable income, is then compared to the appropriate income level in determining eligibility for Medicaid.

**INCOME
UNEARNED****UNEMPLOYMENT INSURANCE BENEFITS (UIB)**

Description: Unemployment Insurance Benefits (UIB) are benefits to offset the loss of earned income for certain workers who have lost their jobs through no fault of their own. The program is administered by the New York State Department of Labor. The claimant applies by making a toll-free phone call or through an on-line process at the NYSDOL website. Benefits are paid by check. The amount of benefits is based upon income earned while employed.

Policy: UIB is countable unearned income.

NOTE: The American Recovery and Reinvestment Act (ARRA) of 2009 "Stimulus Bill", Public Law 111-5 Section 2002 authorized additional unemployment insurance benefits (UIB) of \$25 per week effective the period March 1, 2009 through the week ending December 12, 2010. The additional payment of \$25 per week must be disregarded when determining retroactive, initial, and on-going eligibility for all Medicaid A/Rs receiving UIB.

Reference:

INFs	88 INF-84
GISs	10 MA/024 09 MA/018 09 MA/012

When to Verify:

- (a) When the A/R indicates in the application that s/he has applied for, or is receiving UIB;
- (b) When the A/R indicates in the application that s/he has recently been employed, but is now unemployed;
- (c) When the case record indicates that the A/R has been in receipt of UIB, but does not declare in the application that s/he is currently in receipt of UIB.

Verification: Benefits may be verified by:

- (a) The Resource File Integration (RFI) WMS subsystem;
- (b) Seeing the benefit check;
- (c) Seeing the UIB claim award letter sent to the A/R detailing the status and amount of the claim;
- (d) Seeing a current on-line printout of UIB that the A/R can access with their unique password; or

**INCOME
UNEARNED****UNEMPLOYMENT INSURANCE BENEFITS (U.I.B.)**

(e) If none of the above is available and cannot readily be obtained by the A/R or additional information is needed, clear through the NYS Department of Labor (DOL) Unemployment Insurance On-line System. This system can be accessed through the county's TTSS coordinator.

Documentation: Sufficient to establish an audit trail:

- (a) Screen print of the RFI WMS subsystem, filed in the case record;
- (b) Date, number and amount of check;
- (c) Date of initial filing and benefit amount;
- (d) Returned clearance from the NYS UIB-MIS filed in the case record.

Related Form: LDSS-3861 (UIB Current Inquiry) and LDSS-3936 (UIB Investigative Inquiry).

**INCOME
UNEARNED**

**NEW YORK STATE DISABILITY INSURANCE
BENEFITS, WORKERS' COMPENSATION AND SICK PAY**

Description: (1) **New York State Disability Insurance Benefits (DIB)** are cash benefits to offset the loss of earned income for certain workers who are unable to work because of a non-job-related injury, disease, or condition. There are also cash benefits to offset the loss of Unemployment Insurance Benefit (UIB) for persons who are unemployed and are unable to accept employment because of illness or injury.

For employed persons and those unemployed less than four weeks, application is made to the employer. Medical verification is required. When the person is eligible, the employer's insurance carrier pays benefits bi-weekly by check.

For persons unemployed more than four weeks, application is made to the local office of the State Department of Labor. Medical verification is required. If eligible, benefits are paid bi-weekly by state check.

(2) **Workers' Compensation** can be a cash benefit to offset the loss of earned income for certain workers who are unable to work because of a job-related injury or disease. It can also be a payment made directly to a medical provider for the cost of care required to treat a work related injury. Payments made directly to medical providers are not considered unearned income. Rather they are similar to third party health insurance payments. If the injury or disease results in death, the benefits may be paid to the surviving dependents of the worker. Benefits include all necessary medical care arising from the job-related injury or illness. A claim for Workers' Compensation is made with the employer. Medical verification is required.

Benefits are paid by either the employer or in most cases his/her insurance carrier on a bi-weekly basis or as a lump sum. Benefits may be either temporary or permanent, and either partial or total, dependent on the severity and prognosis of the injury or disease. Only the cash benefit to offset loss of earned income is considered unearned income.

**INCOME
UNEARNED****NEW YORK STATE DISABILITY INSURANCE
BENEFITS, WORKERS' COMPENSATION AND SICK PAY**

- (3) **Sick Pay as Unearned Income** are any payments made due to sickness and/or accident disability more than six months after the A/R stopped working because of that sickness or disability, is unearned income. Sick pay received during the first six months is earned income (See **INCOME EARNED**).

Policy: NYS DIB, Workers' Compensation and sick pay are countable income.

When to Verify: When the A/R indicates in the application that s/he has applied for or is receiving DIB and/or Workers' Compensation Benefits;

When the A/R indicates in the application that s/he has recently been employed or has recently received UIB and indicates in the application that s/he is ill or injured;

When the case record indicates that the A/R was in receipt of DIB, Workers' Compensation and/or sick pay, but the A/R does not declare that s/he is currently receiving DIB, Workers' Compensation and/or sick pay.

Verification: Benefits may be verified by:

- Seeing the benefit check;
- Seeing a letter from the insurance carrier or the Workers' Compensation Board denying or terminating benefits;
- Clearing in writing through the usual local district procedure.

Documentation: Sufficient to establish an audit trail:

Date, number and amount of check, and name and address of payer (insurance or state fund);

Date and sender of letter, and disposition;

Returned clearance filed in case record.

NOTE: Workers' Compensation and New York State DIB and sick pay do not establish incapacity or SSI-related disability status for Medicaid purposes. A separate determination of incapacity or disability is done for A/Rs. (See **CATEGORICAL FACTORS INCAPACITY**)

**INCOME
UNEARNED**

**SOCIAL SECURITY (RETIREMENT, SURVIVORS' AND
DISABILITY INSURANCE), RAILROAD RETIREMENT AND VETERANS' BENEFITS**

- Description:**
- 1) **Retirement, Survivors' and Disability Insurance (RSDI)**, commonly referred to as Social Security, is a federally administered program which provides cash benefits to offset the loss of earned income for retired, certified disabled workers and/or the dependents of the retired, disabled or deceased income earner.
 - 2) **Railroad Retirement** cash benefits are paid to retired or certified disabled railroad workers and/or to the surviving dependents of retired, disabled or deceased railroad workers.
 - 3) **Veterans' benefits** are cash benefits paid to retired or disabled veterans and their dependents, or to surviving dependents of veterans.

References: ADM 93 ADM-31

- Interpretation:**
- 1) **RSDI** - Application for these benefits is made at a Social Security Administration district office. Verification of age, medical disability if under age 65, relationship and/or earnings may be required. Recipients may be eligible for Medicare Parts A and B.

When an individual is in RSDI claim status, s/he is identified by a Social Security Number with a benefit identification code suffix which describes his/her status. The following is a list of commonly used suffixes and the status which they describe:

<u>Suffix Code</u>	<u>Status</u>
A	Primary Claimant
B(1-9), (A-Y)	Husband or wife of Primary Claimant
C(1-9), (A-K)	Child, includes minor child, disabled child, and student child
D(1-9), (A-Z)	Widow, widower, or surviving divorced spouse
E(1-9), (A-M)	Widowed parent or surviving divorced parent
F(1-8)	Parent, stepparent, adopting parents, second alleged parent
J(1-4)	Primary Prouty Benefit (Special over age 72)

**INCOME
UNEARNED**

**SOCIAL SECURITY (RETIREMENT, SURVIVORS' AND
DISABILITY INSURANCE), RAILROAD RETIREMENT AND VETERANS' BENEFITS**

<u>Suffix Code</u>	<u>Status</u>
K(1-9) or KA-M	Wife's Prouty Benefit (Special over age 72)
W(1-9)	Disabled widow, disabled widower or surviving disabled divorced spouse

- (2) **Railroad Retirement Benefits** - When the eligible employee is alive, all benefits, including dependents' benefits, are paid to him/her. Survivors' benefits are paid directly to the surviving dependents. Benefits are paid monthly. Beneficiaries are also potentially eligible for Medicare Parts A and B.
- (3) **Veterans' Benefits** - The veteran may be retired, or partially or totally disabled by either a service connected or non-service connected disability.

Dependents or surviving dependents of veterans may also be entitled to benefits. In addition to cash benefits, eligible veterans and their dependents may receive educational benefits, medical and/or dental care. When a veterans' benefit paid to the A/R includes a dependent's benefit, only the portion of the benefit designated by the Veterans' Administration to the A/R is considered in determining the A/R's eligibility. If the dependent is not applying, his/her portion is disregarded.

NOTE: Even if a veteran is not eligible for cash VA payment, s/he may be eligible for medical care through the VA. (See **OTHER ELIGIBILITY REQUIREMENTS VETERANS' AFFAIRS REFERRAL**) Availability of these medical benefits does not affect eligibility for Medicaid.

When to Verify:

- (a) When there is an indication either in the application or by a benefit suffix as listed above, that an A/R, a member of the applying household or a legally responsible relative is in benefit status for RSDI;
- (b) When the A/R indicates in the application that s/he is 62 years of age or older;
- (c) When the A/R declares on the application that s/he is widowed and 60 years of age or older and/or is caring for minor children;

**INCOME
UNEARNED**

**SOCIAL SECURITY (RETIREMENT, SURVIVORS' AND
DISABILITY INSURANCE), RAILROAD RETIREMENT AND VETERANS' BENEFITS**

- (d) When the A/R declares on the application that s/he is blind or disabled and the disability is permanent or is expected to last a year;
- (e) When the A/R declares on the application that a spouse or the parent of a minor child under age 18 (or under age 19 if the child is still a student in secondary school) is deceased, retired or disabled;
- (f) When the case record indicates that the A/R received RSDI, but the A/R does not indicate that s/he is currently in benefit status;
- (g) When the A/R declares on the application that s/he or other family members are receiving Medicare;
- (h) When the A/R declares on the application that s/he is receiving Railroad Retirement benefits;
- (i) When the A/R declares on the application that s/he has been an employee of the railroad or is the dependent or surviving dependent of someone who has;
- (j) When the case record shows that the A/R received Railroad Retirement benefits, but the A/R does not declare that s/he is currently receiving such benefits;
- (k) When the A/R declares on the application that s/he is a veteran, the spouse of a veteran or the spouse of a deceased veteran or the child of a veteran;
- (l) When the case record indicates that the A/R received veterans' benefits, but the A/R does not currently declare that s/he is receiving them.

Verification: Benefits from RSDI, Railroad Retirement, or the Veterans' Administration may be verified by:

- (a) Seeing the Notice of Award or award letter;
- (b) Seeing the current benefit check;
- (c) Obtaining information on the type and date of discharge and armed forces serial number;

**INCOME
UNEARNED**

**SOCIAL SECURITY (RETIREMENT, SURVIVORS' AND
DISABILITY INSURANCE), RAILROAD RETIREMENT AND VETERANS' BENEFITS**

- (d) Obtaining necessary information on RSDI benefits from the Beneficiary Data Exchange (Bendex) which is available in each local district.

Documentation: Sufficient to establish an audit trail

- (a) Date of award letter, amount of award and to whom paid;
- (b) Date, amount and number of current benefit check;
- (c) Returned clearance filed in case record.

NOTE: When an A/R is receiving a benefit, it is determined if a portion of the benefit or the entire benefit is intended for the support of a dependent.

**INCOME
UNEARNED****DIVIDENDS AND INTEREST**

Description: Dividends and interest are returns on capital investments such as stocks, bonds, or savings accounts.

Policy: Dividends and interest are considered unearned income. Interest or dividend income from certain resources is exempt for SSI-related A/Rs under community budgeting,

NOTE: Certain trust funds, which are unavailable as a resource may pay interest or dividends and, therefore, are carefully reviewed. Trust instruments are often very complicated documents. They may need to be reviewed by an attorney to determine the availability of the trust principal and any dividends or interest they may pay. (See **RESOURCES** TRUST FUNDS for treatment of trusts as resources.)

References:

ADMs	11 OHIP/ADM-1
GISs	05 MA/01 04 MA/027

Interpretation: Except for interest or dividend income derived from certain resources for SSI-related A/Rs under community budgeting, income from dividends and interest is included with all other sources of income in the eligibility determination process. Dividends and interest often vary from month to month depending on deposits, withdrawals, or company profits. Since dividends and interest credited to an individual account are generally not reflected until the end of the quarter, local districts project the amount of monthly dividends or interest based on the most current information available. If dividends or interest are credited/paid quarterly, one third of the quarterly interest or dividend is counted as income each month. Interest or dividends credited on other than a monthly or quarterly basis generally are annualized and divided by twelve to determine a monthly amount.

NOTE: Account service fees or penalties for early withdrawal do not reduce the amount of dividend or interest income.

The following describes when dividends or interest are considered countable unearned income for categories other than SSI-related:

INCOME UNEARNED

DIVIDENDS AND INTEREST

Series H/HH U.S. Savings Bonds - Series H/HH bonds pay interest semi-annually by check or electronic funds transfer. Count interest on these bonds as unearned income in the month available to the individual, either when the check is received or when the interest is electronically transferred to the individual's account.

NOTE: Series E/EE U.S. Savings Bonds - Interest on series E/EE U.S. Savings Bonds is only available to the individual upon expiration of the minimum retention period. When series E/EE bonds are redeemed, the interest is to be counted as an increase in the value of the resource (it is not income).

Zero Coupon Bonds - Owners of zero coupon bonds do not receive interest payments, even though the accruing interest may be taxed by the Internal Revenue Service (IRS). Interest accrues on zero coupon bonds and is paid when the bond matures. The accrued interest is to be considered countable unearned income in the month the bond matures. It is not prorated. The equity value of the zero coupon bond is a countable resource.

Dividend Reinvestment - When an individual chooses to reinvest rather than receive interest or dividends on stocks, bonds or mutual funds, the reinvested interest or dividends is counted as unearned income in the month credited to the A/R's account and available for use, and is an available resource the following month.

Capital Gains - Capital gains on property (e.g., stocks or real estate) are an increase in the value of the resource. A capital gain distribution outside of a trust is considered unearned income in the month received. A capital gain distribution within a trust is considered a part of the trust principal, unless specified otherwise in the trust. (See **RESOURCES TRUST FUNDS**) Capital gains distributions are generally made at the end of the year. Taxes or transaction fees are not deducted in determining the value of capital gains.

Life Insurance Policy - The dividends paid on a life insurance policy are not income. If the life insurance policy pays interest on dividends, the interest is income. (See **RESOURCES LIFE INSURANCE**)

**INCOME
UNEARNED**

DIVIDENDS AND INTEREST

Promissory Note or Other Loan Agreement - A promissory note held by the A/R pays interest or pays principal and interest in the same payment. The interest is unearned income.

Interest or dividend income derived from most resources is disregarded for SSI-related A/Rs.

Although most interest/dividends are treated as excludable income, there are some exceptions when interest and dividends are counted. Interest/dividend income is still countable for SSI-related A/Rs if generated by the following resources:

Retroactive SSI and Retirement, Survivors and Disability (RSDI) payments for nine months following the month of receipt;

Unspent State or local government relocation payments (but not federal or federally assisted funds) for nine months following the month of receipt;

Unspent tax refunds related to an earned income tax credit (EITC), paid either as a refund from the Internal Revenue Service or as an advance from an employer, or child tax credit (CTC) for the period beginning with the second calendar month following the month of receipt through the ninth month.

Excluded funds (i.e., from an organization described in Section 501(c)(3) of the Internal Revenue Code of 1986 which is exempt from taxation under Section 501(a)) from gifts to children under 18 years of age with life threatening conditions, if the funds are an in-kind gift of any amount that is not converted to cash, or if cash gifts, up to \$2,000 in any year; and

Unspent State victims' crime compensation payments for nine months following the month of receipt.

INCOME UNEARNED

DIVIDENDS AND INTEREST

NOTE: The SSI-related interest/dividend income exclusion only applies to community budgeting, not to chronic care budgeting, regardless of whether the resources are above or below the appropriate resource level.

Although some life insurance policies pay dividends, these dividends are generally treated as a resource.

Periodic payments received by an SSI-related A/R from an annuity and/or IRA continue to be treated as countable unearned income. Capital gain distributions (e.g. from mutual funds) noted on Internal Revenue Form 1099-DIV, Dividends and Distributions, whether paid as cash or reinvested, are to be treated as unearned income. (See GIS 04MA/027, page 2)

- When to Verify:**
- (a) When the A/R declares in the application that s/he receives dividends or interest.
 - (b) When the A/R declares in the application that s/he has bank accounts, stocks/bonds, trust funds, or life insurance.
 - (c) When the case record indicates that the A/R received income from dividends or interest, but the A/R does not now declare that it is being received.
 - (d) When the A/R declares membership in a credit union.
 - (e) When the Resource File Integration (RFI) report indicates that the A/R has income.
 - (f) If the A/R voluntarily reports a change in interest income.

Verification: Income from dividends and interest can frequently be verified by seeing bankbooks, benefit check stubs, correspondence, etc. If the A/R is not able to obtain these records, they are cleared through the usual local district procedure with stockbrokers, life insurance companies, banks, mutual fund companies, etc. The local district obtains the consent of the A/R before it can obtain such information.

**INCOME
UNEARNED**

DIVIDENDS AND INTEREST

Documentation: All Medicaid recipients who do not have a resource test may, at renewal attest to the amount of interest income generated by resources.

Districts must continue to review RFI reports to identify resources belonging to individuals who do not have a resource test to determine when a resource identified by RFI is significant enough to generate interest that would/could affect the individual's eligibility. In such instances, the district must request documentation of the interest income and re-calculate eligibility as appropriate.

Districts are encouraged to minimize the scope of the investigation into resources.

Documentation must be sufficient to establish an audit trail:

- Include such facts as type of resource from which income is obtained, amount and frequency of payment and the name and address of person(s) or institution(s) making the payment and the type of documentation seen;
- In all cases, a returned clearance filed in the case record is adequate documentation if it includes the appropriate facts.

INCOME UNEARNED

RETIREMENT FUNDS

Description: Retirement funds are annuities or work-related plans for providing income when employment ends (e.g., pension, disability, or other retirement plans administered by an employer or union). Other examples are funds held in an individual retirement account (IRA) and plans for self-employed individuals (e.g., Keogh plans). Also, depending on the requirements established by the employer, some profit sharing plans may qualify as retirement funds.

Medicaid A/Rs who are eligible for periodic retirement benefits must apply for those benefits to be eligible for Medicaid. Periodic retirement benefits are payments made to an individual at some regular interval (e.g., monthly, quarterly, annually), which result from entitlement under a retirement fund. An individual commonly selects a payment plan, and, generally, only an initial filing for benefits is needed.

An individual is eligible for periodic payments if he/she is authorized to receive distributions on a regularly scheduled basis without having a penalty assessed. An individual is not entitled to periodic payments if he/she is not permitted to take regularly scheduled withdrawals penalty free. Ordinary taxes are not considered a penalty. Once periodic payments are received, the periodic payments are unearned income, and the fund is not a countable resource.

An A/R, who ordinarily might not be eligible for benefits, may be able to access his/her retirement fund sooner, without incurring a penalty under certain circumstances. The circumstances can vary, depending on the type of account and rules for the specific retirement fund. Examples of possible situations: when an A/R may be able to receive periodic benefits without incurring a penalty, when the A/R is found to be disabled (a finding of disability), or when the withdrawal of distributions are considered as part of a series of substantially equal periodic payments. If an A/R can receive distributions from a retirement fund on a regularly scheduled basis without having a penalty assessed, the individual would be considered to be eligible for periodic payments. The A/R would be required to file for maximized periodic payments as a condition of Medicaid eligibility.

**INCOME
UNEARNED****RETIREMENT FUNDS**

If the individual has a choice between periodic payments and a lump sum, the individual must choose the periodic payments. The individual must apply for the maximum payment amount that could be made available over the individual's lifetime. By federal law, if the Medicaid A/R has a living spouse, the maximum income payment option that is available will usually be less than the maximum income payment option available to a single individual. This provision applies to all Medicaid A/Rs.

NOTE: An individual who has met the minimum benefit duration requirement of a New York State Partnership for Long-Term Care (NYSPLTC) policy is not required to maximize income from a retirement fund. If, however, the amount of any interest earned since the purchase of the policy, which would have been added to the value of the retirement fund, is available to be withdrawn, a qualified NYSPLTC participant is required to pursue or cooperate in the pursuit of the amount of the income payments. This requirement applies to a qualified NYSPLTC participant who is subject to chronic care budgeting. It does not apply under community budgeting. Non-applying spouses/parents are not required to apply for periodic payments or to maximize income from a retirement fund.

References: GIS 98 MA/024

When to Verify: When the A/R indicates s/he receives a pension or retirement benefit.

When the A/R has left his/her employment and is retired or disabled.

When the record indicates that the A/R received a pension or retirement benefit in the past.

When the Resource File Integration (RFI) report indicates that the A/R has income.

When the A/R indicates that s/he has group health insurance.

When the A/R's bank records indicate recurring electronic deposits.

**INCOME
UNEARNED**

RETIREMENT FUNDS

Verification: Benefits from pensions may be verified by:

- (a) Seeing the benefit check;
- (b) Seeing a benefit award letter;
- (c) If neither of the above are available or cannot readily be obtained, clear through the usual local district procedure.

Documentation: Sufficient to establish an audit trail:

- (a) Date, amount and number of benefit check and name of payor;
- (b) Date, amount of benefit and name of organization paying pension.

NOTE: An A/R with low income and large recurring medical bills may not be required to pay income tax or may pay income tax at a reduced rate. A/Rs may elect to change or revoke the amount of federal income tax withheld from their pensions. The A/R may complete the appropriate IRS form and file it with the IRS.

**INCOME
UNEARNED****UNION BENEFITS (OTHER THAN PENSIONS)**

Description: Union benefits are payments received by the A/R from labor organizations during strikes, lockouts, periods of unemployment or periods of disability. Many unions have strike funds, layoff funds or health and welfare funds that pay benefits to members when they are not working. These vary considerably in amount and availability by such factors as the type of union, the number of members out of work and the reason for the unemployment.

Policy: Union benefits are countable unearned income.

When to Verify:

- (a) When the A/R declares in the application that s/he is in receipt of union benefits;
- (b) When the A/R declares in the application that s/he was recently employed and declares in the application that s/he is a past or present union member;
- (c) When the case record indicates that the A/R received union benefits, but the A/R does not now declare that s/he is receiving them.
- (d) When the Resource File Integration (RFI) report indicates that the A/R has income.

Verification: Union benefits may be verified by:

- (a) Seeing the benefit check;
- (b) Seeing a statement of benefits or correspondence from the union relating to benefits;
- (c) If neither of the above are available or cannot readily be obtained, clear through the usual local district procedure.

Documentation: Sufficient to establish an audit trail:

- (a) Date and amount of check, name and address of union;
- (b) Date and type of correspondence, amount of benefit;
- (c) Returned clearance filed in the case record.

**INCOME
UNEARNED**

SUPPORT PAYMENTS (VOLUNTARY AND COURT-ORDERED)

Description: Support payments are payments made to the A/R by a legally responsible relative or a divorced spouse. (See **OTHER ELIGIBILITY REQUIREMENTS LEGALLY RESPONSIBLE RELATIVES (LRRS)**) Support payments may be either court-ordered or voluntary. Voluntary payments of support in some cases are formalized by agreements in writing, but in other cases are highly informal and may vary in amount. Court-ordered support payments are an amount specified by a court order.

Policy: Support payments (voluntary and court-ordered) are countable unearned income. If an applicant is receiving voluntary support payments, s/he is referred to the Child Support Enforcement Unit (CSEU), unless the applicant is otherwise exempt.

The first \$100 of court-ordered support received is disregarded from the A/R's income.

References:

SSL Sect.	366.3
Dept. Reg.	360-3.2 360-4.3 360-4.6 360-7.4
ADMs	93 ADM-21 92 ADM-40 91 ADM-40 84 ADM-43 79 ADM-82

Interpretation: To what extent support payments are considered in determining eligibility for Medicaid depends on the category of the A/R (see categorical disregards). If the amount being received in support is less than the court-ordered amount, a referral is made to the Child Support Enforcement Unit (CSEU), unless the applicant is pregnant or one of the other exceptions exists.

When determining eligibility for a retrospective period, budget the actual support payments received.

When determining eligibility for a prospective period, an average anticipated weekly support amount is established. Generally, the A/R's support for the four weeks preceding the determination is averaged. If the A/R received exceptionally high or low support payments for any of the four weeks, those weeks are not used in calculating the average.

**INCOME
UNEARNED**

SUPPORT PAYMENTS (VOLUNTARY AND COURT-ORDERED)

- When to Verify:**
- (a) When the A/R declares in the application that s/he is receiving support payments;
 - (b) When the A/R declares in the application that s/he has a spouse living elsewhere;
 - (c) When the A/R declares in the application that the parents of minor children are living elsewhere;
 - (d) When the case record indicates that the A/R received support payments, but the A/R does not now declare that s/he is receiving them;
 - (e) When the Resource File Integration (RFI) report indicates that the A/R has income.

Verification: If a support agreement is in existence, the terms of the agreement are verified as well as the effective date. If drawn up by an attorney, the name of the attorney is included. If the support is court-ordered, the amount ordered is verified as well as the amount actually being paid.

The amount received or ordered may be verified by:

- (a) Seeing the court order for either paternity, support or alimony; or if this is not readily available or cannot easily be obtained, communicating in writing with the appropriate court or probation office to obtain the necessary information;
- (b) Seeing a support payment check;
- (c) Seeing a statement from the person making the payments or his/her records;
- (d) Seeing the attorney's records;

**INCOME
UNEARNED****SUPPORT PAYMENTS (VOLUNTARY AND COURT-ORDERED)**

Documentation: Sufficient to establish an audit trail:

- (a) Copy of court order, if available;
- (b) Name of court ordering the support, name of the person who is ordered to pay, date and amount of the order, docket number, name of person for whom the support is intended;
- (c) If a written agreement exists, document the terms, names, dates and amounts as well as the attorney's name if any;
- (d) Amounts and dates of payment and the source of the information, such as payment checks, statement of the person making the payment, etc.;
- (e) Returned clearance filed in the case record;
- (f) Written or phone verification from Support/Collection unit.

**INCOME
UNEARNED****CONTRIBUTIONS FROM NON-LEGALLY RESPONSIBLE
RELATIVES AND FRIENDS**

- Description:** Cash contributions from relatives and friends who are not legally responsible, when such contributions are not in return for work performed, are considered unearned income. (See **INCOME INKIND INCOME** for a discussion of in-kind income and **INCOME EARNED** for a discussion of earned income.)
- Policy:** Cash contributions may be countable unearned income when such contributions are not in return for work performed. (See **INCOME SSI-RELATED DISREGARDS** for SSI-related income disregards)
- References:** Dept. Reg. 352.16(a)
- Interpretation:** Since payments of this type are based only on the relative or friend's willingness or ability to pay, they frequently are irregular. A local district decision is required as to whether and in what amount they are to be considered. While benefits are verified and documented, this should not be pursued to the point where it jeopardizes continued receipt of the contribution. The obligation is not a legal one and the person who is paying may not be willing to put the information in writing. In these instances, the circumstances and the basis for making the decision, as well as any statement are recorded in the case record.
- When to Verify:**
- (a) When the A/R declares in the application that s/he receives income from friends or non-legally responsible relatives;
 - (b) When the case record indicates that the A/R received contributions from friends or non-legally responsible relatives, but the A/R does not declare that it is now being received;
 - (c) When the maintenance picture is unclear, that is, when expenses seem to exceed the income that the A/R claims to be available.
- Verification:**
- (a) Seeing the payment check;
 - (b) Seeing a signed statement from the person providing the income;

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**CONTRIBUTIONS FROM NON-LEGALLY RESPONSIBLE
RELATIVES AND FRIENDS**

- (c) When these are not available or cannot readily be obtained, clear through the usual local district procedure.

Documentation: Sufficient to establish an audit trail:

- (a) Amount, date of check, frequency and regularity and person paying (name and address);
- (b) Date of statement, amount, frequency and regularity, name, address and relationship of person paying;
- (c) Returned clearance filed in the case record.

**INCOME
UNEARNED****RENTAL INCOME**

Description: Rent is a payment that an individual receives for the use of real or personal property, such as land, housing or machinery. Net rental income is gross rent less the ordinary and necessary expenses paid in the same taxable year.

Policy: For SSI-related A/Rs, net rental income is unearned income unless it is earned income from self-employment (e.g., someone who is in the business of renting properties).

For S/CC, LIF and ADC-related A/Rs, net rental income is earned income.

References: SSL Sect. 366

Dept. Reg. 360-4.3 (d)

Interpretation: For SSI-related A/Rs: income received from non-business rental property is considered unearned income after allowable expenses have been deducted.

For LIF, S/CC and ADC-related A/Rs: income received from non-business rental property is considered earned income after allowable expenses have been deducted. (See **RESOURCES REAL PROPERTY** and **REAL PROPERTY INCOME-PRODUCING**)

Ordinary and necessary expenses are those necessary for the production or collection of rental income. Examples of deductible expenses are:

- (1) Property, school, water and sewer taxes;
- (2) The cost of utilities if they are included in the rent;
- (3) The cost of fire, windstorm, flood, theft and liability insurance;
- (4) Interest payments on mortgages for such property;
- (5) The cost of essential repairs on such property (i.e., minor correction to an existing structure);
- (6) Wages paid to employees for maintaining the property;

**INCOME
UNEARNED**

RENTAL INCOME

- (7) Advertising for tenants;
- (8) Any other expenses essential to maintaining the property (lawn care/snow removal).

Examples of non-deductible expenses:

- (1) Payments on the principal of mortgages;
- (2) Improvements to the property (i.e., an expense for an addition or increase in the value of the property);
- (3) Any other expenses which are **not** directly related to maintaining the property.

NOTE: Depreciation or depletion of property is not a deductible expense from rental income.

Expenses are deducted when paid, not when incurred.

When the rental property is also the A/R's homestead (i.e., two-family residence), the allowable expenses is prorated based on the number of units designated for rent compared to the total number of units.

Rental deposits are not income to the landlord while subject to return to the tenant. Rental deposits used to pay rental expenses become income to the landlord at the point of use.

- When to Verify:**
- (a) When the A/R declares in the application that part of his/her own home is rented out;
 - (b) When the A/R declares in the application that s/he receives income from rent;
 - (c) When the A/R declares in the application that s/he owns property other than a homestead;

**INCOME
UNEARNED****RENTAL INCOME**

- (d) When the case record indicates that the A/R received income from rent, but s/he does not now declare that s/he is receiving it.

Verification: Income from rental property may be verified in a number of ways:

- (a) seeing a lease or other rental agreement;
- (b) Seeing documents in the A/R's possession, including copies of bills, receipts for payments received, ledgers and income tax records may be seen;

Expenses for rental property may be verified by seeing bills or receipts for interest, taxes, insurance, utilities or repairs or by statements from the individuals or organization which received those payments. Any of the above may be cleared in writing through the usual local district procedure if the A/R is unable to provide verification.

Documentation: Sufficient to establish an audit trail:

- (a) Name of tenants, amount and frequency of payment and document seen;
- (b) Type, amount and frequency of expense and document seen;
- (c) A copy of the returned clearance filed in case record.

Disposition: Rental income is determined. Business expenses are deducted to determine net rental income. This net amount is then budgeted according to the category of the A/R.

**INCOME
UNEARNED****MILITARY DEPENDENCY ALLOTMENT**

Description: Military dependency allotments are payments received by the A/R for support while a legally responsible relative (or sometimes another relative) is on active service with the armed forces. Military dependency allotments are received monthly as a government check.

Policy: Military dependency allotments are countable unearned income.

References: Dept. Reg. 360-4.3

Interpretation: Persons in active military service can make allotments of military pay and allowances to spouses, former spouses, other dependents, and relatives who are not designated legally as dependents. When these allotments are received by an A/R, they are counted as unearned income.

NOTE: Third party insurance benefits are available to dependents of active military personnel (CHAMPUS) and are used for medical expenses before Medicaid is used. (See **RESOURCES THIRD PARTY RESOURCES**)

When to Verify:

- (a) When the A/R declares in the application that a military dependency allotment is being received;
- (b) When the A/R declares in the application that a spouse and/or parent who is living elsewhere is in the military service;
- (c) When the case record indicates that the A/R received military payments, but does s/he not currently declare that s/he is receiving them.

Verification:

- (a) Seeing the benefit check;
- (b) Seeing correspondence about the allotment;
- (c) If the above are not available or cannot readily be obtained, clear through the usual local district procedure.

**INCOME
UNEARNED**

MILITARY DEPENDENCY ALLOTMENT

Documentation: Sufficient to establish an audit trail:

- (a) Date and amount of check;
- (b) Date and type of correspondence, amount of allotment, armed forces serial number, any other file or reference numbers;
- (c) Returned clearance filed in the case record.

**INCOME
UNEARNED****REVERSE MORTGAGES**

Description: A homeowner can convert home equity into cash without moving out of the home through a variety of home equity conversion plans. The home is either sold or mortgaged, but remains occupied by the homeowner until a future date or the death of the homeowner.

Under a reverse mortgage (RM), the homeowner borrows up to a fixed percentage of the appraised value of the home, for a set period of time, usually five to ten years. The funds borrowed are generally paid to the homeowner monthly. Repayment of the loan and any accrued interest is not due until the end of the loan term, the death of the borrower, or the sale of the property. A reverse annuity mortgage (RAM) is an RM in which the funds borrowed are paid to the homeowner through the purchase of an annuity.

Policy: For LIF, S/CC and ADC-related A/Rs, both RMs and RAMs are disregarded as income and resources.

For SSI-related A/Rs, an RM is generally disregarded as income and countable as a resource if retained beyond the month received. However, if the RM is a RAM, the annuity payments are unearned income in the month received and a resource thereafter.

References: SSL Sect. 366.1
 366.2

Documentation: Sufficient to establish an audit trail:

- (a) Reverse Mortgage Agreement - date, amount, terms, name of lender;
- (b) Reverse Mortgage Annuity - date, amount, terms, name of lender.

**INCOME
UNEARNED**

IN-KIND INCOME

Description: In-kind income is received in goods or services rather than in cash. It can either be earned or unearned.

Policy: The value of goods and services is considered in determining eligibility for Medicaid only when they are provided by a legally responsible relative living outside the household or in return for services rendered.

NOTE: Clothing received by an SSI-related A/R from a legally responsible relative is not countable as in-kind income. If the clothing is received from an employer instead of cash, the value of the clothing is counted as in-kind earned income.

When persons other than legally responsible relatives provide goods or services to the A/R and the A/R has not provided any services in return for these goods or services, the in-kind income is not considered in determining eligibility for Medicaid.

References:

SSL Sect.	366.2
Dept. Reg.	352.17 360-4.3 (e)
ADMs	84 ADM-21
GIS	05 MA/029

Interpretation: To evaluate if in-kind income is countable, local districts determine the relationship of the A/R to the person providing the goods or services and whether or not the A/R performs any services to earn the in-kind income.

In-kind income might include free lodging, meals, groceries or farm produce. In-kind income may be received by itself or together with income in cash as in the case of certain employed persons (e.g., dishwasher who receives wages and meals in compensation for his/her services).

The value of in-kind income is based upon the fair market value of the goods or maintenance received by the A/R. The fair market value is the dollar amount that an individual would receive if the goods or maintenance were sold on the open market in the A/R's local area.

**INCOME
UNEARNED**

IN-KIND INCOME

The fair market value of in-kind income, other than shelter, may also be determined by obtaining a statement from the person providing the in-kind income. The statement should specify the dollar value of the goods or maintenance provided.

In-kind income that is provided by persons other than legally responsible relatives for whom the A/R has not rendered a service is not considered in determining eligibility for Medicaid. This type of in-kind income includes donations from relatives (who are not legally responsible, as well as from friends or charitable and civic organizations. See **INCOME UNEARNED CONTRIBUTIONS FROM NON-LEGALLY RESPONSIBLE RELATIVES AND FRIENDS** for monetary donations.)

In instances where the A/R is a member of a communal organization or religious order which provides in-kind goods and services (e.g., meals, housing, personal items, clothing, etc.), the value of such in-kind goods and services is counted in the determination of eligibility.

In the absence of a clearly established fair market value for the goods and services provided (e.g., goods are purchased in bulk, members live in dormitory settings, etc.), the value of the goods and services provided is determined by reference to the local district-specific schedule for shelter, utilities, day care, food stamps, etc. This comparison provides a reasonable basis for evaluating the value of the goods and services without the necessity of determining the fair market value of such goods and services in each instance. The value of in-kind income for shelter cannot exceed the maximum Public Assistance allowance for shelter, based on the living arrangements of the A/R.

- When to Verify:**
- (a) When the A/R declares in the application that food, shelter, or other needs are provided by another person or organization;
 - (b) When the A/R declares in the application that s/he shares housing arrangements or lives with another person;

**INCOME
UNEARNED****IN-KIND INCOME**

- (c) When the A/R declares in the application that s/he lives in the employer's house or the employer pays rent for the A/R's living accommodations;
- (d) When the A/R declares that his/her landlord and employer are the same;
- (e) When the A/R is employed where meals are prepared and served; or
- (f) When the A/R declares his/her occupation to be any occupation in which accommodations and/or meals are likely to be provided (building superintendent, tenant farmer, farm laborer, live-in domestic worker).

Verification:

- (a) Seeing pay envelopes, check stubs, or wage statements;
- (b) Obtaining employer's statement as to what is provided as part of the compensation for the job and the dollar value of such compensation;
- (c) Obtaining a dated statement from the person or group providing in-kind income specifying his/her relationship, if any, to the A/R, what compensation is provided and whether or not the A/R performs any services in return for the compensation;
- (d) Seeing a copy of a court order that included in-kind support; or
- (e) Seeing a statement from the legally responsible relative specifying what goods or services are provided and the frequency with which they are provided.

Documentation: Sufficient to establish an audit trail:

- (a) Name and address of employer, person, or organization providing the in-kind income, and a statement as to what is provided, the relationship, if any, to the A/R and the terms and frequency of the arrangement;

**INCOME
UNEARNED****IN-KIND INCOME**

- (b) The basis of the local district's decision as to the amount to be budgeted as income to the A/R for the goods and services provided by the employer or the legally responsible relative ;
or
- (c) Name of court, docket number, date of order, terms, and name of the legally responsible relative when such in-kind income is ordered by the court.

**INCOME
UNEARNED****LUMP SUM PAYMENTS**

Description: Lump sum payments are deferred or delayed payments. They include, but are not limited to benefit awards, bonuses, year-end profit sharing, severance pay, and retroactive pay increases.

Policy: All lump sum payments are reviewed to determine if they are available and countable. (See **OTHER ELIGIBILITY REQUIREMENTS OWNERSHIP AND AVAILABILITY**) Lump sum payments as a result of employment, such as bonuses, retroactive pay increases and severance pay are considered earned income. Lump sum payments such as benefit awards from railroad retirement or Social Security are unearned income.

Essential expenses incurred when attaining a payment are deducted from that payment. Essential expenses are deducted from the first and any subsequent payments until the expenses are met. When an A/R receives a retroactive payment from a benefit program, other than SSI, legal fees connected with the claim are deducted.

Countable lump sum payments are considered income in the month received. To determine if a lump sum payment is disregarded as income consult the disregards section. (See **INCOME LIF DISREGARDS**, **INCOME ADC-RELATED DISREGARDS**, and **INCOME S/CC DISREGARDS**)

Certain lump sum payments are exempt or excluded as a resource in the month received. To determine if a lump sum is disregarded or excluded as a resource in the month of receipt, consult the resource disregards section. (See **RESOURCES SSI-RELATED RESOURCE DISREGARDS**)

References: SSL Sect. 366.2

ADMs OMM/ADM 97-2
92 ADM-11

**INCOME
UNEARNED****LUMP SUM PAYMENTS**

Interpretation: After allowable deductions, countable lump sum payments are considered income in the month received. The lump sum is combined with any other countable income. Allowable disregards are subtracted. The remaining income is compared to the appropriate income level. (See **REFERENCE MEDICALLY NEEDY INCOME AND FEDERAL POVERTY LEVELS**) Any excess income is considered available to meet the cost of medical care and services.

When to Verify: When the A/R indicates that s/he recently received a benefit award, bonus, year-end profit share, retroactive pay increase, or other lump sum.

When the A/R indicates that s/he is anticipating a lump sum payment.

When the record indicates that the A/R has applied for a benefit and may be eligible for a retroactive payment.

When the Resource File Integration (RFI) report indicates that the A/R has income.

**Verification/
Documentation:**

Sufficient to establish an audit trail:

- Lump sum payments are verified. State computer matches are reviewed to determine the source of income.
- The amount, date and source of all lump sums are documented. The preferred forms of verification/documentation are checks, check stubs, award letters, or other written statements from the payer of the lump sum.

**INCOME
UNEARNED****WINDFALLS**

Description: Windfall payments are one-time only payments. They include, but are not limited to, lottery winnings, gifts and court settlements.

Policy: Treatment of windfall payments, in the month of receipt, varies depending on the category of the A/R. When determining eligibility for LIF and ADC-related A/Rs, windfall payments are generally considered countable resources in the month received. When determining eligibility for SSI-related and S/CC A/Rs, windfall payments are considered countable income in the month received.

Essential expenses incurred when attaining a payment are deducted from that payment. Essential expenses are deducted from the first and any subsequent payments until the expenses are met. From a payment received for damages in connection with an accident: legal, medical, and other expenses connected with the accident are allowable deductions.

When any or all of a windfall payment is retained beyond the month of receipt, it is considered a resource, regardless of the A/R's category.

References: SSL Sect. 366.2.

ADMs OMM/ADM 97-2
92 ADM-11

Disposition: For LIF and ADC-related A/Rs, in the month of receipt and thereafter (if the windfall or part of it is retained), the amount of the windfall payment is a resource. (See **RESOURCES EXCESS RESOURCES** for rules regarding the treatment of excess resources.)

For SSI-related and S/CC A/Rs, windfall payments are considered income in the month of receipt. The windfall is combined with any other countable income. Allowable disregards are subtracted. The remaining income is compared to the appropriate income level.

When an SSI-related or S/CC A/R retains any or all of a windfall payment beyond the month of receipt, it is considered a resource. For SSI-related A/Rs, the windfall together with other countable resources is compared to the appropriate resource level.

**INCOME
UNEARNED****INDIVIDUAL SUPPORT SERVICES DISREGARD**

Description: The Individual Support Services (ISS) program under the Office for People with Developmental Disabilities (OPWDD) assists people remaining in or being placed into the community to help meet their needs. ISS provides assistance to help individuals achieve or maintain self-sufficiency, including reduction or prevention of dependency, and to prevent or reduce inappropriate institutional care.

Policy: ISS payments are disregarded in determining eligibility for Medicaid for all categories.

References: INF 95 INF-23

INCOME**INCOME LEVELS**

- Description:** Income levels are the amount of income a person or household can retain and still be eligible for Medicaid.
- Policy:** In determining eligibility for Medicaid, an A/R's net available income is compared to the appropriate Medicaid level or standard. An A/R's income may be compared to more than one income level or standard.
- References:**
- | | |
|------------|---|
| SSL Sect. | 366
369-ee |
| Dept. Reg. | 352
360-4.3
360-4.6
360-4.7(b) |
| GISs | 08 MA/022
05 MA/013
04 MA/031 |
- Interpretation:** Generally, the amount of the income level or standard increases as the size of the household increases. Persons who are ADC-related, SSI-related, under age 21, pregnant, stepparents, and/or fathers of unborns with no children of their own in the household are allowed the Medically Needy income level, or the Medicaid Standard (and MBL Living Arrangement Chart as appropriate) whichever is most beneficial. In some instances (pregnant women and some children), the federal poverty levels are used.
- Persons who are SCC-related and LIF are allowed the Medicaid Standard.
- Pregnant women and children under age 19 are allowed the Medicaid expanded levels (federal poverty levels). Family Health Plus, Medicaid Buy-In Program for Working People with Disabilities, Medicare Savings Program and Family Planning Benefit Program A/Rs are allowed the applicable percentage of the federal poverty level.
- Disposition:** Net available income is compared to the appropriate income level to determine eligibility for Medicaid. For some persons, income in excess of the level is available to meet the cost of medical care and services as determined according to Department regulations. (See **INCOME EXCESS**)

INCOME

INCOME LEVELS

The following subjects are covered in this section:

- Medically Needy Income Level
- Medicaid Standard
- Federal Poverty Levels (FPL)
 - Medicaid Expanded Levels
 - Medicare Savings Program
 - Family Health Plus (FHPlus)
 - Family Planning Benefit Program (FPBP)
 - Medicaid Buy-In for Working People with Disabilities (MBI-WPD). (See **CATEGORICAL FACTORS** MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES (MBI-WPD) for the federal poverty level allowed for MBI-WPD A/Rs)

INCOME**MEDICALLY NEEDED INCOME LEVEL**

Policy: The medically needy income level is used to determine eligibility for all categories except S/CC and LIF.

NOTE: See **REFERENCE MEDICALLY NEEDED INCOME AND FEDERAL POVERTY LEVELS** for a chart displaying the Medicaid Levels and Federal Poverty Levels.

References:	SSL Sect.	101 101-a 365 366
	Public Law	94-48 94-603 92-603
	Dept. Reg.	360-1.4 (r) 360.7 (d) 360.4.1 (b) 360-4.3 360.4.3 (f) 360-4.6 360-4.7(b) 360-4.8 (a) (c)
	ADMs	06 OMM/ADM-4 05 OMM/ADM-4 05 OMM/ADM-2 04 OMM ADM-5 04 OMM/ADM-2 03 OMM/ADM-4 02 OMM/ADM-7 02 OMM/ADM-1 01 OMM/ADM-1 99 OMM/ADM-3 98 OMM/ADM-28 98 OMM/ADM-6

INCOME**MEDICALLY NEEDY INCOME LEVEL**

GISs	08 MA/022
	07 MA/005
	06 MA/029
	06 MA/006
	05 MA/047
	05 MA/045
	05 MA/027
	05 MA/013
	05 MA/011
	04 MA/030
	04 MA/031
	03 MA/006
	03 MA/005
	02 MA/029
	02 MA/018
	02 MA/010
	02 MA/008

Interpretation: Determine the A/R's household size and net available monthly income in accordance with the A/R's category. For A/Rs who are ADC-related, SSI-related, under age 21, pregnant, stepparents, and/or fathers of unborns with no children of their own in the household the net available income is compared to the Medically Needy Income level or the Medicaid Standard, (and MBL Living Arrangement Chart as appropriate) whichever is most beneficial.

INCOME**MEDICAID STANDARD**

Policy: The Medicaid Standard is used to determine eligibility for Singles Childless Couples (S/CC) and Low Income Family (LIF) categories.

NOTE: See **REFERENCE MEDICALLY NEEDY INCOME AND FEDERAL POVERTY LEVELS** for a chart displaying the Medicaid Levels and Standards and Federal Poverty Levels.

References: GIS 08 MA/022

Interpretation: Determine the A/R's household size and net available monthly income in accordance with the A/R's category. For A/Rs who are LIF or S/CC, the net available income is compared to the Medicaid Standard (and MBL Living Arrangement Chart as appropriate).

Medically Needy A/Rs will have their net available monthly income compared to the Medically Needy Income level or the Medicaid Standard (and MBL Living Arrangement Chart as appropriate) whichever is most beneficial.

Effective April 1, 2008, the Medicaid Standard is used to determine Medicaid eligibility for single individuals and childless couples, regardless of their living arrangement, since medical care is now considered an unmet need. Therefore, it is not necessary to determine if there is an unmet need.

When the A/R resides in specified living arrangements, a water allowance and/or a special shelter amount is added to the Medicaid Standard. (See **REFERENCE MBL LIVING ARRANGEMENT CHART** to determine when such items should be added to the Medicaid Standard)

NOTE: A request for documentation of a water bill shall be made when the additional allowance affects eligibility under the LIF and S/CC categories. If documentation of a water bill is not provided, the A/R must be budgeted without the additional allowance.

**INCOME
FEDERAL POVERTY LEVELS**

MEDICAID EXPANDED INCOME LEVELS

Policy: The expanded income levels represent 100%, 133% and 200% of the federal poverty level (FPL). They are used to determine eligibility as follows:

- pregnant women - 100% or 200% (See **CATEGORICAL FACTORS PREGNANCY** and **OTHER ELIGIBILITY REQUIREMENTS PRESUMPTIVE ELIGIBILITY PREGNANT WOMEN**);
- infants under the age of one (1) - 200%
- children between the age of one (1) and eighteen (18) - 133%

NOTE: See **REFERENCE MEDICALLY NEEDED INCOME AND FEDERAL POVERTY LEVELS** for a chart displaying the Medicaid Levels and Federal Poverty Levels.

References:	SSL Sect.	366.4 (m), (n) and (o)
	Dept. Reg.	360-4.1(b) 360-4.7(b) 360-4.8(a)
	ADMs	06 OMM/ADM-4 05 OMM/ADM-2 98 OMM/ADM-6 90 ADM-42 90 ADM-9
	GISs	11 MA/021 07 MA/005 06 MA/029 06 MA/006 05 MA/045 05 MA/013 05 MA/011 02 MA/008

Interpretation: When determining eligibility under the Medicaid expanded income levels, household size is determined by counting those applying, their legally responsible relatives and any siblings under age 21 residing with them, whether or not the siblings are applying (See **OTHER ELIGIBILITY REQUIREMENTS HOUSEHOLD COMPOSITION, HOUSEHOLD SIZE FOR POVERTY LEVEL PROGRAMS (PREGNANT WOMEN AND CHILDREN)**).

**INCOME
FEDERAL POVERTY LEVELS**

MEDICAID EXPANDED INCOME LEVELS

When the A/R is pregnant and the pregnancy is medically verified, the household size is increased by one, effective the month of conception or three months prior to the month of application, whichever is later.

When determining eligibility for a pregnant woman, appropriate income disregards (See **INCOME** ADC-RELATED DISREGARDS) are subtracted before comparing the remaining income to the Medically Needy Income level, the Medicaid Standard, or 100% of the federal poverty level, whichever is higher/most beneficial. When the A/R's household income is equal to or less than the appropriate level, the pregnant woman and any children under age 19 are fully eligible for Medicaid. If the pregnant woman's income exceeds 100% FPL, compare to 200% FPL. When the A/R's family income is equal to or less than 200% FPL, the pregnant woman is eligible for Medicaid coverage of perinatal services. Perinatal care includes all Medicaid services necessary to promote a healthy birth outcome from the determination of pregnancy through the postpartum period. A pregnant woman whose income exceeds 200% FPL must spend down to the medically needy level to be eligible.

When determining eligibility for an infant under age one, subtract the appropriate income disregards. The household income of the infant is compared to the Medically Needy Income level or the Medicaid Standard (and MBL Living Arrangement Chart, as appropriate) whichever is most beneficial. If ineligible under that level, household income is then compared to 200% of the poverty level. The infant under one is fully eligible for Medicaid if household income is equal to or less than 200% of the poverty level.

When determining Medicaid eligibility for a child from the age of one (1) through 18, the household income of the child, after appropriate disregards, is compared to the Medically Needy Income level or the Medicaid Standard, (and MBL Living Arrangement Chart as appropriate) whichever is most beneficial. If income exceeds the appropriate level, compare to 133% of the poverty level. A child under the age of 19, with household income

**INCOME
FEDERAL POVERTY LEVELS**

MEDICAID EXPANDED INCOME LEVELS

above 133% of the federal poverty level must spend down to the medically needy income levels to be eligible for Medicaid coverage.

It may be necessary to compare the household income to several levels to determine Medicaid eligibility.

For example:

Household Composition - Pregnant Mother
Child A age 10 months
Child B age 16 years

All members of the household are applying. The mother is employed. After applicable deductions, her income is at 200% of the poverty level for a household of four. The mother is eligible for Medicaid coverage of perinatal services. Child A is eligible for full Medicaid coverage. Child B is not eligible.

NOTE: Pregnant women, infants and children under age 19 cannot spend down to their applicable percentage of the poverty level to achieve eligibility. A pregnant woman with income between 100% and 200% of the federal poverty level is eligible for Medicaid covered ambulatory prenatal services. Ambulatory Prenatal Care includes all outpatient Medicaid services necessary to promote a healthy birth outcome. She must spend down to the medically needy income level to be eligible for full Medicaid coverage. An infant, under one (1) year of age, with household income above 200% of the federal poverty level and children under age 19 with household income above the applicable percentage of the federal poverty level must spend down to the Medically Needy Income level to be eligible for full Medicaid coverage.

**INCOME
FEDERAL POVERTY LEVELS**

MEDICARE SAVINGS PROGRAM

Policy: Certain A/Rs who receive Medicare may be eligible for Medicaid to pay the Medicare premium, coinsurance and deductible amounts.

References: SSL Sect. 367-a (3)a

GISs 10 MA/10
08 MA/016
05 MA/013

Interpretation: The A/R may spend down income to become eligible for Medicaid and also eligible for Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLIMB) however, the Medicare premium cannot be applied in whole or in part to reduce excess income. At the time of application, the applicant is encouraged to make a choice to apply the Medicare Premium to their spenddown to attain Medicaid eligibility OR to forego Medicaid eligibility for eligibility in the Medicare Savings Program. The advantages and disadvantages of both programs are fully explained. An A/R may switch between spenddown and Medicare Savings Program; however, in the interest of accuracy and administrative efficiency, the A/R is encouraged to select one of the two programs.

Eligibility for the MSPs must be determined even if an applicant does not indicate that he or she is applying for the MSP on the LDSS-2919 or the DOH-4220. If applying for MSP only the DOH-4328 is used.

NOTE: When two spouses reside together in a household, eligibility for MSP will be determined by comparing income to a household of two, regardless of the income or category of the spouses.

There are four groups that are eligible for payment or part-payment of Medicare premiums, coinsurance and deductibles.

NOTE: See **REFERENCE MEDICALLY NEEDY INCOME AND FEDERAL POVERTY LEVELS** for a chart displaying the Medicaid Levels and Federal Poverty Levels.

Qualified Medicare Beneficiaries (QMBs)

The A/R must:

1. be entitled to benefits under Part A of Medicare; and
2. have income equal to or less than 100% of the federal poverty level.

**INCOME
FEDERAL POVERTY LEVELS**

MEDICARE SAVINGS PROGRAM

Qualified Medicare Beneficiaries (QMBs)

The A/R must:

1. be entitled to benefits under Part A of Medicare; and
2. have income equal to or less than 100% of the federal poverty level.

If the A/R meets the above criteria, s/he is eligible for Medicaid payment of the Medicare Part A and B premiums, coinsurance and deductible amounts.

Specified Low-Income Medicare Beneficiaries (SLIMBs)

The A/R must:

1. have Part A of Medicare; and
2. have income greater than 100% but less than 120% of the federal poverty level.

If the A/R meets the above criteria s/he is eligible for Medicaid payment of the Medicare Part B premiums.

Qualified Disabled and Working Individuals (QDWIs)

The A/R must:

1. have lost Part A benefits because of return to work;
2. be a disabled worker less than 65 years of age;
3. have income equal to or less than 200% of the federal poverty level;
4. have resources not in excess of twice the SSI limit; therefore, resources cannot exceed \$4,000 for a household of one or \$6,000 for a household of two; and
5. not be otherwise eligible for Medicaid.

**INCOME
FEDERAL POVERTY LEVELS**

MEDICARE SAVINGS PROGRAM

If the A/R meets the above five criteria s/he is eligible for Medicaid payment of the Medicare Part A premium, not the Medicare Part B premium.

Qualifying Individuals (QI)

The A/R must:

1. have Part A of Medicare;
2. have income greater than or equal to 120% but less than 135% of the federal poverty level.

If the A/R meets the above criteria s/he is eligible for Medicaid payment of the Medicare Part B premiums. The monthly amounts are identified in **REFERENCE MEDICARE PART A and PART B PREMIUMS**. Each state has been given a capped allocation to fund these premium payments.

NOTE: See **REFERENCE** section for a chart displaying the Medicaid Levels and Federal Poverty Levels. The A/R can either be eligible for the Medicare Savings Program or apply his/her income/resources, in excess of the appropriate Medically Needy level (See **REFERENCE MEDICALLY NEEDED INCOME AND FEDERAL POVERTY LEVELS** and **MEDICAID RESOURCE LEVELS**) to the cost of medical care and services, spending down to become eligible for Medicaid coverage. At the time of application, the applicant is encouraged to make a choice. The advantages and disadvantages of both programs are fully explained. An A/R may switch between spenddown and Medicare Savings Program; however, in the interest of accuracy and administrative efficiency, the A/R is encouraged to select one of the two programs.

**INCOME
FEDERAL POVERTY LEVELS**

FAMILY HEALTH PLUS (FHPlus)

Policy: The federal poverty level is used to determine eligibility for FHPlus. The gross countable income of parents or persons age 19 and 20 who live with their parents is compared to 150% of the federal poverty level for the appropriate family size. For single individuals and childless couples, both disabled and non-disabled, and for 19 and 20 year-olds not residing with their parents, gross countable income is compared to 100% of the federal poverty level for the family size.

Reference:

SSL	369-ee
ADMs	06 OMM/ADM-4 01 OMM/ADM-6
GISs	07 MA/005 06 MA/029 06 MA/006 05 MA/047 05 MA/045 05 MA/013

NOTE: See **REFERENCE MEDICALLY NEEDY INCOME AND FEDERAL POVERTY LEVELS** for a chart displaying the Medicaid Levels and Federal Poverty Levels and **CATEGORICAL FACTORS FAMILY HEALTH PLUS (FHPLUS)** for discussion of other eligibility criteria for FHPlus.

**INCOME
FEDERAL POVERTY LEVELS**

FAMILY PLANNING BENEFIT PROGRAM (FPBP)

Policy: The federal poverty level is used to determine eligibility for FPBP. The net countable income of applicants who meet the appropriate criteria (See **CATEGORICAL FACTORS FAMILY PLANNING BENEFIT PROGRAM (FPBP)** for a discussion of the categorical requirements) is compared to 200% of the federal poverty level for the appropriate family size.

Reference: SSL Sect. 366(1)(a)(11)

ADM 02 OMM/ADM-7

NOTE: See **REFERENCE MEDICALLY NEEDED INCOME AND FEDERAL POVERTY LEVELS** for a chart displaying the Medicaid Levels and Federal Poverty Levels.

INCOME**BUDGETING**

Description: Budgeting is the process that is used to determine the value of an A/R's income. The budgeting of income to determine eligibility for Medicaid varies according to category.

Policy: The budgeting process involves several steps, some of which are common to all budgeting methodologies and some of which include elements that are specific to a particular category.

References:

SSL Sect.	366
Dept. Reg.	360-4
ADM	OMM/ADM 97-2

Interpretation: To determine eligibility for Medicaid, five budgeting methodologies are used:

- (1) Low Income Families (LIF) budgeting methodology is used for the following:
 - Parents living with their dependent children under age 21;
 - Persons under age 21;
 - Pregnant women; and
 - FNP parents.
- (2) When ineligible under LIF criteria, the ADC-related budgeting methodology is used for the following:
 - Parents living with their dependent children under age 21;
 - Persons under age 21;
 - Pregnant women; and
 - FNP parents.

NOTE: This budgeting methodology is used for pregnant women and children under age 19 in determining their eligibility under the poverty levels.

- (3) The SSI-related budgeting methodology is used for the following: aged (65 or over), certified blind, or certified disabled A/ Rs and for all of the Medicaid A/Rs who are applying for and determined eligible for payment or part payment of the Medicare premiums, coinsurance and deductibles. (See **INCOME MEDICAID EXPANDED INCOME LEVELS**)

INCOME**BUDGETING**

- (4) The Singles/Childless Couples (S/CC) budgeting methodology is used for A/Rs age 21 and over, but under age 65, who are not living with dependent children under age 21, not pregnant and who are not certified blind or certified disabled.
- (5) The chronic care budgeting methodology is used for all individuals in permanent absence status (See **GLOSSARY**).

NOTE: FNP parents can NOT spenddown to obtain full Medicaid coverage.

Frequently, more than one budgeting methodology is used to determine eligibility. For example, a certified disabled person may be given the choice between LIF, ADC-related budgeting and SSI-related budgeting. The remaining family members are only eligible for either LIF or ADC-related budgeting, as appropriate.

(See **INCOME MEDICARE SAVINGS PROGRAM** for the treatment of Medicare beneficiaries (QMBs, SLMBs, etc.))

Disposition:

After applying the appropriate methodology to arrive at the net available income, the net available income is compared to the appropriate income/resource level. All other eligibility requirements must be met.

INCOME**LIF DISREGARDS**

Description: Disregards of income are not considered in whole or in part in determining eligibility for Medicaid.

Policy: The following types of income are disregarded in the determination of gross monthly income for Medicaid: (See **REFERENCE INCOME DISREGARDS** for chart)

AMERICORPS - Child care allowances and other benefits and services including payments for living expenses provided by Americorps VISTA;

Child care allowances and all other benefits and services except payments for living expenses, provided by Americorps USA and Americorps NCCC;

ASSISTANCE BASED ON NEED - Any regular cash assistance payments based on need received by the A/R and furnished as supplemental income by the federal government, a State or political subdivision;

Support and maintenance assistance based on need and furnished either in-kind by a private non-profit agency or in cash or in-kind by one of the following: a supplier of home heating oil or gas, an entity whose revenues are primarily derived on a rate-of-return basis regulated by a State or Federal governmental entity or a municipal utility providing home energy;

BLOOD PLASMA SETTLEMENTS - Payments received as a result of a federal class action settlement with four manufacturers of blood plasma products on behalf of hemophilia patients who are infected with human immunodeficiency virus (HIV);

BONA FIDE LOAN - A bona fide loan received by the A/R from an institution or person not legally liable for the support of the A/R. The loan must be a written agreement, signed by the A/R and the lender. The written agreement must indicate: the A/R's intent to repay the loan within a specific time; and how the loan is to be repaid, by specific real or personal property, held as collateral, or from future income. The loan remains an exempt resource as long as it retains the characteristics of a bona fide loan. Any interest accrued is considered unearned income in the month received.

INCOME**LIF DISREGARDS**

CASH ASSISTANCE INCOME - Any income of a cash assistance recipient in the A/R's household. However, any room/board such cash assistance recipient may pay to a LIF A/R is countable;

CHILD CARE INCOME - Five dollars a day per child for a homemaker providing family day care for children other than his/her own is disregarded from the total amount of childcare payments received;

CHILDCARE SERVICES PAYMENTS - Payments made to the A/R for childcare services or the value of any childcare services provided by the A/R to a recipient of employment-related and JOBS-related childcare services. Transitional child care services, at-risk low income child care services or child care and development block grant services;

CHILDCARE/INCAPACITATED ADULT CARE COSTS- paid by the A/R subject to dollar limitations (See **INCOME LIF BUDGETING METHODOLOGY CHILD/INCAPACITATED ADULT CARE COST**);

Payments received from Child and Adult Care Food Program (CACFP);

CHILD SUPPORT ARREARAGE PAYMENTS- all arrearage payments must be budgeted as income in the month following the month the payment is issued and as a resource thereafter.

DISASTER RELIEF AND EMERGENCY ASSISTANCE - Any federal major disaster and emergency assistance provided under the Disaster Relief Act of 1974 (P.L. 93-288), as amended by the Disaster Relief and Emergency Assistance Amendments of 1988 (P.L. 100-107), and any comparable disaster assistance provided by states, local governments, and disaster assistance organization;

DONATED FOODS - The value of federally donated foods;

EARNED INCOME, PERCENTAGE OF, (See **INCOME LIF BUDGETING METHODOLOGY EARNED INCOME DISREGARD**).

INCOME**LIF DISREGARDS**

EARNED INCOME TAX CREDIT PAYMENTS;

FEDERAL ECONOMIC OPPORTUNITY ACT, TITLE III - Any loan made to a family under Title III of the Federal Economic Opportunity Act;

FEDERAL ENERGY ASSISTANCE PAYMENTS

FEDERAL OLDER AMERICANS ACT OF 1965 - Any assistance (other than wages or salaries) to an individual under the Federal Older American Act of 1965. Green Thumb assistance is countable if wages or salaries; other Green Thumb assistance is disregarded.

FEDERAL RELOCATION ASSISTANCE - Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.

FOSTER PARENT PAYMENTS - Payments received for a child boarded out in the home of a recipient by an agency or a relative of the child.

FOOD STAMPS - The value of food stamps.

FREE MEALS - The value of free meals, other than school meals, except when more than one meal a day is furnished or when the A/R receives an allowance for meals away from home.

GARDEN PRODUCE OR LIVESTOCK - The value of produce from a garden or livestock when used exclusively by the A/R and members of his/her household.

GI BILL DEDUCTION - That portion of a military person's pay that is deducted by mandate to help fund the GI Bill.

HOUSING AND URBAN DEVELOPMENT (HUD) COMMUNITY DEVELOPMENT BLOCK GRANT FUNDS.

INCOME TAX REFUNDS - Any income tax refund or federal advance payment received by an A/R is disregarded in the month received and considered an exempt resource in the following month.

INCOME

LIF DISREGARDS

INDIVIDUAL DEVELOPMENT ACCOUNTS - These accounts are trusts which allow recipients to set aside funds, outside of the resource limits, for the purposes of post-secondary education at an eligible educational institution, first home purchases and business capitalization.

Eligible educational institution means:

- (a) an institution described in section 481(a)(1) or 1201(a) of the Higher Education Act of 1965 as such sections were in effect on August 26, 1996; or
- (b) an area vocational education school as defined in subparagraph (C) or (D) section 521(4) of the Carl D. Perkins Vocational and Applied Technology Education Act as such sections were in effect on August 26, 1996.

Post-secondary educational expenses means:

- (a) tuition and fees required for the enrollment or attendance of a student of an eligible education institution; or
- (b) fees, books, supplies, and equipment required for courses of instruction at an eligible education institution.

Qualified acquisition costs means the cost of acquiring, constructing, or reconstructing a residence. The term includes any usual or reasonable settlement, financing or other closing cost.

Qualified business means any business that does not contravene any law or public policy.

Qualified business capitalization expenses are qualified expenditures for the capitalization of a qualified business pursuant to a qualified plan.

Qualified expenditures are expenditures included in a qualified plan, including capital, plant, equipment, working capital, and inventory expenses.

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INCOME**LIF DISREGARDS**

Qualified first-time homebuyer is a taxpayer (and, if married, the taxpayer's spouse) who has no present ownership interest in a principal residence during the 3-year period ending on the date of acquisition of the principal residence.

Date of acquisition means the date of entry into a binding contract to acquire, construct, or reconstruct the principal residence.

Qualified plan means a business plan which:

- (a) is approved by a financial institution, or by a nonprofit loan fund having demonstrated fiduciary integrity; and
- (b) includes a description of services or goods to be sold, a marketing plan, and projected financial statements; and
- (c) may require the individual to obtain the assistance of an experienced entrepreneurial advisor.

Qualified principal residence is a principal residence (within the meaning of Section 1034 of the Internal Revenue Code of 1986), the qualified acquisition costs of which do not exceed 100% of the area purchase price applicable to such residence (determined in accordance with paragraphs (2) and (3) of section 143 (e) of the Internal Revenue Code).

INSURANCE PAYMENTS - Moneys from insurance payments for the purpose of repairing or replacing a disregarded resource, which was lost, damaged or stolen, are disregarded. Any interest received from such payments is also disregarded.

JOB CORPS - Money received by a family based on the enrollment of a child in the Job Corps.

NATIVE AMERICAN PAYMENTS -Seneca Nation Settlement Act payments made by the State and Federal governments, under P.L. 101-503, to the Seneca Nation.

Distribution to Native Americans of funds appropriated in satisfaction of judgments of the Indian Claims Commission or the United States Court of Federal Claims. This includes up to \$2,000 per year of income for interests of individual Native Americans in trust or restricted lands, from funds appropriated in satisfaction of the Indian Claims Commission or the United States Court of Federal Claims.

INCOME**LIF DISREGARDS**

Alaskan Native Claims Settlement Act (ANCSA) distributions. The following distributions from a native corporation formed pursuant to ANCSA are disregarded as income or resources:

- a. cash, to the extent that it does not, in the aggregate, exceed \$2,000 per individual per year;
- b. stock;
- c. a partnership interest;
- d. land or an interest in land; and
- e. an interest in a settlement trust.

NYS DEPARTMENT OF LABOR PAYMENTS - Payments from Youth Education, Employment and Training Programs (Department of Labor programs).

OVERPAYMENTS - The amount of income that is withheld to recover a previous overpayment is not income if the individual received Medicaid at the time of the overpayment and the overpayment amount was included in determining the individual's Medicaid eligibility.

PERSECUTION PAYMENTS - Benefits received by eligible Japanese-Americans, Aleuts, or Pribilof Islanders under the Civil Liberties Act of 1988, the Wartime Relocation of Civilians Law, and the Aleutian and Pribilof Islands Restitution Act.

Payments made to individuals because of their status as victims of Nazi persecution, including: German Reparation Payments; Austrian Reparation Payments made pursuant to sections 500-506 of the Austrian General Social Insurance Act; and Netherlands Reparation Payments based on Nazi, but not Japanese, persecution.

INCOME**LIF DISREGARDS**

PREVENTATIVE HOUSING SERVICE - Payments provided as a preventive housing service under 18 NYCRR 423.4(l).

RADIATION EXPOSURE COMPENSATION TRUST FUND PAYMENTS - Payments for injuries or deaths resulting from exposure to radiation from nuclear testing and uranium mining.

ROOM AND/OR BOARD - The first \$60 per month of any income from each boarder and the first \$15 per month from each roomer (lodger). If the A/R can document that the actual expenses incurred in providing the room for the roomer, exceeds \$15 per month, or that the actual expenses incurred in providing room and board for a boarder exceeds \$60 per month, then the actual documented expenses are disregarded.

SSI, SUPPLEMENTAL SECURITY INCOME- Any SSI payments received by the A/R.

STUDENTS - Earned Income - Student earned income as described below:

If the under age 21 A/R is not employed full-time, all earned income is disregarded whether the A/R is a full or part-time student. It is not necessary to verify school attendance, unless there is an indication that the A/R is not attending. The A/R's statement on the application that s/he is a high school student is sufficient.

If the under age 21 A/R is employed full-time, the treatment of earned income depends on whether the A/R is a full or part-time student.

If the under age 21 A/R is a full-time student all earned income is disregarded for a six-month period per calendar year. Thereafter, such income becomes countable.

INCOME

LIF DISREGARDS

If the under age 21 A/R is a part-time student all earned income is countable.

School and Employment Status	Income Disregarded
Full-time student employed full-time	Yes (Income disregarded for up to six months per calendar year)
Full-time student employed part-time	Yes
Part-time student employed full-time	No
Part-time student employed part-time	Yes

NOTE: Summer employment is seasonal and not considered full-time employment.

Graduate Educational Grants or Scholarships - Educational grants, fellowships or scholarships for a graduate student, obtained and used for educational purposes only. This precludes their use for meeting current living expenses. The student must attest to this in writing. The language of the attestation attached to 83 ADM-67 must be used without change.

When an A/R is in receipt of a graduate assistantship, the local district receives verification from the financial aid office involved to determine if the assistantship is considered employment or an educational grant. If the assistantship is a grant, it is treated as outlined in the previous paragraph. When the assistantship is considered employment, the A/R receives any appropriate earned income disregards (See **INCOME EARNED INCOME DISREGARD**), but additional deductions for educational expenses are not allowed.

School Meals - The value of free school meals.

Student Loans - Student loans received by a graduate or undergraduate student.

Undergraduate Educational Grants, Scholarships or Work-Study - Educational grants, scholarships, fellowships or work-study for undergraduate students.

INCOME

LIF DISREGARDS

NOTE: This does not apply to V.A. Educational Grants which are part of the G.I. Bill and which provide a monthly allowance for support while veterans are enrolled in school. Only specific education-related expenses such as tuition, books, school fees, transportation, etc., are exempt for recipients of G.I. Bill educational money. The remainder is considered available unearned income in determining eligibility for Medicaid.

SUPPORT PAYMENTS - The first \$100 of current total household support payments, including child support and alimony in any month including support payments collected and paid to the family by the local district.

TRADE READJUSTMENT ALLOWANCE (TRA) - TRA benefits are paid as part of Unemployment Benefits (UIB). When an A/R loses his/her job as the result of import competition, s/he may qualify for a TRA allowance. When an A/R is receiving a TRA allowance, as part of his/her UIB, for transportation and/or books for the purpose of attending training, the TRA benefit is exempt.

U.S. CENSUS - Earnings from census employment.

VIETNAM VETERANS - Agent Orange Settlement Fund – Payments from the Agent Orange Settlement Fund or any other fund established pursuant to the Agent Orange product liability litigation, and payments from court proceedings brought for personal injuries sustained by veterans resulting from exposure to dioxin or phenoxy herbicide in connection with the war in Indochina in the period of January 1, 1962 through May 7, 1975.

Children - Monthly allowances paid to certain Vietnam Veterans' children with Spina Bifida.

VISTA - Payments received by VISTA volunteers under Part A of Title I of Public Law 93-113 (VISTA) are disregarded as income and resources in determining eligibility and degree of need, provided that all of the VISTA payment is to be counted as income when the Director of the ACTION agency determines that the value of all such payments, adjusted to reflect the number of hours such volunteers are serving, is equivalent to or greater than the minimum wage. (See **REFERENCE** NEW YORK STATE MINIMUM WAGE)

INCOME**LIF DISREGARDS**

VOLUNTEER PROGRAM PAYMENTS - Payments received by participants in volunteer programs under Title II of P.L. 93-113 (Domestic Volunteer Services Act of 1973). These include: retired senior volunteer, foster grandparent, senior companion and senior health aid programs. Payments made in the form of stipends, allowances and/or reimbursements for incurred expenses are disregarded when determining Medicaid eligibility.

Payments received by participants in volunteer programs established under Title III of P.L. 93-133. These include the Service Corps of Retired Executives (SCORE) and the Active Corps of Executives (ACE) programs.

WOMEN, INFANTS AND CHILDREN (WIC) - The value of benefits under the WIC program.

WORK EXPENSE - \$90 work expense from earned income. (See **INCOME \$90 WORK EXPENSE DISREGARD**)

WORKFORCE INVESTMENT ACT (WIA)—formerly known as *JOB TRAINING PARTNERSHIP ACT (JTPA)* - Income (earned or unearned) derived through participation in a program carried out under the JTPA and paid to a dependent minor. Earned income is disregarded for only one six-month period per calendar year. Further discussion of JTPA payments can be found in the Public Assistance Source Book.

Payments for supportive services paid under JTPA to any A/R to defray costs attributable to training such as transportation, meals, childcare, etc.

References:	SSL Sect.	366.2 366.3
	Dept. Reg.	352.22 360-4.6(a)(1) 360-4.6(a)(3)
	ADMs	OMM/ADM 97-2 97 ADM-23 94 ADM-10 92 ADM-43 92 ADM-42 92 ADM-32

INCOME**LIF DISREGARDS**

	92 ADM-11
	90 ADM-3
	84 ADM-21
	84 ADM-1
	83 ADM-67
	81 ADM-38
INFs	95 INF-30
	94 INF-7
	90 INF-33
LCMs	95 LCM-53
	92 LCM-120
GISs	11 MA/004
	01 MA/024
	98 MA/017
	98 MA/016
	97 MA/022
	95 ES/DC006

Interpretation: The source and amount of income disregards are documented in the case record and a notation is made that this income is not to be considered in determining eligibility for Medicaid.

INCOME**LOW INCOME FAMILIES (LIF) BUDGETING METHODOLOGY**

Policy: The following persons who apply for Medicaid are entitled to LIF budgeting:

- Families with a dependent child under age 21;
- Persons under age 21;
- Pregnant women
- FNP parents.

References:

SSL Sect.	366
ADMs	OMM/ADM 97-2 97 ADM-23
GIS	08 MA/022

Interpretation: The financial criteria for LIF generally parallel the criteria of the Family Assistance cash program. However, the LIF methodology may not be more restrictive than the methodology used in the Aid to Dependent Children cash program on July 16, 1996.

Financial eligibility for LIF requires that the A/R's countable income meet certain tests. Three income tests are applied in determining whether an A/R may be eligible for LIF. These tests are:

1. comparison of gross income to 185% of the Medicaid Standard. If an A/R's gross income, after certain disregards, exceeds 185% of the Medicaid Standard, the A/R will not be eligible for LIF. (See **INCOME LIF DISREGARDS**)
2. comparison of gross income to the poverty level. If the A/R's gross income exceeds 100% of the federal poverty level, the A/R will not be eligible under LIF. For certain special housing situations (See 97 ADM-23), the income comparison will parallel calculations used in Public Assistance.
3. comparison to the Medicaid Standard. If an A/R's net income after allowable deductions exceeds the Medicaid Standard (and the MBL Living Arrangement Chart, as appropriate), the A/R will not be eligible under LIF.

NOTE: If a family's countable income exceeds the Medicaid Standard the family may not spend down to the Medicaid Standard. However, eligibility may exist under one of the medically needy or expanded eligibility (poverty level) programs.

INCOME**LOW INCOME FAMILIES (LIF) BUDETING METHODOLGY**

This section is comprised of:

- 185% Gross Income Test
- 100% of the Poverty Level Test
- Comparison of net income to the Medicaid Standard

**INCOME
LOW INCOME FAMILIES (LIF) BUDGETING METHODOLOGY**

185% MAXIMUM INCOME TEST

Description: The maximum income limit allowed for a LIF A/R is 185% of the applicable Medicaid Standard (including additional allowances).

Policy: When using LIF budgeting, an A/R's total income, after subtracting any disregards, must be less than or equal to 185% of the applicable Medicaid Standard.

References:

Dept. Reg.	352.18 360-3.3(a)(1)
ADMs	OMM/ADM 97-2 97 ADM-21 85 ADM-33 83 ADM-38 82 ADM-49 81 ADM-55
GIS	08 MA/022

Interpretation: Families with dependent children under age 21, individuals under age 21, pregnant women and FNP parents cannot have gross income exceeding 185% of the Medicaid Standard. All income disregards (See **INCOME LOW INCOME FAMILY DISREGARDS**) except the \$90 work expense, child/incapacitated adult care and the earned income disregard are deducted before determining if the A/R meets the 185% maximum income test. The Public Assistance Source Book for Regulations contains a more detailed description of income excluded from the 185% income limit.

NOTE: Persons in Congregate Care (Levels I, II, and III) are not required to pass the 185% income test.

This income test is performed by multiplying the Medicaid Standard, for the appropriate size household, by 185%. The income of the A/R as described above is then compared to this figure. If the income is less than or equal to 185% of the Standard of Need then the household must pass the next test. If the income exceeds this figure, the household is not eligible for Medicaid under LIF and is further evaluated under medically needy or poverty level budgeting.

**INCOME
LIF BUDGETING METHODOLOGY**

MEDICAID STANDARD

- Policy** The A/R cannot have net income equal to or in excess of the Medicaid Standard (and MBL Living Arrangement Chart, as appropriate) to be eligible under LIF. (See **INCOME LOW INCOME FAMILIES (LIF) BUDGETING METHODOLOGY**)
- References:**
- | | |
|------|---------------------------|
| ADMs | OMM/ADM 97-2
97 ADM-23 |
| GIS | 08 MA/022 |
- Interpretation:** Net income is calculated after disregards have been applied. A/Rs of LIF receive certain deductions from income. (See **INCOME LIF DISREGARDS**)
- Disposition:** The A/Rs net income is compared to the Medicaid Standard (and MBL Living Arrangement Chart, as appropriate) based on the A/R's household size. If the household's income equals or exceeds the Medicaid Standard (and MBL Living Arrangement Chart, as appropriate) the household is ineligible for LIF and eligibility is determined using Medically Needy or poverty level budgeting.

**INCOME
LIF BUDGETING METHODOLOGY**

\$90 WORK EXPENSE DISREGARD

Policy: In determining eligibility for Medicaid, the first item deducted from the gross monthly earnings is \$90 of earned income for those individuals engaged in full-time or part-time employment (including those not employed throughout the month).

NOTE: Whenever an A/R has earned income, the first \$90 per month is disregarded even though the A/R may not currently be employed or working.

References:

SSL Sect.		366
Dept. Reg.	3	52.19 360-4.6(a)(3)
ADMs		OMM/ADM 97-2 90 ADM-3 87 ADM-32
GISs		89 MA028 87 MA0028

Interpretation: When determining net earned income using LIF budgeting (See **INCOME LIF BUDGETING METHODOLOGY DETERMINATION OF ELIGIBILITY**) subtract \$90 for each person working full-time or part-time. The \$90 work expense is given regardless of the amount of the work expenses incurred.

When the A/R earns less than \$90 per month, disregard the entire amount.

Although the A/R may have more than one job, only one \$90 disregard for work-related expenses is allowed.

**INCOME
LIF BUDGETING METHODOLOGY**

EARNED INCOME DISREGARD

Description: An earned income disregard will be applied to the earnings of each income earner in families who have earned income. A percentage of earned income will be disregarded from the earnings of each income earner for families who:

1. pass the three tests
 - 185% of Medicaid Standard,
 - 100% of poverty level test (See **INCOME LOW INCOME FAMILY (LIF) BUDGETING METHODOLOGY: 185% MAXIMUM INCOME TEST** and **100% MAXIMUM INCOME TEST**),
 - 100% of Medicaid Standard, or
2. pass the 185% Medicaid Standard, the 100% poverty level test and received LIF in one out of the four previous months.

No time limit is applied to the earned income disregard.

The earned income disregard will be adjusted annually to reflect changes in the poverty level guidelines. The annual earned income disregard percentages can be found in **REFERENCE EARNED INCOME DISREGARD**.

Policy: After the \$90 work expense is deducted from gross income, the current earned income disregard percentage is applied to the remaining income to determine the amount of the earned income disregard. The earned income disregard is then deducted from gross income.

References: SSL Sect. 366

 ADMs 05 ADM-09
 OMM/ADM 97-2

**INCOME
LIF BUDGETING METHODOLOGY**

EARNED INCOME DISREGARD

GISs	08 MA/022
	07 MA/012
	06 MA/007
	05 MA/021
	00 MA/008

Interpretation: The earned income disregard is computed as follows:

- (a) Subtract the \$90 work expense disregard from the gross earned income;
- (b) Multiply the remainder by the appropriate percentage; and
- (c) Subtract that amount from the net income.

When to Verify:

- (a) When the A/R or the case record indicates that the A/R is employed and has received Medicaid under LIF budgeting in one of the four previous months;
- (b) When the A/R's earned income is equal to or less than the Medicaid Standard, (and MBL Living Arrangement Chart, as appropriate).

**INCOME
LIF BUDGETING METHODOLOGY**

CHILD /INCAPACITATED ADULT CARE COST

Policy: The actual cost of care up to \$175 a month for each dependent child age two or over, or incapacitated adult that the A/R pays for may be deducted from the earned income of the A/R. The actual cost of care, up to \$200 a month, may be deducted for each dependent child under age two. The children or adult must reside in the same home as the A/R who is making the payments.

NOTE: Although the adult care deduction was eliminated in statute, Medicaid retains the deduction for the LIF category because it was part of the ADC program on July 16, 1996. LIF budgeting may not be more restrictive than the ADC cash program in effect on July 16, 1996.

References: SSL Sect. 366
Dept. Reg. 360-4.6(a)(3)(iv)
ADMs 91 ADM-8
90 ADM-3
81 ADM-55

Verify Status: When the A/R indicates that s/he is employed full or part-time and that there are dependent children or an incapacitated adult in the household for whom care is being provided and paid for by the A/R while s/he works. Only one parent is required to be employed to be eligible for this deduction from earned income even if there are two parents in the home.

Verification: Seeing a statement from the caretaker or day care center including the hours of care and the amount charged for such care.

Documentation: Sufficient to establish an audit trail:

Name of caretaker or day care center, children names and ages, amount paid, hours of care and receipts for payment.

**INCOME
LIF BUDGETING METHODOLOGY**

DETERMINATION OF ELIGIBILITY

Policy: LIF budgeting is used to determine eligibility for persons who meet the following categorical requirements:

- Families with a dependent child under age 21;
- Persons under age 21;
- Pregnant women, or
- FNP parents.

Eligibility is determined by comparing the net available income of the A/R to the Medicaid Standard (and MBL Living Arrangement chart, as appropriate). (See **REFERENCE MEDICALLY NEEDY INCOME AND FEDERAL POVERTY LEVELS**)

References:	SSL Sect.	366
	Dept. Reg.	360-4.2 360-4.6(a)(3)
	ADMs	OMM/ADM 97-2
	INFs	98 OMM/INF-02
	GIS	08 MA/022

Interpretation: Eligibility using LIF budgeting is determined as follows:

- (1) Determine the gross monthly income of the person or household. (See **OTHER ELIGIBILITY REQUIREMENTS HOUSEHOLD COMPOSITION** for an explanation of household composition) Certain kinds of income are disregarded in whole or in part. (See **INCOME LOW INCOME FAMILY DISREGARDS**)
- (2) Compare the gross monthly income to 185% of the Medicaid Standard. (See **INCOME LOW INCOME FAMILIES (LIF) BUDGETING METHODOLOGY 185% MAXIMUM INCOME TEST**) If gross income exceeds 185% of the Medicaid Standard, the A/R is not eligible for Medicaid using LIF budgeting. If the gross monthly income is equal to or less than 185% of the Medicaid Standard, then

**INCOME
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DETERMINATION OF ELIGIBILITY

- (3) Compare the gross monthly income to 100% of the federal poverty level. If gross income exceeds 100% of the federal poverty level, the A/R is not eligible for Medicaid using LIF budgeting. If the gross monthly income is equal to or less than 100% of the federal poverty level, then
- (4) Deduct the \$90 work expense disregard;
- (5) Deduct child/incapacitated adult care costs paid by the A/R up to the cap;
- (6) Determine if the household received Medicaid under LIF budgeting in one of the previous four months. If so, subtract the earned income disregard from the A/R's earned income. (See **INCOME LIF BUDGETING METHODOLOGY EARNED INCOME DISREGARD**)
- (7) Compare the resulting net income to the Medicaid Standard.

If the A/R did not receive Medicaid under LIF budgeting in one of the previous four months and the A/R's income is equal to or less than the Medicaid Standard, the earned income disregard is then applied.

If the A/R did not receive Medicaid under LIF budgeting in one of the previous four months and the A/R's income is more than the Medicaid Standard, no earned income disregard is applied. If a family's countable income exceeds the Medicaid Standard, the family may not spend down to the Medicaid Standard. However, eligibility may exist and should be evaluated under one of the Medically Needy or Expanded Eligibility (poverty level) programs, Family Health Plus., or Family Planning Benefit Program.

INCOME**ADC-RELATED DISREGARDS**

Description: Disregards of income are not considered in whole or in part in determining eligibility for Medicaid.

Policy: The following types of income are disregarded in the determination of gross monthly income for Medicaid: (See **REFERENCE INCOME DISREGARDS** for chart)

AMERICORPS - Child care allowances and other benefits and services including payments for living expenses provided by Americorps VISTA;

Child care allowances and all other benefits and services except payments for living expenses, provided by Americorps USA and Americorps NCCC;

ASSISTANCE BASED ON NEED - Any regular cash assistance payments based on need received by the A/R and furnished as supplemental income by the federal government, a State or political subdivision;

Support and maintenance assistance based on need and furnished either in-kind by a private non-profit agency or in cash or in-kind by one of the following: a supplier of home heating oil or gas, an entity whose revenues are primarily derived on a rate-of-return basis regulated by a State or Federal governmental entity or a municipal utility providing home energy;

BLOOD PLASMA SETTLEMENTS - Payments received as a result of a federal class action settlement with four manufacturers of blood plasma products on behalf of hemophilia patients who are infected with human immunodeficiency virus (HIV);

BONA FIDE LOAN - A bona fide loan received by the A/R from an institution or person not legally liable for the support of the A/R. The loan must be a written agreement, signed by the A/R and the lender. The written agreement must indicate: the A/R's intent to repay the loan within a specific time; and how the loan is to be repaid, by specific real or personal property, held as collateral, or from future income. The loan remains an exempt resource as long as it retains the characteristics of a bona fide loan. Any interest accrued is considered unearned income in the month received.

INCOME**ADC-RELATED DISREGARDS**

CASH ASSISTANCE INCOME - Any income of a cash assistance recipient in the A/R's household. However, any room/board such cash assistance recipient may pay to an ADC-related A/R is countable, after the \$90 room and board (See **INCOME INCOME FROM ROOMERS (LODGERS) AND BOARDERS**) and \$90 earned income (See **INCOME ADC-RELATED BUDGETING METHODOLOGY \$90 WORK EXPENSE DISREGARD**) disregards.

CHILDCARE INCOME- Five dollars a day per child for an A/R who provides family day care for children other than his/her own is disregarded from the total amount of childcare payments received.

CHILDCARE SERVICES PAYMENTS - Payments made to the A/R for childcare services or the value of any childcare services provided by the A/R to a recipient of employment-related and JOBS-related childcare services. Transitional child care services, at-risk low income child care services or child care and development block grant services.

CHILDCARE/INCAPACITATED ADULT CARE COSTS- paid by the A/R subject to dollar limitations (See **INCOME ADC-RELATED BUDGETING METHODOLOGY CHILD/INCAPA-CITATED ADULT CARE COST**).

Payments received from Child and Adult Care Food Program (CACFP).

CHILD SUPPORT ARREARAGE PAYMENTS- all arrearage payments must be budgeted as income in the month following the month the payment is issued.

DISASTER RELIEF AND EMERGENCY ASSISTANCE - Any federal major disaster and emergency assistance provided under the Disaster Relief Act of 1974 (P.L. 93-288), as amended by the Disaster Relief and Emergency Assistance Amendments of 1988 (P.L. 100-107), and any comparable disaster assistance provided by states, local governments, and disaster assistance organization.

DONATED FOODS - The value of federally donated foods.

EARNED INCOME TAX CREDIT PAYMENTS.

INCOME**ADC-RELATED DISREGARDS**

FEDERAL ECONOMIC OPPORTUNITY ACT, TITLE III - Any loan made to a family under Title III of the Federal Economic Opportunity Act.

FEDERAL ENERGY ASSISTANCE PAYMENT.

FEDERAL OLDER AMERICANS ACT OF 1965 - Any assistance (other than wages or salaries) to an individual under the Federal Older Americans Act of 1965. Green Thumb is countable if wages or salaries; other Green Thumb assistance is disregarded.

FEDERAL RELOCATION ASSISTANCE - Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.

FOOD STAMPS - The value of food stamps.

FOSTER PARENT PAYMENTS - Payments received for a child boarded out in the home of a recipient by an agency or a relative of the child.

FREE MEALS - The value of free meals, other than school meals, except when more than one meal a day is furnished or when the A/R receives an allowance for meals away from home.

GARDEN PRODUCE OR LIVESTOCK - The value of produce from a garden or livestock when used exclusively by the A/R and members of his/her household.

GI BILL DEDUCTION - That portion of a military person's pay, which is deducted by mandate to help fund the GI Bill.

HOUSING AND URBAN DEVELOPMENT (HUD) COMMUNITY DEVELOPMENT BLOCK GRANT FUNDS.

HEALTH INSURANCE PREMIUMS.

INCOME TAX REFUNDS - Any income tax refund or federal advance payment received by an A/R is disregarded in the month received and considered an exempt resource in the following month.

INSURANCE PAYMENTS - Moneys from insurance payments for the purpose of repairing or purchasing disregarded resource,

INCOME**ADC-RELATED DISREGARDS**

which was lost, damaged or stolen, are disregarded. Any interest received from such payments is also disregarded.

JOB CORPS - Money received by a family based on the enrollment of a child in the Job Corps.

NATIVE AMERICAN PAYMENTS - Seneca Nation Settlement Act payments made by the State and Federal governments, under P.L. 101-503, to the Seneca Nation.

Distribution to Native Americans of funds appropriated in satisfaction of judgments of the Indian Claims Commission or the United States Court of Federal Claims. This includes up to \$2,000 per year of income for interests of individual Native Americans in trust or restricted lands, from funds appropriated in satisfaction of the Indian Claims Commission or the United States Court of Federal Claims.

Alaskan Native Claims Settlement Act (ANCSA) distributions - The following distributions from a native corporation formed pursuant to ANCSA are exempt as income or resources:

- cash, to the extent that it does not, in the aggregate, exceed \$2,000 per individual per year;
- stock;
- a partnership interest;
- land or an interest in land; and
- an interest in a settlement trust.

NYS DEPARTMENT OF LABOR PAYMENTS - Payments from Youth Education, Employment and Training Programs (Department of Labor programs).

INCOME**ADC-RELATED DISREGARDS**

OVERPAYMENTS - The amount of income that is withheld to recover a previous overpayment is not income if the individual received Medicaid at the time of the overpayment and the overpayment amount was included in determining the individual's Medicaid eligibility.

PERCENTAGE OF EARNED INCOME, (See **INCOME ADC-RELATED DISREGARDS \$30 and 1/3 EARNED INCOME DISREGARD**).

PERSECUTION PAYMENTS - Benefits received by eligible Japanese-Americans, Aleuts, or Pribilof Islanders under the Civil Liberties Act of 1988, the Wartime Relocation of Civilians Law, and the Aleutian and Pribilof Islands Restitution Act.

Payments made to individuals because of their status as victims of Nazi persecution, including: German Reparation Payments; Austrian Reparation Payments made pursuant to sections 500-506 of the Austrian General Social Insurance Act; and Netherlands Reparation Payments based on Nazi, but not Japanese, persecution.

PREVENTATIVE HOUSING SERVICE - Payments provided as a preventive housing service under 18 NYCRR 423.4(l).

RADIATION EXPOSURE COMPENSATION TRUST FUND PAYMENTS - Payments for injuries or deaths resulting from exposure to radiation from nuclear testing and uranium mining.

ROOM AND/OR BOARD - The first \$90 per month of any income from each boarder or roomer (lodger). If the A/R can document that the actual expenses incurred in providing the room or room and board exceeds the \$90 per month, then actual documented expenses are disregarded.

SUPPLEMENTAL SECURITY INCOME (SSI) - Any SSI payments received by the A/R.

INCOME

ADC-RELATED DISREGARDS

STUDENTS - Earned Income - Student earned income as described below:

If the under the age 21 A/R is not employed full-time, all earned income is disregarded whether the A/R is a full or part-time student. It is not necessary to verify high school attendance, unless there is an indication that the A/R is not attending. The A/R's statement on the application that s/he is a high school student is sufficient. Attendance in other educational programs must be verified.

If the under age 21 A/R is employed full-time, the treatment of earned income depends on whether the A/R is a full or part-time student.

If the under age 21 A/R is a full-time student, all earned income is disregarded for a six-month period per calendar year. Thereafter, such income becomes countable.

If the under age 21 A/R is a part-time student, all earned income is countable.

School and Employment Status	Income Disregarded
Full-time student employed full time	Yes (Income disregarded for up to six months per calendar year)
Full time student employed part-time	Yes
Part-time student employed full-time	No
Part-time student employed part-time	Yes

NOTE: Summer employment is seasonal and not considered full-time employment.

INCOME

ADC-RELATED DISREGARDS

Graduate Educational Grants or Scholarships- Educational grants, fellowships or scholarships for a graduate student, obtained and used for educational purposes only. This precludes their use for meeting current living expenses. The student must attest to this in writing. The language of the attestation attached to 83-ADM-67 must be used without change.

When an A/R is in receipt of a graduate assistantship, the local district receives verification from the financial aid office involved to determine if the assistantship is considered employment or an educational grant. If the assistantship is a grant, it is treated as outlined in the previous paragraph. When the assistantship is considered employment, the A/R receives any appropriate earned income disregards (See **INCOME ADC-RELATED DISREGARDS**), but additional deductions for educational expenses are not allowed.

School Meals - The value of free school meals.

Student Loans - Student loans received by a graduate or undergraduate student.

Undergraduate Educational Grants, Scholarships or Work-Study - Educational grants, scholarships, fellowships or work-study for undergraduate students.

NOTE: This does not apply to V.A. Educational Grants which are part of the G.I. Bill and which provide a monthly allowance for support while veterans are enrolled in school. Only specific education-related expenses such as tuition, books, school fees, transportation, etc., are exempt for recipients of G.I. Bill educational money. The remainder is considered available unearned income in determining eligibility for Medicaid.

INCOME**ADC-RELATED DISREGARDS**

SUPPORT PAYMENTS - The first \$100 of current total household support payments, including child support and alimony, in any month including support payments collected and paid to the family by the local district.

TRADE READJUSTMENT ALLOWANCE (TRA) - TRA benefits are paid as part of Unemployment Benefits (UIB). When an A/R loses his/her job as the result of import competition, s/he may qualify for a TRA allowance. When an A/R is receiving a TRA allowance, as part of his/her UIB, for transportation and/or books for the purpose of attending training, the TRA benefit is exempt.

U.S. CENSUS - Earnings from census employment.

VIETNAM VETERANS - Agent Orange Settlement Fund - Payments from the Agent Orange Settlement Fund or any other fund established pursuant to the Agent Orange product liability litigation, and payments from court proceedings brought for personal injuries sustained by veterans resulting from exposure to dioxin or phenoxy herbicide in connection with the war in Indochina in the period of March 1, 1962 through May 7, 1975.

Children - Monthly allowances paid to certain Vietnam Veterans' Children with Spina Bifida.

VISTA - Payments received by VISTA volunteers under Part A of Title I of Public Law 93-113 (VISTA) are disregarded as income and resources in determining eligibility and degree of need, provided that all of the VISTA payment is to be counted as income when the Director of the ACTION agency determines that the value of all such payments, adjusted to reflect the number of hours such volunteers are serving, is equivalent to or greater than the minimum wage. (See **REFERENCE NEW YORK STATE MINIMUM WAGE**)

INCOME

ADC-RELATED DISREGARDS

VOLUNTEER PROGRAM PAYMENTS - Payments received by participants in volunteer programs under Title II of P.L. 93-113 (Domestic Volunteer Services Act of 1973). These include: retired senior volunteer, foster grandparent, senior companion and senior health aid programs. Payments made in the form of stipends, allowances and/or reimbursements for incurred expenses are disregarded when determining Medicaid eligibility.

Payments received by participants in volunteer programs established under Title III of P.L. 93-133. These include the Service Corps of Retired Executives (SCORE) and the Active Corps of Executives (ACE) programs.

WOMEN, INFANTS AND CHILDREN (WIC) - The value of benefits under the WIC program.

WORK EXPENSE - \$90 work expense from earned income. (See **INCOME ADC-RELATED BUDGETING METHODOLOGY \$90 WORK EXPENSE DISREGARD**)

WORKFORCE INVESTMENT ACT (WIA)—formerly known as JOB TRAINING PARTNERSHIP ACT (JTPA) - Income (earned or unearned) derived through participation in a program carried out under the JTPA and paid to a dependent minor. Earned income is disregarded for only one six-month period per calendar year. Further discussion of JTPA payments can be found in the Public Assistance Source Book.

Payments for supportive services paid under JTPA to any A/R to defray costs attributable to training such as transportation, meals, childcare, etc.

INCOME

ADC-RELATED DISREGARDS

References:	SSL Sect.	366.2 366.3
	Dept. Reg.	352.22 360-4.6(a)(1) 360-4.6(a)(3)
	ADMs	01 OMM/ADM-6 OMM/ADM 97-2 97 ADM-23 94 ADM-10 92 ADM-43 92 ADM-42 92 ADM-32 92 ADM-11 91 ADM-8 90 ADM-3 84 ADM-21 84 ADM-1 83 ADM-67 81 ADM-38
	INFs	95 INF-30 94 INF-7 90 INF-33
	LCMs	95 LCM-53 92 LCM-120
	GISs	11 MA/004 01 MA/024 98 MA/017 98 MA/016 97 MA/022 95 ES/DC006

Interpretation: The kinds of income listed previously are not considered in determining eligibility for Medicaid for the ADC-related category. Only available income is counted in the determination of eligibility. (See **OTHER ELIGIBILITY REQUIREMENTS OWNERSHIP AND AVAILABILITY** for a more detailed discussion of availability of income.)

INCOME**ADC-RELATED DISREGARDS**

NOTE: Most ADC-related categorical disregards are used when determining gross countable income for parents or persons age 19 and 20 who are applying for Family Health Plus.

Documentation: The source and amount of income disregards are documented in the case record and a notation is made that this income is not to be considered in determining eligibility for Medicaid.

INCOME

ADC-RELATED BUDGETING

Policy: The following persons who apply for Medicaid are entitled to ADC-related budgeting, if they are ineligible under LIF budgeting:

- Families with a dependent child under age 21;
- Persons under age 21;
- Pregnant women, and
- FNP parents.

References:

SSL Sect.	366
Dept. Reg.	360-4.6
ADMs	OMM/ADM 97-2 91 ADM-8 90 ADM-3 87 ADM-32 84 ADM-39 82 ADM-6 81 ADM-55
GIS	90MA063

Interpretation: There are certain forms of income that are not considered in the calculation of gross monthly income for budgeting purposes.

The following topics are discussed in detail for ADC-related budgeting:

- \$90 work expense disregard;
- \$30 and 1/3;
- Child care/incapacitated adult care cost; and
- Health insurance premiums.

These disregards are discussed in the order that they are subtracted from the A/R's income. In addition, **INCOME ADC-RELATED DISREGARDS** describes the \$100 support payment disregard that is deducted from support income (child support and alimony) only before determining the countable gross income of the A/R.

**INCOME
ADC-RELATED BUDGETING METHODOLOGY**

\$90 WORK EXPENSE DISREGARD

Policy: In determining eligibility for Medicaid, the first item deducted from the gross monthly earnings is \$90 of earned income for those individuals engaged in full-time or part-time employment (including those not employed throughout the month).

NOTE: Whenever an A/R has earned income, the first \$90 per month is disregarded even though the A/R may not currently be employed or working.

References:

SSL Sect.	366
Dept. Reg.	352.19 360-4.6(a)(3)
ADMs	OMM/ADM 97-2 90 ADM-3 87 ADM-32
GISs	89 MA028 87 MA0028

Interpretation: When determining net earned income using ADC-related budgeting (See **INCOME ADC-RELATED BUDGETING**) subtract \$90 for each person working full-time or part-time. The \$90 work expense is given regardless of the amount of the work expenses incurred.

When the A/R earns less than \$90 per month, disregard the entire amount.

Although the A/R may have more than one job, only one \$90 disregard for work-related expenses is allowed.

**INCOME
ADC-RELATED BUDGETING METHODOLOGY**

\$30 AND 1/3 EARNED INCOME DISREGARD

Policy: The \$30 and 1/3 Earned Income Disregard (EID) applies when using ADC-related budgeting for employed persons who have received Medicaid under a LIF budget in one out of the four preceding months. The \$30 and 1/3 disregard applies when a family with earned income loses LIF eligibility and is not eligible for Transitional Medicaid (TMA).

After the \$90 work expense is disregarded, the first \$30 plus 1/3 of income remaining is subtracted. Eligible persons are entitled to receive this disregard for four consecutive months. In addition, these persons may receive a \$30 disregard per month for a period of eight months following this four month period provided the A/R continues to be employed.

Description: The \$30 and 1/3 Earned Income Disregard (EID) is calculated by subtracting the first \$30 of earned income and then subtracting 1/3 of the remaining earned income.

References:

SSL Sect.	366
Dept. Reg.	352.2 360-4.6(a)(3)
ADMs	90 ADM-3 85 ADM-33 82 ADM-21 81 ADM-55
INF	98 OMM/INF-02

Interpretation: The \$30 and 1/3 or \$30 disregard is applicable only to earned income. The income earner(s) in the applying household is entitled to receive the \$30 and 1/3 portion of this disregard if they have received Medicaid under a LIF budget in one of the four preceding months. The \$30 and 1/3 or \$30 disregard is applicable regardless of the reason for the loss of eligibility under the LIF program. Eligible individuals may receive the \$30 and 1/3 disregard for four consecutive months.

**INCOME
ADC-RELATED BUDGETING METHODOLOGY**

\$30 AND 1/3 EARNED INCOME DISREGARD

In addition, these persons are entitled to the \$30 disregard for eight additional months as long as they continue to be employed. The eight-month period continues to run even if the recipient goes off assistance. If the individual reapplies for Medicaid at any time during the eight-month period, the \$30 disregard is deducted from earned income in determining eligibility.

Once the eight-month maximum has been reached, the individual may not receive the \$30 and 1/3 or \$30 disregard again until s/he has been off Medicaid under LIF budgeting for 12 consecutive months.

See **CATEGORICAL FACTORS** MEDICAID EXTENSIONS/CONTINUATIONS for information about certain groups of people that are eligible for Medicaid as a result of their eligibility remaining in effect from a previous period of time. Because of this automatic eligibility, these persons are not entitled to the \$30 and 1/3 disregard.

When to Verify:

- (a) When the recipient or the case record indicates that the recipient is employed and has received Medicaid under LIF budgeting in one of the four previous months;
- (b) When the A/R indicates that his/her Medicaid case, under LIF budgeting, was closed for a reason other than an increase in income.

**INCOME
ADC-RELATED BUDGETING METHODOLOGY**

CHILD /INCAPACITATED ADULT CARE COST

Policy: The actual cost of care up to \$175 a month for each dependent child age two or over, or incapacitated adult that the A/R pays for may be deducted from the earned income of the A/R. The actual cost of care, up to \$200 a month, may be deducted for each dependent child under age two. The child(ren) or adult must reside in the same home as the A/R who is making the payments.

References: SSL Sect. 366
Dept. Reg. 360-4.6(a)(3)(iv)
ADMs 91 ADM-8
90 ADM-3
81 ADM-55

Verify: When the A/R indicates that s/he is employed full or part-time and that there are dependent children or an incapacitated adult in the household for whom care is being provided and paid for by the A/R while s/he works. Only one parent is required to be employed to be eligible for this deduction from earned income even if there are two parents in the home.

Verification: Seeing a statement from the caretaker or day care center including the hours of care and the amount charged for such care.

Documentation: Sufficient to establish an audit trail:

Name of caretaker or day care center, children's names and ages, amount paid, hours of care and receipts for payment.

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ADC-RELATED BUDGETING METHODOLOGY**

HEALTH INSURANCE PREMIUMS

Description: Health insurance premiums are premiums paid for insurance which covers hospital, medical, dental, drug and/or other charges for medical care and services.

Policy: Health insurance premiums are deducted from income in determining eligibility for Medicaid.

References:

SSL Sect.	366.2(a)(6)
Dept. Reg.	360-4.6(a)(3)(vii)
ADMs	93 ADM-28
	91 ADM 53
	91 ADM-27
	87 ADM-40
	83 ADM-44

Interpretation: When using ADC-related budgeting (See **INCOME ADC-RELATED BUDGETING**), the amount of the work expense disregard, the \$30 and 1/3 or \$30 disregard, the child or incapacitated adult care and the premium paid for health insurance are disregarded from earned income. When the A/R has no earned income or his/her entire earned income has been disregarded, the amount of the health insurance premium paid is deducted from unearned income.

Health insurance policies, which indemnify the A/R against charges for medical care and services, are considered for this disregard. These include: Medicare Parts A & B, Blue Cross, Blue Shield, Major Medical insurance, dental insurance, prescription drug insurance, long term care insurance, union health fund premiums, and other hospital and medical insurance.

Policies, which indemnify the A/R against loss of income due to illness or disability, may be considered for this disregard. These include: income protection insurance, medical liability insurance and any other insurance which offsets the loss of wages due to illness or hospitalization. A policy, which pays the A/R a certain amount of money for each day s/he is hospitalized, but does not cover specific hospital services, may be eligible for this disregard. The policy must be assignable (See **OTHER ELIGIBILITY REQUIREMENTS THIRD PARTY RESOURCES ASSIGNMENT AND SUBROGATION**) a hospital and be cost effective for its premiums to be considered as a deduction. A policy belonging to a non-applying spouse does not have to be assignable in order to receive the premium disregard.

**INCOME
ADC-RELATED BUDGETING METHODOLOGY**

HEALTH INSURANCE PREMIUMS

RESOURCES ENROLLMENT IN GROUP HEALTH INSURANCE contains information on the eligibility requirement that A/Rs obtain any health insurance available through their employer. When the health insurance is cost-effective and the A/R is below the income level and SSI-related A/R is below the resource level, the local districts may pay the recipient's premium, unless it is an income protection policy.

When a child is covered under a non-applying or ineligible parent's health insurance policy, the health insurance premium may be paid in full by the local district if the child is otherwise eligible and the premium payment is cost effective. This reimbursement policy does not apply to a non-applying or ineligible parent if the health insurance premium is court-ordered.

- When to Verify:**
- (a) When the A/R declares in the application that s/he or other family members are covered by health insurance;
 - (b) When the A/R declares in the application that s/he or other family members are covered by Medicare, Part A or B;
 - (c) When the A/R declares in the application that health insurance premiums are being withheld from his/her pay;
 - (d) When the A/R or absent parent is employed;
 - (e) When the A/R is receiving RSDI; and
 - (f) When the A/R is receiving a pension.

- Verification:** Health insurance premiums may be verified by:
- (a) The health insurance policy;
 - (b) The health insurance card; or
 - (c) Seeing the A/R's paycheck stub, pay envelope, or a statement from his/her employer.

- Documentation:** Sufficient to establish an audit trail:
- (a) Amount of premium, frequency, date of pay stub or envelope, policy number and employer's name; or

INCOME
ADC-RELATED BUDGETING METHODOLOGY

HEALTH INSURANCE PREMIUMS

- (b) For privately paid policies, amount, date and frequency of payment, insurance company name and policy number; and
- (c) Returned clearance filed in case record.

Disposition: When the amount of health insurance premiums paid is indicated, that amount is disregarded to determine net available income. (See **RESOURCES THIRD PARTY RESOURCES** for when the local district may pay the health insurance premium.)

**INCOME
ADC-RELATED BUDGETING METHODOLOGY**

DETERMINATION OF ELIGIBILITY

Policy: ADC-related budgeting is used to determine eligibility for persons who meet the following categorical requirements and who are ineligible under LIF budgeting:

- Families with dependent children under age 21;
- Persons under age 21;
- Pregnant women; and
- FNP parents.

Eligibility is determined by comparing the net available income of the A/R to the Medically Needy Income level, or the Medicaid Standard (and MBL Living Arrangement Chart, as appropriate) whichever is most beneficial. (See **REFERENCE MEDICALLY NEEDED INCOME AND FEDERAL POVERTY LEVELS**), whichever is higher. For pregnant women and children under specified ages, income may be compared to the federal poverty level. (See **REFERENCE MEDICALLY NEEDED INCOME AND FEDERAL POVERTY LEVELS**)

References:	SSL Sect.	366
	Dept. Reg.	360-4.2 360-4.6(a)(3)
	ADMS	OMM/ADM 97-2 91 ADM-8 90 ADM-9
	INFs	98 OMM/INF-02
	GISs	08 MA/022 91MA041 90MA063

Interpretation: ADC-related eligibility is determined as follows:

- (1) Determine the A/R's household size by counting those persons who are applying and their legally responsible relatives (See **OTHER ELIGIBILITY REQUIREMENTS HOUSEHOLD COMPOSITION ADC-RELATED HOUSEHOLD**).

**INCOME
ADC-RELATED BUDGETING METHODOLOGY**

DETERMINATION OF ELIGIBILITY

- (2) Determine the monthly income of the person or household. All income from all sources is reviewed to determine if it is to be included in the eligibility determination. Certain kinds of income are disregarded in whole or in part. Determine the monthly income of the person or household. All income from all sources is reviewed to determine if it is to be included in the eligibility determination. Certain kinds of income are disregarded in whole or in part (See **INCOME ADC-RELATED DISREGARDS**) and not counted as part of the monthly income. The income is converted to a monthly figure.
- (3) Deduct the applicable disregards from the A/R's income in the following order to determine the net income:
- (a) \$90 for work related expenses
 - (b) The first \$30 and 1/3 of the remainder or the first \$30 in those cases where it is applicable;
 - (c) The actual cost of child or dependent care up to \$175 a month for each child, age 2 or over, or incapacitated adult, the actual cost of child care, up to \$200 a month for each child under age 2;
 - (d) Health insurance premiums and

(See **INCOME ADC-RELATED BUDGETING METHODOLOGY: \$90 WORK EXPENSE DISREGARD, \$30 and 1/3 EARNED INCOME DISREGARD, CHILD/INCAPACITATED ADULT CARE COST, and INCOME HEALTH INSURANCE PREMIUMS**)
 - (e) \$100 Support Payment Disregard (child support and alimony. (See **INCOME ADC RELATED DISREGARDS**)

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ADC-RELATED BUDGETING METHODOLOGY**

DETERMINATION OF ELIGIBILITY

- (4) The resulting net income is compared to the appropriate income level. If the income is less than or equal to the applicable income level, the person or household is eligible for Medicaid. If the income exceeds the level for pregnant women and children under age 19, household income is compared to the applicable percentage of the federal poverty level (See **INCOME MEDICALLY NEEDY INCOME AND FEDERAL POVERTY LEVELS** to determine if a pregnant woman is fully eligible or eligible for prenatal services only). For pregnant women and children under the age of 19 whose income exceeds the appropriate federal poverty level, income in excess of the Medicaid level or Medicaid Standard is considered available. The resulting net income is compared to the appropriate income level. If the income is less than or equal to the applicable income level, the person or household is eligible for Medicaid. If the income exceeds the level for pregnant women and children under age 19, household income is compared to the applicable percentage of the federal poverty level (See **INCOME MEDICALLY NEEDY INCOME AND FEDERAL POVERTY LEVELS** to determine if a pregnant woman is fully eligible or eligible for prenatal services only). For pregnant women and children under the age of 19 whose income exceeds the appropriate federal poverty level, income in excess of the Medicaid level is considered available to meet the cost of medical care and services. Parents in a household with a deprivation, pregnant women and persons under age 21 may become eligible for Medicaid if the household incurs medical bills which equal or exceed the amount of excess income. Persons who spend down must spend down to the Medicaid level not the Medicaid Standard or poverty level. For a more detailed discussion of excess income see **INCOME EXCESS SIX-MONTH**.

INCOME**ADOPTED CHILDREN**

Policy: Children eligible for Title IV-E adoption assistance are automatically eligible for Medicaid. In addition, a child with a non-IV-E adoption assistance agreement in effect is eligible for Medicaid when a special medical or rehabilitative need makes his/her placement for adoption difficult without Medicaid coverage and s/he was in receipt of, or eligible, for Medicaid during the three months prior to the adoption agreement.

Adopted children not meeting the above criteria must have their eligibility for Medicaid determined.

References:

SSL Sect.	453 (1)(b)
Dept. Reg.	421.24(c) 360-3.3(a)(6)
ADMs	92-ADM-42 92 ADM-23 87 ADM-22 86 ADM-36 85 ADM-33 81 ADM-10

Interpretation: Children eligible for Title IV-E adoption assistance payments are eligible for Medicaid as soon as the adoption assistance agreement is signed by the respective parties and approved by New York State. The district that entered in to the Title IV-E adoption agreement remains responsible for the child's Medicaid as long as the adoption agreement remains in effect and the child remains a resident of New York State. When a voluntary authorized agency places a child for adoption and the State is paying the subsidy for IV-E and non IV-E special needs eligible children, then the district where the child resides with his/her adoptive parents authorizes the adopted child's Medicaid. If a child enters certain facilities certified by the Office of Mental Health (OMH) or the Office for People with Developmental Disabilities (OPWDD), the State may be responsible for the child's Medicaid coverage while s/he remains in the facility (See **OTHER ELIGIBILITY REQUIREMENTS STATE AND FEDERAL CHARGES**)

INCOME

ADOPTED CHILDREN

When the child moves out of New York State, the state where the child resides is responsible for providing his/her Medicaid. When a child residing in New York State has a Title IV-E adoption agreement in effect, which was initiated by another state, the adoptive parent(s) must complete a Medicaid application, on behalf of the child, in the district where the child resides. The parent(s) documents the child's name, date of birth, Social Security number, Title IV-E eligibility, and any information concerning any available third party health insurance coverage. No further documentation is required because the Title IV-E child is otherwise automatically eligible for Medicaid.

A child with a non-IV-E adoption agreement in effect is eligible for Medicaid when a special medical or rehabilitative need makes his/her placement for adoption difficult without Medicaid coverage and s/he was in receipt of or eligible for Medicaid during the three months prior to the adoption agreement (COBRA).

The cases of all children eligible for Medicaid under Title IV-E are reviewed annually by services. The adoption agreement must continue in effect. The adoptive parent(s) must continue to be legally responsible for the child and continue to support the child.

Prior to the adoption finalization, the child is considered a household of one. Once the adoption is finalized, Medicaid eligibility is determined using the household size of the child, adoptive parent(s) and any other applying siblings. The child's adoption subsidy is counted in the eligibility determination unless the child has been deleted from the household based on Mehler/Vailes. The child's adoption subsidy is counted in the eligibility determination unless the child is not counted in the household. Adoption subsidy children remain Medicaid eligible, regardless of their treatment under Mehler/Vailes.

Adopted children not meeting the IV-E or COBRA criteria are not automatically eligible for Medicaid and must have their eligibility determined.

When a child, with a non-IV-E adoption agreement which provides for Medicaid, moves out of state to a non-reciprocal COBRA state, the New York State Medicaid case remains open. The adoptive parents must seek out providers who are enrolled or willing to enroll in the New York State Medicaid program in the new state of residence.

INCOME**SSI-RELATED DISREGARDS**

Description: Disregards of income are not considered in whole or in part in determining eligibility for Medicaid.

Policy: The following types of income are disregarded in the determination of income for Medicaid: (See **REFERENCE INCOME DISREGARDS** for chart)

AMERICORPS - Child care allowances and other benefits and services including payments for living expenses provided by Americorps VISTA.

Child care allowances and all other benefits and services except payments for living expenses, provided by Americorps USA and Americorps NCCC.

ASSISTANCE BASED ON NEED - Any regular cash assistance payments based on need received by the A/R and furnished as supplemental income by the federal government, a State or political subdivision.

Support and maintenance assistance based on need and furnished either in-kind by a private non-profit agency or in cash or in-kind by one of the following: a supplier of home heating oil or gas, an entity whose revenues are primarily derived on a rate-of-return basis regulated by a State or Federal governmental entity or a municipal utility providing home energy.

Money paid by a third party directly to a vendor except for food, clothing and shelter.

BLOOD PLASMA SETTLEMENTS - Payments received as a result of a federal class action settlement with four manufacturers of blood plasma products on behalf of hemophilia patients who are infected with human immunodeficiency virus (HIV).

INCOME**SSI-RELATED DISREGARDS**

BONA FIDE LOAN - A bona fide loan received by the A/R from an institution or person not legally liable for the support of the A/R. The loan may be an oral or written agreement, signed by the A/R and the lender. The written agreement must indicate: the A/R's intent to repay the loan within a specific time; and how the loan is to be repaid, by specific real or personal property, held as collateral, or from future income.

BURIAL FUNDS/BURIAL ARRANGEMENT (EXCLUDED) - Interest earned on excluded burial funds and appreciation in the value of an excluded burial arrangement.

CASH ASSISTANCE INCOME - Any income of a cash assistance recipient in the A/R's Medicaid household. However, any room/board received by an SSI-related A/R from a cash assistance recipient, who is living in the A/R's home but is not in the A/R's Medicaid household, is countable room/board income to the SSI-related A/R. Appropriate room/board deductions are allowed to determine countable roomer/boarder income.

CERTIFIED BLIND OR CERTIFIED DISABLED CHILD SUPPORT PAYMENTS - One third of any support payments received by a certified blind or certified disabled child from an absent parent.

CERTIFIED BLIND REASONABLE WORK-RELATED EXPENSES - For persons who are certified blind all remaining reasonable work-related expenses including mandatory retirement deductions after the other disregards. (See **INCOME SSI-RELATED BUDGETING METHODOLOGY BLIND WORK EXPENSES**)

CHILD CARE SERVICES PAYMENTS- Payments made by the A/R for child care services or the value of any child care services provided by the A/R to a recipient of employment-related and JOBS-related child care services. Transitional child care services, at-risk low income child care services or child care and development block grant services.

INCOME**SSI-RELATED DISREGARDS**

CHILD SUPPORT (including CHILD SUPPORT ARREARAGE) PAYMENTS - For SSI-related children, child support arrearage payments are unearned income to the child in the month the payment is received. One-third of the amount of the child support payment is excluded. If payment is made for several children, a per capita portion of the payment is calculated as unearned income to the SSI-related child.

CRIME VICTIMS' FUND PAYMENTS - Payments received from a fund established by a state to aid victims of crime.

DISASTER RELIEF AND EMERGENCY ASSISTANCE - Any federal major disaster and emergency *assistance* provided under the Disaster Relief Act of 1974 (P.L. 93-288), as amended by the Disaster Relief and Emergency Assistance Amendments of 1988 (P.L. 100-107), and any comparable disaster assistance provided by states, local governments, and disaster assistance organization.

INCOME**SSI-RELATED DISREGARDS**

DIVIDEND/INTEREST INCOME – (See **INCOME INTEREST/DIVIDEND**)

DONATED FOODS - The value of federally donated foods.

EARNED INCOME - The first \$65 of earned income or the first \$65 of a couple's combined earned income and ½ of the remainder after any impairment related work expenses.

EARNED INCOME TAX CREDIT PAYMENTS - Including any federal child tax credit payments and any advance payment of earned income tax credit made by an employer.

EXPENSES OF OBTAINING INCOME - Income does not include that part of a payment that is an essential expense incurred in receiving the payments (legal fees, and other expenses connected with a claim).

FEDERAL ENERGY ASSISTANCE PAYMENTS.

FEDERAL OLDER AMERICANS ACT OF 1965 - Any assistance (other than wages or salaries) provided to an individual under the federal Older Americans Act of 1965. Green Thumb assistance is countable if wages or salaries; other Green Thumb assistance is disregarded.

FEDERAL RELOCATION ASSISTANCE - Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.

FOOD STAMPS - The value of food stamps.

FOSTER CARE - Payments received by foster parents for foster care children.

INCOME

SSI-RELATED DISREGARDS

FREE MEALS - The value of free meals, other than school meals, except when more than one meal a day is furnished or when the A/R receives an allowance for meals away from home.

GI BILL DEDUCTION - That portion of a military person's pay which is deducted by mandate to help fund the GI Bill.

GARDEN PRODUCE OR LIVESTOCK - The value of produce from a garden or livestock when used exclusively by the A/R and members of his/her household.

HEALTH INSURANCE PREMIUMS.

HOSTILE FIRE PAY - Income from hostile fire pay (pursuant to Section 310 of Title 37 US Code) received while in active military service.

HUD COMMUNITY BLOCK GRANTS - Any funds received by an A/R under the Department of Housing and Urban Development community block grants.

INCOME TAX REFUNDS –Any income tax refund or federal advance payment received by an A/R is disregarded as income in the month received.

INFREQUENT OR IRREGULAR INCOME – The first \$30 of earned income and the first \$60 of unearned income in a *calendar quarter* if it is received infrequently or irregularly. Income is infrequent if it is received only once in a calendar quarter from a single source. It is irregular if the A/R could not reasonably expect to receive it or budget for it due to its unpredictability. If the amount of infrequent or irregular income in a month exceeds \$30 or \$60, as applicable, the exclusion still applies. The dollar amount of the exclusion does not increase even if both an individual and spouse have infrequent or irregular income.

INCOME**SSI-RELATED DISREGARDS**

IMPAIRMENT-RELATED WORK EXPENSES - For certified disabled Medicaid A/Rs, non-medical, impairment-related work expenses (See **INCOME** SSI-RELATED BUDGETING METHODOLOGY IMPAIRMENT-RELATED WORK EXPENSES)

INTEREST/DIVIDEND INCOME - From most resources is disregarded. (See **INCOME** DIVIDENDS AND INTEREST for a list of resources which generate interest/dividend income that is countable for SSI-related A/Rs.)

INCOME**SSI-RELATED DISREGARDS**

NATIVE AMERICAN PAYMENTS - Seneca Nation Settlement Act payments made by the State and Federal governments, under P.L. 101-503, to the Seneca Nation.

Distribution to Native Americans of funds appropriated in satisfaction of judgments of the Indian Claims Commission or the United States Court of Federal Claims. This includes up to \$2,000 per year of income for interests of individual Native Americans in trust or restricted lands, from funds appropriated in satisfaction of the Indian Claims Commission or the United States Court of Federal Claims.

Alaskan Native Claims Settlement Act (ANCSA) distributions - The following distributions from a native corporation formed pursuant to ANCSA are exempt as income or resources:

- a. cash, to the extent that it does not, in the aggregate, exceed \$2,000 per individual per year;
- b. stock;
- c. a partnership interest;
- d. land or an interest in land; and
- e. an interest in a settlement trust.

OTHER INCOME - Any other income that a Federal law or regulation requires to be disregarded.

OVERPAYMENTS - The amount of income that is withheld to recover a previous overpayment is not income if the individual received Medicaid at the time of the overpayment and the overpayment amount was included in determining the individual's Medicaid eligibility.

PERSECUTION PAYMENTS - Benefits received by eligible Japanese-Americans, Aleuts, or Pribilof Islanders under the Civil Liberties Act of 1988, the Wartime Relocation of Civilians Law, and the Aleutian and Pribilof Islands Restitution Act.

Payments made to individuals because of their status as victims of Nazi persecution, including: German Reparation Payments; Austrian Reparation Payments made pursuant to sections 500-506 of the Austrian General Social Insurance

INCOME**SSI-RELATED DISREGARDS**

Act; and Netherlands Reparation Payments based on Nazi, but not Japanese, persecution.

PLAN TO ACHIEVE SELF-SUPPORT (PASS) - For certified blind or certified disabled persons under 65 years of age and for certified blind or certified disabled persons aged 65 or over who received SSI payments or aid under the State Plan for the certified blind or certified disabled for the month preceding the month of their 65th birthday, any remaining countable income may be set aside for a plan to achieve self-support. The plan must:

- a. specify planned savings and/or expenditures to achieve a designated feasible occupational objective and a specific period of time to achieve the objective;
- b. provide for identification and segregation of money and goods, if any, being accumulated and saved;
- c. be current, in writing and approved by the local commissioner of social services for not more than 18 months, with the possibility of an extension for an additional 18 months. A second extension for an additional 12 months may be allowed in order to fulfill a lengthy educational or training program; and
- d. be followed by the individual.

PREVENTATIVE HOUSING SERVICE - Payments provided as a preventive housing service under 18 NYCRR 423.4(l).

RADIATION EXPOSURE COMPENSATION TRUST FUND PAYMENTS - Payments for injuries or deaths resulting from exposure to radiation from nuclear testing and uranium mining.

REDUCED (LIMITED) \$90 VETERANS' ADMINISTRATION PENSION.

REFUNDS - Any refund received from a public agency of taxes paid on real estate or food purchases

RELOCATION ASSISTANCE PAYMENTS – interest/dividend income generated from unspent State or local government

INCOME

SSI-RELATED DISREGARDS

relocation assistance payments (not federal or federally assisted funds) for 9 months following the month of receipt.

REPLACEMENT OF ASSISTANCE ALREADY PAID - Replacement of assistance already paid, such as a lost or stolen check.

RETROACTIVE BENEFITS UNDER THE SSI PROGRAM.

ROOM/BOARD (LODGER) INCOME - The first \$90 per month of any income from each boarder or roomer (lodger). If the A/R can document that the actual expenses incurred in providing the room or board exceeds the \$90 per month, actual documented expenses are disregarded.

STATE OR LOCAL RELOCATION ASSISTANCE PAYMENTS - State or local relocation assistance payments received on or after May 1, 1991. The payments must be comparable to payments under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.

STUDENTS' INCOME –

Earned Income – The allowable monthly and annual income effective in January each year can be found in the **REFERENCE DISREGARDS, SSI-DISREGARDS STUDENT INCOME**. The amount is the earned income allowed to be earned by a student under 22 years of age (regardless if s/he is married or the head of a household) who is regularly attending a school, college, university, or a course of vocational or technical training.

Educational-Related Income - Any portion of a grant, scholarship, fellowship or gift used to pay the cost of tuition and other education-related fees at any educational (including technical or vocational) institution. This disregard does not apply to any portion set aside or actually used for food, clothing or shelter.

When an A/R is in receipt of a graduate assistantship, the local district receives verification from the financial aid office involved to determine if the assistantship is considered employment or an educational grant. If the assistantship is a grant, it is treated as outlined in the previous paragraph.

INCOME**SSI-RELATED DISREGARDS**

When the assistantship is considered employment, the A/R receives any appropriate earned income disregards (See **INCOME SSI-RELATED DISREGARDS**), but additional deductions for educational expenses are not allowed.

NOTE: This does not apply to V.A. Educational Grants which are part of the G.I. Bill and which provide a monthly allowance for support while veterans are enrolled in school. Only specific education-related expenses such as tuition, books, school fees, transportation, etc., are exempt for recipients of G.I. Bill educational money. The remainder is considered available unearned income in determining eligibility for Medicaid.

School Meals - The value of free school meals.

Student Loans - Student loans received by a graduate or undergraduate student.

SUPPLEMENTAL SECURITY INCOME (SSI) - Any SSI payments received by the A/R.

THIRD PARTY INSURANCE PAYMENTS - Insurance payments paid directly to a third party such as a loan company or a bank to cover loan or installment payments in case of death or disability (example: mortgage insurance).

TITLE III, FEDERAL ECONOMIC OPPORTUNITY ACT - Any loan made to a family under Title III of the Federal Economic Opportunity Act.

UNEARNED INCOME - Only one \$20 disregard is permitted per month per couple. A certified blind or a certified disabled child living with parents is entitled to a separate \$20 disregard from his/her total unearned income. If an A/R's unearned income is under \$20, the balance will be deducted from earned income.

U.S. CENSUS - Earnings from census employment.

INCOME**SSI-RELATED DISREGARDS**

VETERANS - Payments to veterans for Aid & Attendance (A&A) or payments for Unusual Medical Expenses (UME).

VIETNAM VETERANS - Agent Orange Settlement Fund - Payments from the Agent Orange Settlement Fund or any other fund established pursuant to the Agent Orange product liability litigation, and payments from court proceedings brought for personal injuries sustained by veterans resulting from exposure to dioxin or phenoxy herbicide in connection with the war in Indochina in the period of January 1, 1962 through May 7, 1975.

Children - Monthly allowances paid to certain Vietnam Veterans' Children with Spina Bifida.

VISTA - Payments received by VISTA volunteers.

VOCATIONAL REHABILITATION ACT - Any payments made under the Vocational Rehabilitation Act.

VOLUNTEER PROGRAM PAYMENTS - Payments received by participants in volunteer programs under Title II of P.L. 93-113 (Domestic Volunteer Services Act of 1973). These include: retired senior volunteer, foster grandparent, senior companion and senior health aide programs. Payments made in the form of stipends, allowances and/or reimbursements for incurred expenses are disregarded when determining Medicaid eligibility.

Payments received by participants in volunteer programs established under Title III of P.L. 93-133. These include the Service Corps of Retired Executives (SCORE) and the Active Corps of Executives (ACE) programs.

WIC PROGRAM - The value of benefits under the WIC program.

References:

SSL Sect.	366.2 366.3
Dept. Reg.	352.22 360-4.6(a)(1) 360-4.6(a)(2)

INCOME**SSI-RELATED DISREGARDS**

ADMs	94 ADM-13
	92 ADM-42
	92 ADM-32
	91 ADM-23
	91 ADM-8
	83 ADM-17
	81 ADM-38
INFs	95 INF-30
	90 INF-33
LCM	92 LCM-120
GISs	11 MA/004
	06 MA/029
	05 MA/001
	04 MA/030
	04 MA/027
	00 MA/012
	98 MA/017
	98 MA/016
	97 MA/022
	95 MA/001

Interpretation: The types of income listed previously are not considered in determining eligibility for Medicaid for the SSI-related category. Only available income is counted in the determination of eligibility. **OTHER ELIGIBILITY REQUIREMENTS OWNERSHIP AND AVAILABILITY** discusses availability of income in more detail.

Documentation: The source and amount of income disregards are documented in the case record and a notation is made that this income is not to be considered in determining eligibility for Medicaid.

INCOME**SSI-RELATED BUDGETING METHODOLOGY**

Description: New York State has contracted with the Social Security Administration so that eligibility for SSI generally means automatic eligibility for Medicaid. The SSI recipient does not need to file an application for Medicaid.

There is a group of people, however, who do not receive SSI but who meet the categorical requirements of the program. These persons are: aged (65 or over), certified blind, or certified disabled. Generally, these individuals must apply for Medicaid separately and have their eligibility determined by the local social services district where they live. In determining eligibility for these SSI-related persons, the SSI-related budgeting methodology is used. This methodology is patterned after the method used by the Social Security Administration to determine eligibility for SSI.

Policy: SSI-related budgeting is used to determine eligibility for those persons who are aged (65 or over), certified blind or certified disabled and not in receipt of Supplemental Security Income (SSI). (See **CATEGORICAL FACTORS SSI-RELATED**)

SSI-related budgeting is used for Medicaid A/Rs for whom payment or part payment of the Medicare premiums, coinsurance and deductibles is made. (See **INCOME MEDICARE SAVINGS PROGRAM**)

When determining eligibility for the Medicaid Buy-In Program for Working People with Disabilities, SSI-related budgeting, including allocation and deeming is used.

Persons potentially eligible for COBRA continuation of their health insurance when employment ends and those applying for the AIDS Health Insurance Program have their income and resources budgeted in accordance with the SSI-related methodologies.

Disregards of income for SSI-related persons are discussed and listed in **INCOME SSI-RELATED DISREGARDS** and the determination of eligibility for SSI-related persons is described in **INCOME DETERMINATION OF ELIGIBILITY**.

References:

SSL Sect.	366
Dept. Reg.	360-3.3(a)(3) 360-3.3(b)(1) and (2) 360-4.2

INCOME**SSI-RELATED BUDGETING METHODOLOGY**

ADMs	04 OMM/ADM-5
	03 OMM/ADM-4
	93 ADM-28
	91 ADM-53
	91 ADM-27
	83 ADM-17

Interpretation: SSI-related children are budgeted as a household of one, using their own income and any income deemed from their parent(s). SSI-related adults, who are unmarried or not living with a spouse, are budgeted as a household of one.

An SSI-related couple is budgeted as a household of two.

SSI-related adults, who reside with a non-SSI-related spouse, are budgeted as a household of two for income, unless the income of the non-SSI-related spouse (after allocation) is less than the difference between the Medicaid income level for a two-person household and the Medicaid income level for an individual. If it is below that amount, the non-SSI-related spouse and his/her income are not counted and the SSI-related person is budgeted as a household of one.

SSI-related adults who reside with a spouse of any category are always budgeted as a household of two for resources.

Persons in receipt of cash assistance (PA or SSI) are not considered in the household count nor are their income considered when determining income eligibility.

SSI-related budgeting takes the needs and income of other family members into consideration by the process of allocation and deeming. This process is discussed in detail in the sections that follow:

Allocation

Deeming

INCOME
SSI-RELATED BUDGETING METHODOLOGY

ALLOCATION

Description: Allocation is the budgeting process that sets income aside for the needs of non-SSI-related children under the age of 18 and for the needs of parents (regardless of category) of SSI-related children.

The allocation amount to a non-SSI-related child is the difference between the Medicaid income level for a two-person household and the Medicaid income level for an individual.

NOTE: Although parents are financially responsible for their non-disabled children under the age of 21, allocation to dependent children ceases at age 18.

In determining eligibility for an SSI-related child, the allocation amount to a single parent is the federal benefit rate (FBR) for an individual. The allocation amount to a two-parent household is the FBR for a couple.

When an SSI-related parent and a non-SSI-related parent reside with an SSI-related child and at least one non-SSI-related child, the amount allocated to the parents in determining the SSI-related child's eligibility, is the federal benefit rate (FBR) for a couple living alone, plus the SSI State supplement for an individual living with others.

Policy: Allocation is the first step in the deeming process (See **INCOME DEEMING**) and the first step in the SSI-related budgeting process. Allocation is used when:

- there is a non-SSI-related adult, his/her SSI-related spouse and a non-SSI-related child living in the same household;
- there is an SSI-related child, a non-SSI-related child, and at least one parent (regardless of category) in the household who is not receiving cash assistance; or
- an SSI-related child is living with one or both parents (regardless of category) and those parents are not receiving cash assistance.

INCOME

ALLOCATION

The allocation amounts, effective January 1st each year, can be found in the **REFERENCE INCOME ALLOCATION**.

Allocation to	How Determined
Non-SSI Child	<u>2005</u> : Difference between Medicaid income standard for one and two <u>2006 and 2007</u> : Difference between the Federal Benefit Rate (FBR) for one and two
Single parent (regardless of category)	Federal SSI Benefit Rate (FBR) for one
Two parents (regardless of category)	Federal SSI Benefit Rate (FBR) for two
An SSI-related parent and a non-SSI-related parent residing with an SSI-related child and a non-SSI-related child	The Federal SSI Benefit Rate (FBR) for two, living alone, plus the SSI State supplement for one, living with others

Interpretation: Allocation is the first step in the SSI-related budgeting process. Allocation is used in the family situations previously described. Allocation is **not** used when determining eligibility for:

- a single SSI-related person living alone;
- an adult couple one or both of whom may be SSI-related;
or
- SSI-related parents living with a non-SSI-related child.

(1) The process of allocating to non-SSI-related children is as follows:

- (a) The amount allocated to each non-SSI-related child is the difference between the Medicaid Income standard for one and two;

INCOME

ALLOCATION

- (b) This allocation amount is offset on a dollar for dollar basis by any other income the child receives in his/her own right (whether or not the child is applying);
 - (c) In determining eligibility for an SSI-related adult, the remaining allocation amount, not offset by the non-SSI-related child's own income, is allocated from the unearned income of the non-SSI-related parent after deducting any court-ordered support paid by the non-SSI-related spouse from his/her unearned income. When the non-SSI-related parent does not have sufficient unearned income to meet the allocation, the remaining allocation is made from the non-SSI-related parent's earned income after deducting any court-ordered support paid by the non-SSI-related spouse from his/her earned income.
 - (d) In determining eligibility for an SSI-related child, the remaining allocation amount not offset by the non-SSI-related child's own income is allocated from the unearned income of the parents after deducting any court-ordered support paid by the parents from his/her unearned income. When the parents do not have sufficient unearned income to meet the allocation, the remaining allocation is made from the parents' earned income after deducting any court-ordered support paid by the parents from his/her earned income.
- (2) The process of allocating to parents is as follows:
- (a) In determining eligibility for an SSI-related child, after allocating to any non-SSI-related children, as shown above in step (1), the remaining income of the parents, whether earned, unearned or a combination, is computed;

NOTE: If there is no allocation to any non-SSI-related child, subtract any court-ordered support paid by either parent before combining the parents' earned and unearned income.

INCOME**ALLOCATION**

- (b) After applying the SSI-related disregards a portion of the parents' remaining income is allocated to meet their needs. The amount allocated to the parent(s) is the Medicaid income standard for an individual or couple. (See **REFERENCE SSI BENEFIT LEVELS**)

INCOME
SSI-RELATED BUDGETING METHODOLOGY

DEEMING

Description: The basis for deeming is inherent in the concept that husbands and wives living together have a responsibility to each other and generally share income. Parents living with their children also have a responsibility for their children and generally provide income for their needs.

Policy: Deeming is the budgeting process by which the income of a legally responsible relative (LRR), in the household, is considered available to the SSI-related individual. Deeming is used in the SSI-related budgeting process to determine the amount of support and maintenance furnished by an LRR.

Interpretation: (1) Deeming is used in the following situations:

- (a) parent to child. When determining eligibility for an SSI-related child under age 18, a portion of the parent's income is deemed to the child unless the parent receives cash assistance. Deeming is used whether or not the parent is SSI-related;
- (b) spouse to spouse. When determining eligibility for an SSI-related person with a non-SSI-related spouse and the non-SSI-related spouse has sufficient income.

(2) Deeming is **not** used when:

- (a) determining eligibility for an SSI-related person living alone;
- (b) determining eligibility for two SSI-related spouses;

NOTE: Although deeming is not used in the budgeting process for an SSI-related couple, the income of both spouses is considered mutually available.

- (c) determining eligibility for an SSI-related child whose parent receives an SSI or PA cash benefit;
- (d) determining eligibility for an SSI-related person whose spouse receives an SSI or PA cash grant;

INCOME
SSI-RELATED BUDGETING METHODOLOGY
DEEMING

- (e) determining eligibility for an SSI-related child who is between the ages of 18 and 21. When the child is married, income may be deemed from the spouse.
- (3) Deeming is performed as follows:

- (a) income is allocated to any non-SSI-related children in the household after deducting any court-ordered support paid by the non-SSI-related spouse as described in **INCOME UNEARNED SUPPORT PAYMENTS**.
- (b) in determining eligibility for an SSI-related adult, the remaining income of the non-SSI-related spouse is deemed to the SSI-related spouse, provided the income is equal to or greater than the difference between the Medicaid level for two and the Medicaid level for one. If the income of the non-SSI-related spouse is not deemed, because the remaining net income is less than the difference between the Medicaid level for two and the Medicaid level for one, then only the income of the SSI-related spouse is considered in determining eligibility.

Subtract any allowable disregards from the SSI-related spouse's income. Compare the SSI-related spouse's net income to the Medically Needy Income level or Medicaid Standard (and MBL Living Arrangement Chart, as appropriate) whichever is most beneficial. If income is deemed from the non-SSI-related spouse, subject to any allowable disregards from the couple's combined income, compare the remaining net income to the Medically Needy Income level or Medicaid Standard (and MBL Living Arrangement Chart, as appropriate) whichever is most beneficial.

- (c) in determining eligibility for an SSI-related child, the parents' remaining net income, after allocating to any non-SSI-related child, is subject to the appropriate disregards as described in **INCOME SSI-RELATED DISREGARDS**, and steps C-2 through C-8. The remaining income is deemed to the SSI-related child. The deemed income is added to any income of the SSI-related child and the eligibility process is continued as described in steps C-9 and C-10. (See **INCOME DETERMINATION OF ELIGIBILITY** for steps)

INCOME
SSI-RELATED BUDGETING METHODOLOGY

HEALTH INSURANCE PREMIUMS

Description: Health insurance premiums are premiums paid for insurance which covers hospital, medical, dental, drug and/or other charges for medical care and services.

Policy: In determining eligibility for SSI-related persons, health insurance premiums are deducted if they are paid by the A/R.

References:

SSL Sect.	366.2(a)(6)
Dept. Reg.	360-4.6(a)(2)(vii)
ADMs	93 ADM-28
	91 ADM-54
	91 ADM 53
	91 ADM-27

Interpretation: Health insurance premiums are deducted from the kind of income from which they are being paid. If it is not possible to determine if the health insurance premiums are paid from earned or unearned income, the deduction is made where it is most advantageous to the client.

Health insurance policies, which indemnify the A/R against charges for medical care and services, are considered for this disregard. These include: Medicare Parts A & B, Blue Cross, Blue Shield, Major Medical insurance, dental insurance, prescription drug insurance, long term care insurance, union health fund premiums, and other hospital and medical insurance.

Policies, which indemnify the A/R against loss of income due to illness or disability, may be considered for this disregard. These include: income protection insurance, medical liability insurance and any other insurance which offsets the loss of wages due to illness or hospitalization. A policy, which pays the A/R a certain amount of money for each day s/he is hospitalized, but does not cover specific hospital services, may be eligible for this disregard. The policy must be assignable (See **RESOURCES THIRD PARTY RESOURCES ASSIGNMENT AND SUBROGATION**) to a hospital and be cost effective for its premiums to be considered as a deduction. A policy belonging to a non-applying spouse does not have to be assignable in order to receive the premium disregard.

INCOME
SSI-RELATED BUDGETING METHODOLOGY

HEALTH INSURANCE PREMIUMS

RESOURCES THIRD PARTY RESOURCES ENROLLMENT IN GROUP HEALTH INSURANCE contains information on the eligibility requirement that A/Rs obtains any health insurance available through their employer. When the health insurance is cost-effective and the A/R is below the income/resource level, the local districts may pay the recipient's premium, unless it is an income protection policy.

When a child is covered under a non-applying or ineligible parent's health insurance policy, the health insurance premium may be paid in full by the local district if the child is otherwise eligible and the premium payment is cost effective. This reimbursement policy does not apply to a non-applying or ineligible parent if the health insurance premium is court-ordered.

- When to Verify:**
- (a) When the A/R declares in the application that s/he or other family members are covered by health insurance;
 - (b) When the A/R declares in the application that s/he or other family members are covered by Medicare, Part A or B;
 - (c) When the A/R declares in the application that health insurance premiums are being withheld from his/her pay;
 - (d) When the A/R or absent parent is employed;
 - (e) When the A/R is receiving RSDI; and
 - (f) When the A/R is receiving a pension.

- Verifications:** Health insurance premiums may be verified by:
- (a) The health insurance policy;
 - (b) The health insurance card; or
 - (c) Seeing the A/R's paycheck stub, pay envelope, or a statement from his/her employer.

- Documentation:** Sufficient to establish an audit trail:
- (a) Amount of premium, frequency of paycheck stub or envelope, policy number and employer's name;

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SSI-RELATED BUDGETING METHODOLOGY

HEALTH INSURANCE PREMIUMS

- (b) For privately paid policies, amount, date and frequency of payment, insurance company name and policy number; and
- (c) Returned clearance filed in case record.

Disposition: When the amount of health insurance premiums paid is indicated, that amount is disregarded to determine net available income.

**INCOME
SSI-RELATED BUDGETING METHODOLOGY**

IMPAIRMENT-RELATED WORK EXPENSES

Description: Impairment-related work expenses are non-medical expenses directly related to enabling the disabled SSI-related individual to work. The cost of these expenses is paid by the disabled individual and is not reimbursable from another source. (See **INCOME SSI-RELATED BUDGETING METHODOLOGY BLIND WORK EXPENSES** for work expenses of the blind.)

Policy: For SSI-related persons, impairment related work expenses are subtracted from earned income after the \$65 deduction, but before the one-half of the remaining income disregard.

NOTE: Medical impairment related work expenses are not deductions in the SSI-related budgeting methodology but rather may be used to reduce excess income after the budget calculations are complete (See **INCOME EXCESS**). Where applicable, medical impairment-related work expenses are combined with other incurred medical bills to reduce excess income available to meet medical costs and services. If there is no excess income, medical impairment-related work expenses may be paid by Medicaid.

References:

Dept. Reg.	360-4.6(a)(2)(v)
ADMs	83 ADM-65 83 ADM-17

Disability Manual

Interpretation: Examples of non-medical impairment-related work expenses that may be used as a deduction for SSI-related persons are:

- Cost of modifications made to a car in order to permit a handicapped person to drive to work;
- Wheel chair ramps;
- Cost of special foods needed to maintain dietary restrictions while at work;
- Work-related equipment such as one-hand typewriters, page turning devices, telecommunication devices for the deaf, Braille devices, and
- Interpreters for the deaf.

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IMPAIRMENT-RELATED WORK EXPENSES

- specially designed work tools.
- Residential modifications in the form of changes to the exterior of his/her home in order to create a working space to accommodate an impairment (e.g., enlargement of a doorway leading into the office, modification of work space to accommodate problems in dexterity).

NOTE: For a self-employed person, any cost deducted as a business expense cannot be deducted as an impairment-related work expense.

- Costs of a Seeing Eye dog, including food, licenses and veterinarian services.
- Costs of structural or operational modifications to a vehicle required by an individual in order to get to and from work;
- Mileage allowance for an approved vehicle limited to travel related to employment; AND,
- Cost of driver assistance or taxicabs where such special transportation is not generally required by an unimpaired individual in the community.

These kinds of expenses are generally not covered by Medicaid.

An impairment-related work expense is allowed when it is necessary for employment, even though the A/R may use the "item" outside of work and/or his/her family may benefit from it. For example, the expense of special equipment on a car, needed by a paraplegic for transportation to and from work, is

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IMPAIRMENT-RELATED WORK EXPENSES

an allowable impairment related work expense even though s/he uses the car on weekends to transport his/her family. The entire expense of the special equipment may be deducted as an impairment-related work expense.

NOTE: For self-employed A/Rs, if the cost of an item has been deducted in calculating net earnings from self-employment, the expense cannot be deducted as an impairment-related work expense.

NOTE: When determining if an individual is doing Substantial Gainful Activity (SGA), both medical and non-medical impairment-related work expenses are deducted from earned income before applying the SGA test (See **REFERENCE SUBSTANTIAL GAINFUL INCOME** for maximum amount. See **DISABILITY MANUAL** and **CATEGORICAL FACTORS SUBSTANTIAL GAINFUL ACTIVITY (SGA)** for further information.

Examples of medical impairment-related work expenses that can be deducted when calculating the amount of the A/Rs spenddown: (See **INCOME EXCESS** for more detail on excess income).

- Assistance in traveling to and from work or while at work, assistance with personal functions (e.g., eating, toileting), or with work-related functions (e.g., reading, communicating).
- Assistance at home with personal functions (e.g., dressing, administering medications) in preparation for going to and returning from work. Payments made to a family member for attendant care services may be deducted only if such family member, in order to perform the services, incurs an economic loss by terminating his/her employment or by reducing the number of his/her work hours.
- Medical devices such as wheelchairs, hemodialysis equipment, canes, crutches, inhalators and pacemakers.
- Prosthetic devices such as artificial replacements of arms, legs and other parts of the body.

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IMPAIRMENT-RELATED WORK EXPENSES

- Devices or appliances which are essential for the control of a disabling condition either at home or in the work setting and are verified as medically necessary.
- Drugs or medical services including diagnostic procedures needed to control the individual's impairment. The drugs or services must be prescribed or used to reduce or eliminate symptoms of the impairment or to slow down its progression. The diagnostic procedures must be performed to ascertain how the impairment(s) is progressing or to determine what type of treatment should be provided for the impairment(s).

Some examples of deductible drugs and medical services are:

- Anticonvulsant drugs, antidepressant medication for mental disorders, radiation treatment or chemotherapy, corrective surgery for spinal disorders, and tests to determine the efficacy of medication.
- Expendable medical supplies such as catheters, elastic stockings, face masks and disposable sheets and bags.
- Physical therapy required because of impairment and which is needed in order for the individual to work.
- Payments for transportation costs to attend medical appointments.

- When to Verify:**
- (a) When the A/R indicates that s/he has special equipment in his/her vehicle, home or workplace that assists him/her in performing work;
 - (b) When the A/R indicates special dietary needs.

Verification: Non-medical impairment-related work expenses may be verified by:

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IMPAIRMENT-RELATED WORK EXPENSES

- (a) Seeing a bill or statement from a provider of special equipment;
- (b) Seeing a statement from the A/R's physician regarding special dietary needs or special equipment needed to permit the A/R to work.

Documentation: Sufficient to establish an audit trail:

Name of provider or doctor, date, equipment or service provided and cost.

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BLIND WORK EXPENSES

- Description:** For persons who are certified blind, work expenses include any expenses reasonably attributable to earning of income.
- Policy:** After applying the \$65 plus one-half of the remainder earned income disregard, persons who are certified blind (See **CATEGORICAL FACTORS BLINDNESS** for categorical requirements) are entitled to a work expense disregard.
- References:**
- | | |
|------------|-------------------|
| Dept. Reg. | 360-4.6(a)(2)(xi) |
| ADMs | 83 ADM-17 |
- Interpretation:** Certified blind A/Rs are entitled to a deduction from earned income for work expenses. Work expenses for blind A/Rs include mandatory deductions FICA, taxes, New York State Disability Insurance and lunch, transportation, union dues, uniforms, and other expenses. It includes expenses related to a guide dog, special visual aid equipment and other expenses necessary to maintain employment.
- When to Verify:** When a certified blind person declares that s/he is employed.
- Verification:**
- (a) Seeing bills or receipts for work-related expenses such as visual aid equipment or food for a guide dog;
 - (b) Seeing bills or receipts for uniforms or tools;
 - (c) Seeing a pay stub or employer's statement for deductions such as union dues or laundry fees for uniforms.
- Documentation:** Sufficient to establish an audit trail:
- (a) Name and address of employer, dates of employment, copies of receipts for equipment, dog food or veterinarian services, name and address of the provider of special equipment.
 - (b) Returned clearance in case record.

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SSI-RELATED BUDGETING METHODOLOGY

PLAN TO ACHIEVE SELF-SUPPORT (PASS)

Policy: After all other disregards are deducted, the remaining income of certain certified blind or certified disabled individuals (See **CATEGORICAL FACTORS** SSI-RELATED DISABILITY) may be disregarded if such income is needed to fulfill a plan for achieving self-support.

This disregard applies to certified blind or certified disabled individuals under 65 years of age, and to certified blind or certified disabled individuals age 65 or over who received SSI payments or aid under the State Plan for the certified blind or certified disabled for the month preceding the month of their 65th birthday.

References: SSL Sect. 366.2(b)
 Dept. Reg. 360-4.6 (a)(2)(xxiv)
 ADMs 83 ADM-17

Disability Manual

Interpretation: The local social services district assists a certified blind or certified disabled A/R who appears to have the potential to benefit from PASS and who is interested in setting up a self-support. The plan must:

- (1) contain specific planned savings and/or expenditures to achieve a designated feasible occupational objective and the period of time for achieving the objective;
- (2) provide for the identification and segregation of money and goods, if any, being accumulated and saved;
- (3) be current, in writing and be approved by the local commissioner of social services for not more than 18 months with the possibility of an extension for an additional 18 months; a further extension of 12 months may be allowed in order to fulfill a plan for a lengthy education or training program; and
- (4) be followed by the individual.

Some examples of goals that an A/R may be striving to meet which are acceptable for self-support plans are:

**INCOME
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PLAN TO ACHIEVE SELF-SUPPORT (PASS)

- saving money for a vehicle specially equipment for handicapped persons;
- accumulating money to start a small business in line with the person's training or background;
- accumulating funds for further education; or
- any other goal which would make the individual more self sufficient and lessen the person's need for assistance.

Disposition:

When a PASS meets the above conditions, the stated amounts for meeting the goals are disregarded after all other applicable disregards have been exempted in determining eligibility for Medicaid. Eligibility is re-evaluated prior to the end of the time period of the plan.

An approved PASS has reports written periodically which indicate how the A/R is progressing and to verify that the A/R is acting in accordance with the provision(s) of his/her plan.

A complete description of how to initiate a PASS as well as other requirements is contained in the DISABILITY MANUAL.

INCOME SSI-RELATED BUDGETING METHODOLOGY

DETERMINATION OF ELIGIBILITY

Policy: Eligibility for persons who are SSI-related is determined by comparing the net available income of the A/R to the Medically Needy Income level or Medicaid Standard (and MBL Living Arrangement Chart as appropriate) whichever is most beneficial. The resources of the A/R are also considered. A discussion of resources is found **RESOURCES**.

References:

SSL Sect.	366
ADMs	94 ADM-13 91 ADM-27 83 ADM-17

Interpretation: SSI-related persons who meet the requirements of any other category (LIF, ADC-related, under age 21 or pregnant) have a choice between LIF, ADC-related budgeting or SSI-related budgeting. A/Rs are informed of this choice by the eligibility worker and shown which budgeting method is more advantageous. Once the A/R chooses a particular method of budgeting, the same method is used for resources as well as income.

The SSI-related budgeting methodology (as described in this Guide) is divided into three parts. Part A describes the determination of countable income for SSI-related A/Rs. Part B describes the determination of eligibility for an SSI-related adult when income is allocated to meet the needs of non-SSI-related children in the household. It also includes the budgeting disregards applicable to an SSI-related adult, whether or not allocation or deeming is appropriate. It is important to carefully review **RESOURCES ALLOCATION** and **DEEMING** to determine if allocation and deeming are necessary in each case. Part C describes the eligibility determination process for an SSI-related child living with at least one parent. It includes the process by which a portion of the parent's income is allocated to any non-SSI-related children in the household as well as the allocation to the parent. It also describes how the parent's income is deemed to the SSI-related child before eligibility is determined for that child.

A. General steps applicable to all SSI-related A/Rs.

Determine the monthly income of the individual or couple. All income from all sources is reviewed to determine if it is

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SSI-RELATED BUDGETING METHODOLOGY

DETERMINATION OF ELIGIBILITY

counted when determining eligibility. Certain kinds of income are disregarded in whole or in part (See **INCOME SSI-RELATED DISREGARDS**) when determining monthly income.

B. Determining eligibility for an SSI-related adult.

B-1 In determining eligibility for an SSI-related adult, income is first allocated to meet the needs of any non-SSI-related children in the household. Allocation is described **INCOME ALLOCATION AND DEEMING**. If the non-SSI-related adult has no income, no allocation is made to the children.

B-2 Determine whether or not income is deemed from a non-SSI-related spouse. If after allocating to any non-SSI-related children, the non-SSI-related spouse's remaining income is less than the difference between the monthly medically needy income level for two and the monthly medically needy level for an individual (See **INCOME MEDICALLY NEEDY INCOME LEVEL**), no income is deemed to the SSI-related spouse and only the income of the SSI-related spouse is considered in determining his/her eligibility.

If after allocating to any non-SSI-related children, the income of the non-SSI-related spouse equals or exceeds the difference between the monthly medically needy level for two and the medically needy level for a single individual, the non-SSI-related spouse's income is deemed to the SSI-related spouse. The non-SSI-related spouse's remaining unearned income is combined with the unearned income of the SSI-related spouse and the non-SSI-related spouse's earned income is combined with any earned income of the SSI-related spouse.

B-3 Unearned Income – Deduct the \$20 income disregard. If the unearned income is less than \$20, the remainder of the disregard is subtracted as the first deduction from earned income; and

Deduct health insurance premiums if paid from unearned income. If the health insurance premium is greater than the amount of unearned income, the remainder is subtracted from earned income.

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B-4 Earned Income –

- Deduct the balance of the \$20 income disregard, if it is not offset by unearned income;
- Deduct \$65;
- Deduct any impairment related work expenses (See **INCOME SSI-RELATED BUDGETING METHODOLOGY IMPAIRMENT-RELATED WORK EXPENSES**);
- Deduct one-half of the remaining earned income. (The one-half deduction is rounded up to the nearest dollar);
- Deduct work expenses for certified blind individuals (See **INCOME SSI-RELATED BUDGETING METHODOLOGY BLIND WORK EXPENSES**); and
- Deduct health insurance premiums, if not deducted from unearned income.

B-5 Any remaining earned income is added to the remaining unearned income. Deduct any amount set aside for an approved plan to achieve self-support. (See **INCOME SSI-RELATED BUDGETING METHODOLOGY PLAN TO ACHIEVE SELF-SUPPORT (PASS)**)

B-6 The resulting net income is then compared to the Medically Needy Income level or Medicaid Standard (and MBL Living Arrangement Chart as appropriate) whichever is most beneficial. For an SSI-related adult, not married or not living with a spouse, the A/R is budgeted as a household of one. SSI-related couples are budgeted as a household of two. In both instances the income deductions noted in B-1 – B-5 are applied.

NOTE: For purposes of SSI-related budgeting, a certified blind or certified disabled child age 18 or over is budgeted as an SSI-related adult.

C. Determining eligibility for an SSI-related child (under age 18).

C-1 In determining eligibility for an SSI-related child income is first allocated to meet the needs of any non-SSI related children in the household as follows:

INCOME SSI-RELATED BUDGETING METHODOLOGY

DETERMINATION OF ELIGIBILITY

When the SSI-related child resides with a non-SSI-related child and only one parent, income is first allocated from the parent's unearned income (after subtracting any court ordered support paid out from unearned income). If the unearned income is insufficient, the remaining allocation amount is subtracted from the parent's earned income (after subtracting any court ordered support paid out from earned income).

The amount allocated to the non-SSI-related child is the difference between the monthly medically needy level for two and the monthly medically needy level for a single individual. The allocation amount is first offset on a dollar-for-dollar basis by any income of the child. The allocation amount is then subtracted from the parent's income (first unearned income then earned income). The remaining parental income is used in the deeming process.

When the SSI-related child resides with a non-SSI-related child and either two non-SSI-related parents or two SSI-related parents, the parents' unearned income is combined and the allocation is made first from the combined unearned income (after subtracting any court ordered support paid out from unearned income). If there is not sufficient unearned income, the parents' earned income is combined and the balance of the allocation is made from earned income (after subtracting any court ordered support paid out from earned income). The remaining parental income is used in the deeming process.

When the SSI-related child resides with a non-SSI-related child, a non-SSI-related parent and an SSI-related parent, income is first allocated from the non-SSI-related spouse's unearned income (after subtracting any court ordered support paid out from unearned income). If the unearned income is insufficient, the remaining allocation amount is subtracted from the parent's earned income (after subtracting any court ordered support paid out from earned income). After allocating to the non-SSI-related child, the non-SSI-related spouse's remaining unearned income is

INCOME SSI-RELATED BUDGETING METHODOLOGY

DETERMINATION OF ELIGIBILITY

combined with the unearned income of the SSI-related spouse and the non-SSI-related spouse's earned income is combined with any earned income of the SSI-related spouse. The deductions listed in steps B-3 – B-5 are then subtracted. The remaining parental income is used in the deeming process starting with the deduction of the parental allocation (See note under C-2 on this page).

C-2 To determine the amount of parental income to deem available to an SSI-related child, when a parent has income remaining after allocating to any non-SSI-related children:

Deduct the \$20 income disregard from the remaining unearned income. (See **INCOME SSI-RELATED DISREGARDS**) When the unearned income is insufficient, or there is only earned income, the balance of the \$20 income disregard is subtracted first from any earned income.

Deduct any health insurance premiums, if paid from unearned income. If the health insurance premium is greater than the amount of unearned income, the remainder is subtracted from earned income.

Deduct \$65 from earned income, then subtract one-half of any remaining earned income. (The one-half deduction is rounded up to the nearest dollar.)

Deduct any health insurance premiums, if paid from earned income or any balance remaining from unearned income.

Add any remaining countable unearned income to any remaining countable earned income and deduct the appropriate parental allocation, the Federal Benefit Rate (FBR). (See **REFERENCE SSI BENEFIT LEVELS**)

- Single parent – FBR for an individual
Two parent household – FBR for a couple

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SSI-RELATED BUDGETING METHODOLOGY

DETERMINATION OF ELIGIBILITY

NOTE: In cases where the SSI-related child is residing with a non-SSI-related parent, SSI-related parent and a non-SSI-related child, the parent allocation is the FBR for a couple, plus the state supplement for an individual.

Any income remaining after deducting the parent allocation is deemed available to the SSI-related child. If there is more than one SSI-related child in the household, divide the deemed amount of income evenly.

C-3 Any parental income that is deemed available to the SSI-related child is added to any unearned income of the child, after any disregards. (See **INCOME** SSI-RELATED DISREGARDS)

C-4 Deduct the SSI-related child's \$20 income disregard. The child is allowed the \$20 income disregard regardless of whether or not s/he has any income of his/her own.

C-5 Deduct any health insurance premiums paid out of the child's unearned income.

C-6 Deduct one-third of any court-ordered support payments received by the SSI-related child from an absent parent.

C-7 If the SSI-related child has earned income, s/he is allowed the appropriate earned income disregards listed in Steps B-4 – B-5.

C-8 The remaining income is then compared to the Medically Needy Income level or Medicaid Standard (and MBL Living Arrangement Chart, as appropriate) whichever is most beneficial.

Disposition: After all appropriate allocation, deeming and the deduction of disregards, the remaining income of the SSI-related individual is compared to the Medically Needy Income level or Medicaid Standard (and MBL Living Arrangement Chart, as appropriate) whichever is most beneficial. Any excess income remaining after applying the appropriate level, is considered available to meet the cost of medical care and services. (See **INCOME** EXCESS)

INCOME**MEDICAID BUY-IN PROGRAM
FOR WORKING PEOPLE WITH DISABILITIES (MBI-WPD)**

Policy: The federal poverty level is used to determine eligibility for MBI-WPD. The net countable income of the A/R is compared to 250% of the federal poverty level for the appropriate family size of a household for one or two.

SSI-related budgeting, including, disregards, allocation and deeming, is used for determining net available income. (See **INCOME: SSI-RELATED DISREGARDS, SSI-RELATED BUDGETING METHODOLOGY, INCOME ALLOCATION, DEEMING, HEALTH INSURANCE PREMIUMS, IMPAIRMENT-RELATED WORK EXPENSES, BLIND WORK EXPENSES, PLAN TO ACHIEVE SELF-SUPPORT (PASS),** and **DETERMINATION OF ELIGIBILITY** and **REFERENCE INCOME ALLOCATION** for a discussion of SSI-related budgeting.)

Reference: See **CATEGORICAL FACTORS** and **RESOURCES: MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES,** and **OTHER ELIGIBILITY REQUIREMENTS MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES PREMIUM PAYMENTS** for a discussion of other eligibility criteria for MBI-WPD.

SSL Sect. 366(1)(a)(12) & (13)

ADMs 04 OMM/ADM-5
03 OMM/ADM-4

NOTE: See **REFERENCE MEDICALLY NEEDY INCOME AND FEDERAL POVERTY LEVELS** for a chart displaying the Medicaid Levels and Federal Poverty Levels.

INCOME**S/CC DISREGARDS**

Description: Disregards of income are not considered in whole or in part in determining eligibility for Medicaid.

Policy: The following types of income are disregarded in the determination of gross monthly income for Medicaid: (See **REFERENCE INCOME DISREGARDS** for chart)

AMERICORPS - Child care allowances and other benefits and services including payments for living expenses provided by Americorps VISTA.

Child care allowances and all other benefits and services except payments for living expenses, provided by Americorps USA and Americorps NCCC.

ASSISTANCE BASED ON NEED - Any regular cash assistance payments based on need received by the A/R and furnished as supplemental income by the federal government, a State or political subdivision.

Support and maintenance assistance based on need and furnished either in-kind by a private non-profit agency or in cash or in-kind by one of the following: a supplier of home heating oil or gas, an entity whose revenues are primarily derived on a rate-of-return basis regulated by a State or Federal governmental entity or a municipal utility providing home energy.

BONA FIDE LOAN - A bona fide loan received by the A/R from an institution or person not legally liable for the support of the A/R. The loan must be a written agreement, signed by the A/R and the lender. The written agreement must indicate: the A/R's intent to repay the loan within a specific time; and how the loan is to be repaid, by specific real or personal property, held as collateral, or from future income. The loan remains an exempt resource as long as it retains the characteristics of a bona fide loan. Any interest accrued by the A/R is considered unearned income in the month received.

CASH ASSISTANCE INCOME - Any income of a cash assistance recipient in the A/R's household. However, any room/board such cash assistance recipient may pay to an S/CC A/R is countable, after applicable disregards (i.e., \$90-work expense (See **INCOME S/CC BUDGETING METHODOLOGY \$90 WORK EXPENSE**

INCOME**S/CC DISREGARDS**

DISREGARD) and the \$60-boarder or \$15-roomer disregard. (See **INCOME S/CC DISREGARDS**)

CHILDCARE INCOME - Five dollars a day per child for a A/R who provides family day care for children other than his/her own is disregarded from the total amount of childcare payments received.

CHILDCARE SERVICES PAYMENTS- Payments made to the A/R for childcare services or the value of any childcare services provided by the A/R to a recipient of employment-related and JOBS-related childcare services. Transitional child care services, at-risk low income child care services or child care and development block grant services.

Payments received from Child and Adult Care Food Program (CACFP).

CHILD SUPPORT ARREARAGE PAYMENTS – Child support arrearage payments received by the A/R are not counted if the child is not a member of the MA case and/or the child is over 21 and/or not residing in the household.

DONATED FOODS - The value of federally donated foods.

EARNED INCOME TAX CREDIT PAYMENTS.

EMERGENCY SAFETY NET PAYMENTS.

FEDERAL ECONOMIC OPPORTUNITY ACT, TITLE III - Any loan made to a family under Title III of the Federal Economic Opportunity Act.

FEDERAL ENERGY ASSISTANCE PAYMENTS.

FEDERAL RELOCATION ASSISTANCE - Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.

FOSTER PARENT PAYMENTS - Payments received for a child boarded out in the home of a recipient by an agency or a relative of the child.

FOOD STAMPS - The value of food stamps.

INCOME**S/CC DISREGARDS**

FREE MEALS - The value of free meals, other than school meals, except when more than one meal a day is furnished or when the A/R receives an allowance for meals away from home.

GARDEN PRODUCE OR LIVESTOCK - The value of produce from a garden or livestock when used exclusively by the A/R and members of his/her household.

GI BILL DEDUCTION - That portion of a military person's pay which is deducted by mandate to help fund the GI Bill.

HOUSING AND URBAN DEVELOPMENT (HUD) COMMUNITY BLOCK GRANT FUNDS.

INCOME TAX REFUNDS – Any income tax refund or federal advance payment received by an A/R is disregarded in the month received and considered an exempt resource in the following month.

JOB CORPS - Money received by a family based on the enrollment of a child in the Job Corps.

NATIVE AMERICAN PAYMENTS - Seneca Nation Settlement Act payments made by the State and Federal governments, under P.L. 101-503, to the Seneca Nation.

Distribution to Native Americans of funds appropriated in satisfaction of judgments of the Indian Claims Commission or the United States Court of Federal Claims. This includes up to \$2,000 per year of income for interests of individual Native Americans in trust or restricted lands, from funds appropriated in satisfaction of the Indian Claims Commission or the United States Court of Federal Claims.

Alaskan Native Claims Settlement Act (ANCSA) distributions - The following distributions from a native corporation formed pursuant to ANCSA are exempt as income or resources:

- a. cash, to the extent that it does not, in the aggregate, exceed \$2,000 per individual per year;
- b. stock;

INCOME**S/CC DISREGARDS**

- c. a partnership interest;
- d. land or an interest in land; and
- e. an interest in a settlement trust.

NYS DEPARTMENT OF LABOR PAYMENTS - Payments from Youth Education, Employment and Training Programs (Department of Labor programs).

OVERPAYMENTS - The amount of income that is withheld to recover a previous overpayment is not income if the individual received Medicaid at the time of the overpayment and the overpayment amount was included in determining the individual's Medicaid eligibility.

PERSECUTION PAYMENTS - Benefits received by eligible Japanese-Americans, Aleuts, or Pribilof Islanders under the Civil Liberties Act of 1988, the Wartime Relocation of Civilians Law, and the Aleutian and Pribilof Islands Restitution Act.

Payments made to individuals because of their status as victims of Nazi persecution, including: German Reparation Payments; Austrian Reparation Payments made pursuant to sections 500-506 of the Austrian General Social Insurance Act; and Netherlands Reparation Payments based on Nazi, but not Japanese, persecution.

PREVENTATIVE HOUSING SERVICE - Payments provided as a preventive housing service under 18 NYCRR 423.4(l).

ROOM AND/OR BOARD - The first \$60 per month of any income from each boarder and the first \$15 per month from each roomer (lodger). If the A/R can document that the actual expenses incurred in providing the room for the roomer, exceeds \$15 per month, or that the actual expenses incurred in providing room and board for a boarder exceeds \$60 per month, then the actual documented expenses are disregarded.

INCOME**S/CC DISREGARDS**

STUDENTS - **Earned Income** - Student earned income is generally countable.

NOTE: Persons under age 21 are not related to the S/CC category. They are generally categorically related to ADC/LIF categories.

Graduate Educational Grants or Scholarships - Educational grants, fellowships or scholarships for a graduate student, obtained and used for educational purposes only. This precludes their use for meeting current living expenses. The student must attest to this in writing. The language of the attestation attached to 83 ADM-67 must be used without change.

When an A/R is in receipt of a graduate assistantship, the local district receives verification from the financial aid office involved to determine if the assistantship is considered employment or an educational grant. If the assistantship is a grant, it is treated as outlined in the previous paragraph. When the assistantship is considered employment, the A/R receives any appropriate earned income disregards (See **INCOME S/CC DISREGARDS**), but additional deductions for educational expenses are not allowed.

School Meals - The value of free school meals.

Student Loans - Student loans received by a graduate or undergraduate student.

Undergraduate Educational Grants, Scholarships or Work-Study - Educational grants, scholarships, fellowships or work-study for undergraduate students.

NOTE: This does not apply to V.A. Educational Grants which are a part of the G.I. Bill and which provide a monthly allowance for support while veterans are enrolled in school. Only specific education-related expenses such as tuition, books, school fees, transportation, etc., are exempt for recipients of G.I. Bill educational money. The remainder is considered available unearned income in determining eligibility for Medicaid.

INCOME**S/CC DISREGARDS**

SUPPORT PAYMENTS - The first \$100 of current total household support payments, including child support and alimony, in any month including support payments collected and paid to the family by the local district.

SUPPLEMENTAL SECURITY INCOME (SSI) - Any SSI payments received by the A/R.

TRADE READJUSTMENT ALLOWANCE (TRA) - TRA benefits are paid as part of Unemployment Benefits (UIB). When an A/R loses his/her job as the result of import competition, s/he may qualify for a TRA allowance. When an A/R is receiving a TRA allowance, as part of his/her UIB, for transportation and/or books for the purpose of attending training, the TRA benefit is exempt.

U.S. CENSUS - Earnings from census employment.

VIETNAM VETERANS - Agent Orange Settlement Fund - Payments from the Agent Orange Settlement Fund or any other fund established pursuant to the Agent Orange product liability litigation, and payments from court proceedings brought for personal injuries sustained by veterans resulting from exposure to dioxin or phenoxy herbicide in connection with the war in Indochina in the period of January 1, 1962 through May 7, 1975.

Children - Monthly allowances paid to certain Vietnam Veterans' Children with Spina Bifida.

VISTA - Payments received by VISTA volunteers under Part A of Title I of Public Law 93-113 (VISTA) are disregarded as income and resources in determining eligibility and degree of need, provided that all of the VISTA payment is to be counted as income when the Director of the ACTION agency determines that the value of all such payments, adjusted to reflect the number of hours such volunteers are serving, is equivalent to or greater than the minimum wage. (See **REFERENCE NEW YORK STATE MINIMUM WAGE** for amount)

INCOME**S/CC DISREGARDS**

VOLUNTEER PROGRAM PAYMENTS - Payments received by participants in volunteer programs under Title II of P.L. 93-113 (Domestic Volunteer Services Act of 1973). These include: retired senior volunteer, foster grandparent, senior companion and senior health aid programs. Payments made in the form of stipends, allowances and/or reimbursements for incurred expenses are disregarded when determining Medicaid eligibility.

Payments received by participants in volunteer programs established under Title III of P.L. 93-133. These include the Service Corps of Retired Executives (SCORE) and the Active Corps of Executives (ACE) programs.

WORK EXPENSE - \$90 work expense from earned income (See **INCOME S/CC BUDGETING METHODOLOGY \$90 WORK EXPENSE DISREGARD**)

WORKFORCE INVESTMENT ACT (WIA)—formerly known as JOB TRAINING PARTNERSHIP ACT (JTPA) - Income (earned or unearned) derived through participation in a program carried out under the JTPA and paid to a dependent minor. Earned income is disregarded for only one six-month period per calendar year. Further discussion of JTPA payments can be found in the Public Assistance Source Book.

Payments for supportive services paid under JTPA to any A/R to defray costs attributable to training such as transportation, meals, childcare, etc.

References:	SSL Sect.	366.2 366.3
	Dept. Reg.	352.22 360-4.6(a)(1) 360-4.6(a)(3)
	ADMs	01 OMM/ADM-6 OMM/ADM 97-2 97 ADM-23 94 ADM-10 92 ADM-43 92 ADM-42 92 ADM-32

INCOME

S/CC DISREGARDS

	92 ADM-11
	91 ADM-8
	90 ADM-3
	84 ADM-21
	84 ADM-1
	81 ADM-38
INFs	95 INF-30
	94 INF-7
	90 INF-33
LCMs	95 LCM-53
	92 LCM-120
GISs	11 MA/004
	98 MA/017
	98 MA/016
	95 ES/DC006

Interpretation: The kinds of income listed previously are not considered in determining eligibility for Medicaid for the S/CC category. Only available income is counted in the determination of eligibility. (See **OTHER ELIGIBILITY REQUIREMENTS OWNERSHIP AND AVAILABILITY** for a more complete discussion of the availability of income)

Documentation: The source and amount of income disregards are documented in the case record and a notation is made that this income is not to be considered in determining eligibility for Medicaid.

INCOME**SINGLES/CHILDLESS COUPLES (S/CC) BUDGETING METHODOLOGY**

Policy: Single individuals or childless couples who are: (1) at least age 21, but not yet 65; (2) not certified blind or certified disabled; (3) not pregnant; and (4) not caretaker relatives of children under age 21 are determined eligible for Medicaid using the S/CC budgeting methodology.

References:

SSL Sect.	366.1(a)
Dept. Reg.	352 360-4.6 370
ADMs	OMM/ADM 97-2 97 ADM-21
GIS	08 MA/022

Interpretation: Eligibility using S/CC budgeting is determined as follows:

- (1) determine the monthly income of the person or household as described in **OTHER ELIGIBILITY REQUIREMENTS HOUSEHOLD COMPOSITION**. Certain kinds of income are disregarded in whole or in part (See **INCOME S/CC DISREGARDS**);
- (2) compare the monthly income to 185% of the Public Assistance Standard of Need (See **INCOME S/CC BUDGETING METHODOLOGY 185% MAXIMUM INCOME LIMIT**). If the income exceeds 185% of the Medicaid Standard, the A/R is not eligible for Medicaid. If the monthly income is equal to or less than 185% of the Medicaid Standard; then
- (3) compare the monthly income to 100% of the federal poverty level. If the income exceeds 100% of the federal poverty level the A/R is not eligible for Medicaid. If the monthly income is equal to or less than 100% of the federal poverty level, then
- (4) deduct the \$90 work expense disregard;
- (5) deduct mandatory items from unearned income;
- (6) deduct that part of income from self-employment or a small business as described in **INCOME EARNED SELF-EMPLOYMENT OR SMALL BUSINESS INCOME** of this guide. Depreciation, personal business and entertainment

INCOME**SINGLES/CHILDLESS COUPLES (S/CC) BUDGETING METHODOLOGY**

expenses, personal transportation, personal income tax, purchase of capital equipment and payment on the principal of loans are not excluded or disregarded;

- (7) deduct the \$100 spousal support payment disregard, (See **INCOME S/CC DISREGARDS**);
- (8) compare the resulting net income to the Medically Needy Income level or Medicaid Standard (and MBL Living Arrangement Chart as appropriate) whichever is most beneficial.

Disposition:

To determine eligibility for Medicaid, using S/CC budgeting methodology, the net income of the A/R, after all appropriate disregards have been deducted, is compared to the Medically Needy Income level or Medicaid Standard (and MBL Living Arrangement Chart as appropriate) whichever is most beneficial. (See **REFERENCE MBL LIVING ARRANGEMENT CHART** and **REFERENCE MEDICALLY NEEDED INCOME AND FEDERAL POVERTY LEVELS**). If the A/R's income equals or exceeds the Medicaid Standard, s/he is ineligible for Medicaid.

**INCOME
S/CC BUDGETING METHODOLOGY**

185% MAXIMUM INCOME LIMIT

Description: The maximum income limit allowed for an S/CC A/R is 185% of the Medicaid Standard (including additional allowances).

Policy: When using S/CC budgeting, an A/R's total income, after subtracting any disregards, must be less than or equal to 185% of the applicable Medicaid Standard.

References:

Dept. Reg.	352.18
ADMs	OMM/ADM 97-2 97 ADM-21 85 ADM-33 83 ADM-38 82 ADM-49 81 ADM-55
GIS	08 MA/022

Interpretation: Individuals and childless couples who are S/CC cannot have gross income exceeding 185% of the Medicaid Standard. (See **INCOME MEDICAID STANDARD**) All income disregards (See **INCOME S/CC DISREGARDS**) except the \$90 work expense are deducted before determining if the A/R meets the 185% maximum income test. The Public Assistance Source Book for Regulations contains a more detailed description of income excluded from the 185% income limit.

NOTE: S/CC persons in Congregate Care (all levels) are not required to pass the 185% income test.

This income test is performed by multiplying the Medicaid Standard, for the appropriate size household, by 185%. The income of the A/R as described above, is then compared to this figure. If the income exceeds this figure, the individual or childless couple is ineligible for Medicaid. If the gross income is less than or equal to 185% of the Medicaid Standard then the budgeting procedures described in **INCOME SINGLE/CHILDLESS COUPLES (S/CC) BUDGETING METHODOLOGY** are followed.

**INCOME
SINGLES/CHILDLESS COUPLES BUDGETING METHODOLOGY**

100% MAXIMUM INCOME TEST

Description: The 100% maximum income test is a test performed after the S/CC household passes the 185% income test. Earned and unearned income is compared to 100% of the federal poverty level for a household of the appropriate size.

Policy: The income of the S/CC applicant household, after disregards, must be less than or equal to 100% of the federal poverty level.

References: ADMs OMM/ADM 97-2
 97 ADM-23

Interpretation: S/CC A/Rs cannot have income exceeding 100% of the federal poverty level. All disregards noted in **INCOME S/CC DISREGARDS** except the \$90 work expense, are disregarded before determining if the client meets the 100% test.

NOTE: Persons in Congregate Care (Levels I, II, and III) are not required to pass the 100% income test.

This income test is performed by comparing the income of the S/CC household with the federal poverty level for the appropriate household size (See **REFERENCE MEDICALLY NEEDY INCOME AND FEDERAL POVERTY LEVELS** for the federal poverty levels). If the income exceeds this figure, the household is not eligible for Medicaid under S/CC budgeting. If the gross income is less than or equal to 100% of the federal poverty level then the budgeting procedures described in **INCOME SINGLES/CHILDLESS COUPLES (S/CC) BUDGETING METHODOLOGY DETERMINATION OF ELIGIBILITY**.

**INCOME
S/CC BUDGETING METHODOLOGY**

\$90 WORK EXPENSE DISREGARD

Policy: In determining eligibility for Medicaid, the first item deducted from the monthly earnings is \$90 of earned income for those individuals engaged in full-time or part-time employment (including those not employed throughout the month).

NOTE: Whenever an A/R has earned income, the first \$90 per month is disregarded even though the A/R may not currently be employed or working.

References:

SSL Sect.	366
Dept. Reg.	352.19
ADMs	OMM/ADM 97-2 90 ADM-3 87 ADM-32
GISs	89 MA028 87 MA0028

Interpretation: When determining net earned income using S/CC budgeting (See **INCOME SINGLES/CHILDLESS COUPLES (S/CC) BUDGETING METHODOLOGY**) subtract \$90 for each person working full-time or part-time. The \$90 work expense is given regardless of the amount of the work expenses incurred.

When the A/R earns less than \$90 per month, disregard the entire amount.

Although the A/R may have more than one job, only one \$90 disregard for work-related expenses is allowed.

**INCOME
SINGLES/CHILDLESS COUPLES (S/CC) BUDGETING METHODOLOGY**

DETERMINATION OF ELIGIBILITY

Policy: Eligibility for single persons and childless couples who are over the age of 21, but under the age of 65, and who are not certified blind, certified disabled or pregnant is determined by comparing the net available income of the A/R to the Medicaid Standard (and MBL Living Arrangement Chart as appropriate). (See **REFERENCE MEDICAID STANDARD** and **MBL LIVING ARRANGEMENT CHART**) In order for such a person to be eligible for Medicaid, s/he must meet the eligibility criteria for S/CC. (See **CATEGORICAL FACTORS SINGLES/CHILDLESS COUPLES (S/CC)**)

NOTE: Effective April 1, 2008, the Medicaid standard is used to determine Medicaid eligibility for single individuals and childless couples, regardless of their living arrangement, since medical care is now considered an unmet need. Therefore, it is not necessary to determine if there is an unmet need.

References:

SSL Sect.	366
Dept. Reg.	360-3.3(a) (1)
ADMs	OMM/ADM 97-2
GIS	08 MA/022

Interpretation: Eligibility for S/CC persons is determined as follows:

- (1) Determine the A/R's household size by counting those persons who are applying and their legally responsible relatives (See **RESOURCES PERSONAL NEEDS ALLOWANCE**). An S/CC household cannot be larger than two.
- (2) Determine the gross monthly income of the person or household. All income from all sources is reviewed to determine if **it is to be included in the eligibility** determination. The income of a non-applying spouse who lives in the same household is counted in the eligibility determination process, unless such spouse refuses to make his/her income available. Certain kinds of income are disregarded in whole or in part. (See **INCOME S/CC DISREGARDS**) The income is converted to a monthly figure.
- (3) Compare the monthly income to 185% of the Medicaid Standard as described in **REFERENCE MEDICAID STANDARD**. If the income exceeds 185% of the Medicaid

INCOME S/CC BUDGETING METHODOLOGY

DETERMINATION OF ELIGIBILITY

Standard, the A/R is ineligible for Medicaid and the determination of eligibility goes no further. If the income is less than or equal to 185% of the Medicaid Standard, the eligibility determination continues.

- (4) Compare the monthly income to 100% of the federal poverty level. If the A/R's income exceeds the poverty level, the A/R will not be eligible under S/CC (See 97 ADM-23). In situations requiring special allowances (housing, restaurant, etc.) which bring the Medicaid Standard above the federal poverty level there will be no 100% federal poverty level test.
- (5) Deduct the applicable disregards from the monthly income in the following order:
 - (a) \$90 work expense disregard. (See **INCOME S/CC BUDGETING METHODOLOGY \$90 WORK EXPENSE DISREGARD**);
 - (b) where applicable, the first \$100 of spousal support payments is disregarded. (See **INCOME S/CC DISREGARDS**)
- (6) Compare remaining income to the Medicaid Standard. If the income is less than the Medicaid Standard, the A/R is income eligible for Medicaid. If the income equals or exceeds the Medicaid Standard, the A/R is ineligible for Medicaid.

NOTE: If a family's countable income exceeds the Medicaid Standard, the family may not spend down to the Medicaid Standard. However, eligibility may exist and should be evaluated under one of the Medically Needy or Expanded Eligibility (poverty level) programs or Family Health Plus.

INCOME**FAMILY HEALTH PLUS (FHPlus)**

Policy: All adults age 19-64, who apply for Medicaid and appear to be ineligible for reasons of excess income.

References: SSL Sect. 369-ee
ADM 01 OMM/ADM-6
GIS 07 MA/021

Interpretation: Eligibility for FHPlus is determined as follows.

- (1) Determine that the A/R is financially ineligible for Medicaid.
- (2) Determine the gross monthly income of the A/R. Certain types of income are not counted when determining gross monthly income for FHPlus. For all applicants, income received from the following is not counted when determining eligibility:
 - AMERICORPS/VISTA;
 - ASSISTANCE BASED ON NEED;
 - BONAFIDE LOANS;
 - CASH ASSISTANCE INCOME;
 - CHILD AND ADULT CARE FOOD PROGRAM (CACFP);
 - CHILD SUPPORT ARREARAGE PAYMENTS;
 - DONATED FOODS;
 - EARNED INCOME OF FULL-TIME STUDENTS UNDER THE AGE OF 21;
 - EARNED INCOME TAX CREDIT;
 - FEDERAL ECONOMIC OPPORTUNITY ACT (Title III);
 - FEDERAL ENERGY ASSISTANCE PAYMENTS;
 - FEDERAL RELOCATION ASSISTANCE;
 - FOOD STAMPS;
 - FOSTER CARE PAYMENTS;
 - FREE MEALS;
 - GARDEN PRODUCE OR LIVESTOCK FOR PERSONAL USE;
 - GI BILL DEDUCTION;
 - GRADUATE/EDUCATIONAL GRANTS (for educational expenses) OR UNDERGRADUATE EDUCATIONAL GRANTS, SCHOLARSHIPS OR WORK STUDY;

INCOME**FAMILY HEALTH PLUS (FHPlus)**

- HUD COMMUNITY BLOCK GRANTS;
- INCOME TAX REFUNDS (in month received);
- IN-KIND MAINTENANCE (such as rent, groceries, etc.) not from a legally responsible relative and not for goods or services rendered;
- JOB CORPS;
- JOB TRAINING PARTNERSHIP ACT PAYMENTS (WORKFORCE INVESTMENT ACT (WIA));
- NATIVE AMERICAN PAYMENTS (including Alaskan Native payments);
- NYS DEPARTMENT OF LABOR PAYMENTS: i.e. Youth Education and Employment and Training Programs;
- PERSECUTION PAYMENTS (German/Austrian/Netherlands Reparation payments, and payments to Japanese-Americans, Aleuts or Pribilof Islanders);
- PREVENTATIVE HOUSING SERVICE PAYMENTS;
- SCHOOL MEALS AND STUDENT LOANS;
- SUPPLEMENTAL SECURITY INCOME (SSI);
- VIETNAM VETERANS AGENT ORANGE SETTLEMENT FUND and payments to Children with Spina Bifida;
- VOLUNTEER PROGRAM PAYMENTS UNDER THE VOLUNTEERS SERVICES ACT (foster grandparents, SCORE, ACE);
- WOMENS, INFANT, CHILDREN (WIC)

In addition, for parents living with their children under the age of 21, and persons age 19 and 20, income received from the following is not counted when determining eligibility for FHPlus:

- BLOOD PLASMA SETTLEMENTS;
- DISASTER RELIEF;
- INSURANCE PAYMENTS- Moneys from insurance payments for the purpose of repairing or purchasing disregarded resource, which was lost, damaged or stolen, are disregarded. Any interest received from such payments is also disregarded.;
- RADIATION EXPOSURE COMPENSATION

NOTE: See **INCOME ADC RELATED DISREGARDS** for further definition of each of the above income types.

INCOME**FAMILY HEALTH PLUS (FHPlus)**

- (3) Determine the gross monthly income of the A/R, as follows:

Compare the gross countable income to the appropriate federal poverty level. The gross countable income of parents or persons age 19 and 20 who live with their parents is compared to 150% of the federal poverty level for the appropriate family size. For single individuals and childless couples, both disabled and non-disabled, and for 19 and 20 year-olds not residing with their parents, gross countable income is compared to 100% of the federal poverty level for the appropriate family size.

Documentation: Documentation of income is the same as for the regular Medicaid program. The source and amount of income is documented in the case record.

**INCOME
PERSONS IN MEDICAL FACILITIES**

**ASSESSMENT/DETERMINATION OF INCOME
AVAILABLE FOR THE COST OF CARE**

Policy: Either spouse may request an assessment/determination of:

- the community spouse's monthly income allowance;
- any family allowances;
- any contribution requested from the community spouse toward the institutionalized spouse's care; and
- the methods used to determine any allowances.

An assessment may be requested at the beginning or after the commencement of a continuous period of institutionalization. The request may or may not be accompanied by an application for Medicaid.

References:	SSL Sect.	366
	Dept. Reg.	360-4.3(f) 360-4.9 360-4.10
	ADMs	89 ADM-47
	INFs	90 INF-19
	GIS	05 MA/002

Interpretation: Income solely in the name of the institutionalized spouse or the community spouse is considered available only to that spouse. When income is in the name of both spouses, or when ownership of the income cannot be established, one half (1/2) is considered available to each spouse. Income in the name of one or both spouses and in the name of another person is considered available to each spouse in proportion to that spouse's interest. When the income is in the name of both spouses and no share is specified, one half (1/2) of the joint share is considered available to each spouse. Income from a trust is considered available to each spouse as directed by the trust. If the trust is not specific, the above guidelines are followed.

**INCOME
PERSONS IN MEDICAL FACILITIES**

**ASSESSMENT/DETERMINATION OF INCOME
AVAILABLE FOR THE COST OF CARE**

The community spouse is allowed a Minimum Monthly Maintenance Needs Allowance (MMMNA). (See **REFERENCE** MMMNA) This amount may be increased as the result of a fair hearing or court order.

When determining the community spouse's otherwise available monthly income, only the following deductions are allowed from his/her income:

- actual incapacitated adult/child care expenses;
- court-ordered support payments; and
- health insurance premiums.

When the community spouse's otherwise available monthly income is less than the MMMNA, the institutionalized spouse's income may be used to bring the community spouse's income up to the MMMNA. (See **REFERENCE** MMMNA)

When a family member (See **RESOURCES** PERSONAL NEEDS ALLOWANCE) resides with the community spouse and has over 50% of his/her maintenance needs met by either spouse, the family member may be eligible for a family member allowance (FMA) from the institutionalized spouse. When determining the family member's otherwise available monthly income, only the following deductions are allowed:

- actual incapacitated adult/child care expenses;
- court-ordered support payments; and
- health insurance premiums.

If the family member is eligible for a FMA, the institutionalized spouse's income may be made available to the family member. (See **REFERENCE** FAMILY MEMBER ALLOWANCE for current maximum dollar amount)

NOTE: German, Austrian, and Netherlands reparation payments are to be disregarded in determining the otherwise available income of the community spouse and family members.

**INCOME
PERSONS IN MEDICAL FACILITIES**

**ASSESSMENT/DETERMINATION OF INCOME
AVAILABLE FOR THE COST OF CARE**

No other disregards are allowed when determining the community spouse's or family member's otherwise available income. All types of income are counted, except Public Assistance. When determining income available from self-employment or rental property, the community spouse/family member is allowed SSI-related disregards. (See **REFERENCE SSI-RELATED DISREGARDS**)

When the community spouse's otherwise available monthly income exceeds the MMMNA plus any family member allowance(s), the community spouse is requested to contribute twenty-five percent (25%) of the excess income to the cost of care for the institutionalized spouse.

An institutionalized spouse will not be denied Medicaid because the community spouse refuses or fails to make his/her income available to meet the cost of necessary care or assistance. However, the local social services district may seek to recover the cost of any Medicaid provided for the institutionalized spouse from the community spouse.

An A/R or his/her community spouse may request a fair hearing if either is dissatisfied with the determination of the community spouse monthly income allowance, the family allowance or the amount of monthly income otherwise available to the community spouse. If either spouse establishes that the community spouse needs income above the MMMNA, based upon exceptional circumstances which result in significant financial distress, the local district, pursuant to a fair hearing or court order, substitutes an amount adequate to provide additional necessary income from the income available to the institutionalized spouse. When the MMMNA is increased, based on exceptional needs, the case is closely monitored. If the exceptional need decreases or ceases, the case is re-evaluated, the appropriate adjustment made to the MMMNA and both spouses adequately and timely notified of the change.

**INCOME
PERSONS IN MEDICAL FACILITIES**

**CHRONIC CARE BUDGETING METHODOLOGY
FOR INSTITUTIONALIZED SPOUSES**

Policy: Chronic care budgeting procedures are used for institutionalized spouses in permanent absence status.

References:

SSL-Sect.	366 366-ee
Dept. Reg.	360-4.9 360-4.10
ADMs	10 OHIP/ADM-01 95 ADM-19 92 ADM-32 89 ADM-47
GISs	09 MA/027 01 MA/021

Interpretation: An institutionalized spouse as defined in the Glossary is in permanent absence status as of the month of institutionalization or the month s/he begins receiving home and community-based waived services. Chronic care budgeting begins the first day of the first month following the establishment of permanent absence.

NOTE: Spousal rules and definitions apply to an institutionalized S/CC or ADC-related individual who has a community spouse and is seeking Medicaid coverage. For such individuals, there will be no coverage for nursing home care until the individual has been certified disabled.

An institutionalized spouse's eligibility for Medicaid and the amount of his/her income applied to the cost of his/her medical care are determined by making the appropriate deductions from his/her available monthly income.

The local district may not require that the following income of the A/R be applied toward the cost of care:

BLOOD PLASMA SETTLEMENTS - Payments received as a result of a federal class action settlement with four manufacturers of blood plasma products on behalf of hemophilia patients who are infected with human immunodeficiency virus (HIV).

CASH ASSISTANCE INCOME - SSI benefits paid under Section

**INCOME
PERSONS IN MEDICAL FACILITIES**

**CHRONIC CARE BUDGETING METHODOLOGY
FOR INSTITUTIONALIZED SPOUSES**

1611(e)(1)(E) of the Social Security Act.

INSURANCE PAYMENTS - Moneys from insurance payments for the purpose of repairing an exempt resource, which was lost, damaged or stolen, are exempt in the month received and for six (6) months following the month of receipt. Any interest received from such payments is also exempt. If the A/R uses the insurance money to purchase a countable resource prior to the expiration of the six months, the value of the countable resource is considered immediately.

MONEY FROM RESIDENTIAL HEALTH CARE FACILITY LEGAL ACTION - Money received as the result of a legal action against a residential health care facility because of improper and/or inadequate treatment.

PERSECUTION PAYMENTS - Benefits received by eligible Japanese-Americans, Aleuts, or Pribilof Islanders under the Civil Liberties Act of 1988, the Wartime Relocation of Civilians Law, and the Aleutian and Pribilof Islands Restitution Act.

Payments made to individuals because of their status as victims of Nazi persecution, including: German Reparation Payments; Austrian Reparation Payments made pursuant to sections 500-506 of the Austrian General Social Insurance Act; and Netherlands Reparation Payments based on Nazi, but not Japanese, persecution.

PLAN TO ACHIEVE SELF SUPPORT - Income necessary to achieve a plan of self support (See **INCOME PLAN TO ACHIEVE SELF-SUPPORT (PASS)** for details);

RADIATION EXPOSURE COMPENSATION TRUST FUND PAYMENTS - Payments for injuries or deaths resulting from exposure to radiation from nuclear testing and uranium mining;

VETERANS - Payments to veterans for Aid and Attendance (A&A) or payments for Unusual Medical Expenses (UME).

VIETNAM VETERANS - Agent Orange Settlement Fund - Payments from the Agent Orange Settlement Fund or any other fund established pursuant to the Agent Orange product liability litigation, and payments from court proceedings brought for

**INCOME
PERSON IN MEDICAL FACILITIES**

**CHRONIC CARE BUDGETING METHODOLOGY
FOR INSTITUTIONALIZED SPOUSES**

personal injuries sustained by veterans resulting from exposure to dioxin or phenoxy herbicide in connection with the war in Indochina in the period of January 1, 1962 through May 7, 1975.

Children - Monthly allowances paid to certain Vietnam Veterans' Children with Spina Bifida.

To determine the institutionalized spouse's eligibility for Medicaid and the amount of his/her income to be applied to the cost of care, deductions are made in the following order:

- (a) An amount to meet the personal needs (PNA) of the institutionalized spouse.

The first month or partial month of permanent absence, determine the institutionalized spouse's income and subtract SSI-related disregards from income to arrive at the countable monthly income. Subtract the Medically Needy Income level for one or the Medicaid Standard for one, whichever is higher.

The month following the month in which permanent absence is established, subtract the appropriate Personal Needs Allowance (PNA) from the institutionalized spouse's income. The A/R is no longer allowed the SSI-related income disregards.

When the A/R has no earned income and resides in a medical facility as defined by Article 28 of Public Health Law, deduct \$50.00 for the PNA.

When the A/R has no earned income and resides in a medical facility regulated by Article 31 of Mental Hygiene Law, deduct \$35.00 for the PNA.

When the A/R has no earned income and is receiving home and community-based waiver services or is a non-institutionalized participant in the Program of All Inclusive Care for the Elderly (PACE), deduct the PACE PNA amount (found in **REFERENCE PACE PNA**). (See **GLOSSARY** for a definition of PACE) This amount equals the difference between the Medically Needy Income level for a household of two and the level for one.

**INCOME
PERSON IN MEDICAL FACILITIES**

**CHRONIC CARE BUDGETING METHODOLOGY
FOR INSTITUTIONALIZED SPOUSES**

When the A/R has earned income, the PNA consists of \$50.00, \$35.00 or PACE PNA amount (See **REFERENCE PACE PNA**) as applicable, plus the SSI-related earned income disregards listed on **INCOME SSI-RELATED DISREGARDS**. The total PNA amount may not exceed the Medicaid income level or Standard for one.

When a waiver or non-institutionalized PACE participation recipient is not living with his/her spouse and does not make his/her income and resources available to the spouse, the local district uses community budgeting procedures to determine the waiver recipient's Medicaid eligibility.

- (b) When the community spouse's otherwise available monthly income is less than the minimum monthly maintenance needs allowance (MMMNA), deduct the amount required to bring the community spouse's otherwise available monthly income up to the MMMNA (See **REFERENCE MMMNA** for the current amount) from the institutionalized A/R's income. (See **GLOSSARY** for the determination of otherwise available income). This deduction is only allowed if the A/R is or will be actually making the income available to his/her community spouse.

**INCOME
PERSON IN MEDICAL FACILITIES**

**CHRONIC CARE BUDGETING METHODOLOGY
FOR INSTITUTIONALIZED SPOUSES**

- (c) When the A/R has a dependent family member(s) (See **GLOSSARY**), deduct a family member allowance for each family member. The family member allowance is deducted for each dependent whether or not the income is actually made available to the family member. The family member allowance is first deducted from any excess income of the community spouse. If the community spouse's income is insufficient to cover a family member allowance then the remainder is deducted from the income of the institutionalized individual.
- (d) Deduct any expenses incurred for health insurance, medical care, services or supplies and/or remedial care for the institutionalized spouse, not paid by Medicaid or a third party.

Any remaining available income of the institutionalized spouse and any amount actually contributed from the community spouse is applied to the cost of care on a monthly basis.

A community spouse or family member who is also applying for Medicaid may not refuse to accept his/her monthly income allowance or family member allowance in order to qualify for Medicaid. However, an otherwise eligible community spouse or family member who is under age 21, pregnant, SSI-related or ADC-related and a legally responsible relative of the institutionalized spouse may achieve Medicaid eligibility by contributing any excess income to the cost of the institutionalized spouse's care.

**INCOME
PERSONS IN MEDICAL FACILITIES**

**BUDGETING FOR INSTITUTIONALIZED SPOUSES IN SPECIFIED HOME AND
COMMUNITY BASED WAIVERS (HCBS)**

Policy: Spousal budgeting procedures used for institutionalized spouses in permanent absence status who are also participants in the Traumatic Brain Injury (TBI), Nursing Home Transition and Diversion (NHTD), and Office for People with Developmental Disabilities (OPWDD) Home and Community Based Service (HCBS) waivers differ from those used in all other permanent absence status situations including other HCBS waivers.

References:

SSL Sect.	366-c (4)
Dept. Reg.	360-4.9 360-4.10
ADMs	08 OLTC-01 95 ADM-19 92 ADM-32 89 ADM-47
GISs	08 MA/024 01 MA/021

Interpretation: An institutionalized spouse as defined in the **GLOSSARY** is in permanent absence status as of the month s/he begins receiving home and community-based waived services. For participants in the TBI, NHTD, OPWDD HCBS waiver, spousal impoverishment eligibility rules are used to determine the waiver participant's eligibility but post eligibility/chronic care deductions are not applied.

To determine the waiver participant's eligibility for Medicaid and the amount of his/her income to be applied to the cost of care, deductions are made from the waiver A/R's income in the following order:

- a) Deduct all applicable SSI-related disregards (See **INCOME SSI-RELATED DISREGARDS**).

**INCOME
PERSONS IN MEDICAL FACILITIES**

**BUDGETING FOR INSTITUTIONALIZED SPOUSES IN SPECIFIED HOME AND
COMMUNITY BASED WAIVERS (HCBS)**

- b) Compare the resulting figure to the Medicaid Income Level for One or the Medicaid Standard and MBL Living Arrangement Chart, as appropriate, whichever is most beneficial. (See **REFERENCE** MEDICALLY NEEDY INCOME AND FEDERAL POVERTY LEVELS for Medicaid Standard and MBL LIVING ARRANGEMENT CHART for Congregate Care Levels)

NOTE: In instances where 2 spouses are participating in the waiver, the resulting income of the two spouses is compared to the appropriate household for two.

- c) Income of the non-waiver spouse is not considered available.
- d) No income is deducted to bring the non-waiver spouse's income up to the Minimum Monthly Maintenance Needs Allowance (MMMNA).
- e) No family member allowance is deducted.

If there is any remaining available income, the waiver participant may spend down. (See **INCOME EXCESS**)

A non-waiver spouse or family member who is also applying for Medicaid must have their eligibility determined as a separate household from the waiver participant.

**INCOME
PERSONS IN MEDICAL FACILITIES**

CHRONIC CARE BUDGETING METHODOLOGY FOR INDIVIDUALS

Policy: Chronic care budgeting procedures are used for institutionalized individuals in permanent absence status.

References:

SSL- Sect.	366 366-ee
Dept. Reg.	360-1.4(c), (k) and (p) 360-4.9
ADMs	10 OHIP/ADM-01 89 ADM-47
GIS	09 MA/027 08 MA/022

Interpretation: For chronic care budgeting purposes, an institutionalized individual is a person in permanent absence status who does not have a community spouse. (See the **GLOSSARY** for the definition of community spouse and the definition of permanent absence)

NOTE: When both members of a couple are in permanent absence status, they are each budgeted as individuals.

When an A/R enters a medical facility on a permanent basis, the first month or partial month of permanent absence, the A/R and any persons residing in his/her former household are budgeted as a community household. Appropriate disregards are used to determine monthly net income. The monthly income of the A/R and his/her household (if any) is compared to the Medically Needy Income level or Medicaid Standard (and MBL Living Arrangement Chart, as appropriate) whichever is most beneficial.

Unmarried ADC and S/CC-related recipients who are temporarily placed in a nursing home and subsequently become "permanently absent" will be budgeted using community budgeting rules until a disability determination is completed. Any excess income for the ADC-related recipient is the individual's liability toward his/her nursing home care pending the disability determination.

**INCOME
PERSONS IN MEDICAL FACILITIES**

CHRONIC CARE BUDGETING METHODOLOGY FOR INDIVIDUALS

NOTE: A person must be a resident of a medical facility as of 12:01 a.m. on the first day of the month for that month to be considered a full month.

Beginning the month following the month in which permanent absence is established, the A/R's income is budgeted using the chronic care budgeting methodology. The following income of the A/R is not applied toward the cost of care:

BLOOD PLASMA SETTLEMENTS - Payments received as a result of a federal class action settlement with four manufacturers of blood plasma products on behalf of hemophilia patients who are infected with human immunodeficiency virus (HIV);

CASH ASSISTANCE INCOME – SSI benefits paid under Section 1611(e)(1)(E) of the Social Security Act.

**INCOME
PERSONS IN MEDICAL FACILITIES**

CHRONIC CARE BUDGETING METHODOLOGY FOR INDIVIDUALS

MONEY FROM RESIDENTIAL HEALTH CARE FACILITY LEGAL ACTION - Money received as the result of a legal action against a residential health care facility because of improper and/or inadequate treatment;

PERSECUTION PAYMENTS - Benefits received by eligible Japanese-Americans, Aleuts, or Pribilof Islanders under the Civil Liberties Act of 1988, the Wartime Relocation of Civilians Law, and the Aleutian and Pribilof Islands Restitution Act;

Payments made to individuals because of their status as victims of Nazi persecution, including: German Reparation Payments; Austrian Reparation Payments made pursuant to sections 500-506 of the Austrian General Social Insurance Act; and Netherlands Reparation Payments based on Nazi, but not Japanese, persecution;

PLAN TO ACHIEVE SELF SUPPORT – Income necessary to achieve a plan of self support (See **INCOME PLAN TO ACHIEVE SELF-SUPPORT (PASS)** for details);

RADIATION EXPOSURE COMPENSATION TRUST FUND PAYMENTS – Payments for injuries or deaths resulting from exposure to radiation from nuclear testing and uranium mining;

VETERANS – Payments to veterans for Aid and Attendance (A&A) or payments for Unusual Medical Expenses (UME); and

Reduced (limited) \$90 Veterans' Administration pension;

VIETNAM VETERANS – Agent Orange Settlement fund - Payments from the Agent Orange Settlement Fund or any other fund established pursuant to the Agent Orange product liability litigation, and payments from court proceedings brought for personal injuries sustained by veterans resulting from exposure to dioxin or phenoxy herbicide in connection with the war in Indochina in the period of January 1, 1962 through May 7, 1975;

Children - Monthly allowances paid to certain Vietnam Veteran's Children with Spina Bifida;

**INCOME
PERSONS IN MEDICAL FACILITIES**

CHRONIC CARE BUDGETING METHODOLOGY FOR INDIVIDUALS

To determine the individual's eligibility for Medicaid and the amount of his/her income to be applied to the cost of care, deductions are made in the following order:

- (a) Subtract the appropriate Personal Needs Allowance (PNA) from his/her available income. The A/R is no longer allowed the SSI-related income disregards.

When the A/R has no earned income and resides in a medical facility as defined by Article 28 of Public Health Law, deduct \$50 for the PNA.

When the A/R has no earned income and resides in a medical facility regulated by Article 31 of Mental Hygiene Law, deduct \$35.00 for the PNA.

When the A/R has earned income the PNA consists of \$50.00 or \$35.00 as applicable, plus the SSI-related earned income disregards. The total PNA amount may not exceed the Medically Needy Income level or Medicaid Standard for one.

- (b) Deduct an amount to cover any third party health insurance premium;
- (c) The needs of any children under 21 years of age for whom the A/R is legally responsible, in his/her former family household are then considered. The A/R's income is used to bring such children's income up to the appropriate Medically Needy Income level or Medicaid Standard, whichever is higher.

NOTE: The maintenance needs of children for whom the A/R is legally responsible, in his/her former family household are considered, regardless of their resources.

- (d) Deduct any expenses incurred for medical care, services or supplies and/or remedial care, not paid by Medicaid or a third party.

**INCOME
PERSONS IN MEDICAL FACILITIES**

CHRONIC CARE BUDGETING METHODOLOGY FOR INDIVIDUALS

Any remaining income is applied to the cost of care on a monthly basis.

When an individual enters a medical facility on a temporary basis and is expected to return to the community, s/he is considered temporarily absent. S/he and any persons residing in his/her household are budgeted as a community case. His/her income is compared to the Medically Needy Income level or the Medicaid Standard (and MBL Living Arrangement Chart, as appropriate) whichever is most beneficial.

**INCOME
PERSONS IN MEDICAL FACILITIES**

**PERSONAL NEEDS ALLOWANCES (PNA) FOR PERSONS TRANSFERRED OR
DISCHARGED**

Policy: For persons in psychiatric facilities, developmental centers or intermediate care facilities regulated by Article 31 of the Mental Hygiene Law, the Personal Needs Allowance (PNA) is \$35.00, rather than the \$50 PNA allowed to persons in facilities regulated by Article 28 of Public Health Law. When a recipient transfers between facilities with different Personal Needs Allowance (PNA) levels, s/he is allowed the applicable PNA for the facility in which s/he was residing on the first of the month. The PNA is not pro-rated.

For example:

Mr. Smith has resided in a facility regulated by Article 31 of the Mental Hygiene Law since November 6, 1998. On March 10, 1999, he is transferred to a nursing home. His PNA for March, 1999 is \$35.00. Effective April 1, 1999 his PNA increases to \$50.

On June 15, 1999, Mr. Smith returns to the Article 31 facility. His PNA is \$50 for June, 1999. Effective July 1, 1999 his PNA decreases to \$35.00.

Individuals (other than institutionalized spouses) discharged from a medical facility into the community are entitled to community budgeting as of the calendar month of discharge.

For example:

Miss Brown is discharged from a nursing home to the community on August 20, 1998. She is entitled to community budgeting for the entire month of August.

Institutionalized spouses discharged from a medical facility into the community are entitled to community budgeting as of the month following the month of discharge. Institutionalized spouses are budgeted as chronic care cases in the month of discharge.

For example:

Mrs. Jones is discharged from a nursing home to the community on August 20, 1998. She is budgeted as a chronic care case for the month of August. Effective September 1, spousal impoverishment rules no longer apply.

**INCOME
PERSONS IN MEDICAL FACILITIES**

COMMUNITY SPOUSE AND FAMILY MEMBER ALLOWANCES

Policy: The minimum monthly maintenance needs allowance was established October 1, 1989 at \$1,500. It is increased annually by the same percentage as the percentage increase in the federal Consumer Price Index. The amount, effective each January 1st, can be found in the **REFERENCE INCOME COMMUNITY AND INSTITUTIONALIZED and FAMILY MEMBER ALLOWANCE.**

A higher MMMNA amount may be established by court order or fair hearing.

The family allowance for each family member is an amount equal to one-third (1/3) of the amount by which one twelfth (1/12) of the applicable percentage of the annual federal poverty level for a family of two exceeds the amount of the otherwise available monthly income of the family member. The maximum Family Member Allowance (FMA) can be found in the **REFERENCE FAMILY MEMBER ALLOWANCE.**

References:	Dept. Reg.	360-4.10
	ADMs	06 OMM/ADM-3 04 OMM/ADM-4 89 ADM-47
	GISs	07 MA/001 06 MA/029 05 MA/013 05 MA/002 04 MA/032

INCOME**FAMILY PLANNING BENEFIT PROGRAM (FPBP) BUDGETING METHODOLOGY**

Policy: Depending on the A/R's category, s/he is allowed the budgeting disregards/exemptions for LIF/ADC-related or S/CC.

After appropriate categorical disregards, an FPBP A/R's net income is compared to 200% of the federal poverty level. (For LIF see **INCOME LIF DISREGARDS** and **INCOME LIF BUDGETING METHODOLOGY**, for ADC see **INCOME ADC-RELATED DISREGARDS** and **INCOME ADC-RELATED METHODOLOGY**, for S/CC see **INCOME S/CC DISREGARDS** and **INCOME S/CC BUDGETING METHODOLOGY**)

References: SSL Sect. 366(1)(a)(11)
ADM 02 OMM/ADM-7

Interpretation: SSI budgeting methodology is not used in determining eligibility for the FPBP. For example if a certified disabled individual living alone is ineligible for Medicaid, his/her eligibility for FPBP is determined using S/CC income disregards/exemptions.

When a person under the age of 21 who lives with his/her parents does not have his/her parent's financial information, eligibility for the A/R is determined using only the income of the A/R under the age of 21 and, if applicable, the income of the A/R's spouse.

Applicants cannot spend down to 200% of the federal poverty level to qualify for the Family Planning Benefit Program.

INCOME**EXCESS**

Description: Excess income or “spenddown” is available net income in excess of an individual’s Medicaid level or standard. When determining Medicaid eligibility for A/Rs who are SSI-related, ADC-related, under age 21 or pregnant, any available monthly income in excess of the Medically Needy Level or Medicaid Standard whichever is higher is considered available to meet the cost of medical care and services.

Policy: When the available income of the A/R is greater than the Medically Needy Level or Medicaid Standard whichever is higher, the excess is considered available to meet the cost of medical care and services. In order to become eligible for Medicaid, ADC-related, SSI-related, under age 21 or pregnant A/R(s) may:

- pay or incur medical expenses equal to or greater than their excess income; or
- pay the amount of the excess income directly to a local district; or
- use a combination of paid or incurred medical bills and pay directly to the local district.

There are two types of **Medicaid Coverage** available under the Excess Income Program:

- **Outpatient Coverage-** Provided to an A/R who meets his/her spenddown on a monthly basis.
- **Inpatient and Outpatient Coverage-** Provided to an A/R who meets a six-month excess.

To meet either the one or six-month excess, the A/R must demonstrate that he/she has either paid or incurred the amount of the excess income toward a medical need (met the excess income). This is done by submitting paid or incurred medical bills or by paying the excess amount to the LDSS.

The amount and type of the medical bill(s) submitted by the A/R determines the length of time for which the Medicaid coverage (either outpatient-only, or inpatient and outpatient coverage) is granted.

In determining an individual’s eligibility, local districts use accounting periods:

- Accounting Period- a period of time from one to six months, over which medical bills are applied to excess income;

INCOME

EXCESS

- First Prospective Period- the first accounting period that includes the month of application;
 - Medical expenses paid in the retro period that exceed the A/R's excess income may be carried forward into the first prospective period;
- Current Period- an accounting period that occurs after the first prospective period.

There are a variety of factors that affect the ability to apply/use bills in the eligibility determination including: timeframes, paid vs. unpaid bills (viability), the type of bill, the prioritization of the bill and the accounting period.

In addition to other medical bills, not paid by the A/R, bills that are paid by a public program of the State (such as EPIC or ADAP) or its political subdivisions may be used to meet an A/R's excess income liability.

A/Rs who meet their excess income must spend down to the appropriate Medically Needy Income Level or Medicaid Standard whichever is higher. A/Rs are not permitted in any instance to spend down income to the Federal Poverty Levels. This includes applicants applying for coverage under the Medicaid Buy-In Program for Working People with Disabilities (MBI-WPD).

A/Rs with income in excess of the applicable Family Health Plus (FHPlus) standard cannot meet their excess to attain FHPlus eligibility. Applicants who are ADC-related, SSI-related, under age 21 or pregnant who have medical expenses which would allow them to meet their excess to obtain coverage under Medicaid, and who are eligible for FHPlus, complete an application and enrollment form, and are given the choice of participating in either in the Medicaid Spenddown Program or FHPlus. Persons eligible for both Medicaid spenddown and FHPlus are informed of the differences in services provided by each program and all the Medicaid requirements.

References:

SSL Sect.	366(1)(a)(12) & (13) 366 (2)(b) 369-ee
Dept. Reg.	360-4.8
ADMs	04 OMM/ADM-5

INCOME**EXCESS**

03 OMM/ADM-4
01 OMM/ADM-6
96 ADM-15
91 ADM-11
87 ADM-4

Interpretation: A/Rs who meet their excess income on a monthly basis are eligible for Outpatient Coverage only. A/Rs who meet a six month excess are eligible for both Inpatient and Outpatient coverage. Any A/R with excess income requesting coverage of an inpatient bill must first meet a six month excess.

The use of medical expenses to offset excess income is known as "spenddown". The direct payment of excess income to the local district is known as "Pay-In".

A/Rs who can participate in the Excess Income Program include:

- Individuals who are in a federally participating category (SSI-related, ADC-related or a child under the age of 21) and SSI-related are who also eligible under the appropriate Medicaid Resource Level.

NOTE: SSI-related individuals eligible to participate in the Excess Income Program who also have excess resources may spend down their excess resources (See **RESOURCES EXCESS RESOURCES**). Bills must be applied to excess resources first. Any remaining bills or portions of bills may then be used to reduce excess income.

When the income of a legally responsible relative is counted in the eligibility determination process, medical expenses, which are the legal responsibility of the relative, may also be used to offset any excess income of the applicant. Such expenses may include the medical expenses of the legally responsible relative as well as medical expenses of other family members for whom such relative is legally responsible.

Excess Income or Spenddown is met by:

Showing the LDSS either a paid bill or an incurred bill.

INCOME**EXCESS****Types of bills that can be used to meet the Excess/
Spendedown:**

- a) Medicare and other health insurance deductibles or other coinsurance charges;
- b) Necessary medical and remedial services that are recognized under State law but are not covered by Medicaid, e.g. chiropractic care; and
- c) Necessary medical and remedial services that are covered under the Medicaid Program (See **REFERENCE MEDICAID COVERED SERVICES**).

Such expenses include:

- Medical Expenses
- Medical Transportation
- Prescription Drugs
- Surgical Supplies/Medical Equipment/Prosthetic Devices
- Non-Participating Provider Services (Once Medicaid coverage is authorized, the recipient **MUST** receive services from Medicaid providers in order for the Medicaid payment to be made. Credit or refunds will **NOT** be provided for covered services rendered to the recipient by non-participating providers.)
- Over-the-counter drugs when ordered by a physician
- Medical expenses paid/incurred by a public program, e.g. ADAP and EPIC
- Copays
- Non-covered services
- Medical expenses for an individual for whom the A/R is legally responsible
- Medical expenses from a legally responsible relative whose income is available to the A/R

When the A/R presents a combination of bills, the local district uses its judgment in selecting the most appropriate alternatives in order to satisfy program requirements.

INCOME**EXCESS****A Prioritization/Hierarchy is applied to bills when evaluating the spenddown:**

- Bills not payable by the Medicaid Program such as:
 - Paid bills- Bills paid in the pre-retroactive period (the period prior to the first day of the third month prior to the month of application) cannot be used to grant eligibility.

Paid expenses are “anchored”/deducted from the income in the accounting period in which it is paid. Exception: An exception is made for expenses incurred and paid in the three-month retroactive period. When no part of the retroactive period is included in the first prospective accounting period, expenses incurred and paid during the retroactive period, which have not been used previously to establish eligibility can be deducted from income in the first prospective accounting period.

Credit for paid bills may be carried forward for no more than six months, or until there is a break in coverage.

- Non-covered services
- Non-participating providers
- Medical Expenses from a legally responsible relative whose income is available to the A/R
- Co-pays
- Unpaid medical bills
 - Must be viable (the provider continues to seek payment and has not “written-off” the expense) and not previously used to establish eligibility.
 - Credit can be given in a subsequent accounting period if the individual’s liability is met in an accounting period without deducting all incurred, unpaid expenses and the bill is NOT payable by the Medicaid program.

INCOME**EXCESS**

- Unpaid bills may be carried forward until there is a break in coverage.
- Unpaid bills from both the retroactive and pre-retroactive periods can be used to grant eligibility
- Medical bills payable by Medicaid.

NOTE: An expense paid or incurred by a public program can be used to provide no more than six months of Medicaid coverage at a time.

The following subjects are covered in this section:

- Six-month; and
- Pay-In.

**INCOME
EXCESS****SIX-MONTH**

Policy: When determining eligibility for acute in-patient care in a medical facility, the excess income for a six-month period is considered available for meeting the cost of medical care and services.

NOTE: If a person meets the definition of an institutionalized spouse, the excess income liability is computed on a monthly basis.

References:

SSL Sect.	366 (2)(b)
Dept. Reg.	360-4.8(c)
ADMs	96 ADM-15 91 ADM-11 90 ADM-46 87 ADM-4

Interpretation: When an A/R has a spenddown, and has or expects to have an acute in-patient care expense, excess income for a period of six months is considered available to meet the cost of such in-patient care. Any outstanding medical bills for which a provider is actively seeking payment may be used to reduce the six-month excess. (See **INCOME EXCESS** for the hierarchy of the application of medical bills)

For purposes of Medicaid coverage for an acute in-patient stay, the six-month consecutive period must include the month of hospitalization; however, it cannot include any month prior to the three-month retroactive period.

Once an A/R incurs a six-month excess liability, the A/R is eligible for Medicaid coverage of both inpatient and outpatient care and services for that period.

For any acute in-patient stay in which the A/R's liability for payment (excess income) for medical care exceeds the Medicaid payment rate for the length of the stay, but is less than the private charges for care, one of the procedures outlined below must be utilized:

- I. For acute stays where the Medicaid payment rate is calculated utilizing a MEDICAID PER DIEM RATE:

**INCOME
EXCESS****SIX-MONTH**

- (1) Determine the average private per diem rate by dividing the total private charges by the length of the stay (date of admission until, but not including, date of discharge);
- (2) Calculate the number of hospital days fully covered by the A/R's liability by dividing the average private per diem rate into the patient liability;
- (3) Apply the remaining liability, if any, to the next acute day.
 - (a) If the remaining liability exceeds the Medicaid per diem, no portion of that day will be paid by Medicaid.

Enter the following day in the Service FROM Date field on the Principal Provider Subsystem (PPS), the date of discharge as the Service TO Date, and enter zero in the Net Available Income (NAMI) field.

- (b) If the remaining liability is less than the Medicaid per diem rate, Medicaid will pay the difference between the remaining liability and the Medicaid per diem rate.

Enter this day (commonly referred to as a "partial day") in the Service FROM Date field, the date of discharge as the Service TO Date, and enter the remaining liability in the NAMI field on PPS;

- (4) Instruct the hospital to bill only for the days covered by Medicaid, and to enter the remaining liability, if any, in the surplus field of the claim form.

II. For hospital stays where the Medicaid payment rate is calculated utilizing DIAGNOSTIC RELATED GROUPS (DRG):

- (1) Determine the percentage of the hospital stay covered by the A/R's liability by dividing the liability by the private pay charges;

**INCOME
EXCESS
SIX-MONTH**

- (2) Determine the percentage of the hospital stay to be covered by Medicaid (100% minus the percentage covered by the A/R's liability);
- (3) Multiply the DRG case payment amount by the Medicaid percentage to arrive at the Medicaid payment amount;
- (4) Subtract the Medicaid payment amount from the DRG case payment amount. Enter this amount as the Net Available Monthly Income (NAMI) in the Principal Provider Subsystem (PPS). Please note: the amount entered in the PPS will be different from the client's actual liability. Local districts must ensure that the case record, client notices, and the notice to the hospital reflect the actual liability;
- (5) Enter the actual dates of service in the Principal Provider Subsystem (PPS);
- (6) Instruct the hospital to enter the adjusted client liability as the surplus on the claim form, and complete the rest of the claim form according to normal procedures.

90 ADM-46 contains a more detailed description of "Watkins" cases using the Medicaid per diem rate, or Diagnostic Related Groups (DRG) case payment amount and includes some case examples.

When to Verify:

When an SSI-related, ADC-related, under age 21 or pregnant A/R, has income in excess of the Medically Needy level or Medicaid Standard whichever is higher and:

- (1) Declares in the application that s/he has unpaid acute in-patient expenses; or
- (2) Indicates in the application that any member of the family household is in, or will require acute in-patient care, or has acute in-patient expenses.

**INCOME
EXCESS****SIX-MONTH**

Verification: Expenses for acute in-patient care may be verified by:

- (1) Seeing hospital bills;
- (2) Seeing Medicare or insurance explanation of benefits;
- (3) Clearing with the medical provider.

Documentation: Sufficient to establish an audit trail:

- (1) Date, length of stay, amount of charge and name of medical facility;
- (2) Date and type of service, amount of charge and name of provider;
- (3) If a third party insurer is involved, the amount of the third party payment or the denial of benefits, and the net amount of the A/R's responsibility.

Disposition: Once an A/R with excess income has paid or incurred a charge for acute in-patient care, his/her six-month excess income is computed. Medicaid is authorized for all or any part of the cost of acute in-patient care, which is greater than the A/Rs' spenddown amount. Once the A/R has incurred expenses equal to or greater than his/her excess income for a six-month period, s/he is eligible for Medicaid coverage during this period.

If income and/or household composition (See **OTHER ELIGIBILITY REQUIREMENTS** HOUSEHOLD COMPOSITION) changes during this six-month period, the amount of the excess is recomputed prospectively and the appropriate notice is sent to the A/R.

NOTE: If the A/R is covered by Third Party Health Insurance (e.g., Medicare, Blue Cross/Blue Shield, etc.) the amount of health insurance available for medical bills does not reduce the liability of the A/R. S/he is personally liable for medical bills equal to the amount of his/her excess.

**INCOME
EXCESS****PAY-IN**

Policy: Local social services districts are required to offer individuals with excess income the opportunity to reduce their excess income by pre-paying to the district the amount by which their income exceeds the Medically Needy Income level or Medicaid Standard, whichever is higher. Participation in the Pay-In program is optional on the part of the A/R. The A/R may elect to pay-in for periods of one to six months. When the pay-in period is longer than one month, the individual may pay the full excess income amount at the beginning of the period or may pay in monthly installments.

References:

SSL. Sect.	366(2)(b)
Dept. Reg.	360-4.8
ADMs	96 ADM-15 94 ADM-17

Interpretation: In order to obtain coverage, the participant pays to the local social services district the amount by which his or her net available income exceeds the Medically Needy Income level or Medicaid Standard, whichever is higher, for the appropriate period. In determining this amount, the district deducts from income any necessary medical expenses incurred during the period which are not payable by the Medicaid program. The A/R may elect to pay-in for periods of one to six months.

For pay-in periods of less than six months, inpatient coverage will not be authorized; instead outpatient coverage will be authorized. When the A/R pays the full excess income liability for a six-month period, inpatient and outpatient coverage will be authorized for that period.

If the individual has paid his/her liability to the local district and subsequently incurs expenses during the covered period for services not covered by the Medicaid program, the local district either refunds to the recipient the amount of the medical expense from the recipient's account, or may credit the amount to the recipient's account in a subsequent excess income period.

**INCOME
EXCESS****PAY-IN**

NOTE: Once the individual has paid in the amount of his/her excess income to the local social services district, s/he is treated like any other Medicaid recipient. Thus, the recipient must receive services from Medicaid providers in order for Medicaid payment to be made. Expenses paid or incurred from non-participating providers will not provide credit or refunds for covered services rendered to the recipient.

The local district establishes a special account to safeguard the funds paid by the individuals. Such amounts are not retained in interest-bearing accounts.

Local districts periodically reconcile the amount in the Medicaid recipient's account with the amount of Medicaid payments made on the recipient's behalf. The amount in the account is compared to the Medicaid payments made for services provided during the covered period. Any unused pay-in amounts are refunded to the recipient or credited to a subsequent excess income period.

NOTE: When reconciling the individual's Pay-In account, local districts take into consideration any off-line payments made on behalf of a participant, since these payments will not be reflected in the Adjudicated Claims history report.

Verification: Expenses for outpatient medical care, including prosthetic appliances, may be verified by:

- (1) Seeing medical bills;
- (2) Seeing cancelled checks or receipts;
- (3) Seeing Medicare or insurance explanation of benefits;
- (4) Clearing with the medical provider.

Documentation: Sufficient to establish an audit trail:

- (1) Date and type of services, amount of charge and name of provider; and
- (2) If a third party insurer is involved, the amount of the third party payment or the denial of benefits and the net amount of the A/R's responsibility.

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RESOURCES

Description: Resources are property of all kinds including: real, personal, tangible, and intangible.

Policy: All resources of an SSI-related A/R are reviewed to determine their availability and value as of the first day of the month for which the SSI-related A/R is applying for or receiving Medicaid. When the SSI-related applicant is requesting Medicaid coverage for the three-month retroactive period (See **OTHER ELIGIBILITY REQUIREMENTS AUTHORIZATION**), the value and availability of the applicant's resources are determined as of the first day of the month for each month that the applicant is seeking Medicaid coverage.

References:

SSL Sect.	366 366.2(a) 366-ee
Dept. Reg.	360-2.3 360-4 360-4.4 360-4.6 360-4.7 360-4.8
ADMs	10 OHIP/ADM-1 08 OHIP/ADM-4 04 OMM/ADM-6 97 OMM/ADM-2 91 ADM-17
INFs	05 OMM/INF-2
GISs	09 MA/027 08 MA/22 08 MA/013

Interpretation: Resources are cash or those assets, which can be readily converted to cash, such as financial institution accounts, life insurance, stocks, bonds, mutual fund shares and promissory notes. Resources include property not readily converted to cash (i.e., real property).

Lump sum payments and windfall payments may be considered either income or resources. (See **RESOURCES LUMP SUM PAYMENTS**)

RESOURCES

Effective for eligibility periods beginning on or after January 1, 2010 FHPlus and non-SSI-related Medicaid A/Rs will not have resources considered in determining eligibility. This change includes the following Medicaid categories: Singles/Childless Couples (S/CC), Low Income Families (LIF), ADC-related (including adults who spend down excess income to the Medicaid income level), children under 21 years of age when comparing income to the Medicaid income level (Under age 21), and parents living with their dependent child(ren) under age 21 with income at or below the Medicaid income level (FNP Parents).

In determining eligibility, resources are never considered for pregnant women and infants under one year of age. Resources are also not considered for children over age one but under age 19 if income is at or below the appropriate poverty level.

In addition, there is no resource test for applicants for the Family Planning Benefit Program, Medicaid Cancer Treatment Program, the Medicare Savings Program including the Qualified Individual Program (QI), Qualified Medicare Beneficiaries (QMB) and Specified Low Income Medicare Beneficiaries (SLIMB), AIDS Health Insurance Program (AHIP) and policy holders who have utilized the minimum required benefits under a total asset Partnership for Long-Term Care insurance policy. (See **RESOURCES** NEW YORK STATE PARTNERSHIP FOR LONG-TERM CARE)

Resource requirements continue to apply to SSI-related Medicaid A/Rs whose eligibility is determined using the SSI-related budgeting methodology, unless they are applying for Medicare Savings Program (MSP)-only. Qualified Disabled and Working Individuals (QDWIs) and applicants for the Medicaid Buy-In for Working People with Disabilities (MBI-WPD) have a resource test as do applicants for COBRA Continuation Coverage.

SSI-related Medicaid A/Rs, including MBI-WPD A/Rs, who are not seeking coverage of long-term care services, are allowed to attest to the amount of their resources rather than provide proof. However, if an SSI-related or MBI-WPD A/R is seeking Medicaid coverage of community-based long-term care services, the A/R must provide documentation of current resources only, and if otherwise eligible, is entitled to coverage of all Medicaid covered care and services, except for nursing facility services.

RESOURCES

An SSI-related A/R who also meets the ADC-related categorical requirements has a choice between ADC-related budgeting and SSI-related budgeting. In determining eligibility under ADC-related budgeting, there is no resource test.

Disposition: To determine eligibility for Medicaid for A/Rs who are subject to a resource test, available, countable resources are compared to the applicable resource level. If the value exceeds that level, the A/R has excess resources. (See **RESOURCES** EXCESS RESOURCES for spend down of resources).

Although there is no resource test for non-SSI-related and FHPlus A/Rs, districts must continue to review the Resource File Integration (RFI) reports. Districts are encouraged to minimize the scope of investigation into resources of the non-SSI-related or FHPlus A/R to those resources that are related to current income. Any action associated with the income verification should be maintained in the case record and/or appended to the applicable RFI report.

Interpretation: The following sections describe resources in detail:

- Financial Institution Accounts
- Uniform Gifts to Minors Act/Uniform Transfer to Minors Act
- Retirement funds
- Personal needs allowance accounts
- Lump sum payments
- Windfalls

RESOURCES

FINANCIAL INSTITUTION ACCOUNTS

Description: Financial institution accounts include checking accounts, saving accounts, money market accounts, time deposits (also known as Certificates of Deposit - CDs) and guardianship accounts. Financial Institution accounts do not include stocks, bonds and mutual funds.

Policy: All financial institution accounts are reviewed to determine their availability and value. The value of the account is the amount of monies that the A/R can currently withdraw. If there is a penalty for early withdrawal the value of the account is the amount available after the penalty deduction. Any income taxes due are not deductible in determining the account's value. It is important that local districts evaluate potential unearned income from interest earned from such accounts. (See **INCOME DIVIDENDS AND INTEREST** for a more complete description of income from dividends and interest.)

References:

SSL Sect.	366 366.2(b) 366-ee
Dept. Reg.	360-2.3 360-4.4 360-4.6(b)(5)
ADMs	10 OHIP/ADM-01 96 ADM-8 92 ADM-11
GIS	09 MA/027

Interpretation: As long as the A/R is designated as the sole owner by the account's title, and can withdraw funds and use them for his or her support and maintenance, the A/R is presumed to own all of the funds in the account, regardless of their source. The presumption cannot be rebutted.

NOTE: When the letters ITF (In Trust For) appear on an account, the account is owned by the person(s) whose name(s) appears before the ITF. The person named after the ITF will receive the proceeds of the account upon the death of the owner(s).

When investigating financial institution accounts, note all major transactions. If large amounts of money have been deposited or withdrawn, the A/R is questioned as to the reason for the transaction, i.e., how the money was acquired or disposed of.

RESOURCES

FINANCIAL INSTITUTION ACCOUNTS

An SSI-related child's savings account of less than \$500 is disregarded when determining Medicaid eligibility. The funds must be accumulated from gifts from non-legally responsible relatives and/or from the child's own earned income. Each SSI-related child is allowed one account; when the child has more than one savings account, the A/R is allowed up to 30 days to consolidate the funds into one account.

When an SSI-related A/R and one or more persons jointly own a savings account, the SSI-related A/R is presumed to have a 100% interest in the account. The presumption can be rebutted. Evidence that the account is, in fact, the property of only one of the persons named as an owner or that the ownership is not divided equally is documented in the case record. It is not uncommon for additional names to be listed on savings accounts for tax advantages, convenience in obtaining proceeds or inheritance purposes.

NOTE: In addition when an SSI-related A/R converts his/her resource to a joint account, transfer of assets implications are evaluated.

NOTE: An A/R may deposit recurring income, such as wages or a pension into his/her checking account each month. The A/R may draw on this money during the month to pay rent, utilities and other bills. Care is taken not to count this recurring income as a resource and income in the same month. However, if a balance is carried forward to the next month, it may be considered a countable resource in that month.

- When to Verify:**
- (a) When the SSI-related A/R declares s/he has a financial institution account;
 - (b) When the SSI-related A/R declares ownership of a money market fund or certificate of deposit;
 - (c) When the SSI-related A/R declares membership in a credit union;

RESOURCES

FINANCIAL INSTITUTION ACCOUNTS

- (d) When current or past maintenance indicates the probability of an existing savings account.

Verification:

Verification of financial institution accounts may be accomplished in several ways:

- (a) Bank accounts: seeing the bankbook or most recent statement;
- (b) Certificates of deposit: seeing the most recent statement including the maturity date of the certificate or account;
- (c) Checking accounts: seeing the most recent statement. Seeing the checkbook is not sufficient for verification; however, it may provide information concerning the type and amount of major transactions;
- (d) Credit union accounts: seeing the most recent statement.
- (e) When the Resource File Integration (RFI) reports indicate that the A/R has income from financial institution accounts.

If the A/R is unable to provide statements, the local district contacts the institution directly.

Documentation:

Sufficient to establish an audit trail:

Copy of account statement; the name and address of the institution, account number, amount of current balance, date and amount of highest balance plus the date and amount of all major withdrawals and deposits.

RESOURCES

UNIFORM GIFTS TO MINORS ACT/ UNIFORM TRANSFER TO MINORS ACT

Policy: The New York State Uniform Gifts to Minors Act (UGMA) and the Uniform Transfers to Minors Act (UTMA) provide a simple and inexpensive method of making gifts to minors. The custodian of a UGMA/UTMA custodial account may provide to the minor, or expend for the minor's benefit, as much of the custodial property as the custodian considers advisable for the use and benefit of the minor. However, the minor has no entitlement to the custodial property until he or she becomes an adult, a term which is defined differently under the UGMA and the UTMA.

References:

SSL Sect.	366 366-ee
ADM	10 OHIP/ADM-01
GIS	09 MA/027

Interpretation: The UGMA was repealed in 1997, and the provisions of the UTMA govern accounts established under either statute. The UTMA generally requires the custodian to transfer the custodial property to the minor when the minor reaches the age of 21 (unless the person creating the account, in designating the custodian, elects the age of 18 instead). However, with respect to accounts created before January 1, 1997 (i.e., accounts created when the UGMA was in effect), including deposits made to such accounts on or after January 1, 1997, the custodian is required to turn over the custodial property when the minor reaches the age 18.

For an SSI-related child, UGMA/UTMA funds are disregarded when determining Medicaid eligibility. Disbursements from such accounts may be countable income to the child if used to make certain third party vendor payments. A third party vendor payment is a payment made directly to a vendor (e.g., a merchant, retailer or contractor) by a third party for goods or services the vendor has provided to an A/R.

When the minor reaches age 21 (or age 18, as the case may be), the UGMA/UTMA funds become available. They are treated as unearned income in the month the child turns such age and a resource thereafter, if retained.

RESOURCES

QUALIFIED STATE SAVINGS PROGRAMS (SECTION 529)

Description: Section 529 of the Internal Revenue Code permits account owners and designated beneficiaries of a qualified tuition savings program to qualify for federal tax benefits. The qualified tuition savings program allows for either prepayment of a student's tuition or contributions to an account established for paying a student's qualified higher education expenses at an eligible educational institution. New York's 529 College Savings Program, a qualified tuition program, enables individuals to save for a student's qualified higher education expenses by providing investment choices and tax benefits.

Policy: Assets in a Section 529 account are considered to belong to the account owner. The account owner can withdraw money from the account. An account owner must be a U.S. citizen or resident alien and have a Social Security number or taxpayer identification number. Fiduciaries or agents for trusts, estates, corporations, companies, partnerships, and associations may also be account owners.

For purposes of determining Medicaid eligibility, New York's 529 College Savings Program is a countable resource for the account owner. The assets are not taken into consideration in determining Medicaid eligibility for the designated beneficiary of the account. The amount of the account that is a countable resource is its value minus any penalties (e.g., a 10% federal tax penalty) for a non-qualified withdrawal. Ordinary federal, State, and local income taxes are not deductible in determining the resource value.

If an SSI-related minor is an account owner of a New York's 529 College Savings Program (owning the funds in the account rather than just being a designated beneficiary), the assets are a countable resource for the minor.

RESOURCES

RETIREMENT FUNDS

Description: Retirement funds are annuities or work-related plans for providing income when employment ends. They include but are not limited to: pensions; Individual Retirement Accounts (IRAs); 401(k) plans; and Keogh plans.

Policy: A retirement fund owned by an SSI-related individual is a countable resource if the SSI-related individual is not entitled to periodic payments, but is allowed to withdraw any of the funds. The value of the resource is the amount of money that s/he can currently withdraw. If there is a penalty for early withdrawal, the value of the resource is the amount available after the penalty deduction. Any ordinary income taxes due are not deductible in determining the value of the resources.

References:

Dept. Reg.	360-4.4 360-4.6(b)(2)(iii) 366 366-ee
ADMs	11 OHIP/ADM-07 10 OHIP/ADM-01 90 ADM-36 88 ADM-30
GISs	09 MA/027 06 MA/004 98 MA/024

Interpretation: A retirement fund is not a countable resource if an individual must terminate employment in order to obtain any payment. If the SSI-related individual is in receipt of or has elected to receive periodic payments, the retirement fund is not a countable resource. Effective October 1, 2011 retirement funds of a participating MBI-WPD A/R or his/her spouse are disregarded.

NOTE: That the SSI-related individual may choose to take money out of a retirement account on a non uniform and/or inconsistent basis. An example would be an individual electing to withdraw \$350 from a retirement fund in February and \$600 in October. These irregular withdrawals are not treated as periodic payments. The non-periodic distributions are considered a conversion of a resource and not countable income. In this situation, the retirement fund is treated as an available, countable resource.

Effective January 1, 2006, if a Community Spouse (CS) is NOT

RESOURCES

RETIREMENT FUNDS

receiving periodic payments from his/her available retirement fund, the fund is considered a countable resource for purposes of determining the community spouse resource allowance (CSRA) and the institutionalized spouse's Medicaid eligibility. This includes situations where the retirement fund of the CS exceeds the CSRA.

Medicaid applicants/recipients who are eligible for periodic retirement benefits must apply for such maximized benefits as a condition of eligibility. If individual does not choose to apply for available periodic benefits, the LDSS can deny/discontinue Medicaid based on the failure to pursue potential income that may be available.

- Verify Status:**
- (a) When A/R declares a retirement account;
 - (b) When A/R is receiving retirement income;
 - (c) When A/R indicates past employment with an employer that is likely to have provided a retirement plan.
- Verification:**
- (a) Seeing current statements from the employer, mutual fund, insurance company, or bank where the fund is deposited;
 - (b) If a retirement fund is invested in bonds and stock certificates, the current market value may be verified by a stock broker or newspaper.
- Documentation:**
- (a) current information including names of funds, banks and/or companies controlling funds;
 - (b) names of stocks and/or bonds, issuer's name, date issued, date of maturity if applicable;
 - (c) account numbers;
 - (d) name of owner; and
 - (e) current value.

RESOURCES

PERSONAL NEEDS ALLOWANCE ACCOUNTS

- Description:** Personal needs allowance (PNA) is the amount that is set aside to meet the personal needs of persons who: are residing in a medical institution and are in permanent absence status; or have community spouses and are in receipt of home and community-based waived services. The Personal Needs Allowance (PNA) amount is the reduced standard of need for persons who are residing in a medical facility and are in permanent absence status. (See **GLOSSARY**)
- Policy:** Medical facilities must offer each resident who is a Medicaid recipient or his/her representative the choice of: depositing his/her PNA in an interest bearing account managed by the facility; or managing his/her own PNA account. The PNA account is intended to meet the recipient's incidental expenses not provided by the medical facility.
- References:**
- | | |
|------------|----------------------------------|
| SSL Sect. | 369(b)(i)&(ii)
366(2)(a)(10) |
| Dept. Reg. | 360-4.9
10 NYCRR 415.26(h)(5) |
| ADM | 94 ADM-17 |
- Interpretation:** Services included in a facility's Medicaid per diem rate may not be charged against an individual's PNA account. In addition, no charge may be made against the PNA account for other services provided under Medicaid, Medicare, or other third party coverage. When the recipient selects the medical facility to manage his/her PNA funds, the facility must:
- (a) maintain an accurate account of the funds, including the nature and dates of all deposits/withdrawals, any accumulated interest and a continuing balance;
 - (b) document all transactions by securing and maintaining paid bills, vouchers, and signed receipts. The signature of the resident or his/her designated representative is recorded for each transaction;

RESOURCES

PERSONAL NEEDS ALLOWANCE ACCOUNTS

- (c) report quarterly to the local social services district. The report must include the recipient's case number, client identification number (CIN), last quarter balance, total receipts, total expenditures, and the current balance; and
- (d) notify the recipient when the account balance is \$200 less than the SSI resource level for one person. The facility must also advise the recipient that if his/her total countable resources exceed the SSI resource level for one, s/he may lose eligibility for Medicaid.

When a recipient is discharged to the community, the facility must provide the patient with a final accounting statement and a check for the amount of his/her closing balance.

A recipient being transferred to another facility has the option of receiving the balance in his/her account or transferring the balance to an account in the new facility.

Upon the death of a recipient, PNA funds on deposit with a nursing facility generally are payable to the recipient's estate.

Under certain circumstances, the nursing facility can make payment of the deceased recipient's PNA funds on deposit directly to a local social services district. The local social services district determines if any or all of the PNA is recoverable for medical expenses paid. (See **OTHER ELIGIBILITY REQUIREMENTS RECOVERIES**)

**Verification/
Documentation:**

The local social services district is responsible for reviewing the quarterly report to ensure that PNA funds are not misappropriated, and that the recipient's resources remain below the allowable level.

All quarterly reports submitted by medical facilities are reviewed as part of the recertification process. When the report indicates that a recipient is approaching or has exceeded the appropriate resource level, the case is reviewed to determine if the recipient remains eligible.

RESOURCES

PERSONAL NEEDS ALLOWANCE ACCOUNTS

Quarterly reports are reviewed for: the current balance, any significant withdrawals, and any indication of irregularities or misappropriation of the funds in the account. The local social services district has the right to audit the accounts of patients for whom Medicaid payments are made. The facility assists in resolving any questions related to the account.

RESOURCES

LUMP SUM PAYMENTS

Description: Lump sum payments are deferred or delayed payments. They include, but are not limited to benefit awards, bonuses, year-end profit sharing, severance pay, and retroactive pay increases.

Policy: All lump sum payments are reviewed to determine if they are available and countable. (See **OTHER ELIGIBILITY REQUIREMENTS OWNERSHIP AND AVAILABILITY**)

Countable lump sum payments are considered income in the month received. For SSI-related A/Rs, if any or all of the lump sum is retained beyond the month of receipt, it is considered a resource. To determine if a retained lump sum payment is countable as a resource, consult the resource disregard section and look for the specific payment type. (See **RESOURCES SSI-RELATED RESOURCE DISREGARDS**)

References:

SSL Sect.	366 366.2 366-ee
ADMs	10 OHIP/ADM-01 OMM/ADM 97-2 92 ADM-11
GIS	09 MA/027

Interpretation: For all A/Rs, lump sum payments are counted as income in the month they are received.

For SSI-related A/Rs only, the month after the lump sum is received it is added to other countable resources and compared to the appropriate resource level. (See **RESOURCES EXCESS RESOURCES**)

Verify Status: Verify status when:

- the A/R indicates that s/he recently received a benefit award, bonus, yearend profit share, retroactive pay increase, or other lump sum.
- the A/R indicates that s/he is anticipating a lump sum payment.
- the record indicates that the A/R has applied for a benefit and may be eligible for a retroactive payment.

RESOURCES**LUMP SUM PAYMENTS****Verification/****Documentation:**

Lump sum payments are verified. State computer matches are reviewed to determine the source of income. Documentation is sufficient to establish an audit trail. The amount, date and source of all lump sums are documented. The preferred forms of verification/documentation are checks, check stubs, award letters, or other written statements from the payer of the lump sum.

RESOURCES**WINDFALLS**

Description: Windfall payments are one-time only payments. They include, but are not limited to, lottery winnings, inheritances, gifts and court settlements.

Policy: When determining eligibility for SSI-related A/Rs, windfall payments are considered countable income in the month received.

When any or all of a windfall payment is retained beyond the month of receipt, it is considered a resource.

References: SSL Sect. 366
366.2
366-ee

ADMs 10 OHIP/ADM-01
OMM/ADM 97-2
92 ADM-11

GIS 09 MA/027

Disposition: For SSI-related A/Rs, windfall payments are considered income in the month of receipt. (See **INCOME WINDFALLS**)

When an SSI-related A/R retains any or all of a windfall payment beyond the month of receipt, it is considered a resource. Together with other countable resources, the windfall is compared to the appropriate resource level. (See **RESOURCES LEVELS**)

RESOURCES

LIFE INSURANCE

Description: Life insurance is a contract between an individual(s) (owner) and an insurance company. The individual(s) pays premiums to the company that provides the insurance and the company in return agrees to pay a specified sum to the designated beneficiary upon the death of the insured. Banks also issue life insurance.

Face Value: The basic death benefit or maturity amount of the policy, which is specified, on its face. The face value does not include dividends, additional amounts payable because of accidental death or other special provisions; and

Cash Surrender Value: This is the amount that the insurer will pay upon cancellation of the policy before death (or maturity). This value usually increases with the age of the policy. This amount may be decreased by loans against the policy.

Policy: A life insurance policy is a resource if it generates a cash surrender value (CSV). Its value as a resource is the amount of the CSV. For SSI-related A/Rs, a life insurance policy is an excluded resource if its face value and the face value of any other life insurance policies the individual owns on the same insured total \$1,500 or less.

References:	SSL Sect.	366 366(2)(b)(1) 366-ee
	Dept. Reg.	360-4.4
	ADMs	10 OHIP/ADM-01
	GISs	09 MA/027

Interpretation: The basic types of life insurance are defined as follows:

Ordinary Life Insurance (Whole Life): The insured pays premiums during his/her lifetime (straight life) or until the age 100 (unless purchased by a single premium or by letting dividends accumulate). The company pays the face amount or the cash amount, whichever is higher, of the policy to the beneficiary upon the death of the insured. This type of insurance usually has a cash surrender value after the second year. The policy is flexible in premium payments. Dividends may be used to pay off the contract at an earlier date, or the

RESOURCES

LIFE INSURANCE

premium payment period can be limited to suit the financial resources of the insured. In this situation, the policy is a limited payment life insurance policy;

Limited Payment: Similar to ordinary life, but the premiums are higher while the period of payment may be reduced. The result is a larger cash reserve than whole life;

Endowment: The face value is payable after the time period for payment of the premiums has expired, or the insured has died; and

Term Insurance: A contract of temporary protection. The insured pays relatively small premiums for a limited number of years. The company agrees to pay the face amount of the policy only if the insured dies within the time specified in the policy. Generally term insurance does not have a cash surrender value, however some newer types have a cash value.

NOTE: Generally ordinary life, limited payment life and endowment policies carry a cash surrender value. Although term insurance frequently has no cash surrender value, in those instances where the agency is aware of a term life insurance policy with a cash surrender value, that policy is treated in the same manner as ordinary life insurance policies. When an insurance policy pays annual dividends and those dividends have accumulated, the cash value will be increased, thus increasing the value of the resource.

Individual and Group Policies:

Individual policies are issued to a person and are paid for entirely by the owner;

Group policies are usually issued through an employer or organization and may receive some contribution from the employer.

Accelerated Life Insurance Payments (Living Needs Benefits): These are cash payments to the owner of a life insurance policy. These benefits may be payable upon the diagnosis of a terminal illness or if the insured will need long term care or treatment. Accelerated payments may be made as lump sums or monthly payments. They reduce the death

RESOURCES

LIFE INSURANCE

benefit and cash surrender value, if any. The availability of the option to elect accelerated benefits is not considered a resource; however, when cash payments are actually made, the payments are considered income in the month received and a countable resource if retained into the following month.

If the consent of another individual is needed to surrender a policy for its cash surrender value and that consent cannot be obtained, the policy is not included as a resource.

- When to Verify:**
- (a) When the SSI-related A/R indicates on the application that s/he has life insurance or is paying premiums;
 - (b) When the SSI-related A/R indicates s/he is employed or has present or past membership in a labor union;
 - (c) When an SSI-related A/R indicates that s/he or a member of the family belongs to a fraternal organization, e.g. Elks, Knights of Columbus, etc.;
 - (d) When an SSI-related A/R indicates in the application that s/he is paying the premium on a life insurance policy for him/herself, family or a person outside the family household; or
 - (e) When the SSI-related A/R indicates that s/he or a spouse is a veteran or in the armed forces.

Verification: The life insurance policy itself will generally provide all the information needed to determine when it is counted as a resource and the amount to be counted. If the policy does not provide needed information, contact the insurance company, local agent, or, in the case of group insurance, the employer's payroll office.

Documentation: Sufficient to establish an audit trail:

- (a) Name of the insurance company, the owner of the policy, name of the insured and the policy number; and
- (b) The type of insurance, cash value, face value and the amount of any outstanding loans against the policy.

Owner: To determine the owner of a policy, contact the insurance company issuing the policy.

RESOURCES

STOCKS, BONDS AND SECURITIES

Policy: Stocks, bonds and other securities owned by the A/R are evaluated when determining eligibility for Medicaid. The value of stocks, bonds and securities is considered a countable resource of an SSI-related A/R.

References:

SSL Sect.	366 366.2 366-ee
Dept. Reg.	360-1.2 360-2.3 360-4.4
ADM	10 OHIP/ADM-01
GISs	09 MA/027 08 MA/006 05 MA/001 04 MA/027

Interpretation: The value of stocks, bonds and securities owned by an SSI-related A/R or a legally responsible relative is considered a countable resource for purposes of determining eligibility. (See **OTHER ELIGIBILITY REQUIREMENTS OWNERSHIP AND AVAILABILITY** for determining ownership of resources)

All stocks, bonds and securities are evaluated as to their availability and values. The available value is counted toward the appropriate resources level. (See **RESOURCES LEVELS**)

NOTE: For all Medicaid categories except SSI-related individuals be sure to consider as potential unearned income, dividends and interest received from stocks, bonds and securities. For SSI-related A/Rs who are subject to community budgeting, interest and dividend income from stocks, bonds and securities is excluded from countable income. (See **INCOME UNEARNED DIVIDENDS AND INTEREST**)

Stocks, bonds and securities include, but are not limited to:

- stocks;
- mutual fund shares;
- corporate, municipal and government bonds;
- U.S. Savings Bonds; and
- zero coupon bonds

RESOURCES

STOCKS, BONDS AND SECURITIES

Stocks

Shares of stock represent ownership in a business corporation. The value of a stock is determined by the demand for it at the time it is bought or sold; thus, it may vary from day to day.

Mutual funds

A mutual fund is a pool of assets (e.g., stocks, bonds, etc.) administered by an entity that buys and sells securities and other investments. Absent evidence to the contrary, the owner of a mutual fund share should be able to convert it to cash within 20 working days and thus it is considered an available liquid resource. The current value of a mutual fund may vary from day to day.

Bonds

A bond (e.g., municipal, corporate, and government bond) is not cash, but a promise to pay cash at a future specified date. Most bonds (but not U.S. Savings Bonds) are negotiable and transferable. To redeem a corporate or municipal bond for its stated value, it must be held until the specified date of maturity. The current cash value of a bond is determined by the market for it.

A savings bond is a U.S. Treasury security that increases in value until it is cashed or reaches final maturity. A U.S. Savings Bond is not transferable. It can only be sold back to the federal government. Some bonds must be held for a minimum period of time from the date of issue (e.g., twelve months) before they can be converted to cash. Generally these bonds are not considered an available resource until after the minimum retention period has expired.

Effective February 11, 2008, A/Rs who are in receipt of or are applying for coverage of long-term care services and who own a U.S. Savings Bond must, as a condition of eligibility for Medicaid, request to have the minimum bond retention period waived. A/Rs with Electronic Savings Bonds may request early redemption by email on the United States Department of the Treasury website

RESOURCES

STOCKS, BONDS AND SECURITIES

(<http://treasurydirect.gov>). For paper bonds, the SSI-related A/R or the A/R's legal representative should contact a financial institution that routinely cashes savings bonds. The A/R must sign the bond in the presence of a certifying officer. The certifying officer must also sign the bond and affix the institution's official stamp or seal in the space provided. The bond(s) and a letter explaining the reason(s) for the hardship request are mailed to the United States Department of the Treasury, Bureau of the Public Debt, PO Box 7012, Parkersburg, WV 26106-7012. When sending bonds for consideration of hardship, the front of the envelope should be marked "HARDSHIP", in capital letters, so the request may be expedited. Federal regulations allow the United States Department of the Treasury to waive the minimum retention period in situations including:

- Unusual or excessive medical expenses;
- Bankruptcy;
- Foreclosures;
- Eviction notice;
- Utility shut-off notice;
- Natural disaster (flood, fire, etc.); and
- Inability to meet essential expenses (food, clothing, house/rent).

Pending notification of approval or disapproval of a hardship request, Medicaid eligibility must be determined without regard to the bond.

If a waiver of the minimum retention period is granted, the value of the bond is counted as a resource for SSI-related A/Rs beginning the first day of the month following the month in which the bond is available. Only the amount actually received is counted as a resource, as early redemption of a savings bond may result in a cash penalty being taken from the bond proceeds.

NOTE: Ordinary income taxes due on the interest earned on the savings bonds are not an allowable deduction from the bond proceeds.

If a waiver of the minimum retention period is not granted, the bond is to be excluded as an available resource for SSI-related A/Rs for the duration of the minimum retention period. If a new bond is purchased with the proceeds from an unavailable bond, the individual is required to apply for a hardship waiver.

RESOURCES

STOCKS, BONDS AND SECURITIES

Copies of hardship requests and denials should be kept in the case record.

The owner of the bond is the individual in whose name the bond is registered is the owner.

However, other individuals (e.g., parents or grandparents) may control a child's access to the money. In these cases, the social security number on the bond may not be that of the actual owner. The Social Security number on the bond is not proof of ownership. If a person other than the A/R will not relinquish possession of the bond, the bond is not considered an available resource.

Savings Bond Interest

Interest on U.S. Savings Bonds is treated as follows:

RESOURCES

STOCKS, BONDS AND SECURITIES

(1) Series E or EE and Series I U.S. Savings Bonds

Interest on series E/EE and Series I U.S. Savings Bonds is only available to the individual when the bond is redeemed. At redemption, for SSI-related individuals the interest is to be counted as an increase in the value of the resource (not as income).

(2) Series HH or H U.S. Savings Bonds

Series HH/H bonds pay interest semi-annually (i.e., every 6 months based on the purchase date of the bond) by check or electronic funds transfer until maturity or redemption, whichever comes first. Interest on these bonds is counted as unearned income in the month available to the A/R, either when the check is received or when the interest is credited (i.e., electronically transferred) to the A/R's account, whichever is earlier. As of September 1, 2004, the U.S. Treasury is no longer issuing HH/H Savings Bonds. Investors are no longer able to reinvest HH/H Bonds or exchange Series EE/E Bonds for HH Bonds.

NOTE: Interest on Savings Bonds is not countable income for SSI-related A/R's under community budgeting.

Zero Coupon Bonds

Purchasers of zero coupon bonds buy the bonds at a deep discount from their face value, which is the amount a bond will be worth when it matures or comes due. As the bond matures it increases in value from its purchase price due to the accrued interest.

Owners of zero coupon bonds do not receive periodic interest payments, even though they have to pay taxes on the imputed or "phantom" interest that accrues each year. If the investor holds the zero coupon bond until maturity, he/she will receive the full face value of the bond (i.e., the initial investment plus interest that has accrued over the years). Investors can purchase different

RESOURCES

STOCKS, BONDS AND SECURITIES

kinds of zero coupon bonds that have been issued from a variety of sources, including the U.S. Treasury, corporations, and state and local government entities.

For all Medicaid A/Rs, except SSI-related A/R's who are subject to community budgeting, the accrued interest is considered countable unearned income in the month the bond matures. The equity value of the zero coupon bond is a countable resource for SSI-related A/Rs.

Coupon Bonds (Bearer Bonds)

A coupon bond is a bond that pays periodic interest (usually every six (6) months) to the bond holder. Previously such bonds had coupons attached to them which the owner would present to the bond issuer or bank for payment. Coupon bonds have also been known as "bearer bonds" meaning the bearer or the person who had physical possession owned it.

Today such bonds are issued as "registered" meaning the bond is registered in your name and interest is mailed to you every six (6) months. Registered bonds generally do not have coupons attached to them; however, if they pay interest periodically they may be called coupon bonds. Interest is counted as income for all A/Rs.

Verify Status:

- (a) When the A/R indicates that s/he or a member of the household owns stocks, bonds or securities;
- (b) When the A/R's pay stubs show a deduction for profit sharing;
- (c) When an A/R or a member of the household currently or formerly has been employed by a company known to offer profit sharing.

RESOURCES

STOCKS, BONDS, SECURITIES

Verification: The existence of stocks, bonds and securities is verified by seeing the actual stock certificate, bond, note or brokerage statement. If not available, the local district contacts the stockbroker or local bank for verification.

The preferred method for verifying the value of stocks is contact with the A/R's stockbroker. The closing price on the date of application or recertification for over-the-counter stocks may also be verified by consulting the following day's financial or local newspaper. The closing price represents the current market value for stock and the bid price or current market price represents the current market value for a bond. The A/R's statement that a stock is worthless can also be supported by a stockbroker's statement that there is no market for that stock.

When determining the current market value of a mutual fund or bond, other than U.S. Savings Bonds, follow the same procedures as for stock.

To establish the value of a U.S. Savings Bond, the date of issue on the face of the bond and the type of savings bond (EE, HH, etc), are the controlling factors. The value depends on the time elapsed from the date of issue. Although some U.S. Savings Bonds have a table of values on the reverse side, this table is often inaccurate since the interest rate may have changed since the bond was issued. Contact a bank for verification of the current value.

If, after local district examination of a promissory note, it cannot be determined whether it is negotiable or not, a bank is able to resolve the question. If the note is not negotiable, it is not a resource. If negotiable, it is a resource in the amount of the outstanding principal balance.

Documentation: Sufficient to establish an audit trail:

- (a) Name of the corporation, stock certificate number, issue date, current market value, name of stock broker or newspaper (including date) from which the value was obtained and the number of shares the A/R owns;

RESOURCES

PROMISSORY NOTES

Policy: Promissory notes owned by an SSI-related A/R or a legally responsible relative are evaluated when determining eligibility for Medicaid. The countable values of promissory notes are considered resources of the A/R.

References:

SSL Sect.	366 366.2 366-ee
Dept. Reg.	360-1.2 360-2.3 360-4.4
ADM	10 OHIP/ADM-01
GISs	09 MA/027 98 MA/030

Interpretation: A promissory note is a written, unconditional promise, signed by a person, to pay a specified sum of money at a specified time or on demand to the person named on the note. For the owner, (i.e., seller or creditor) of the agreement, a promissory note, if negotiable, is considered a resource in the amount of the outstanding principal balance. (See **RESOURCES** TRANSFER OF ASSETS for further information on promissory notes.)

A promissory note owned by an SSI-related A/R or his/her legally responsible relative, if negotiable, is considered a resource in the amount of the outstanding principal balance. Districts should obtain a copy of the promissory note and assume, absent evidence to the contrary, that the note is bona fide and negotiable.

Regardless of whether the promissory note is negotiable, any payments of principal and interest made toward satisfaction of the note are considered income to all A/Rs in establishing or evaluating continued eligibility for assistance.

Verify Status: When the A/R indicates that s/he or a member of the household owns a promissory note.

RESOURCES

REAL PROPERTY

Description: Real property is land and generally whatever is erected upon, growing upon, or affixed to the land. Real property also includes rights arising out of or in connection with land, such as air, mineral, water, or access rights. Real property may be owned in whole or in part. When determining eligibility, all real property owned by an A/R is evaluated.

Policy: When determining Medicaid eligibility for an SSI-related individual, ownership of real property is reviewed in order to determine if it is a countable resource.

The equity value of real property is a countable resource and is applied toward the appropriate resource level, with the following exceptions:

- a homestead is exempt; its value is not applied toward the resource level. (See **INCOME HOMESTEAD** for a definition of homestead);
- a portion of the value of real property used to produce income may be exempt (See **INCOME RENTAL INCOME**); and
- the first \$12,000 equity value of real property used to produce personal goods/services is exempt (See **INCOME RENTAL INCOME**).

The equity value of any second home (See **OTHER ELIGIBILITY REQUIREMENTS OWNERSHIP AND AVAILABILITY**) is determined and is applied toward the appropriate resources level. (See **RESOURCES LEVELS**)

The equity value is derived by subtracting any encumbrances, for example liens and mortgages, from the fair market value.

References:

SSL Sect.	366 366.1 366.2 366-ee
Dept. Reg.	352.23(b) 360-1.4(f) 360-4.4(e) 360-4.7(a)(1)

RESOURCES**REAL PROPERTY**

ADMs	10 OHIP/ADM-01 97 ADM-23 OMM/ADM 97-2 91 ADM-30
GIS	09 MA/027

Interpretation: The sections that follow discuss these forms of real property:

- Homestead;
- Contiguous property and non-contiguous property;
- Income-producing property; and
- Property used to produce personal goods/services.

**RESOURCES
REAL PROPERTY****HOMESTEAD**

Description: A homestead is the primary residence occupied by an A/R and/or members of his/her family in which the A/R has ownership interest. Family members include the A/R's spouse, minor children, certified blind or certified disabled children and other dependent relatives. The homestead includes the home, land and integral parts such as garages and outbuildings. The homestead may be a house, condominium, cooperative apartment or mobile home. Vacation homes, summer homes or cabins are generally not considered homesteads.

NOTE: Land adjoining the homestead, which is on a separate deed, is considered contiguous property, and not part of the homestead. See contiguous property.

Policy: A homestead is exempt as long as it is the primary residence of an SSI-related A/R or a family member. The homestead remains exempt during a period of temporary absence. When an SSI-related A/R is absent from his/her homestead, the homestead is not a countable resource as long as the A/R indicates an intent to return home (regardless of the individual's actual ability to return home).

References:

SSL Sect.	366 366.2(a)(1) 366-ee
Dept. Reg.	360-1.4(f) 360-4.7(a)(1)
ADMs	10 OHIP ADM-01 92 ADM-53 91 ADM-30
GISs	09 MA/027 06 MA/009

Interpretation: A homestead, including an income-producing homestead, is an exempt resource for SSI-related A/Rs, as long as it is the primary residence of the A/R or a family member. If the SSI-related A/R or family member no longer resides in the home that home is evaluated to determine if it is a countable resource.

**RESOURCES
REAL PROPERTY**

HOMESTEAD

The equity value is derived from subtracting any encumbrances, for example liens, mortgages, etc. from the fair market value.

An SSI-related A/R's homestead and any contiguous property remains exempt as a countable resource if the A/R is not occupying the home, but intends to return to the home. When an A/R expresses his/her intent to return home, the homestead and contiguous property will be treated as an exempt resource without regard to the A/R's actual ability to return home. Although the homestead remains exempt, a lien may be imposed against a permanently institutionalized individual's homestead in certain circumstances. (See **RESOURCES HOMESTEAD** further discussions of liens)

NOTE: A homestead that is an exempt resource must be reviewed under the home equity limit provisions if the A/R is applying for Nursing Facility Services or Community-Based Long Term Care.

RESOURCES

HOMESTEAD

Institutionalized SSI-related A/Rs

INTENT TO RETURN HOME	RESOURCE STATUS	PLACE LIEN *
Yes, intends to return home.		
Occupied by spouse, minor or certified blind or certified disabled adult child	Exempt	No
Occupied by a sibling with equity interest who lived in the home for at least 1 year prior to the A/R's admission to a medical facility.	Exempt	No
Occupied by a dependent relative other than one described above.	Exempt	Yes
No, does not intend to return home.		
Occupied by spouse, minor or certified blind or certified disabled adult child.	Exempt	No
Occupied by a sibling with equity interest who lived in the home for at least 1 year prior to the A/R's admission to a medical facility.	Countable**	No
Occupied by a dependent relative other than one described above.	Exempt	Yes
Not occupied by a relative described above.	Countable	No

*If A/R is not reasonably expected to be discharged from the medical institution and return home.

**However, the property is not countable as a resource if: the sibling's name is on the deed and the sibling does not agree to liquidate the property or purchase the A/R's share of the property; or the sibling is a dependent relative of the A/R.

RESOURCES REAL PROPERTY

CONTIGUOUS PROPERTY AND NON-CONTIGUOUS PROPERTY

Description: Contiguous property is any land adjoining the homestead, which is held on a separate deed from the homestead and may be liquidated separately. Property is considered to adjoin the homestead if the only intervening real property is an easement or public right of way, such as a street, road or utility. Non-contiguous property is property owned by the A/R that does not adjoin the homestead.

Policy: For SSI-related A/Rs, contiguous property is considered part of the homestead and therefore exempt.

References:

SSL Sect	366 366-ee
Dept. Reg.	360-1.4(f) 360-4.4 360-4.7 (a)(1)
ADM	10 OHIP/ADM-01
GISs	09 MA/027 06 MA/009

Interpretation: An A/R may own parcels of land contiguous to his/her homestead. Land is considered to be contiguous when the land is on a separate deed from the homestead and may be liquidated separately from the homestead. Contiguous property is considered an essential part of the homestead of SSI-related A/Rs.

The A/R may also own land, which is not contiguous to the homestead. The equity value of non-contiguous land (other than income-producing property) is considered a resource for SSI-related A/Rs. (See **RESOURCES REAL PROPERTY INCOME PRODUCING** for the treatment of income-producing property)

**RESOURCES
REAL PROPERTY**

CONTIGUOUS PROPERTY AND NON-CONTIGUOUS PROPERTY

Verification: The preferred method of verifying market value is to obtain an independent appraisal by a licensed real estate appraiser. If this is not practical, use the listed asking price accompanied by a market analysis or appraisal, if any; or, if neither is available, use a full value tax assessment. However, if it is clear based on the approximate value of the property that the SSI-related A/R is ineligible due to excess resources, the local district may rely on a statement from the applicant as to the property's value. The A/R cannot be required to pay for an appraisal.

All liens and mortgages against the property are verified by reviewing the documentation.

**RESOURCES
REAL PROPERTY**

INCOME-PRODUCING

Description: Real property may produce income as part of a business (for example, the building, which houses a store or factory and which, is listed as an asset of the business). In the alternative, real property can be used to produce income and not be part of a business (for example, the A/R owns a house, which s/he rents to someone else).

Policy: Income-producing real property, which is part of the A/R's homestead is exempt. (See **INCOME HOMESTEAD**)

All non-homestead income-producing real property is reviewed to determine if it is a countable resource. Income-producing real property of an SSI-related A/R used in a trade or business is exempt. Income-producing real property not used in a trade or business is subject to the \$12,000 and 6% test explained below.

If income-producing real property produces a net return on equity of 6% or more, the first \$12,000 of the SSI-related A/R's equity is not counted. Any remaining equity value plus any other countable resources owned by the SSI-related A/R are compared to the appropriate resource level. (See **RESOURCES LEVELS**)

If the net return is less than 6% of the equity value, the entire equity value of one income-producing real property is a countable resource. The entire real property equity value plus any other countable resources owned by the SSI-related A/R are compared to the appropriate resource level. (See **RESOURCES LEVELS**)

References:	SSL Sect	366 366-ee
	Dept. Reg.	360-4.3 (c) & (d) 360-4.4 (b)(3) 360-4.4 (d) ADM 91 ADM-30
	ADM	10 OHIP/ADM-01
	GIS	09 MA/027

RESOURCES REAL PROPERTY

INCOME-PRODUCING

Interpretation: When an SSI-related A/R owns income producing real property that is not used in a trade or business, that property is subject to the \$12,000 and 6% test. The local district determines the SSI-related A/R's equity value in the real property and the amount of net annual income the A/R receives from the property. Equity value is the current market value minus any legal encumbrances (e.g. mortgages). Equity value includes, but is not limited to the value of land and buildings.

In instances where there is a low rate of return, local districts must determine if the low rate of return is due to reasons beyond the A/R's control. Consideration is given for extraordinary circumstances, such as: drought, fire, etc. If the real property is producing a net annual rate of return below 6% due to extraordinary circumstances, beyond the A/R's control (e.g., drought, fire, illness, etc.), the first \$12,000 of equity value can be excluded for up to a 24 month grace period. After the 24-month period the property is evaluated to determine if it is producing a 6% net rate of return. The 24-month period begins the first day of the tax year following the year in which the net rate of return dropped below 6%.

If the SSI-related A/R owns more than one income-producing property not used in a trade or business, each parcel of real property producing income is subject to a 6% test. However, only a maximum equity value of \$12,000 can be exempt.

Net income is the gross annual income from the real property less the expenses, as allowed by the Internal Revenue Service (except depreciation and personal business deductions), to produce that income.

**Verification/
Documentation:**

Ownership of real property may be verified by:

- a) Deed or mortgage records;
- b) Property tax records; or
- c) Sales agreements or real estate records.

As with other sources of income, documentation of the income produced by real property is obtained. The preferred documentation is the A/R's tax returns.

**RESOURCES
REAL PROPERTY**

INCOME-PRODUCING

The A/R's most recent income tax returns are used to determine income from real property. Tax returns for at least two (2) years prior to the current tax year are used to determine whether the property is producing a 6% annual rate of return.

When tax returns are not available or do not provide information concerning property expenses, other documentation can be used. Documentation includes, but is not limited to: receipts, check registers, invoices, sales slips and bank statements.

**RESOURCES
REAL PROPERTY****PRODUCING PERSONAL GOODS/SERVICES**

Description: Real property used to produce personal goods/services includes, but is not limited to: garden plots; wood lots; and pastureland.

Policy: Real property which is used to produce personal goods/services and which is part of the A/R's homestead is exempt. (See **RESOURCES REAL PROPERTY HOMESTEAD**)

All non-homestead real property of an SSI-related A/R used to produce personal goods/services is reviewed to determine if it is a countable resource.

Interpretation: For SSI-related A/Rs, the first \$12,000 equity value of any non-homestead real property used to produce personal goods/services is exempt. If the SSI-related A/R owns more than one piece of real property that produces personal goods/services only a total equity value of \$12,000 is exempt. The remaining equity value plus any other countable resources owned by the SSI-related A/R are compared to the appropriate resource level.

NOTE: There is no 6% test as there is for income-producing property. (See **RESOURCES REAL PROPERTY INCOME-PRODUCING**)

References: Dept. Reg. 360-4.4(d)(3)
366
366-ee

ADMs 10 OHIP/ADM-01
91 ADM-30

GIS 09 MA/027

RESOURCES**ESSENTIAL PERSONAL PROPERTY**

Policy: Household goods and personal effects determined essential property is exempt from consideration in determining eligibility for Medicaid. If they are non-essential, their value is considered with all other countable resources in determining an SSI-related A/Rs eligibility for Medicaid.

References:

SSL Sect.	366 366.2(a)(2) 366-ee
Dept. Reg.	360-4.4(a) 360-4.7(a)(2)
ADM	10 OHIP/ADM-01
GIS	09 MA/027

Interpretation: Items which are considered essential personal property include but are not limited to:

- household furniture;
- personal effects;
- household appliances;
- televisions;
- radios;
- stereos, records, CDs, and cassette tapes;
- china & flatware;
- clothing;
- jewelry with sentimental value, e.g. wedding or engagement rings, family heirlooms;
- books;
- household tools, such as a lawn mower, garden tools, home repair tools, etc.; and
- tools and equipment which are necessary for a trade, occupation or business.

NOTE: See **RESOURCES PERSONAL PROPERTY AUTOMOBILES AND OTHER VEHICLES** for the treatment of automobiles as essential personal property.

RESOURCES

ESSENTIAL PERSONAL PROPERTY

The major consideration in exempting personal property is that the SSI-related A/R or members of his/her household are currently using it. If, for example, the A/R is in a nursing home, does not intend to return home and there are no other members of the family living in the household, his/her household goods and personal effects are evaluated together with other assets and may be considered as available resources.

Jewelry such as wedding or engagement rings, wristwatches or other similar items of personal property are exempt. If, however, the SSI-related A/R has chosen to invest in jewelry, antiques, etc., the property is not considered an exempt resource.

Collections such as stamps, coins or books are evaluated. If they are of limited value, they need not be considered. Valuable collections, however, are considered together with other available resources of the SSI-related A/R.

Verification: If the SSI-related A/R owns household goods, or personal effects which are not being used, their value may be determined by obtaining appraisals from the appropriate qualified professionals, e.g., jewelers, coin or stamp dealers, furriers, etc.

Documentation: Sufficient to establish an audit trail:

Any household goods, or personal effects, which are determined nonessential, are documented as to their value, including any identifying numbers or characteristics.

**RESOURCES
PERSONAL PROPERTY**

AUTOMOBILES AND OTHER VEHICLES

Policy: Ownership of one or more automobiles by an SSI-related A/R is reviewed and evaluated.

An automobile of any value is exempt as long as the SSI-A/R or a member of his/her household is using it. An automobile that is temporarily inoperable may be excluded if it is expected to be used for transportation within 12 calendar months after the month of the Medicaid eligibility determination. A second automobile may be exempt if there is a medical need for it, or the automobile is needed for employment-related activities or a Plan for Achieving Self-Support (PASS). If an automobile does not meet any of the exemption criteria, it loses its exempt status, and the full equity value of the automobile is a countable resource. The equity value of an automobile is the price the car can reasonably be expected to sell for on the open market in a particular geographic area, minus any encumbrances.

**RESOURCES
PERSONAL PROPERTY**

AUTOMOBILES AND OTHER VEHICLES

References:	SSL Sect.	366 366.2(a)(2) 366-ee
	Dept. Reg.	360-4.7(a)(2)(iv)
	ADMs	10 OHIP/ADM-01 OMM/ADM 97-2
	INF	98 OMM/INF-02
	GISs	09 MA/027 09 MA/016 05 MA/029

Interpretation: A second automobile is exempt if there is a medical need for it or the automobile is needed for employment-related activities or a Plan to Achieve Self-Support (PASS).

Recreational vehicles such as campers, snowmobiles and boats are not exempt unless the SSI-related A/R can demonstrate that the vehicle is essential for the production of a livelihood or is essential for personal use. An example is a person who lives on an island and needs a boat for such everyday tasks as buying food, going to work, or visiting the doctor.

Verify Status:

- (a) When the SSI-related A/R declares ownership of one or more automobiles or other motor vehicles;
- (b) When the SSI-related A/R lives a substantial distance from his/her place of employment;

**RESOURCES
PERSONAL PROPERTY**

AUTOMOBILES AND OTHER VEHICLES

- (c) When the SSI-related A/R declares an occupation or business which requires travel;
- (d) When the SSI-related A/R states that s/he or a member of the household travels regularly for medical care and services;
- (e) When the SSI-related A/R declares ownership of a driver's license.

Verification:

The primary verification for ownership of a motor vehicle is the motor vehicle registration. The New York State Department of Motor Vehicles (DMV) can also establish whether or not the A/R owns or has owned an automobile and furnish information on the vehicle. Information available usually includes the purchase price, encumbrances against the vehicle, and the name of the organization financing the purchase. DMV can also establish non-ownership of a vehicle.

The "Blue Book" of car values is an additional source to establish the market value of motor vehicles. Other sources include car dealers who can provide an approximate value based on the make, year, and model of the vehicle.

Documentation:

Sufficient to establish an audit trail:

- (a) The make, model, year, and identification number of motor vehicles owned by the SSI-related A/R are documented in the case record; and/or
- (b) If exempted, the reasons are also recorded in the case record.

RESOURCES

BUSINESS PROPERTY

Policy: When determining eligibility for an SSI-related A/R, business property and all cash reserves necessary for the operation of the business are exempt.

Liquid business resources must be held in a separate business account and cannot be commingled with personal funds.

Business property includes, but is not limited to: motor vehicles; machinery; farm equipment; inventories; supplies; tools; equipment; government permits; livestock; and produce.

(See **RESOURCES** REAL PROPERTY INCOME-PRODUCING for the treatment of real property that is also income-producing.)

Interpretation: For any portion of trade or business property to be exempt, the property must be in current use or there must be a reasonable expectation that the property will be used to produce income within 12 months from the month in which the property stopped producing income. An additional 12 months may be allowed when the property is not in use due to the A/R being disabled. The A/R need not be certified disabled.

References:

SSL Sect.	366 366-ee
Dept. Reg.	352.23(b)(7) 360-4.4(a)(3) 360-4.4(d)
ADMs	10 OHIP/ADM-10 91 ADM-30
GIS	09 MA/027

RESOURCES

BUSINESS PROPERTY

**Verification/
Documentation:**

Indications that an SSI-related A/R has an equity interest in a business or trade include, but are not limited to: the A/R files a business tax return with the appropriate IRS Schedule (F for farms, E for non-business, C for sole proprietorship, 1065 for partnership or 1120 for corporations); a certified statement from an accountant; business expenses or receipts for the last 12 months; the trade or business has separately identifiable assets; the trade or business has a name; the trade or business has consistently produced income; the trade or business has been in continual operation; the A/R has no other occupation; the A/R presents him/herself as operating a trade or business; or the A/R signs a statement detailing the trade or business, including its assets, number of years in operation and the identity of any co-owners.

RESOURCES

LIFE ESTATES

Description: A life estate is limited interest in real property. A life estate holder does not have full title to the property, but has the use of the property for his or her lifetime, or for a specified period. Generally, a person possesses a life estate in property that the person is using, or has used, for a homestead.

Policy: For the purpose of determining an SSI-related A/R's net available resources, a life estate is not considered a countable resource, and no lien may be placed on the life estate. Local social services districts cannot require an SSI-related A/R possessing a life estate to try to liquidate the life estate interest or to rent the life estate property.

References:

SSL Sect	366 366-ee
Dept. Reg.	360-4.4(c)
ADMs	10 OHIP/ADM-01 06 OMM/ADM-5 96 ADM-8
GISs	09 MA/027 06 MA/016

Interpretation: If an SSI-related A/R transfers property and retains a life use for his/her lifetime the value of the life estate is subtracted from the fair market value of the property in determining the uncompensated value of the transfer.

The value of a life estate is determined based on the current fair market value of the property and the age of the person and a life estate table. A life estate and remainder interest table is contained in 96 ADM-8. Local districts may, but are not required to, use this table in calculating the value of life estates and remainder interests. If a life estate terminates at a time other than death, for example, when the life use holder enters a nursing home or leaves the property without intent to return, compensation for the retained/remaining life use can only be given for the time the A/R received life use.

If an SSI-related A/R possessing a life estate sells the life estate interest, the proceeds of this liquidation are a countable resource for purposes

RESOURCES

LIFE ESTATES

of the A/R's Medicaid eligibility. If the SSI-related A/R sells the life estate interest for less than fair market value, the uncompensated value of the life estate interest is the amount transferred for purposes of the Medicaid transfer-of-assets rule.

If an A/R possessing a life estate rents the property, any net rental income received is counted in determining eligibility. Unless the instrument creating the life estate indicates otherwise, it is assumed the life estate holder pays taxes and maintenance on the property. These costs can be deducted from the rental income. If the life estate holder does not pay any taxes or maintenance, a gross rental figure is used.

When an SSI-related A/R or the A/R's spouse transfers assets to purchase a life estate interest in property owned by another individual on or after February 8, 2006, the purchase is to be treated as a transfer of assets for less than fair market value unless the purchaser resides in the home for at least a continuous period of one year after the date of purchase. (See **RESOURCES: TRANSFER OF ASSETS** for additional information.)

RESOURCES

MORTGAGES AND CONTRACTS OF SALE

Description: A mortgage is a pledge of real property for the payment of a debt or the performance of some other obligation, within a prescribed time period.

A contract of sale is when the A/R sells property but does not receive payment in full for the property. The purchaser pays for the property in installments. The A/R may retain certain rights to the property until the contract is paid in full.

Policy: Mortgage agreements/contracts of sale are assumed to be negotiable unless the A/R presents convincing evidence of a legal impediment to transferring ownership.

For SSI-related A/Rs if there is no legal impediment to transferring the mortgage/contract of sale, the value of the mortgage/contract of sale is an available resource. The debtor's payments against the principal are considered the conversion of part of this resource, and thus are not counted as income in determining eligibility. The debtor's payments of interest are counted as unearned income. The value of the mortgage is the outstanding principal balance, unless the SSI-related A/R documents that the current market value of the mortgage is less by submitting an evaluation from someone regularly engaged in the business of making such evaluations, such as a bank or other financial institution, licensed private investor or real estate broker.

For Medicaid A/Rs who are not subject to a resource test, the debtor's payments of principal and interest are counted as unearned income.

If there is a legal impediment to transferring the mortgage/contract of sale, the value of the mortgage is not counted as an available resource for the SSI-related A/R. However, the debtor's payments of both principal and interest are counted as unearned income for A/Rs of all categories.

If the SSI-related A/R sells a mortgage for less than fair market value, the sale is reviewed as a potential prohibited transfer.

If the mortgage/contract of sale is satisfied (paid off) with a lump sum payment, or sold for a lump sum, that lump sum is considered a countable resource of an SSI-related A/R.

RESOURCES**MORTGAGES AND CONTRACTS OF SALE**

References:	SSL Sect.	366 366-ee
	Dept. Reg.	352.23
	ADMs	10 OHIP/ADM-01 06 OMM/ADM-5 96 ADM-8
	GISs	09MA/-027 06 MA/016

RESOURCES

MORTGAGES AND CONTRACTS OF SALE

Interpretation: The local district evaluates whether or not there is a legal impediment to transferring/selling the mortgage/contract of sale. If there is a legal impediment to transferring/selling, the mortgage/contract of sale, then it is considered an unavailable resource in determining eligibility for the SSI-related A/R.

NOTE: For applications filed on or after August 1, 2006, for nursing facility services, including requests for an increase in coverage of nursing facility services, if an A/R or the A/R's spouse purchases a loan, promissory note or mortgage, the funds used are to be treated as a transfer for less than fair market value unless certain criteria are met. (See **RESOURCES** TRANSFER OF ASSETS for more information.)

When to Verify:

- (a) When the A/R indicates that s/he owns a mortgage, contract of sale or life estate;
- (b) When the A/R indicates ownership of property other than a homestead;
- (c) When the A/R indicates that s/he has transferred property;
- (d) When the A/R indicates that s/he receives income from property;
- (e) When the A/R indicates that s/he does not have a shelter expense.

Verification: The existence and terms of mortgages and contracts of sale are verified by seeing the actual mortgage certificate or contract document. If this is not possible, the attorney who handled the mortgage contract, when one was involved may provide verification.

Documentation: Sufficient to establish an audit trail:

- (a) Type of document, name of owner, date of contract/ mortgage, date of maturity, current value, value at maturity;
- (b) Name, address and title of person providing information.

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TRUST FUNDS

Description: A trust is a legal instrument by which an individual gives control over his/her assets to another (the trustee) to disburse according to the instructions of the individual creating the trust.

Policy: Trust funds are real or personal property held by a party known as the trustee. The trustee has the duty of administering such funds or property for the benefit of the beneficiary of the trust. The beneficiary does not own trust funds, either private or established by court order. They are under the control of a trustee who must carry out the conditions of payment as specified in the trust.

Trusts must be evaluated to determine if there is any countable income and/or resources and to determine if there has been a transfer of assets for less than fair market value. The treatment of trusts depends on who established the trust and what type of trust it is.

References:

SSL Sect.	366 366.2(b)
Dept. Reg.	360-4.4 360-4.5
ADMs	10 OHIP/ADM-10 04 OMM/ADM-6 96 ADM-8 92 ADM-45 89 ADM-45 88 ADM-32
INFs	05 OMM/INF-1
GISs	09 MA/027 08 MA/020

Interpretation: There are a number of different types of trusts, including escrow accounts and investment accounts.

- a. **Exception Trusts** – Exception trusts are trusts established on or after August 11, 1993, which are required to be disregarded as available income and resources for the purposes of determining Medicaid eligibility. Income diverted directly to an exception trust or income received

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TRUST FUNDS

by an A/R and then placed into an exception trust is not counted as income to the A/R in the Medicaid eligibility determination process. Verification that the income was placed into the trust is required. In order to eliminate a monthly verification, the A/R is advised to have the income diverted directly to the exception trust. Any trust assets actually distributed to the A/R are counted as income in the month received and as a resource for SSI-related A/Rs if retained into subsequent months. Exception trusts generally will conform to the definition of supplemental needs trust. There are two types of exception trusts:

- (1) One type of exception trust is a trust created for the benefit of a disabled person under the age of 65. It must:

be created with the individual's own assets;

be created by the disabled person's parent, grandparent, legal guardian, or by a court of competent jurisdiction; and,

include language specifying that upon the death of the disabled person, the local social services district will receive all amounts remaining in the trust, up to the amount of Medicaid paid out on behalf of the individual.

Once established, additional funds can be added to the trust until the person reaches age 65. However, any additions to the trust made after the person reaches age 65 would be treated as a transfer of assets, and may require the imposition of a penalty period. If a local district

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has imposed a Social Services Law Section 104-b or Section 369 lien against assets to be used to establish an exception trust, the lien is satisfied (or, in the district's discretion, compromise) before the trust is established.

- (2) The other type of exception trust is a trust created for the benefit of a disabled person of any age, and is a pooled trust, as described below:

the trust is established and managed by a non-profit association per Section 1917(d)(4)(C)(i) of the Social Security Act;

the assets are pooled with other assets and are managed by a non-profit organization which maintains separate accounts for each person whose assets are included in the pooled trust;

the disabled individual's account in the trust is established by the disabled individual, by the disabled individual's parent, grandparent or legal guardian, or by a court of competent jurisdiction;

the trust will be disregarded for Medicaid purposes regardless of the age of the individual when the pooled trust account is established, or when the assets are added to the pooled trust account; however, there is no exception to the transfer rules for transfers of assets to trusts created for the benefit of persons 65 years of age or older;

upon the death of the individual, the district's right of recovery is limited to those funds not retained by the non-profit organization; and

if the trust is subject to oversight by the NYS Attorney General's office, no bonding is required.

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NOTE: Although exception trusts created in accordance with the criteria set forth above are exempt as resources in the eligibility determination process regardless of the disabled individual's age, for purposes of the transfer provisions, any additions to the trust after the individual becomes 65 years of age are subject to applicable transfer penalties.

Amounts paid out of the pooled trust for the benefit of the disabled individual subsequent to the transfer and prior to the Medicaid eligibility determination for nursing home care must be used to offset all or a portion of the assets transferred to the trust. It is the responsibility of the disabled individual to provide proof of the amounts that the non-profit association which managed the pooled trust paid for expenses to meet the needs of the individual during this period. (See **RESOURCES** TRANSFER OF ASSETS)

It is the responsibility of the trustee of an exception trust to ensure that the funds are expended for the benefit of the disabled person. In some cases, this disbursement of funds may indirectly benefit someone other than the beneficiary. Such disbursements are valid, as long as the primary benefit accrues to the disabled person. For example, payment of travel expenses for a companion to a disabled person going on vacation may be appropriate. Also, the abilities and capabilities of the person are taken into account. The purchase of sophisticated computer equipment to assist a physically disabled person to communicate would be considered appropriate, while purchase of the same type of equipment for an individual who could not be trained to use it, would not.

b. **Irrevocable Trust** – An irrevocable trust is a trust created by an individual, over which the individual may or may not be able to exercise some control, but which may not be cancelled under any circumstances.

When an irrevocable trust is established by an SSI-related A/R or the A/R's spouse on or after August 11, 1993, any portion of the trust principal, and income generated by the trust principal, from which no payments may be made to or for the benefit of

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the A/R or the A/R's spouse, is considered to be an asset transferred for less than fair market value for purposes of the transfer of assets rule. (See **RESOURCES** TRANSFER OF ASSETS)

1. Payments made from the trust to or for the benefit of the A/R of any category or the A/R's spouse are considered available income in the month received. Any portion of the principal of the trust, or the income generated from the trust, which can be paid to or for the benefit of the SSI-related A/R or the A/R's spouse, is considered an available resource. If the language of the trust specifies that the money can be made available for a specific event, that amount is considered an available resource to an SSI-related A/R, whether or not that event has occurred.
2. Payments which are made from trust assets considered available to the SSI-related A/R or the A/R's spouse, as described in paragraph (1) above, and which are not made to or for the benefit of the A/R or the A/R's spouse, are considered assets transferred for less than fair market value for purposes of the transfer of assets rule. (See **RESOURCES** TRANSFER OF ASSETS)

c. **Revocable Trust** – A revocable trust is a trust created by an individual, which the individual has the right to revoke or terminate.

When a revocable trust is established by an SSI-related A/R or the A/R's spouse, the entire value of the trust is considered an available resource.

1. All payments made from the trust to or for the benefit of the A/R of any category or the A/R's spouse are considered available income in the month received.
2. All payments made from the trust fund to a person other than the SSI-related A/R or the A/R's spouse are considered to be assets transferred for less than fair market value for purposes of the transfer of assets rule. (See **RESOURCES** TRANSFER OF ASSETS)

d. **Supplemental Needs Trust (SNT)** – A supplemental

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needs trust, as defined in Section 7-1.12 of the Estates, Powers and Trust Law, is a trust established for the benefit of an individual of any age with a severe and chronic or persistent impairment, designed to supplement government benefits for which the individual is otherwise eligible. Under the terms of such a trust:

1. the beneficiary does not have the power to assign, encumber, direct, distribute, or authorize distributions from the trust; and
2. the trust document generally prohibits the trustee from expending funds in any way that would diminish the beneficiary's eligibility for or receipt of any type of government benefit.

If a supplemental needs trust conforms to the rules of an exception trust, the trust is not counted for the purpose of determining the eligibility of the A/R who is the beneficiary of the trust. (See **RESOURCES EXCEPTION TRUST**) If the trust was created from the A/R's own assets and the trust is not an exception trust, the rules for irrevocable trust apply. Payments made to and for the benefit of a disabled person, other than for personal items, are considered available income. If a supplemental needs trust is created with the assets of someone other than the A/R and the trust is not an exception trust, the trust is a third party trust as defined below. Any distribution of trust assets actually made to the A/R of any category is counted as income in the month received.

e. **Testamentary Trust** – A testamentary trust is any trust established by will. Testamentary trusts are third party trusts, as defined below.

f. **Third Party Trusts** – A third party trust is a trust established with the funds of someone other than the A/R. A third party trust may or may not be a supplemental needs trust, as defined in Section 7-1.12 of the Estates, Powers and Trust Law. For purposes of

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determining the eligibility of an A/R who is a beneficiary of a third party trust, the principal and accumulated income of the trust are not considered available to the A/R. However, any distributions of trust assets actually made to an A/R of any category are counted as income in the month received.

- Verify Status:**
- (a) When the A/R states that s/he or a member of the household is the trustee of a trust fund;
 - (b) When the A/R states that s/he or a member of the household is the beneficiary of a trust fund;
 - (c) When the A/R states that s/he or a member of the household has created a trust;
 - (d) When the A/R states that s/he has a child who was injured in an accident.

Verification: The local district contacts the trustee, court or financial institution involved to obtain a copy of the trust, determine the terms of the trust, and whether or not it can be invaded.

NOTE: Although SSI-related Medicaid A/Rs who are not seeking coverage of long-term care services (Community Coverage without Long-Term Care) may attest to the amount of their resources at application (See **RESOURCES** DOCUMENTATION REQUIREMENTS), they must provide documentation of any trust agreement in which the applicant is named the creator or beneficiary. This enables the district to determine the availability of any trust income/principal.

- Documentation:** Sufficient to establish an audit trail:
- (a) Type of trust, name of trustee, name of beneficiary, amount of trust, amount and frequency of payments derived from the trust; and
 - (b) Name of person contacted for verification of trust, date of contact, determination of availability with reasonable explanation.

RESOURCES

PRE-NEED FUNERAL AGREEMENTS

Description: As a result of changes in State law, effective January 1, 1997, all Medicaid A/Rs may establish an irrevocable pre-need funeral agreement with a funeral firm, funeral director, undertaker, or any other person, firm or corporation which can create such an agreement. The agreement may be made with the assets of the A/R or the assets of a legally responsible relative. Effective January 1, 2011, such irrevocable pre-need funeral agreements may be for the funeral and/or burial expenses of the A/R or his/her family member. Moneys paid for such an agreement are held in trust and cannot be refunded to the Medicaid A/R or other purchaser of pre-need goods and services.

Policy: Pre-need funeral agreements entered into by Medicaid A/Rs on or after January 1, 1997 with assets of the A/R or a legally responsible relative must be irrevocable. As such the A/R is not entitled to have his/her money returned once it is paid. Any funds remaining after payment of all funeral and burial expenses must be paid to the social services official responsible for arranging indigent burials in the district where the decedent resided.

Effective January 1, 2011, pre-need funeral agreements established with assets of an A/R or legally responsible relative for the funeral and/or burial expenses of a family member must also be irrevocable and are subject to the rules described above.

Since the money paid in connection with such agreements must be used only for funeral and burial expenses they are not available resources of the A/R. As long as the A/R pays fair market value for the goods and services to be furnished, the amount paid to the funeral director is a compensated transfer of assets, and does not result in a transfer-of-assets penalty. The A/R, therefore, can purchase non-burial space items in excess of \$1,500 (\$3,000 for a couple) through an irrevocable pre-need funeral agreement.

Generally, all pre-paid burial space items are covered under the irrevocable pre-need funeral agreement. However, certain burial space items purchased and paid for in full prior to entering into an irrevocable pre-need funeral agreement may remain outside the agreement, such as a cemetery plot, urn, vault, mausoleum, crypt, or headstone.

NOTE: Effective January 1, 2010 the resource test applies ONLY to Medicaid A/Rs who are SSI-related. Therefore a review of a pre-need funeral agreement is not required for Medicaid applicants who do not have a resource test.

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PRE-NEED FUNERAL AGREEMENTS

In certain situations, SSI-related A/Rs may supplement their irrevocable pre-need funeral agreement with a separate burial fund. To determine if a supplemental burial fund would be allowed, the local district determines the amount designated for non-burial space items in the irrevocable pre-need funeral agreement. If that amount does not equal \$1,500 (\$3,000 for a couple) the SSI-related A/R and the A/R's spouse may establish a supplemental burial fund. A supplemental burial fund must be separately identifiable with a maximum initial value of \$1,500 (\$3,000 for a couple), or greater if it is court ordered. Court ordered burial funds are allowed in any amount. However, should the court ordered burial fund exceed \$1,500 (\$3,000 for a couple) the district may appeal the order. If the court ordered burial fund is less than \$1,500 (\$3,000 for a couple) a supplemental burial fund may be established as appropriate. Exempt burial funds cannot be commingled with non-burial related expenses.

Life insurance policies will be counted first toward the supplemental burial fund, as follows:

1. If the combined face value of the life insurance policies owned by the A/R is \$1,500 or less, add the amount designated for non-burial space items in the irrevocable funeral agreement to the combined face value of the life insurance policies. If the total is less than \$1,500 a supplemental burial fund for the difference is allowed.
2. If the combined face value of life insurance policies is greater than \$1,500, the cash value is a countable resource. The A/R may designate the cash value as a burial fund in order to bring the non-burial space items up to the allowable \$1,500. If the life insurance policies have a face value of greater than \$1,500 and their cash value exceeds \$1,500 only \$1,500 of the cash value is exempt as a burial fund. Any cash value in excess of the allowable supplemental burial fund is a countable resource.
3. When the cash value exceeds \$1,500 the A/R must provide a written statement that the entire cash value is intended for burial expenses. Although only \$1,500 may be disregarded, the excess over \$1,500 is considered funds set aside for burial expenses which avoids the prohibition against commingling burial funds with non burial-related funds.
4. If the A/R does not have life insurance or the face/cash value, as applicable, does not equal \$1,500 other resources may be used to establish or add to a burial fund.

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PRE-NEED FUNERAL AGREEMENTS

The same rules are applied when determining whether a supplemental burial fund may be established for the A/R's spouse.

NOTE: If the SSI-related A/R has more than \$1,500 (\$3,000 for a couple) designated for non-burial space items in the irrevocable pre-need funeral agreement, the entire amount paid in connection with the agreement is disregarded. However, the SSI-related A/R is not allowed to have a separate burial fund.

In instances when a pre-need funeral agreement contains an amount of \$1,500 (\$3,000 for a couple) or more which is designated for non-burial space items, an SSI-related A/R is, nevertheless, entitled to a separate disregard of the cash value of life insurance policies with a combined face value of \$1,500 (\$3,000 for a couple) or less. (See **RESOURCES** BURIAL SPACES for a discussion of burial space items.)

An SSI-related A/R who is eligible to spenddown excess resources must be given ten days from the date they are advised of an excess resource amount to reduce the excess resource by establishing an irrevocable pre-need funeral agreement and/or a burial fund. In establishing eligibility for the three month retroactive period, only amounts used to purchase an irrevocable funeral agreement and/or a burial fund for the applicant and the applicant's spouse can be used to reduce excess resources. The ten day period may be extended if more time is needed.

Pre-1997 Funeral Agreements

An SSI-related A/R who did not have Medicaid eligibility authorized prior to January 1, 1997, and who has a revocable funeral agreement worth more than \$1,500, must convert the agreement to an irrevocable pre-need funeral agreement in order to have the entire amount of the agreement disregarded. If the agreement remains revocable, only the amounts designated for non-burial space items (up to \$1,500 for an individual and \$3,000 for a couple) can be disregarded.

The SSI-related A/R is allowed ten days from the date of notification to convert the revocable agreement to an irrevocable one. The ten-day period may be extended if more time is needed.

An SSI-related Medicaid recipient whose receipt of Medicaid began prior to January 1, 1997 and who had a revocable pre-need funeral agreement in place, which was considered exempt, may either

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PRE-NEED FUNERAL AGREEMENTS

maintain the revocable agreement or establish an irrevocable agreement.

Family Member Irrevocable Pre-Need Agreements

In determining the eligibility of an SSI-related A/R, the district must review any pre-need funeral agreement purchased by the A/R or his/her spouse for a family member of the A/R to determine if it is exempt. If the agreement was established after January 1, 2011, is irrevocable and contains the appropriate irrevocable disclosure statement, it is disregarded. If the purchase of the agreement is prior to the month the A/R is seeking Medicaid coverage, the amount used to purchase the agreement is a considered a countable resource until the month following the month in which the funds are actually paid to a funeral director. Retroactive eligibility cannot be established by spending down excess resources though the purchase of irrevocable pre-need funeral agreements for family members.

Revocable pre-need agreements for an SSI-related A/R's family member established prior to January 1, 2011 and those purchased on or after January 1, 2011 but before the filing of an application for Medicaid must be converted to an irrevocable agreement or the value of the agreement will be treated as a countable resource. The A/R must be allowed ten days from the date of notification to convert the family member's revocable pre-need agreement to an irrevocable agreement. The ten day period may be extended if more time is needed.

For individuals applying for coverage of nursing facility services, where a pre-need funeral agreement was purchased for a family member during the look –back period, an itemized statement of services and merchandise purchased under the irrevocable pre-need agreement must be reviewed to determine whether an uncompensated transfer of assets has been made.

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PRE-NEED FUNERAL AGREEMENTS

Reference:	SSL Sect.	366 366-ee 209.6 141.6
	General Business Law Sect.	453
	Dept. Reg.	360-4.6(b)(1) 360-4.6(b)(2)(ii) 360-4.7(a)(3)
	ADMs	11 OHIP/ADM-4 10 OHIP/ADM-01 04 OMM/ADM-6
	GIS	09 MA/027

Interpretation: Although the entire amount of money in an irrevocable pre-need funeral agreement is exempt for an SSI-related A/R, the local district reviews a copy of the pre-need burial agreement to make sure that it is irrevocable.

NOTE: Although SSI-related Medicaid A/Rs who are not seeking coverage of long-term care services (Community Coverage without Long-Term Care (See **RESOURCES DOCUMENTATION REQUIREMENTS**)) may attest to the amount of their resources at application, they must provide a copy of their irrevocable pre-need funeral agreement to the local social services district for verification of the type of agreement.

In determining whether a pre-need funeral agreement established for the A/R or a family member with assets of the A/R or the A/R's legally responsible relative is irrevocable, the local social services district must review:

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1. the date of the agreement: pre-need funeral agreements entered into by Medicaid A/Rs on or after January 1, 1997 are required by law to be irrevocable; and
2. the language of the agreement. Irrevocable pre-need funeral agreements are required by law to contain the following disclosure statement:

“NEW YORK LAW REQUIRES THIS AGREEMENT TO BE IRREVOCABLE FOR APPLICANTS FOR RECEIPT OF SUPPLEMENTAL SECURITY BENEFITS UNDER SECTION TWO HUNDRED NINE OF THE SOCIAL SERVICES LAW OR OF MEDICAL ASSISTANCE UNDER SECTION THREE HUNDRED SIXTY-SIX OF THE SOCIAL SERVICES LAW, AND FOR THE MONEYS PUT INTO A TRUST UNDER THIS AGREEMENT TO BE USED ONLY FOR FUNERAL AND BURIAL EXPENSES. IF ANY MONEY IS LEFT OVER AFTER YOUR FUNERAL AND BURIAL EXPENSES HAVE BEEN PAID, IT WILL GO TO THE COUNTY. YOU MAY CHANGE YOUR CHOICE OF FUNERAL HOME AT ANY TIME.”

Effective January 1, 2011 all irrevocable pre-need funeral agreements created in New York are required by law to contain the following revised disclosure statement:

“NEW YORK LAW REQUIRES THIS AGREEMENT TO BE IRREVOCABLE FOR APPLICANTS FOR AND RECIPIENTS OF SUPPLEMENTAL SECURITY BENEFITS UNDER SECTION TWO HUNDRED NINE OF THE SOCIAL SERVICES LAW OR OF MEDICAL ASSISTANCE UNDER SECTION THREE HUNDRED SIXTY-SIX OF THE SOCIAL SERVICES LAW, AND FOR THE MONEYS PUT INTO A TRUST UNDER THIS AGREEMENT TO BE USED ONLY FOR FUNERAL AND BURIAL EXPENSES. WHETHER THIS AGREEMENT IS FOR YOUR FUNERAL AND BURIAL EXPENSES OR FOR THOSE OF A FAMILY MEMBER, IF ANY MONEY IS LEFT OVER AFTER YOUR FUNERAL AND BURIAL EXPENSES HAVE BEEN PAID, IT WILL GO TO THE COUNTY. YOU MAY CHANGE YOUR CHOICE OF FUNERAL HOME AT ANY TIME. IF THIS AGREEMENT IS FOR THE FUNERAL AND BURIAL EXPENSES OF A FAMILY MEMBER, AFTER YOUR DEATH SUCH FAMILY MEMBER MAY CHANGE THE CHOICE OF FUNERAL HOME AT ANY TIME.”

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PRE-NEED FUNERAL AGREEMENTS

In reviewing an irrevocable pre-need funeral agreement, the only reason for a local social services district to break out the non-burial space items from the burial space items is to determine whether an SSI-related A/R has paid at least \$1,500 (\$3,000 for a couple) for non-burial space items under the agreement. As described above, if less than \$1,500 (\$3,000 for a couple) has been paid for non-burial space items, the SSI-related A/R may establish a supplemental burial fund in addition to the pre-need funeral agreement.

Burial space items include conventional gravesites, crypts, vaults, mausoleums, caskets, urns, or other repositories customarily and traditionally used for the remains of deceased persons. Opening and closing the grave, perpetual care of gravesite, headstones, and headstone engraving are also considered burial space items. Non-burial space items include topical disinfection, custodial care, dressing/casketing, cosmetology, supervision for visitation and/or funeral service, hearse, death notices, flowers and out-of-town shipping.

NOTE: Pre-existing irrevocable pre-need funeral agreements established in another state do not have to be converted and shall be disregarded. In addition, an out-of-state irrevocable pre-need funeral agreement does not have to contain the disclosure language set forth above.

RESOURCES

BURIAL FUNDS

Description: A burial fund consists of liquid resources set aside for the purpose of paying for the A/R's or the A/R's spouse's burial expenses.

Policy: When an SSI-related A/R does not have an irrevocable pre-need funeral agreement (See **RESOURCES** PRE-NEED FUNERAL AGREEMENTS) or the funeral agreement includes less than \$1,500 designated for non-burial space items, the A/R may have an exempt burial fund.

An exempt burial fund is separately identifiable with a maximum initial value of \$1,500, or greater if it is court ordered. Funds set aside for burial expenses cannot be commingled with non-burial related resources. When burial funds are combined with non-burial related funds, the burial funds are not exempt.

Interpretation: An SSI-related A/R who does not have an irrevocable pre-need funeral agreement or has less than \$1,500 designated for non-burial space items in the funeral agreement, may have an exempt burial fund. The A/R may also set aside up to \$1,500 as a burial fund for his/her spouse.

At the time of the initial application, the SSI-related applicant cannot have more than \$1,500 or \$3,000 for a couple set aside as a burial fund. If the burial fund contains more than \$1,500/\$3,000, the excess is considered a countable resource.

A burial fund may be established from liquid resources, such as: a bank account; a funeral agreement entered into prior to January 1, 1997 or in the case of a non-applying spouse an agreement entered into on or after January 1, 1997 (See **RESOURCES** PRE-NEED FUNERAL AGREEMENTS); or life insurance with a cash value.

When reviewing a burial fund, the first item considered is the face value of all the SSI-related A/R's life insurance policies. When the total face value of all the SSI-related A/R's policies are equal to or less than \$1,500, that face value is applied to the burial fund. The policies are considered excludable.

When the combined face value exceeds \$1,500, the cash value is a countable resource. The SSI-related A/R may designate the cash value as a burial fund. When the burial fund contains life insurance policies with a face value greater than \$1,500 and their cash value exceeds \$1,500, only \$1,500 of the cash value is exempt as a burial fund. Any cash value in excess of \$1,500 is

RESOURCES

BURIAL FUNDS

applied toward the appropriate resource exemption level. (See **REFERENCE MEDICAID RESOURCE LEVEL** and **RESOURCES MEDICAID BUY-IN FOR WORKING PEOPLE WITH DISABILITIES (MBI-WPD) RESOURCE LEVEL**) A burial fund cannot be combined with funds that are not intended for burial expenses. When the cash value exceeds \$1,500, the SSI-related A/R must provide a written statement that the entire cash value is intended for burial expenses. The excess is then considered funds set aside for burial expenses, which avoids the prohibition against commingling. However, the excess is still applied to the appropriate resource exemption level. If the A/R does not provide a statement, the \$1,500 is not exempt.

When the SSI-related A/R does not have life insurance or the face/cash value as appropriate does not equal \$1,500 other resources may be used to establish or add to a burial fund.

Any interest accumulated in an exempt burial fund is also exempt. Interest accrued on non-exempt burial funds is also exempt.

Court ordered burial funds are allowed in any amount. When the court ordered burial fund exceeds \$1,500 or \$3,000 for a couple, the district may appeal the court order. When the court ordered burial fund is less than \$1,500/\$3,000 a supplemental burial fund may be established as appropriate.

RESOURCES

BURIAL SPACES

Description: Burial space items include, but are not limited to: conventional grave sites, crypts, vaults, mausoleums, caskets, urns, or other repositories customarily and traditionally used for the remains of deceased persons. Opening and closing the grave, perpetual care of the gravesite, headstones, and headstone engravings are also considered burial space items.

Policy: Generally, all pre-paid burial space items are included in the A/R's irrevocable pre-need funeral agreement. (See **RESOURCES PRE-NEED FUNERAL AGREEMENTS**) However, certain items may have been purchased and paid for in full prior to the establishment of an irrevocable pre-need funeral agreement. These items remain outside of the agreement. Such items and any appreciation in their value are exempt.

Burial space items designated for an SSI-related A/R's immediate family member are also exempt. An immediate family member includes the SSI-related A/R's spouse, minor and adult children, stepchildren, brothers, sisters, parents, and the spouses of these persons. These persons need not be dependent on the A/R or living in the same household. Burial space items purchased for an immediate family member will not be in the A/R's irrevocable pre-need funeral agreement.

Since, funeral agreements and contracts which purchase burial space items on installment, other than irrevocable pre-need funeral agreements, do not provide the A/R with a burial space until the contract is paid in full, the amount paid cannot be exempt as a burial space. However, the equity may be applied toward an SSI-related A/R's burial fund. (See **RESOURCES BURIAL FUNDS**)

RESOURCES

RESOURCE DOCUMENTATION REQUIREMENTS

Description: Resource documentation requirements vary depending on the Medicaid coverage option selected by the A/R. In some instances, the A/R is allowed to attest to the value of their resources.

Policy: Coverage options must be offered to all Medicaid A/Rs who have a resource test.

References:

SSL Sect.	366 366-a(2) 366-ee
Dept. Reg.	360-2.3(c)(3) 360-2.3 360-4.4 360-4.6(b)
ADMs	11 OHIP/ADM-1 10 OHIP/ADM-01 04 OMM/ADM-6
INF	05 ADM/INF-2
GISs	09 MA/027 05 MA/012 05 MA/004

Interpretation: When SSI-related individuals, who have a resource test apply for Medicaid, they are asked to choose one of the following coverage options:

1. Community Coverage Without Long-Term Care;
2. Community Coverage with Community-Based Long-Term Care;
or
3. Medicaid coverage for all covered care and services (this option is available only to individuals in Nursing Home Level of Care).

NOTE: Effective for eligibility periods beginning on or after January 1, 2010 FHPlus and non-SSI-related Medicaid A/Rs will not have resources considered in determining eligibility. This change includes the following Medicaid categories: Singles/Childless Couples (S/CC), Low Income Families (LIF), ADC-related (including adults who spend down excess income to the Medicaid income level), children under 21 years of age when comparing income to the Medicaid income level (Under age 21), and parents living with their dependent

RESOURCES

RESOURCE DOCUMENTATION REQUIREMENTS

child(ren) under age 21 with income at or below the Medicaid income level (FNP Parents). In determining eligibility, resources are never considered for pregnant women and infants under one year of age. Resources are also not considered for children over age one but under age 19.

In addition, there is no resource test for applicants for the Family Planning Benefit Program, Medicaid Cancer Treatment Program, the Medicare Savings Program including the Qualified Individual Program (QI), Qualified Medicare Beneficiaries (QMB) and Specified Low Income Medicare Beneficiaries (SLIMB), AIDS Health Insurance Program (AHIP) and policy holders who have utilized the minimum required benefits under a total asset Partnership for Long-Term Care insurance policy. (See **RESOURCES** NEW YORK STATE PARTNERSHIP FOR LONG-TERM CARE)

1. Community Coverage without Long-Term Care services include all Medicaid covered care and services except nursing facility services and community-based long-term care services. If a Medicaid SSI-related A/R elects this coverage, the A/R may attest to the amount of his/her resources. The SSI-related A/R is not required to itemize their resources on the application but is required to do so at renewal.

NOTE: A/Rs of all categories continue to be required to provide documentation of any trust agreement in which the A/R is named the creator or beneficiary. This enables the district to determine the availability of any trust income and/or principal. If an SSI-related A/R has an irrevocable pre-need funeral agreement, a copy of the agreement must be provided to the district in order for the district to verify the type of agreement.

Short-term Rehabilitation Services – SSI-related individuals who attest to their resources can receive Medicaid coverage for short-term rehabilitation services (one commencement/admission in a 12-month period, of up to a maximum of 29 consecutive days of each of the following (for a total of 58 days before being required to provide applicable resource documentation): Certified Home Health Agency (CHHA) services; and nursing home care.) Short-term rehabilitation begins on the first day the A/R receives CHHA services or is admitted to a nursing home on other than a permanent basis, regardless of the payer of care and services. If an SSI-related individual does not apply

RESOURCES

RESOURCE DOCUMENTATION REQUIREMENTS

for Medicaid coverage for a commencement of CHHA services or nursing home admission, that commencement/admission is not counted toward the one commencement/admission limit per the 12-month period.

NOTE: If an SSI-related Medicaid A/R states a transfer was made but does not provide documentation of the transfer, the SSI-related A/R is not eligible for short-term rehabilitative nursing home care admission and that commencement/admission is not counted toward the one commencement/admission limit per the 12-month period.

In the event that that short-term rehabilitation exceeds 29 days, the SSI-related individual must provide proof of his/her resources in order for Medicaid coverage to be established for the rehabilitation services beyond the 29th day. Proof of resources includes resource documentation for prior periods in accordance with transfer of resource policies for nursing facility services (See **RESOURCES TRANSFER OF ASSETS**) and current resource documentation for CHHA services.

If an SSI-related recipient who attested to his/her resources subsequently requests coverage for long-term care services, the date of the request shall be treated as the date of a new application for purposes of establishing the effective date and the three-month retroactive period for increased coverage. The SSI-related recipient must complete the "ACCESS NY Supplement A" and send in the requested resource documentation in order for eligibility to be determined for the requested coverage.

SSI-related Medicaid A/Rs who attest to the amount of their resources may enroll in a managed care plan, provided the SSI-related individual is not enrolling in a managed long-term care plan. Participation in a managed long-term care plan requires resource documentation of current resources for care in the community and resource documentation for prior periods in accordance with transfer of resource policies for care in a nursing home. (See **RESOURCES TRANSFER OF ASSETS**) Once enrolled, the SSI-related recipient will be eligible for all care and services covered by the plan as well as any wraparound services that are covered under Medicaid fee-for-service.

Attesters who are eligible for Medicaid subject to a spenddown requirement may participate in the Excess Income/Optional Pay-In

RESOURCES

RESOURCE DOCUMENTATION REQUIREMENTS

Program. (See **INCOME EXCESS** and **PAY-IN**) Local social services districts may continue to verify the accuracy of the resource information provided by the A/R through collateral investigations. If there is an inconsistency between the information reported by the A/R, and the information obtained by the district is current, the district shall redetermine the recipient's eligibility based on the new information. If the district requires further information about a particular resource in order to make an eligibility decision, the recipient must be notified to provide the necessary information.

2. Community Coverage with Community-Based Long-Term Care includes all Medicaid covered care and services including HCBS waiver services but not nursing facility services. The coverage does, however, include short-term rehabilitative nursing home care. If an SSI-related Medicaid A/R elects this coverage, the A/R must provide documentation of his/her current resources at application. However, the A/R may itemize and attest to the amount of his/her resources at renewal/recertification.

NOTE: If an SSI-related Medicaid A/R states a transfer was made but does not provide documentation of the transfer, the A/R is not eligible for short-term rehabilitative nursing home care.

An otherwise eligible SSI-related individual who fails or refuses to provide adequate resource documentation shall be denied Community Coverage with Community-Based Long-Term Care and shall be authorized for Community Coverage without Long-Term Care if adequate information (not documentation) regarding the individual's resources is provided.

SSI-related recipients with Community Coverage with Community-Based Long-Term Care may be enrolled in managed care and managed long-term care.

3. Medicaid coverage for all covered care and services includes nursing facility services. If an SSI-related Medicaid A/R elects this coverage, the A/R must be in receipt of nursing home care and provide documentation of his/her resources for the prior periods in accordance with transfer of resource policies. (See **RESOURCES TRANSFER OF ASSETS**)

RESOURCES

RESOURCE DOCUMENTATION REQUIREMENTS

If an SSI-related Medicaid A/R does not provide documentation of his/her resources for prior periods in accordance with transfer of resource policies, but does provide current resource documentation, the local district determines eligibility for Community Coverage with Community-Based Long-Term Care. If the SSI-related A/R provides information on the amount of his/her current resources but does not provide supporting documentation, the district determines eligibility for Community Coverage without Long-Term Care.

Temporary Assistance and Supplemental Security Income (SSI) recipients are authorized for Medicaid coverage for all covered care and services. Individuals who lose SSI eligibility continue to be eligible for Medicaid coverage of all covered care and services until a separate determination is made. (See **CATEGORICAL FACTORS SEPARATE HEALTH CARE COVERAGE DETERMINATION**) Unless the individual's SSI was discontinued due to a prohibited transfer, the individual is not required to provide documentation of his or her resources for the purpose of the ex-parte eligibility determination.

Individuals who are ineligible or lose Temporary Assistance for failure to document resources are referred to Medicaid for a separate determination.

Disposition:

Although SSI-related Medicaid applicants choose a coverage option at application, such recipients have the right to supply proof of their resources at any time for a change in coverage. If an individual becomes in need of a service for which he/she does not have coverage, the individual must contact his/her local district immediately for assistance in obtaining the Medicaid coverage required.

RESOURCES

RESOURCE DOCUMENTATION REQUIREMENTS

Resource Verification Indicator (RVI) values are used by local districts to identify if a Medicaid recipient:

attested to his/her resources; verified current resources; verified resources for prior periods in accordance with transfer of resource policies; transferred resources; or is exempt from resource verification.

LONG-TERM CARE SERVICES

LONG-TERM CARE		
Community-Based Long-Term Care Services	Nursing Facility Services	Short-Term Rehabilitation Services
<ul style="list-style-type: none"> ▪ Adult day health care ▪ Assisted living program (ALP) ▪ Certified home health agency (CHHA) ▪ Hospice in the community ▪ Residential treatment facility ▪ Managed long-term care in the community ▪ Personal care services ▪ Waiver and Non-waiver services in the following programs <ul style="list-style-type: none"> a) Long-Term Home Health Care Program b) Traumatic Brain Injury Waiver Program c) Care at Home Waiver Program d) Office for People with Developmental Disabilities Home and Community-Based Waiver Program e) Nursing Home Transition and Diversion Waiver (NHTD) ▪ Consumer directed personal assistance program ▪ Limited licensed home care services ▪ Personal emergency response services ▪ Private duty nursing 	<ul style="list-style-type: none"> ▪ Alternate level of care provided in a hospital ▪ Hospice in a nursing home ▪ Nursing home care ▪ Intermediate care facility ▪ Managed long-term care in a nursing home 	<p>Once commencement/admission in a 12-month period of up to 29 consecutive days of:</p> <ul style="list-style-type: none"> ▪ Nursing home care ▪ Certified home health care

RESOURCES

LEVELS

Description: The resource level is an amount of money and/or other resources which an SSI-related A/R is allowed to retain as a reserve in order to meet any potential needs and still be eligible for Medicaid.

Policy: Effective for eligibility periods beginning on or after January 1, 2010 FHPlus and non-SSI-related Medicaid A/Rs will not have resources considered in determining eligibility. This change includes the following Medicaid categories: Singles/Childless Couples (S/CC), Low Income Families (LIF), ADC-related (including adults who spend down excess income to the Medicaid income level), children under 21 years of age when comparing income to the Medicaid income level (Under age 21), and parents living with their dependent child(ren) under age 21 with income at or below the Medicaid income level (FNP Parents).

In determining eligibility, resources are never considered for pregnant women and infants under one year of age. Resources are also not considered for children over age one but under age 19.

In addition, there is no resource test for applicants for the Family Planning Benefit Program, Medicaid Cancer Treatment Program, the Medicare Savings Program including the Qualified Individual Program (QI), Qualified Medicare Beneficiaries (QMB) and Specified Low Income Medicare Beneficiaries (SLIMB), AIDS Health Insurance Program (AHIP) and policy holders who have utilized the minimum required benefits under a total asset Partnership for Long-Term Care insurance policy. (See **RESOURCES** NEW YORK STATE PARTNERSHIP FOR LONG-TERM CARE)

References:

SSL Sect.	366 366.2 366-ee
Dept. Reg.	360-4.7(a)(4) 360-4.8
ADMs	10 OHIP/ADM-01 OMM/ADM 97-2 90 ADM-42 89 ADM-38
GIS	09 MA/027

RESOURCES

LEVELS

Interpretation: When determining eligibility for Medicaid and Family Health Plus, a clear distinction is made between current income and resources.

As described in the Income Section, income is considered in the month in which it is received. Any income remaining after the month in which it was received is generally considered a resource. All resources of an SSI-related A/R are reviewed and analyzed to determine if they are countable. All countable resources are added together and compared to the appropriate level. Treatment of resources that exceed these levels is discussed in **RESOURCES EXCESS RESOURCES**.

RESOURCES

MEDICAID RESOURCE LEVEL

Policy: A/Rs may retain resources up to the appropriate Medicaid Resource level, when the A/Rs are applying as or for:

- SSI-related;
- Qualified Disabled and Working Individuals (QDWIs);
- Medicaid Buy-In for Working People with Disabilities (MBI-WPD);
- COBRA continuation coverage;

The Medicaid resource levels are established according to family size, and generally change effective January each year. (See **REFERENCE** MEDICAID RESOURCE LEVELS.)

NOTE: Effective for eligibility periods beginning on or after January 1, 2010 FHPlus and non-SSI-related Medicaid A/Rs will not have resources considered in determining eligibility. This change includes the following Medicaid categories: Singles/Childless Couples (S/CC), Low Income Families (LIF), ADC-related (including adults who spend down excess income to the Medicaid income level), children under 21 years of age when comparing income to the Medicaid income level (Under age 21), and parents living with their dependent child(ren) under age 21 with income at or below the Medicaid income level (FNP Parents).

In determining eligibility, resources are never considered for pregnant women and infants under one year of age. Resources are also not considered for children over age one but under age 19.

In addition, there is no resource test for applicants for the Family Planning Benefit Program, Medicaid Cancer Treatment Program, the Medicare Savings Program including the Qualified Individual Program (QI), Qualified Medicare Beneficiaries (QMB) and Specified Low Income Medicare Beneficiaries (SLIMB), AIDS Health Insurance Program (AHIP) and policy holders who have utilized the minimum required benefits under a total asset Partnership for Long-Term Care insurance policy. (See **RESOURCES** NEW YORK STATE PARTNERSHIP FOR LONG-TERM CARE)

RESOURCES

MEDICAID RESOURCE LEVEL

References:	SSL Sect. 366 366-ee
	Dept. Reg. 360-4.4 360-4.7(a)(4) 360-4.8(b)
	ADMs 10 OHIP/ADM-01 06 OMM/ADM-4 05 OMM/ADM-4 05 OMM/ADM-2 04 OMM/ADM-2 98 OMM/ADM-6 90 ADM-42
	GISs 09 MA/027 08 MA/013 06 MA/029 05 MA/047

Interpretation: Persons who are SSI-related, QDWIs, and A/Rs of the MBI-WPD Program, or COBRA continuation may keep a certain amount of resources in reserve and still receive Medicaid. These A/Rs are entitled to resources as set forth in **REFERENCE MEDICAID RESOURCE LEVELS**.

When countable resources are equal to or less than the resource level for the household such individuals are eligible for Medicaid, provided all other eligibility requirements are met.

Countable resources in excess of the appropriate resource level are considered available to meet the cost of medical care and services. An SSI-related A/R may be eligible for Medicaid when s/he incurs medical bills equal to or greater than his/her excess.

NOTE: An SSI-related A/R (including individuals who are 65 years of age or older) who also meets the ADC-related categorical requirements has a choice between ADC and SSI-related budgeting. However, if the individual is found eligible under both budget types, and is not eligible for or does not wish to participate in the MBI-WPD such individual must be given the ADC category which is not limited based on resources. A certified blind or certified disabled individual who documents or attests to resources in excess of the Medicaid resource level must have eligibility considered for FHPlus. Resources are not considered in the eligibility determination for FHPlus.

RESOURCES

SSI-RELATED RESOURCE DISREGARDS

Policy:

Not all of the resources available to an A/R are counted when determining his/her financial eligibility for Medicaid. Certain types and amounts of resources are disregarded. After these resources are disregarded, what remain are the A/R's countable resources. All countable resources are compared to the appropriate resource level. (See **REFERENCE** MEDICAID RESOURCE LEVEL)

The following is a list of disregarded resources:

AUTOMOBILES - Essential personal property including one automobile if in use by the A/R or a member of his/her household. A second vehicle may be exempt when there is a medical need for it, or the automobile is needed for employment-related activities or a Plan for Achieving Self-Support. (See **RESOURCES** ESSENTIAL PERSONAL PROPERTY AUTOMOBILES AND OTHER VEHICLES) If an automobile is not in use it loses its exempt status and the full equity value of the automobile is a countable resource.

BLOOD PLASMA SETTLEMENTS - Payments received as a result of a federal class action settlement with four manufacturers of blood plasma products on behalf of hemophilia patients who are infected with human immunodeficiency virus (HIV).

BURIAL FUNDS - When the A/R does not have an irrevocable pre-need funeral agreement (See **RESOURCES** PRE-NEED FUNERAL ARRANGEMENTS) or has less than \$1,500 designated for non-burial space items in the funeral agreement. The A/R may set aside up to \$1,500 as a burial fund. A \$1,500 burial fund may also be exempt for the A/R's spouse. (See **RESOURCES** BURIAL FUNDS)

BURIAL SPACES - Items customarily and traditionally used for the remains of deceased persons. (See **RESOURCES** BURIAL SPACES) Burial space items included in the A/R's irrevocable pre-need funeral agreement are exempt. Certain items paid for in full prior to entering into an irrevocable pre-need funeral agreement are also exempt. Burial space items for the A/R's immediate family member(s) or agreements purchasing burial space items for the A/R'S immediate family member(s) are disregarded. One burial plot or space per immediate family member is disregarded.

DISASTER RELIEF AND EMERGENCY ASSISTANCE - Any federal major disaster and emergency assistance provided under the Disaster Relief Act of 1974 (P.L. 93-288), as amended by the

RESOURCES

SSI-RELATED RESOURCE DISREGARDS

Disaster Relief and Emergency Assistance Amendments of 1988 (P.L. 100-107), and any comparable disaster assistance provided by states, local governments, and disaster assistance organization.

ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM (EEOICP) – Compensation paid to employees for diseases suffered as a result of their work in the nuclear weapons industry. Survivors of these employees may receive compensation under certain circumstances.

EQUITY VALUE OF A TRADE OR BUSINESS - The equity value of a trade or business, including any real property and liquid resources used to operate it. (See **RESOURCES BUSINESS PROPERTY**)

FEDERAL RELOCATION ASSISTANCE - Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.

HOMESTEAD - A homestead and contiguous property as long as the A/R lives there, expresses an intent to return home or certain family members reside there. (See **RESOURCES REAL PROPERTY HOMESTEAD**)

LIFE INSURANCE POLICIES - Life insurance policies with a combined face value of \$1,500 or less. (See **RESOURCES LIFE INSURANCE**)

NATIVE AMERICAN PAYMENTS - Seneca Nation Settlement Act payments made by the State and Federal governments, under P.L. 101-503, to the Seneca Nation.

Distribution to Native Americans of funds appropriated in satisfaction of judgments of the Indian Claims Commission or the United States Court of Federal Claims. This includes up to \$2,000 per year of income for interests of individual Native Americans in trust or restricted lands, from funds appropriated in satisfaction of the Indian Claims Commission or the United States Court of Federal Claims.

Alaskan Native Claims Settlement Act (ANCSA) distributions - The following distributions from a native corporation formed pursuant to ANCSA are exempt as income or resources:

- a. cash, to the extent that it does not, in the aggregate, exceed \$2,000 per individual per year;
- b. stock;

RESOURCES

SSI-RELATED RESOURCE DISREGARDS

- c. a partnership interest;
- d. land or an interest in land; and
- e. an interest in a settlement trust.

PENSION PLANS OF AN INELIGIBLE OR NONAPPLYING LEGALLY RESPONSIBLE RELATIVE - On or after September 1, 1987, pension funds belonging to an ineligible or non-applying legally responsible relative which are held in individual retirement accounts or in work-related pension plans, including plans for self-employed individuals such as Keogh plans. However, amounts disbursed from a pension fund to a pensioner are income to the pensioner, which will be considered in the deeming process.

PERSECUTION PAYMENTS - Benefits received by eligible Japanese-Americans, Aleuts, or Pribilof Islanders under the Civil Liberties Act of 1988, the Wartime Relocation of Civilians Law, and the Aleutian and Pribilof Islands Restitution Act.

Payments made to individuals because of their status as victims of Nazi persecution, including: German Reparation Payments; Austrian Reparation Payments made pursuant to sections 500-506 of the Austrian General Social Insurance Act; and Netherlands Reparation Payments based on Nazi, but not Japanese, persecution.

PERSONAL PROPERTY, ESSENTIAL - Household goods and personal effects. (See **RESOURCES** ESSENTIAL PERSONAL PROPERTY)

PLAN TO ACHIEVE SELF-SUPPORT (PASS) - For certified blind or certified disabled persons under 65 years of age and for certified blind or certified disabled persons aged 65 or over who received SSI payments or aid under the State Plan for the certified blind or certified disabled for the month preceding the month of their 65th birthday, any remaining countable income may be set aside for a plan to achieve self-support. The plan must:

- a. specify planned savings and/or expenditures to achieve a designated feasible occupational objective and a specific period of time to achieve the objective;
- b. provide for identification and segregation of money and goods, if any, being accumulated and saved;
- c. current, in writing and approved by the local commissioner of social services for not more than 18 months, with the possibility of an extension for an additional 18 months.

RESOURCES

SSI-RELATED RESOURCE DISREGARDS

A second extension for an additional 12 months may be allowed in order to fulfill a lengthy educational or training program; and

- d. be followed by the individual;

PRE-NEED FUNERAL AGREEMENTS - Irrevocable pre-need funeral agreements for the A/R. (See **RESOURCES** PRE-NEED FUNERAL AGREEMENT)

PREVENTATIVE HOUSING SERVICE - Payments provided as a preventative housing service under 18 NYCRR 423.4(l).

RADIATION EXPOSURE COMPENSATION TRUST FUND PAYMENTS – Payments for injuries or deaths resulting from exposure to radiation from nuclear testing and uranium mining.

REAL PROPERTY – INCOME PRODUCING - The first \$12,000 equity value of real property producing income that is not part of a trade or business.

SAVINGS ACCOUNT (CHILD) - A child's savings account under \$500. The funds must be accumulated from gifts from non-legally responsible relatives and/or from the child's own earnings. (See **RESOURCES** FINANCIAL INSTITUTION ACCOUNTS)

STUDENT – Student Loans - Student loans received and retained by a graduate or undergraduate student for educational purposes. Any interest accrued is considered unearned income in the month received.

TIME LIMITED DISREGARDS - Certain resources are disregarded for a limited time period. (See **RESOURCES** TIME-LIMITED SSI-RELATED RESOURCE DISREGARD)

VIETNAM VETERANS – Agent Orange Settlement fund - Payments from the Agent Orange Settlement Fund or any other fund established pursuant to the Agent Orange product liability litigation, and payments from court proceedings brought for personal injuries sustained by veterans resulting from exposure to dioxin or phenoxy herbicide in connection with the war in Indochina in the period of January 1, 1962 through May 7, 1975.

Children - Monthly allowances paid to certain Vietnam Veteran's Children with Spina Bifida.

RESOURCES**SSI-RELATED RESOURCE DISREGARDS**

References:	SSL Sect.	366 366-ee
	Dept. Reg.	360-4.6(b)
	ADMs	10 OHIP/ADM-01 92 ADM-32 92 ADM-11 91 ADM-8
	GISs	09 MA/027 97 MA/022

RESOURCES

TIME LIMITED SSI-RELATED RESOURCE DISREGARDS

Policy:

Certain resources, available to an A/R, are disregarded for a limited time period. When the period has expired, these resources are reviewed to determine their value and availability. All countable resources are compared to the appropriate resource level.

The following is a list of resources which are disregarded for a limited time period:

AID AND ATTENDANCE, RETROACTIVE VETERANS BENEFITS - Moneys from Retroactive Veterans Benefits Awards for Aid and Attendance, unusual medical expenses and/or House-bound Allowances, are disregarded in the month received and the following month.

CASH PAYMENTS FOR MEDICAL SERVICES OR SOCIAL SERVICES - Certain cash payments that enable A/Rs to pay for medical services or social services are disregarded in the month received and for nine (9) months following the month of receipt.

EARNED INCOME TAX CREDIT PAYMENTS (including federal child tax credit payments and any advanced earned income credit made by an employer) - Moneys from Earned Income Tax Credit payments are disregarded in the month received and for nine (9) months following the month of receipt.

EDUCATIONAL-RELATED RESOURCES - Any portion of a grant, scholarship, fellowship or gift used to pay the cost of tuition and other education-related fees at any educational (including technical or vocational) institution are disregarded in the month received and for nine (9) months following the month of receipt. This resource disregard does not apply to any portion set aside or actually used for food, clothing or shelter.

INSURANCE PAYMENTS - Moneys from insurance payments for the purpose of repairing a disregarded resource, which was lost, damaged or stolen, are disregarded for nine (9) months following the month of receipt. An additional nine-month disregard can be given if the A/R has good cause not to have replaced the resource. Any interest received from such payments is also disregarded. If the A/R uses the insurance money to purchase a countable resource prior to the expiration of the nine or eighteen months, the value of the resource is countable.

RESOURCES

TIME LIMITED SSI-RELATED RESOURCE DISREGARDS

REAL PROPERTY SALES - Moneys from the proceeds of the sale of exempt real property are disregarded for a reasonable period of time, not to exceed six months, while the A/R reinvests the proceeds.

RELOCATION ASSISTANCE PAYMENTS – State or local government relocation assistance payments (not federal or federally assisted funds) for 9 months following the month of receipt.

RETROACTIVE SSI, SOCIAL SECURITY AND RAILROAD RETIREMENT BENEFITS - Retroactive SSI, Social Security and Railroad Retirement benefits are disregarded resources for nine (9) months following the month of receipt.

STATE OR LOCAL GOVERNMENT RELOCATION ASSISTANCE - Relocation assistance payments from a state or local government are disregarded from resources for nine (9) months following the month of receipt.

STATE VICTIMS' ASSISTANCE FUNDS - Payments from State Victims Assistance funds are exempt resources for nine (9) months following the month of receipt.

References:

- SSL Sect. 366
 366-ee

- ADMs 10 OHIP/ADM-01
 97 ADM-23
 97 ADM-2
 92 ADM-32
 92 ADM-11

- GISs 09 MA/027
 05 MA/001
 04 MA/030
 96 MA/028

RESOURCES

SSI-RELATED DEEMING OF RESOURCES

Policy: The basis for deeming is inherent in the concept that husbands and wives living together have a responsibility to each other and generally share income. Parents living with their children also have a responsibility for their children and generally provide income for their needs.

References:

20 CFR	416.1165
SSL Sect.	366.2
Dept. Reg.	360-4.4 360-4.6(b)(1)(ii) 360-4.6(b)(2) 360-4.7
ADMs	91 ADM-27 87 ADM-27

Interpretation: The budgeting of resources for SSI-related persons involves the deeming of resources from one spouse to another and from parents to their SSI-related child under age 18. When determining eligibility for an SSI-related individual who is living with his or her spouse, the resources of such spouse, not otherwise excluded under the SSI-related disregards, are considered to be available to the SSI-related individual.

When budgeting the resources of an SSI-related person living with his/her spouse, the final net resources of the SSI-related person and his/her spouse are compared to the Medicaid resource level for two. Children's resources are not counted in determining the SSI-related parent's eligibility.

To determine the amount of resources to be deemed to the child by a single parent, the parent's countable resources are compared to \$2,000, the resource level for one used by the Social Security Administration, to determine eligibility for SSI recipients. The countable resources of a two-parent household are compared to \$3,000, the SSI resource level for two.

In the case of an SSI-related child, the child's resources are deemed to include any resources, not otherwise excluded under the SSI-related disregards, of a parent who is living in the same household to the extent that the parent's countable resources exceed the resource level used by the Social Security

RESOURCES

SSI-RELATED DEEMING OF RESOURCES

Administration. If a child is living with only one parent, the resource level for an individual applies (\$2,000). If the child is living with both parents, the resource levels for a couple apply (\$3,000). Resources in excess of these levels are deemed available to the SSI-related child (if there is more than one SSI-related child in the household, the deemed amount is distributed equally among them). The deemed resources are added to the child's own resources (if any) and compared to the Medicaid resource level for one found in the **REFERENCE MEDICAID RESOURCE LEVELS**.

The deeming of parental resources to an SSI-related child does not reduce the countable resources available to the parents when determining eligibility for them.

Unlike income budgeting for SSI-related persons, there is no allocation of resources to non-SSI-related children in the household.

RESOURCES

**MEDICAID BUY-IN PROGRAM
FOR WORKING PEOPLE WITH DISABILITIES (MBI-WPD)**

Policy: SSI-related budgeting, including disregards and deeming, is used for determining countable resources. (See **RESOURCES** SSI-RELATED RESOURCE DISREGARDS, **RESOURCES** TIME LIMITED SSI-RELATED RESOURCE DISREGARDS and **RESOURCES** SSI-RELATED DEEMING OF RESOURCES)

To be eligible for the MBI-WPD program, effective October 1, 2011, the A/R may have countable resources equal to or less than \$20,000 for a one-person household and \$30,000 for a two-person household. (See **REFERENCE** MEDICAID RESOURCE LEVELS)

Effective October 1, 2011 monies in a retirement account of the MBI-WPD A/R are disregarded. (See **RESOURCES** RETIREMENT FUNDS)

See **CATEGORICAL FACTORS** MEDICAID BUY-IN FOR WORKING PEOPLE WITH DISABILITIES, **INCOME** MEDICAID BUY-IN FOR WORKING PEOPLE WITH DISABILITIES, and **OTHER ELIGIBILITY REQUIREMENTS** MEDICAID BUY-IN FOR WORKING PEOPLE WITH DISABILITIES for a discussion of other eligibility criteria for MBI-WPD.

Reference: SSL Sect. 366(1)(a)(12)&(13)

ADMs 11 OHIP/ADM-07
04 OMM/ADM-5
03 OMM/ADM-4

GIS 08 MA/013
98 MA/024

**RESOURCES
PERSONS IN MEDICAL FACILITIES**

ASSESSMENT/DETERMINATION

Description: Either spouse may request an assessment/determination of the combined countable resources owned by the couple. An assessment may be requested at the beginning or after the commencement of a continuous period of institutionalization. The request may or may not be accompanied by an application for Medicaid.

Policy: Upon receipt of an assessment request or application and all relevant documentation, the local social services district reviews the total value of the couple's countable resources as of the date of the request for an assessment/application. Countable resources are determined by applying SSI-related disregards. Each spouse is provided with a copy of the assessment and the documentation on which it was based. The notice includes a determination of the community spouse's resource allowance and advises the couple of their right to a fair hearing regarding the assessment and the determination of the community spouse resource allowance, after the institutionalized spouse's eligibility for Medicaid has been determined.

References:

SSA	1924
SSL	366-c
Dept. Reg.	360-4.3 (f) 360-4.9 360-4.10 360-2.6
ADMs	06 OMM/ADM-3 04 OMM/ADM-4 03 OMM/ADM-7 96 ADM-11 91-ADM-33 90 ADM-29 89 ADM-47
INF	92 INF-14

**RESOURCES
PERSONS IN MEDICAL FACILITIES**

ASSESSMENT/DETERMINATION

GISs	07 MA/001
	06 MA/006
	06 MA/004
	05 MA/049
	05 MA/002
	04 MA/032
	03 MA/027
	03 MA/012
	01 MA/037
	00 MA/021

Interpretation:

When a request for assessment is not accompanied by a Medicaid application, the assessment is based on the couple's combined countable resources as of the date of the request. When a Medicaid application is filed, the assessment is based on the first month covered by the Medicaid application. (See **OTHER ELIGIBILITY REQUIREMENTS AUTHORIZATION**) In cases where the date of the first continuous period of institutionalization is prior to the date of the request for assessment or the first month for which Medicaid eligibility is sought, an assessment of the couple's resources may be required for both the first month of institutionalization and the date of request for an assessment or the first month for which coverage is sought.

When the total countable resources are greater than \$149,640 for the first continuous period of institutionalization, the local social services district calculates the couple's spousal share in order to determine the maximum amount of resources that can be retained by the community spouse. Local districts determine the spousal share as of the date of the first continuous period of institutionalization of the institutionalized spouse on or after September 30, 1989.

RESOURCES PERSONS IN MEDICAL FACILITIES

ASSESSMENT/DETERMINATION

Regardless of which spouse's name the resources are in, all countable resources are combined and considered available to the institutionalized spouse. The community spouse is permitted to retain from the couple's countable resources an amount equal to the greatest of the following amounts: (1) the State minimum community spouse resource allowance amount; (2) the spousal share up to the federal maximum resource amount; or (3) the amount established by court order or fair hearing. The minimum community spousal resource allowance amount and the federal maximum resource amount can be found in **REFERENCE MINIMUM/ MAXIMUM COMMUNITY SPOUSE ALLOWANCE**.

If the couple's combined countable resources are less than the state minimum community spouse resource allowance, the community spouse may retain all of the couple's countable resources. When the combined countable resources exceed the maximum community spouse amount, the excess is considered available to the institutionalized spouse. The institutionalized spouse is allowed the appropriate SSI-related resource level for one.

NOTE: Effective January 1, 2006 if a community spouse is NOT receiving periodic payments from his/her available retirement fund, the fund is considered a countable resource for purposes of determining; the community spouse resource allowance (CSRA) and the institutionalized spouse's Medicaid eligibility.

After the month for which the institutionalized spouse is determined eligible for Medicaid, the community spouse's resources cannot be considered available to the institutionalized spouse, even if the community spouse's resources increase. The community spouse resource allowance must actually be made available to the community spouse in order for it to be excluded when determining the continuing eligibility of the institutionalized spouse. The community spouse resource allowance must be legally transferred to the community spouse or for his/her sole benefit within 90 days of the eligibility determination. The local social services district may allow a longer period for the transfer, when required.

RESOURCES PERSONS IN MEDICAL FACILITIES

ASSESSMENT/DETERMINATION

When a community spouse fails or refuses to provide information concerning his/her resources, the institutionalized spouse's eligibility cannot be determined and the A/R may be denied Medicaid. However, if such a denial would result in undue hardship and an assignment of support is executed or the institutionalized spouse is unable to execute an assignment, due to physical or mental impairment, Medicaid is authorized. The case is then referred to the district's legal staff for appropriate action.

Undue hardship is a situation where:

- (1) a community spouse fails or refuses to cooperate in providing necessary information about his/her resources;
- (2) the institutionalized spouse is otherwise eligible for Medicaid;
- (3) the institutionalized spouse is unable to obtain appropriate medical care without the provision of Medicaid; and
- (4)
 - (a) the community spouse's whereabouts are unknown; or
 - (b) the community spouse is incapable of providing the required information due to illness or mental incapacity; or
 - (c) the community spouse lived apart from the institutionalized spouse immediately prior to institutionalization; or
 - (d) due to the action or inaction of the community spouse, other than the failure or refusal to cooperate in providing necessary information about his/her resources, the institutionalized spouse will be in need of protection from actual or threatened harm, neglect, or hazardous conditions if discharged from an appropriate medical setting.

After a Medicaid eligibility determination for the institutionalized spouse is completed, if either spouse is dissatisfied with the determination of the community spouse resource allowance, s/he may request a fair hearing.

**RESOURCES
PERSONS IN MEDICAL FACILITES**

ASSESSMENT/DETERMINATION

If either spouse establishes, pursuant to fair hearing or court order, that the income generated from the community spouse resource allowance is inadequate to raise the community spouse's income (including any income from the institutionalized spouse) to the Minimum Monthly Maintenance Needs Allowance (MMMNA), the local district establishes a community spouse resource allowance adequate to provide the additional necessary income. (See **REFERENCE MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE (MMMNA)**)

NOTE: The policy of raising the community spouse's income to the MMMNA does not apply in instances when the institutionalized spouse is a participant in certain waiver programs. (See **INCOME PERSONS IN MEDICAL FACILITIES BUDGETING FOR INSTITUTIONALIZED SPOUSES IN SPECIFIED HOME AND COMMUNITY BASED WAIVERS (HCBS)**)

If the institutionalized spouse does not make the community spouse income allowance available to the community spouse, an additional community spouse resource allowance **cannot** be established.

NOTE: A community spouse who refuses to make his or her resources (in excess of the community spouse resource allowance) available to the cost of care for the institutionalized spouse is allowed the appropriate community spouse monthly income allowance. If the community spouse refuses to provide information concerning his/her resources, the community spouse is not entitled to a monthly income allowance, because the amount of income generated by the resources is not known.

(See **REFERENCE MINIMUM/MAXIMUM COMMUNITY SPOUSE ALLOWANCE**)

References:	ADMs	06 OMM/ADM-4 05 OMM/ADM-5 05 OMM/ADM-2 04 OMM/ADM-5 04 OMM/ADM-2 03 OMM/ADM-4 02 OMM/ADM-7 02 OMM/ADM-1
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**RESOURCES
PERSONS IN MEDICAL FACILITES**

ASSESSMENT/DETERMINATION

01 OMM/ADM-5
99 OMM/ADM-3
98 OMM/ADM-28
96 ADM-11
91 ADM-33
89 ADM-47

GISs

08 MA/024
06 MA/029
06 MA/006
05 MA/013
05 MA/047
05 MA/045
04 MA/032
03 MA/027
01 MA/038
00 MA/027
00 MA/030

**RESOURCES
PERSONS IN MEDICAL FACILITIES**

**BUDGETING FOR INSTITUTIONALIZED SPOUSES IN HOME AND COMMUNITY
BASED WAIVERS (HCBS)**

Policy: HCBS waiver participants with a community spouse are budgeted for resource eligibility in the same manner as institutionalized spouses in permanent absence status. (See **RESOURCES PERSONS IN MEDICAL FACILITIES**)

References:

SSL Sect.	366-c (4)
Dept. Reg.	360-4.9 360-4.10
ADMs	08 OLTC-01 95 ADM-19 92 ADM-32 89 ADM-47
GISs	08 MA/024 01 MA/021

**RESOURCES
PERSONS IN MEDICAL FACILITIES**

DETERMINATION FOR INDIVIDUALS

Policy: A single person who enters a medical facility is entitled to retain countable resources up to the Medicaid level for one. (See **REFERENCE MEDICAID RESOURCE LEVELS**)

References:

SSL- Sect.	366 366-ee
ADMs	10 OHIP/ADM-01 89 ADM-47
GIS	09 MA/027

Interpretation: Unmarried ADC and S/CC Medicaid recipients who are temporarily placed in a nursing home and subsequently become “permanently absent” will be budgeted using community budgeting rules until a disability determination is completed. Until the disability determination is complete, no resource test is applied; however, once disability is certified, a resource look-back for the past 60 months or to February 8, 2006 whichever is shorter, (60 months for trusts) must be done. The resource look-back begins with the first day of the month preceding the month of initial institutionalization. The effective date of Chronic Care budgeting is the first day of the month following the 10-day notice of the change in the budgeting methodology.

NOTE: An S/CC or ADC-related individual who requires temporary nursing home care (i.e., the individual is expected to return home) is budgeted under community rules, and therefore, will have no resource test. There is no durational restriction for temporary placement as long as medical evidence documents that the individual is expected to return home.

NOTE: When both spouses are in permanent absence status, they are budgeted as individuals, whether or not they share a room.

**RESOURCES
PERSONS IN MEDICAL FACILITIES**

TREATMENT OF REAL PROPERTY

Description: Real property is land and generally whatever is erected upon, growing upon, or affixed to the land. Real property also includes rights arising out of or in connection with land, such as air, mineral, water, or access rights. Real property may be owned in whole or in part. When determining eligibility, all real property owned by an A/R is evaluated.

Policy: The homestead of any SSI-related institutionalized A/R who expresses intent to return home remains exempt (regardless of any medical evidence to the contrary). However, if an institutionalized SSI-related A/R is not reasonably expected to be discharged from the medical institution and to return home, it may be appropriate to place a lien against such a homestead or exempt income-producing real property. If an institutionalized SSI-related A/R possesses non-exempt real property (e.g., vacation home or unoccupied homestead to which the A/R does not express an intent to return), the value of such property is counted in the determination of eligibility. (See **RESOURCES REAL PROPERTY HOMESTEAD** for the treatment of a homestead, **OTHER ELIGIBILITY REQUIREMENTS LIENS** for the treatment of liens and **RESOURCES REAL PROPERTY** for the treatment of real property).

References:

SSL Sect	366 366-ee 367-f 369.2
Dept. Regs	360-7.11
ADMs	10 OHIP/ADM-01 92 ADM-53
GIS	09 MA/027

RESOURCES

SUBSTANTIAL HOME EQUITY

Description: The home equity of an SSI-related applicant for nursing facility services or community based long-term care services cannot exceed the home equity limit. (See **REFERENCE** SUBSTANTIAL HOME EQUITY LIMIT)

Policy: An SSI-related A/R whose equity interest in their home exceeds the home equity limit must be denied Medicaid coverage for Nursing Facility Services and Community Based Long-Term Care services. The equity value is derived by subtracting any legal encumbrances (liens, mortgages, etc.) from the fair market value. Absent any evidence to the contrary, if the home is owned jointly with one or more individuals, each owner is presumed to have an equal interest in the property. Individuals cannot spend down excess equity through the use of medical bills to obtain eligibility. Individuals whose equity interest in the home exceeds the home equity limit may, if otherwise eligible, receive Medicaid coverage of Community Coverage Without Long-Term Care.

References:

SSL Sect.	366-a(2) 366 366-c 366-ee
Dept. Reg.	360-2.3 360-4.4 360-4.6
ADMs	10 OHIP/ADM-01 09 OHIP/ADM-3 06 OMM/ADM-5
GISs	10 MA/025 09 MA/027 07 MA/007 06 MA/016

Interpretation: SSI-related individuals applying for nursing facility services or community based long-term care services, or for an increase in coverage for long-term care services on or after January 1, 2006, are to be denied Medicaid coverage for such services if the equity interest in the individual's home exceeds the home equity limit.

The home equity provisions do not apply to persons who are Qualified Partnership Policyholders (QPP) who hold either a Total Asset

RESOURCES

SUBSTANTIAL HOME EQUITY

Protection or Dollar-for-Dollar policy. However, consideration of the home as a countable resource or exempt homestead applies to a QPP who has a Dollar-for-Dollar Asset Protection policy.

The home equity provision does not apply to individuals who applied and were determined eligible for and in receipt of long-term care services before January 1, 2006 and have no break in eligibility for long-term care services after January 1, 2006.

The home equity limitation does not apply if the SSI-related individual's spouse, minor child or certified blind or certified disabled child lawfully resides in the home.

SSI-related individuals may use a reverse mortgage or home equity loan to reduce their equity interest in the home.

NOTE: Although payments received from a reverse mortgage or home equity loan are not counted in the month of receipt for eligibility purposes, if the funds are transferred during the month of receipt, the transfer is to be considered a transfer for less than fair market value for SSI-related individuals applying for coverage of nursing home care.

SSI-related individuals who are subject to the home equity limitation may claim undue hardship. Undue hardship exists if the denial of Medicaid coverage would:

- Deprive the A/R of medical care such that the individual's health or life would be endangered; or
- Deprive the A/R of food, clothing, shelter, or other necessities of life; AND
- There is a legal impediment that prevents the A/R from being able to access his or her equity interest in the property.

Undue hardship determinations must be made within the same period that districts have to determine eligibility. Additional time for providing documentation to determine undue hardship may be approved by the district. If an individual disagrees with the district's determination of undue hardship, the recipient may request a conference and/or fair hearing.

If the SSI-related individual is not eligible for nursing facility services and community-based long-term care services due to substantial home equity, districts should not authorize short-term rehabilitative nursing home care nor certified home health care (CHHA) services.

RESOURCES

SUBSTANTIAL HOME EQUITY

**Verification/
Documentation:**

When an SSI-related A/R indicates that s/he owns and resides in his/her own home. The preferred method of verifying market value is to obtain an independent appraisal by a licensed real estate appraiser. If this is not practical, use the listed asking price accompanied by a market analysis or appraisal, if any; or, if neither is available, use a full value tax assessment. However, if it is clear based on the approximate value of the property that the SSI-related A/R is ineligible due to excess resources, the local district may rely on a statement from the applicant as to the property's value. The A/R cannot be required to pay for an appraisal.

All liens and mortgages against the property are verified by reviewing the documentation.

Sufficient to establish an audit trail:

- a) date of appraisal, name of official or appraiser, value of property from real estate appraisal or a copy of the same in the case record;
- b) listed asking price, accompanied by a marketing analysis;
- c) location of tax records, and date and amount of full value assessment;
- d) name of bank or party holding the mortgage, amount due on mortgage, date of mortgage and any identifying information;
- e) name of party holding a lien against the property and the amount of the lien; and/or
- f) the A/R's written statement concerning the value of the property or a notation in the case file concerning the A/R's statement.

RESOURCES**CONTINUING CARE RETIREMENT COMMUNITY CONTRACTS**

Description: Continuing Care Retirement Communities (CCRCs) entrance fees may be considered a resource in determining eligibility.

Policy: CCRCs are paid primarily with private funds, but a number also accept Medicaid payment for nursing facility services. CCRCs that are certified to accept Medicaid and/or Medicare payment may require in their admissions contracts that residents spend their declared resources on their care, before they apply for Medicaid.

References:

SSL Sect.	366 366-a(2) 366-c 366-ee
Dept. Reg.	360-2.3 360-4.4 360-4.6
ADMs	10 OHIP/ADM-01 06 OMM/ADM-5
GIS	09 MA/027 06 MA/016

Interpretation: Effective for Medicaid applications filed on or after August 1, 2006, an SSI-related individual's entrance fee in a CCRC or life care community shall be considered a resource to the extent that:

- The SSI-related individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for such care;
- The SSI-related individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the continuing care retirement community or life care community contract and leaves the community; AND
- The entrance fee does not confer an ownership interest in the CCRC or life care community.

RESOURCES

CONTINUING CARE RETIREMENT COMMUNITY CONTRACTS

For SSI-related applicants with a community spouse, only that part of the entrance fee that is not protected by the community spouse's resource allowance would be considered in the computation of the applicant's available resources.

**Verification/
Documentation:**

When the SSI-related A/R indicates that s/he resides in a continuing care retirement community or life care community.

Sufficient to establish an audit trail:

- (a) a copy of the CCRC or life care community contract.
- (b) a written statement from the CCRC or life care community. a copy of the cancelled CCRC or life care community contract.

RESOURCES

BUDGETING FOR LEGALLY RESPONSIBLE RELATIVES

Description: Spouses are financially responsible for each other and parents are financially responsible for their children under the age 21 who are not certified blind or certified disabled. Parents are financially responsible for their certified blind or certified disabled children under the age 18 unless the child is expected to be living out of the household for at least 30 days. **OTHER ELIGIBILITY REQUIREMENTS LEGALLY RESPONSIBLE RELATIVES (LRR)** contains a detailed description of legally responsible relatives (LRRs) and their obligation to support their dependents.

Policy: The resources of legally responsible relatives (LRRs) living in the same household as their SSI-related dependents are considered to be available unless the legally responsible relative refuses to make them available.

For married couples, where one member of the couple is an SSI-related institutionalized spouse, See **INCOME CHRONIC CARE BUDGETING METHODOLOGY FOR INSTITUTIONALIZED SPOUSE** to determine the countable resources considered available to the institutionalized spouse.

References:

SSL Sect.	101 101-a 366 366-ee
Dept. Reg.	360-4.3(f)(2)
ADMs	10 OHIP/ADM-01 89 ADM-47
GIS	09 MA.027

Interpretation: When determining Medicaid eligibility, countable resources belonging to the SSI-related A/R and his/her LRRs residing in the same household are considered available to the SSI-related A/R. If an LRR refuses to make his/her countable resources available, eligibility is determined without regard to the LRR's resources. The granting of Medicaid in this situation creates an implied contract with the LRR and the cost of care may be recovered through a referral to Family or Supreme Court.

When an SSI-related A/R residing in the community has an LRR also residing in the community, but in a separate household, each person is allowed to retain resources up to the appropriate level. The LRR is

RESOURCES

BUDGETING FOR LEGALLY RESPONSIBLE RELATIVES

allowed to retain resources up to the appropriate level. The LRR is asked to contribute his/her excess resources toward the cost of the A/R's medical care. Only the amount actually contributed by the LRR is considered available to the SSI-related A/R. However, the local social services district may seek to recover the cost of any Medicaid provided through a referral to court. The SSI-related A/R and LRR are notified when a referral is made to Family or Supreme Court.

Legally responsible relatives who are living apart from an SSI-related A/R are sent the DSS-939 (legally responsible relative questionnaire and letter). If the relative fails to respond to the questionnaire, Medicaid may be granted if the SSI-related A/R is otherwise eligible. Medical support may be pursued in Family or Supreme Court.

Cases which include an SSI-related child under the age of 21, whose parent is absent from the home, are referred to the appropriate agency/unit for possible support. Generally this referral is made to the Child Support Enforcement Unit (IV-D). (See **OTHER ELIGIBILITY REQUIREMENTS** LEGALLY RESPONSIBLE RELATIVES IV-D REQUIREMENTS) for the establishment of the parent's contribution toward the cost of care. See **CATEGORICAL FACTORS** CHILDREN IN FOSTER CARE for the treatment of children in foster care.

Parents are not required to make their countable resources available to meet the medical needs of a certified blind or certified disabled child who ceases to live with them or is in receipt of home and community-based waived services under a model waiver program (i.e. Care at Home Program). For Medicaid purposes, a certified blind or certified disabled child ceases to live with his/her parents when s/he is expected to occupy a separate "residence" for at least 30 days.

- Verify Status:**
- a) When an SSI-related A/R states that a spouse or parent is living outside the household;
 - b) When an SSI-related A/R or a family member is residing in a medical facility or in receipt of home and community-based waived services;
 - c) When it appears that a legally responsible relative has available resources;
 - d) When a potentially certified blind/disabled child is living in a separate residence or in a medical facility.

Verification: Completion of the DSS-939 by the legally responsible relatives.

RESOURCES

EXCESS RESOURCES

Description: Countable resources in excess of the appropriate Medicaid level are considered available to meet the cost of medical care and services of SSI-related A/Rs. The countable value of all resources is determined as of the first day of the month for which the applicant is requesting Medicaid coverage.

Policy: SSI-related applicants, may be eligible for Medicaid coverage during a month in which their medical bills are equal to or greater than their excess resources.

References:

SSL Sect	366 366-ee
Dept. Reg.	360-4.8(b)
ADMs	10 OHIP/ADM-01 OMM/ADM 97-2 91 ADM-31 91 ADM-17
GIS	09 MA/027

Interpretation: An SSI-related applicant’s resources are evaluated as of the first day of the month for which s/he is requesting coverage. Certain resources are disregarded (See **RESOURCES MEDICAID RESOURCE LEVEL**) when determining eligibility for Medicaid. Countable resources are compared to the appropriate Medicaid level. With the exception of transfers of the community spouse resource allowance, countable resources possessed by the applicant on the first day of a month are considered available in that month, even if subsequently transferred.

NOTE: Effective for eligibility periods beginning on or after January 1, 2010 FHPlus and non-SSI-related Medicaid A/Rs will not have resources considered in determining eligibility. This change includes the following Medicaid categories: Singles/Childless Couples (S/CC), Low Income Families (LIF), ADC-related (including adults who spend down excess income to the Medicaid income level), children under 21 years of age when comparing income to the Medicaid income level (Under age 21), and parents living with their dependent child(ren) under age 21 with income at or below the Medicaid income level (FNP Parents).

RESOURCES

EXCESS RESOURCES

In determining eligibility, resources are never considered for pregnant women and infants under one year of age. Resources are also not considered for children over age one but under age 19.

In addition, there is no resource test for applicants for the Family Planning Benefit Program, Medicaid Cancer Treatment Program, the Medicare Savings Program including the Qualified Individual Program (QI), Qualified Medicare Beneficiaries (QMB) and Specified Low Income Medicare Beneficiaries (SLIMB), AIDS Health Insurance Program (AHIP) and policy holders who have utilized the minimum required benefits under a total asset Partnership for Long-Term Care insurance policy. (See **RESOURCES** NEW YORK STATE PARTNERSHIP FOR LONG-TERM CARE)

Disposition:

- (1) Determine the value of the SSI-related applicant's resources as of the first day of the month for which the applicant is seeking coverage. If the SSI-related applicant is seeking coverage for medical bills during the three-month retroactive period (See **OTHER ELIGIBILITY REQUIREMENTS** AUTHORIZATION), the local district determines the value of the SSI-related applicant's resources as of the first day of the month for each retroactive month that the applicant is seeking coverage. Compare the SSI-related applicant's countable resources to the appropriate resource level.
- (2) Determine whether or not an irrevocable pre-need funeral agreement exists.
- (3) Determine the amount of the applicant's medical bills. Bills are applied against excess resources in the following order:
 - viable bills as of the first of the month for which the provider is seeking payment (viable bills are those that providers seek payment for and have not written off their books);
 - viable bills for medical expenses incurred during the month;
 - bills paid by the applicant during the month;
 - bills paid by public programs.

Public program bills are considered viable for up to six consecutive months after payment. The six-month count begins on the first day of the month for which Medicaid coverage is sought.

RESOURCES

EXCESS RESOURCES

NOTE: Bills which are paid by the Child Health Plus program cannot be considered viable because a child cannot be dually eligible for Medicaid and Child Health Plus.

In determining the amount of such bills, first deduct the amount of any third party payment or liability. Third party payments include, but are not limited to health insurance and payments by friends and/or non-applying, non-legally responsible relatives.

When the amount of the SSI-related applicant's medical bills (minus any third party payment or liability) equals or exceeds his/her excess resources, s/he is resource eligible. The excess resource amount is the amount of the client's liability.

NOTE: When an SSI-related applicant with excess resources also has excess income, excess income (See **INCOME EXCESS**) and excess resource rules both apply. Bills or portions of bills applied to meet excess income cannot be applied to excess resources and vice versa.

A community case may be authorized for up to six (6) months of coverage. Coverage for an applicant residing in a medical facility may be authorized for up to 12 months. The SSI-related applicant is not required, as a condition of eligibility, to pay the medical bills used to determine his/her liability. When the local district is notified that the SSI-related applicant's resources have increased, that his/her viable medical bills are being paid by means other than his/her resources, or that the provider is no longer seeking payment for the bills, the case is reviewed to determine if the A/R is still eligible.

After the initial certification period, another snapshot comparison of resources to medical bills is made. The viability of incurred bills is reevaluated. The same viable bills (or portions of bills) used to offset excess resources may again be used to offset these resources if they continue to be available. If the amount of excess resources exceeds the amount of viable bills, the SSI-related A/R is no longer eligible and Medicaid is discontinued after appropriate notification. (See **OTHER ELIGIBILITY REQUIREMENTS DECISION AND NOTIFICATION**) Procedures to continue coverage depend upon what has happened to the resources and what viable bills remain.

RESOURCES

THIRD PARTY RESOURCES

Description: Third party resources include health, hospital, assignable income protection, and/or accident insurance policies. Benefits under these policies partially or fully pay or reimburse the cost of medical care and services. Third party benefits are available through employers, unions, colleges, fraternal organizations, liability carriers, court actions, trust funds, private insurers, the federal and state government, etc.

Policy: Health, hospital, assignable income protection, and/or accident insurance benefits are applied to the fullest extent to insure that Medicaid is the payer of last resort.

The exceptions to this policy occur when individuals are covered by the Children with Physical Disabilities Program or the Crime Victims' Compensation Program. In cases where individuals are covered by either of the above programs, Medicaid becomes the payer of first resort after any other available third party resources have been applied.

With the exception of the types of coverage listed in **CATEGORICAL FACTORS FAMILY HEALTH PLUS AND PREMIUM ASSISTANCE PROGRAM (FHP-PAP)** individuals with third party health insurance (TPHI) may not be eligible for Family Health Plus but may be eligible for the Family Health Plus Premium Assistance Program.

References:

SSL Sect.	104(b) 366.2(f) and (g) 367.a
Dept. Reg.	360-3.2(a)-(f) 360-7.2 360-7.3 360-7.4 360-7.7
ADMs	08 OHIP/ADM-1 05 ADM-5 99 ADM-5 94 ADM-14 89 ADM-23 87 ADM-40

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INFs	09OHIP/INF-1 88 INF-56
GISs	06 MA/003 01 MA/019

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Interpretation: Benefits which pay for the cost of medical care and/or services are used to pay for or reimburse the cost of all inpatient and outpatient medical care and services. Some plans pay for the complete cost of all care and services. However, most plans are limited in the amount of payment, length of care, and type of services. Many plans require the recipient to pay a deductible and/or co-insurance.

When a provider accepts a Medicaid enrollee as a patient the provider agrees to bill Medicaid for services provided or in the case of a Medicaid managed care enrollee agrees to bill the enrollees managed care plan for services covered by the contract.

The provider is prohibited from requesting any monetary compensation from the enrollee or his/her responsible relative except for any applicable Medicaid co-payments. Medicaid enrollees can not be billed and must not be referred to a collection agency for collection of unpaid bills, except for applicable Medicaid co-payments, when the provider has accepted the enrollee as a Medicaid patient.

A provider may charge a Medicaid enrollee, including a Medicaid enrollee enrolled in a managed care plan, only when both parties have agreed prior to the rendering of the services that the enrollee is being seen as a private pay patient. This must be a mutual and voluntary agreement. It is recommended that the provider maintain the patient's signed consent to be treated as private pay in the patient record.

WRAP AROUND POLICIES are no different than other health insurance policies and are treated like any other health insurance in determining eligibility.

Health insurance may be available through an absent parent's employer, union, etc. Generally, a Medicaid household that includes a child with an absent parent is referred to the Child Support Enforcement Unit (IV-D) for pursuit of support. [89 ADM-23 explains the Third Party Resource Unit's (TPRU) responsibility to obtain third party health insurance for Medicaid A/Rs. Also see 92 ADM-19, for information on subrogation of court-ordered health insurance benefits from an absent parent. (See **OTHER ELIGIBILITY REQUIREMENTS LEGALLY RESPONSIBLE RELATIVES PARENTS AND CHILDREN IV-D REQUIREMENTS**)

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Generally, insurance plans allow parents to cover students and disabled children, after they have reached adulthood. Adult disabled children are persons who become disabled prior to the age of 19. Disability is defined by Title II of the Social Security Act.

When an A/R owns an income protection policy, the local district determines if the policyholder can assign payment to a hospital or nursing home. The local district enters the appropriate codes into eMedNY, indicating that the A/R has an assignable income protection policy. If the A/R is admitted to a medical facility, the facility takes an assignment from the A/R. Payments from the income protection policy are made directly to the medical facility. The income is not available to the A/R. In the event that the income protection policy payments are greater than the A/R's bill, it is the responsibility of the facility to return the excess to the A/R. If the income protection policy is not assignable, any income received by the recipient would be counted as income in the month received and a resource thereafter.

MEDICARE is a federal health insurance program administered by the Social Security Administration. Medicare consists of three parts, A (hospital insurance) and B (outpatient care) and D (pharmacy). Part A provides hospital insurance to the elderly (age 65 and over) who are eligible for Social Security or Railroad Retirement benefits and persons who have been in receipt of Social Security disability benefits for twenty-four consecutive months, or suffers from chronic renal (kidney) disease or has Amyotrophic Lateral Sclerosis (ALS). Persons entitled to Part A are automatically enrolled in Part B, unless they decline coverage. In addition, all citizens and lawfully admitted aliens having resided in the U.S. for 5 years who are age 65 or older are eligible for Part B. A person age 65 or older is eligible for Part B, whether or not s/he is eligible for Social Security or Railroad Retirement benefits. Not all persons eligible for Part B are in receipt of Part B. Because there is a premium charge for Part B, individuals may decline Medicare Part B coverage. (See **INCOME FEDERAL POVERTY LEVELS MEDICARE SAVINGS PROGRAM**)

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NOTE: Enrollment in Medicare is a condition of eligibility for Medicaid.

Beginning in 2006, persons entitled to Part A and/or enrolled in Part B are eligible for the prescription drug program, Medicare Part D. The Part D prescription drug program is insurance coverage offered by insurance companies and other private companies and covers both generic and brand name drugs. Those firms serving the fee-for-service Medicare population are called Prescription Drug Plans (PDPs) and those serving Medicare Advantage (Medicare HMO) enrollees are called Medicare Advantage Prescription Drug Plans (MA-PDs). Full-benefit dual eligible beneficiaries (Medicare beneficiaries who are also in receipt of Medicaid) will receive their prescription drug coverage through Medicare rather than through the Medicaid program. Medicare Part D replaced Medicaid as the primary pharmacy coverage for dual eligible recipients. All dual eligibles are required to enroll and remain enrolled in a Medicare prescription drug plan. An exception to this rule is applied in situations where it is determined that the Medicaid applicant/recipient has cost effective health insurance AND will lose that insurance if the recipient enrolls in Part D.

NOTE: This good cause exception will not be allowed in instances where Medicaid has been furnished to an individual whose legally responsible relative has failed or refused to provide medical support.

Medicare individuals who are eligible for Medicare Part A or Part B who are eligible for the QMB, SLIMB, or QI programs or are eligible for Medicaid based on a spenddown are deemed eligible for a subsidy to assist with the premiums, deductibles and co-payments of the Part D program.

The prescription benefit for Medicaid recipients under Medicare Part D includes the following:

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- No premiums if enrolled in a plan with a monthly premium at or below the low income premium subsidy amount (referred to as the “benchmark” plan);
- No deductibles;
- No coinsurance;
- No “donut hole” (the amount of out-of-pocket drug costs that standard beneficiaries are required to pay once their initial coverage limit is reached);
- Co-payment for generic and brand drugs (See **REFERENCE CO-PAYMENT**);
- No co-payment for Medicaid recipients residing in a medical facility. A medical facility is defined as a nursing home, psychiatric center, residential treatment center, developmental center, intermediate care facility. Medicaid recipients residing in other group residences such as Assisted Living Facilities (ALPs), group homes, and adult homes are subject to co-payments.

Spenddown recipients may apply out-of-pocket Part D premiums, coinsurance and deductibles or co-payments to meet a spenddown for the initial month only. Thereafter only the premium paid over the full subsidy amount is allowed as a deduction and copayments may be used to off-set the spenddown. Additionally Medical expenses other than prescription drug costs may continue to be used to meet the spenddown.

Chronic care recipients may only deduct the premium amount that exceeds the full subsidy amount.

MEDICARE ADVANTAGE PLANS (sometimes referred to as Medicare Part C or Medicare Managed Care, or Medicare HMOs) are health plan options available to Medicare beneficiaries. In order to enroll in a Medicare Advantage Plan, the individual must have both Medicare Part A and Part B. Individuals who join these plans receive their Medicare-covered health care through the plan. The plans may or may not include prescription drug coverage. In most of the plans there are additional services and lower co-payments than in the Medicare Program (traditional fee-for-service). Co-payments and premiums can vary by plan. Enrollment in Medicare Advantage Plans is voluntary.

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Enrollees may have to see doctors who participate in the plan or go to certain hospitals to get Medicare covered services. However, there is **NO** requirement for a Medicaid recipient who has enrolled in a Medicare Managed Care Plan to only receive services from the Medicare Managed Care Plan. If an applicant receives a Medicaid covered service from a provider who is enrolled in Medicaid, but does not participate in the recipient's Medicare Managed Care Plan, Medicaid will cover the service.

When a Medicaid recipient is enrolled in the Medicare Buy-In System in eMedNY, and the plan charges a reduced Part B premium, the State is only charged for the lesser amount. If a Medicaid recipient is enrolled in a Plan that charges a premium that is higher than the traditional Part B premium, the local district must pay the difference as a health insurance premium when it has been determined to be cost effective. Medicare Advantage Plan premiums may also be used to meet a spenddown obligation, or may be used as a deduction from income in the determination of eligibility.

Medicaid must pay all deductibles, coinsurance and co-payments for Medicaid recipients enrolled in a Medicare Advantage Plan as long as the provider is also a Medicaid enrolled provider.

Not all Medicare Advantage prescription drug plans offer benchmark plans (a plan that is available to dual eligibles at no cost). Dual eligibles who are enrolled in certain Medicare Advantage Plans may have to pay an additional monthly premium for the prescription drug benefit. If a dual eligible does not want to pay the higher cost, they must disenroll from that Medicare Advantage Plan and choose a different Medicare Advantage Plan or choose traditional fee-for-service Medicare along with a stand-alone prescription drug plan that is a benchmark plan.

Individuals are responsible to pay the Medicare Part D co-payments regardless of whether they receive their drug benefit through a Medicare Advantage Plan or a stand-alone prescription drug plan. Part D co-payments or Part D premiums cannot be submitted to Medicaid for payment or reimbursement. However, such costs may be used to meet a spenddown obligation.

MEDICAID ADVANTAGE AND MEDICAID ADVANTAGE PLUS PLANS are two integrated care plans designed for dual eligible

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recipients. Both plans allow dual eligibles to enroll in the same health plan for most of their Medicare and Medicaid benefits.

Both plans achieve integration of Medicare and Medicaid through a State contract with Medicare Advantage Plans (or Medicare Advantage Special Needs Plans) to provide a defined set of Medicaid wrap-around benefits to dual eligible enrollees on a capitated basis. The Medicaid Advantage Plan benefit includes acute care services not covered by Medicare; the Medicaid Advantage Plus Plan benefit also covers Medicaid long-term care benefits.

To enroll in a Medicaid Advantage Plus Plan, recipients must be eligible for nursing home level of care. If such individuals are residing in the community, they must document current resources and be otherwise eligible in order to participate. If the person enters a nursing home for other than short term rehabilitation, s/he must document resources for the lookback period in order to continue to be eligible to participate.

Dual eligible beneficiaries may enroll in the same managed care organization's Medicare Advantage Plan or Medicare Advantage Special Needs Plan (SNP) and corresponding Medicaid Advantage or Medicaid Advantage Plus Plan product. The Managed Care Organization (MCO) receives two capitation payments; one from CMS for the Medicare Advantage product and one from the State for the Medicaid Advantage or Medicaid Advantage Plus product. Because the State pays the plan directly for any recipient cost-sharing associated with the Medicare Advantage product, Medicaid will not pay Medicaid enrolled providers for co-payments or deductibles for covered benefits for recipients enrolled in Medicaid advantage or Medicaid Advantage Plus. However, enrollees in Medicaid Advantage or Medicaid Advantage Plus are entitled to all Medicaid services they would normally get under the State Medicaid Plan. Therefore, any Medicaid services not included in the combined Medicare and Medicaid Advantage or Medicaid Advantage Plus benefit package offered by the health plan continue to be available to the enrollee when provided by any Medicaid enrolled provider on a Medicaid fee-for-service basis.

Participation by Medicare Advantage Plans or SNPs in Medicaid Advantage or Medicaid Advantage Plus is voluntary. Enrollment in these integrated plans by dual eligibles is also voluntary, and is not limited to the open enrollment period. Medicaid Advantage Plus Plans may also enroll individuals who have a spenddown.

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TRICARE (formerly known as CHAMPUS) is the Department of Defense health care program for members of the uniformed services and their families and survivors, and retired members and their families. All active duty members in the Army, Navy, Air Force, Marines, Coast Guard, National Oceanic and Atmospheric Administration (NOAA) and Public Health Service (PHS), their family members and survivors, retirees and their family members who are under age 65, Medicare eligible because of a disability, and enrolled in Medicare Part B are eligible to participate in TRICARE.

The TRICARE program offers the following three options:

- TRICARE Prime is the managed care option offered by the Department of Defense.
- TRICARE Standard is a fee-for-service option that is the same as the former CHAMPUS benefit. The beneficiary is responsible for deductibles and co-payments.
- TRICARE Extra is similar to TRICARE Standard but offers discounts to patients when they use TRICARE network providers. After paying the deductible, the beneficiary would pay a reduced co-payment.

For additional information regarding TRICARE eligibility and benefits, refer to <http://www.tricare.osd.mil/>.

When injuries are the result of an accident, medical payments may be available from Workers' Compensation, auto, homeowners' liability insurance, or a civil court action.

When a court action is pending, Medicaid may be authorized, provided the A/R is otherwise eligible and a lien is placed against the court settlement. (See **OTHER ELIGIBILITY REQUIREMENTS RECOVERIES**) When the action is settled, the A/R's financial eligibility is re-evaluated, considering any assets gained from the settlement.

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Individuals involved in an automobile accident in New York State are covered under the No-Fault Insurance Law. Benefits include all reasonable and necessary medical and rehabilitation expenses incurred as the result of an automobile accident. Benefits are also available to compensate the victim for non-medical losses resulting from the accident.

When No-Fault, Workers' Compensation, or a liability insurance company is responsible for medical expenses, no payment is made by Medicaid for treatment of the injuries or illness covered.

When No-Fault Insurance is available or potentially available, the local district considers the type of benefit payment. The local district determines if payments are specifically for incurred medical expenses or for a loss. Losses include loss of wages and services (such as the need to hire a baby-sitter, because the accident victim cannot care for his/her children). An injured A/R may also sue the person negligently causing the accident, when the medical expenses and other losses exceed No-Fault benefits.

When No-Fault payments are made to the A/R for other than medical care and service expenditures, the payments are considered a windfall (See **RESOURCES WINDFALLS** for the treatment of windfalls depending on the category of the A/R).

An A/R may have more than one insurance plan or liability claim in existence at one time; for example, an automobile accident suffered while driving on the job. In this instance, the A/R may have hospitalization coverage through his/her employer, a Workers' Compensation claim and a liability claim against another motorist.

When to Verify: Third Party health insurance benefits are verified when:

- The A/R indicates that s/he has health insurance coverage;
- The A/R is employed;
- The A/R is enrolled in college (health insurance is often a mandatory college fee);

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- A member of the household, absent parent or absent spouse is a member of a union, fraternal organization, or armed forces;
- The A/R indicates that s/he was involved in an accident;
- The A/R indicates that s/he has a work related illness/disability;
- The A/R is over age 65 or has been disabled for at least 24 months, suffers from chronic renal (kidney) disease, has Amyotrophic Lateral Sclerosis (ALS) or is a disabled widow; or
- The A/R is a disabled dependent widower between ages 50 and 65.

**Verification/
Documentation:**

Sufficient to establish an audit trail.

- Copies of both sides of benefit cards;
- Name of insurance carrier, persons covered, dates of coverage, name of the policy holder, kinds of coverage, address to which claims are sent;
- Employer or Union name and address; or
- If an accident claim, name of the party who is liable for claim, copy of the police report, date of claim, names of attorneys, status of any legal action and a copy of lien.
- Completion of the Employer Sponsored Health Insurance Request for Information form (DOH-4450)

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Disposition: Third party benefits are fully used in order to reduce the amount of Medicaid paid. As a condition of eligibility an A/R assigns his/her third party benefits. In addition, s/he assigns the rights of any other applying household members for whom s/he has the legal right to make an assignment. The A/R automatically assigns these rights, when s/he signs the application.

The following four sections discuss additional eligibility requirements related to third party resources:

- Good cause not to bill third party health insurance;
- Assignment and subrogation;
- Enrollment in employer group health insurance; and
- New York State Partnership for Long Term Care.

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GOOD CAUSE NOT TO BILL THIRD PARTY HEALTH INSURANCE

Description: Medicaid providers are instructed to bill any available health insurance prior to submitting a bill to the Medicaid program. However, in situations where the billing could jeopardize the health, safety and/or confidentiality of the recipient, the State Department of Health (SDOH) or the local district may determine that there is “good cause” not to bill third party health insurance.

Policy: When appropriate, individuals or providers may request a determination of “good cause” and authorization not to bill third party health insurance. Examples of circumstances in which the recipient’s health, safety or confidentiality could be compromised by third party billing include domestic violence situations, or instances when individuals do not want their families to know they are receiving pregnancy/family planning services.

The eMedNY Third Party Subsystem includes a “good cause” indicator; users can inquire about, add or change information in this field. In situations where available third party insurance should not be billed, the local district can set the good cause indicator on eMedNY for either the date that a service will be provided (if known), a specific period of time, or an open-ended time period. Setting the good cause indicator will also prevent the third party contractor from making a post-payment recovery. Districts should periodically check the eMedNY Mobius reports of individuals for whom the indicator is set, to be certain “good cause” is still appropriate.

In the case of a minor applying for the Family Planning Benefit Program (FPBP), third party health insurance should not be billed unless the local district has an affirmative statement that the insurance can be billed. To prevent billing third party coverage for FPBP, the district may either:

- Not enter the third party insurance information in eMedNY, or
- Enter the third party information and set the good cause indicator.

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GOOD CAUSE NOT TO BILL THIRD PARTY HEALTH INSURANCE

If third party coverage is already on eMedNY, the district may either end-date the insurance or set the good cause indicator.

In situations where a provider is requesting good cause not to bill a patient's third party insurance for reproductive health services, the provider may contact the State Department of Health (SDOH) for a determination of good cause. If granted, the provider must document the call and determination in the client's billing record.

For more information about setting the "good cause" indicator, districts should refer to the "eMedNY Implementation, Third Party Training Manual."

References:	Dept Reg.	360-3.2(a)-(f) 360-7.4(a)(3)
	GIS	01 MA/019

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ASSIGNMENT AND SUBROGATION

Description: Subrogation is the right to substitute one creditor for another. Assignment is the means by which this is accomplished.

Policy: As a condition of eligibility for Medicaid, an A/R assigns any third party benefits to which s/he is entitled to the local district.

References:

SSL Sect.	366.2(f) 366-a
Dept. Regs.	360-3.2(a), (b), (c)
ADMs	92 ADM-19 82 ADM-17

Interpretation: By virtue of his/her signature on the Medicaid application, the A/R assigns to the local department of social services any third party benefits to which s/he is entitled.

The insurance company is also notified of the local district's right to any benefits paid to the A/R. In most cases the insurance company can be notified at the time the health insurance benefit claim is filed. The notices attached to 92 ADM-19 are used to notify the insurance company of the local district's right of subrogation.

If it is determined that medical care and services that have already been paid by Medicaid could have been covered by third party benefits, the local district may exercise its right to subrogation for up to two years after the medical services have been rendered.

When to Verify Status:

- a) When the A/R or a member of the family has health insurance;
- b) When the A/R or member of the family has been injured or killed by accident;
- c) When the A/R or a member of the family is employed;
- d) When the A/R or a member of the family is in the military service or is a veteran;

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ASSIGNMENT AND SUBROGATION

- e) When the A/R or a member of the family belongs to a union or fraternal organization.

Verification Process:

- a) Seeing the insurance ID card;
- b) Obtaining information on the benefits from the employer, union, fraternal organization, veteran's group, or college;

OTHER ELIGIBILITY REQUIREMENTS RECOVERIES contains additional information on recoveries, assignments and liens.

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ENROLLMENT IN GROUP HEALTH INSURANCE

Policy: An employed A/R, eligible for Medicaid without having to reduce excess income and/or resources, must enroll in any group health insurance plan offered by the employer (including health insurance offered by an employer as a COBRA extension) when an employee contribution is not required. When an employee contribution is required, the local district determines if enrollment is cost effective. When enrollment is determined to be cost effective, the local district may require the A/R to enroll, if the local district allows or pays for the employee’s contribution.

- References:**
- SSL Sect. 366.2(g)
 367-a
 - SSA Sect 1906 (b)(1)and (c)(1)(B)
 - Dept. Reg. 360-3.2(a) (1)
 - ADMs 91 ADM-53
 87 ADM-40
 84 ADM-19
 82 ADM-48
 82 ADM-20
 - INFs 88 INF-56
 - GISs 11 MA/008
 06 MA/026
 02 MA/19

Interpretation: An A/R whose employer or union provides group health insurance at no cost to the A/R, must apply for and use such benefits as a condition of eligibility for Medicaid. When the employer or union provides group health insurance benefits, at a cost to the A/R, the local district determines if enrollment is cost effective. In most districts, this determination is done by the Third Party Resources Unit (See 87 ADM-40). If enrollment is cost effective, the A/R may be required to enroll. When more than one insurance plan is available, the district determines which plan is the most cost effective, before requiring the A/R to enroll. The A/R’s contribution is an allowable deduction from income for all categories except S/CC. When the A/R is employed, and is required by the local district to enroll in an available non-contributory health insurance plan, s/he is allowed 30 days to join the plan. The A/R must also utilize benefits available to his/her spouse

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and/or child under such insurance plan. An A/R who fails to comply with the requirement to enroll in an available health insurance plan may be denied Medicaid. Only the employed A/R may be denied. After proof of enrollment is received, OHIP-0052, "Notice of Decision to Pay Third Party Health Insurance Premiums", shall be used to advise the recipient of eligibility for the Medicaid premium payment or reimbursement.

When an A/R has private health insurance coverage in force at the time of application, the local district determines if continuation of the coverage is cost effective. The local district offers to pay health insurance premiums on behalf of all Medicaid A/Rs whenever the health insurance is determined to be cost effective and the A/R's net income and resources are at or below the allowable income/resource levels. Premium Payments are only paid for prospective months as it is generally not cost effective to pay premiums in a retro period. The exception to this may be in the instance where an A/R is at risk for losing the cost-effective insurance if the past premiums are not paid.

Cost effectiveness is determined by comparing the cost of the premiums to the Medicaid costs for the eligible Medicaid family member(s). If the group policy is cost effective, then the local district pays for the entire premium, even if the policy covers non-Medicaid eligible family members. If the group policy is not cost effective, the health insurance premium may be prorated to include the payment of the premium that covers the eligible recipient.

NOTE: With the implementation of Medicare Part D, a policy determined to be cost effective may no longer be cost effective if the policy was used primarily for prescription drug coverage. A review of the policy and the A/Rs circumstances should be made.

If a medically needy recipient pays health insurance premiums from income and such payment, together with other applicable income disregards, reduces the individual's net available income below the appropriate income eligibility standard, the local social services district must pay or reimburse the recipient for the health insurance premium if the premium is determined to be cost-effective. The payment/reimbursement of the health insurance premium cannot exceed the difference between the individual's net available income and the appropriate income eligibility standard. For example, if the individual has a monthly spenddown of \$150.00 and the health

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ENROLLMENT IN GROUP HEALTH INSURANCE

insurance premium is \$200.00, the local district would reimburse the individual \$50.00.

NOTE: The A/R must be fully eligible for Medicaid without the deduction for a health insurance premium before the cost effective premium can be paid by the local district. The health insurance premium is allowed as a deduction from income for all categories except S/CC.

Documentation: Written verification from his/her employer that s/he has enrolled in an available employer group health insurance plan.

- Seeing the ID for the health insurance plan.

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NEW YORK STATE PARTNERSHIP FOR LONG-TERM CARE

Description: The Partnership for Long-Term Care (Partnership) provides an alternative means to fund long-term care while promoting financial independence of New York State residents. This means New York State will share with participating consumers in planning for their long-term care expenses. Individuals and couples who purchase and keep in effect Partnership for Long-Term Care insurance policies will be protected, if they are otherwise eligible, against the costs of extended care situations through the Medicaid Program. State approved Partnership for Long-Term Care insurance policies are sold through private insurance companies. The Insurance Department of the State of New York must approve all Partnership insurance policies, and insurance companies marketing Partnership policies must enter into an Insurer Participation Agreement with the NYSDOH.

Policy: Persons who utilize the required amount of benefits under one of the four Partnership Plans become a Qualified Partnership Policyholder (QPP) and are eligible for Medicaid Extended Coverage (MEC) appropriate to the type of policy purchased. (See **GLOSSARY** for definitions) Although the private insurance component of a Partnership policy may be used outside of New York State to pay for long-term care services, Medicaid Extended Coverage is **ONLY** available for a QPP who is a resident of New York State. Provided a Partnership policyholder is not placed in a New York State institution by another state, or by a public or private organization contracting with the other state for such purposes, an A/R returning to New York State is a resident of New York State upon entering the State. (See **OTHER ELIGIBILITY REQUIREMENTS STATE RESIDENCE AND RESPONSIBILITY FOR ASSISTANCE DISTRICT OF FISCALLY RESPONSIBILITY (DFR)** for determining the district of fiscal responsibility.)

For Total Asset Protection (TAP) plans, income is considered in determining Medicaid eligibility, but resources are exempt. No liens or recoveries are pursued for correctly paid Medicaid.

For Dollar-for-Dollar Asset Protection (DDAP) plans, income AND unprotected resources are considered in determining Medicaid eligibility. The amount of any lien or recovery against the A/R's estate is reduced by the amount of asset protection provided to the A/R as a qualified Partnership policyholder.

All Medicaid income rules in effect at the time of application will apply.

NOTE: The income level used for married QPPs who are subject to SSI-Related community budgeting is the Spousal Impoverishment Minimum Monthly Maintenance Needs Allowance (MMMNA). The income level used for single QPPs subject to SSI-Related community budgeting is one-half of the Minimum Monthly Maintenance Needs Allowance. If the QPP

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has income in excess of these levels, the QPP may spend down to the appropriate MEC income level rather than the Medicaid level. The MMMNA levels do not apply when the QPP is subject to chronic care budgeting.

Local districts are notified of an A/R's qualification for Medicaid Extended Coverage by a 90-day Notice of Qualifying Status for Medicaid Extended Coverage letter which will be provided to the local district by the State Department of Health and/or the A/R. Different 90-day notices are issued depending on whether the A/R is participating in the TAP or DDAP plan and its minimum duration requirement. Such notices will be on insurance company letterhead, and serve as verification that the A/R is a Partnership policyholder who is about to achieve qualifying status.

- References:**
- ADMs 09 OHIP/ADM-3
 - 06 OMM/ADM-5
 - 05 OMM/ADM-1
 - 04 OMM/ADM-6
 - 02 OMM/ADM-3
 - 96 ADM-8
 - 91 ADM-17

 - LCM 97 OMM LCM-3

 - GISs 10 MA/016
 - 07 MA/020

Informational References: <http://www.nyspltc.org>

Interpretation: Total Asset Protection (TAP)

Total Asset 50 policies are identified by the number "3/6/50" and provide a minimum benefit of three years in a nursing home; or six years of home care (community-based long-term care services). In order to be eligible for Medicaid Extended Coverage, a QPP must use benefits under the policy equal to 36 months of paid nursing home care, home care (where two days of home care equal one nursing home day), and certain other policy benefits may be used to satisfy this requirement.

Total Asset 100 policies are identified by the number "4/4/100" and provide a minimum benefit of four years in a nursing home; or four years of home care (community-based long-term care services); or four years in a residential care facility, such as an assisted living program. In order to be eligible for Medicaid Extended Coverage, a QPP must use benefits under the policy equal to 48 months of paid nursing home care or its equivalent. A combination of nursing home care, home care, care in a

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residential care facility, and certain other policy benefits may be used to satisfy this requirement.

The resources of the TAP QPP are exempt from consideration in determining Medicaid eligibility. If the TAP QPP is married, his/her spouse's resources are not considered in determining the QPP's Medicaid eligibility. It is not necessary to collect and/or document information on the TAP QPP's resources or the resources of his/her spouse, except to the extent that such information documents income derived from such resources. Transfer of resources provisions do not apply. However, since income is not exempt, if there is a transfer of a lump sum income payment or a stream of income during the look-back period a transfer penalty may result. If an exempt resource that generates income is transferred, no transfer penalty is imposed. TAP QPPs are exempt from liens and recoveries, annuity requirements and substantial home equity requirements.

Dollar-for-Dollar Asset Protection Plan (DDAP)

Dollar-for-Dollar Asset 50 policies are identified by the number "1.5/3/50" and provide a minimum benefit of one and one-half years in a nursing home; or three years of home care (community-based long-term care services), where two days of home care equal one nursing home day. In order to be eligible for Medicaid Extended Coverage, a QPP must use benefits under the policy equal to 18 months of paid nursing home care or its equivalent. A combination of nursing home care, home care (where two days of home care equal one nursing home day), and certain other policy benefits may be used to satisfy this requirement.

Dollar-for-Dollar Asset 100 policies are identified by the number "2/2/100" and provide a minimum benefit of two years in a nursing home; or two years of home care (community-based long-term care services); or two years in a residential care facility, such as an assisted living program. In order to be eligible for Medicaid Extended Coverage, a QPP must use benefits under the policy equal to 24 months of paid nursing home care or its equivalent. A combination of nursing home care, home care, care in a residential care facility, and certain other policy benefits may be used to satisfy this requirement.

The DDAP QPP is allowed standard Medicaid resource exemptions in addition to the amount of his/her Partnership resource disregard. The amount of the Partnership resource disregard is the dollar amount paid by the policy for benefits received by the QPP. If the DDAP QPP is married, his/her spouse's resources are counted in the eligibility determination to the extent that the couple's combined resources exceed the dollar amount paid by the Partnership policy for benefits. If the DAPP QPP is an institutionalized spouse, the couple's countable resources that exceed

RESOURCES

NEW YORK STATE PARTNERSHIP FOR LONG-TERM CARE

the sum of the community spouse resource level, the dollar amount paid by the Partnership policy for benefits, and the Medicaid resource level for one are considered available for the institutionalized spouse's cost of care.

The resource disregard is applied first to reduce the resources of the QPP that exceed the appropriate resource standard. If excess resources exist, the DDAP QPP can become eligible for Medicaid by spending down the excess resources by incurring or paying for medical expenses.

The collection and documentation of resources for the transfer of assets look-back period is required if a DDAP QPP applies for Medicaid coverage of nursing facility services and is determined to be otherwise eligible for Medicaid. If a DDAP QPP or his/her spouse made a prohibited transfer of resources within the look-back period any remaining dollar – for-dollar disregard not used to establish resource eligibility may be used to offset the transferred resources. In cases where the uncompensated value of a prohibited transfer is entirely offset by the remaining amount of the dollar-for-dollar disregard, no transfer penalty is imposed. Any uncompensated transfer or a portion thereof, is not offset by the dollar-for-dollar disregard may result in a transfer penalty period. Any dollar-for-dollar disregard amount used to offset a prohibited transfer cannot be used again for eligibility purposes, nor can the same dollar-for-dollar amount be used to offset any lien or recovery amount from the DDAP QPP's estate.

If an annuity, such as a deferred annuity, is a countable resource at the time of application for Medicaid Extended Coverage (MEC) the dollar-for-dollar Partnership policy/certificate holder may use the asset protection earned by the Partnership insurance to establish resource eligibility. If the dollar-for-dollar asset protection is not sufficient to disregard the entire value of the annuity, any portion of the annuity value not disregarded is a countable resource for purposes of determining eligibility for MEC. In **no** instance is the dollar-for-dollar policy/certificate holder or his/her spouse required to name the State as a remainder beneficiary of the annuity when the annuity has been determined to be a countable resource.

In instances where the annuity is **not a countable resource** (e.g., a qualified annuity in payment status) and the dollar-for-dollar Partnership policy/certificate holder is applying for Medicaid coverage of nursing facility services, the policy/certificate holder and his/her spouse will be required to name the State as a remainder beneficiary or the annuity will be treated as an uncompensated transfer. Effective August 8, 2006, if the policy/certificate holder or his/her spouse refuse to name the State as remainder beneficiary, any dollar-for-dollar disregard remaining after the establishment of resource eligibility

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may be used to offset the amount of the transfer (purchase price of annuity less any monies actually received from the annuity). A note must be maintained in the case record to avoid re-applying this disregard in the future.

NOTE: Individuals may purchase Partnership Policies of greater duration than the minimum duration requirement. However, Dollar-for-Dollar Asset 50 policies cannot exceed two and one-half years of nursing home care and five years of home care. Dollar-for-Dollar Asset 100 policies cannot exceed two and one-half years of nursing home care, two and one-half years of home care and two and one-half years of care in a residential care facility. Partnership insurance policy coverage that exceeds the minimum required standards for Medicaid Extended Coverage shall be used like any other third-party health insurance to offset Medicaid expenditures for the QPP.

RESOURCES

MEDICARE SAVINGS PROGRAM

Policy: Certain A/Rs who receive Medicare may be eligible for Medicaid to pay the Medicare premium, coinsurance and deductible amounts.

References: SSL Sect. 367-a (3) a

GISs 10 MA/010
08 MA/016
05 MA/033
05 MA/013

Interpretation: The A/R may spend down income to become eligible for Medicaid and also be eligible for QMB or SLMIB, however, the Medicare premium cannot be applied in whole or in part to reduce excess income. At the time of application, the applicant is encouraged to make a choice to apply the Medicaid Premium to their spenddown to attain Medicaid eligibility **OR** to forego Medicaid eligibility for eligibility in the Medicare Savings Program. The advantages and disadvantages of both programs must be fully explained. An A/R may switch between spenddown and Medicare Savings Program; however, in the interest of accuracy and administrative efficiency, the A/R is encouraged to select and remain in one of the two programs.

Eligibility for the MSPs must be determined even if an applicant does not indicate that he or she is applying for the MSP on the DOH-4220 or LDSS-2921. If applying for MSP only, the DOH-4328 is used.

NOTE: The ACCESS NY Supplement A is not required for persons applying for the MSP only.

NOTE: When two spouses reside together in a household, eligibility for MSP will be determined by comparing income to a household of two, regardless of the income or category of the spouses.

There are four groups that are eligible for payment or part-payment of Medicare premiums, coinsurance and deductibles, through the Medicare Savings Program.

NOTE: See **REFERENCE MEDICALLY NEEDY INCOME AND FEDERAL POVERTY LEVELS** for a chart displaying the Medicaid Levels and Federal Poverty Levels.

RESOURCES

MEDICARE SAVINGS PROGRAM

Qualified Medicare Beneficiaries (QMBs)

The A/R must:

1. be entitled to benefits under Part A of Medicare; and
2. have income equal to or less than 100% of the federal poverty level.

If the A/R meets the above criteria, s/he is eligible for Medicaid payment of the Medicare Part A and B premiums, coinsurance and deductible amounts.

There is no resource test.

The DOH-4328 application should be used for individuals applying for QMB only.

Specified Low-Income Medicare Beneficiaries (SLIMBs)

The A/R must:

1. have Part A of Medicare; and
2. have income between 100% but less than 120% of the federal poverty level.

If the A/R meets the above criteria s/he is eligible for Medicaid payment of the Medicare Part B premiums.

There is no resource test.

The DOH-4328 application should be used for individuals applying for SLMB only, unless there is a spenddown in which case the DOH-4220 must be used.

NOTE: The ACCESS NY Supplement A is not required for persons applying for the MSP only.

RESOURCES

MEDICARE SAVINGS PROGRAM

Qualified Disabled and Working Individuals (QDWIs)

The A/R must:

1. have lost Part A benefits because of return to work;
2. be a disabled worker less than 65 years of age;
3. have income equal to or less than 200% of the federal poverty level;
4. have resources not in excess of twice the SSI limit; therefore, resources cannot exceed \$4,000 for a household of one or \$6,000 for a household of two; and
5. not be otherwise eligible for Medicaid.

If the A/R meets the above five criteria s/he is eligible for Medicaid payment of the Medicare Part A premium, not the Medicare Part B premium.

The applicant is required to attest to the amount of his/her resources but does not need to provide proof.

Qualifying Individuals – (QI)

The A/R must:

1. have Part A of Medicare; and
2. have income between 120% - 135% of the federal poverty level.

If the A/R meets the above criteria s/he is eligible for Medicaid payment of the Medicare Part B premiums each month.

Applicants should use the DOH-4328 when applying for this benefit.

Each state has been given a capped allocation to fund these premium payments.

There is no resource test.

RESOURCES**VETERANS NURSING HOME PER DIEM PAYMENTS**

- Description:** The Veteran's Administration (VA) pays states a per diem payment for nursing home care provided to eligible veterans in a facility recognized as a state home for nursing home care.
- Policy:** Public Law 108-422 prohibits Medicaid from offsetting the Veteran's Administration "per diem" payment from the cost of nursing home care.
- References:** GIS 05 MA/040
- Interpretation:** Prior to the enactment of the Veteran's Health Program Improvement Act (VHPIA), the VA per diem payment was considered a third party resource under Medicaid law, and was used to offset the Medicaid payment to nursing homes. Effective November 30, 2004, these VA payments are no longer considered a third party resource, and cannot be used to reduce Medicaid's share of the cost of providing nursing home services to Medicaid recipients. The facility may retain the per diem payment.

RESOURCES

TRANSFER OF ASSETS

Description: Sometimes an SSI-related A/R, the A/R's spouse, or someone acting on his/her behalf, makes a voluntary assignment or transfer of non-exempt assets for less than its fair market value. Under certain circumstances, an SSI-related A/R may be subject to a period of restricted Medicaid coverage or penalty period, when a transfer of assets for less than the fair market value has occurred within the look-back period.

Policy: Once an SSI-related A/R is found financially eligible for Nursing Facility Services a review is made to determine if any assets were transferred during the look-back period for less than fair market value. A/Rs are initially requested to provide an explanation of each bank transaction of \$2,000 or more. If the district identifies that transfers for less than fair market value been made, a review of all transactions made during the look-back period may be performed.

For applications of Medicaid coverage for nursing facility services and for SSI-related recipients who request an increase in coverage for nursing facility services, the look-back period increases from 36 months to 60 months (60 months for trusts) for transfers made on or after February 8, 2006.

The look-back period increases each month by 1-month increments beginning March 1, 2009 (37 months) until February 2011. Effective February 1, 2011, the full 60 month look-back period will be in place for ALL transfers of assets.

NOTE: In cases where the initial days of nursing facility care were covered as short-term rehabilitation under Community Coverage Without Long-Term Care, the look-back period is the period immediately preceding the month the SSI-related individual started to receive the short-term rehabilitation service. Any transfer penalty for an otherwise eligible individual would start the first month the individual started to receive the short-term rehabilitation service.

Once eligibility is established for an SSI-related institutional spouse, any transfers made by the community spouse do not affect the institutionalized spouse's Medicaid eligibility.

NOTE: If an SSI-related Medicaid recipient has been on Medicaid for the past 60* months, has documented current resources at each renewal; not created or funded a trust which requires a 60-month look-back; and not made a prohibited transfer, a separate resource review

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TRANSFER OF ASSETS

Dept. Reg.	360-1.4 360-2.3 360-4.4(b)(2) 360-4.4(c) 360-4.6 360-4.7(a)(1)
ADMs	10 OHIP/ADM-01 09 OHIPADM-3 08 OLTC-01 06 OMM/ADM-5 04 OMM/ADM-6 96 ADM-8 91 ADM-37 91 ADM-31 90 ADM-36 90 ADM-29 89 ADM-45 85 ADM-27
GISs	09 MA/027 09 MA/016 09 MA/007 08 MA/019 07 MA/018 07 MA/007 06 MA/016 05 MA/012

Interpretation: When an institutionalized SSI-related A/R or spouse makes a prohibited transfer, but is otherwise eligible for Medicaid, a penalty period is imposed. During this penalty period, the SSI-related A/R will not be eligible for nursing facility services. (See **RESOURCES RESOURCE DOCUMENTATION REQUIREMENTS** for a complete list of nursing facility services.)

Exceptions:

- The transfer of exempt assets, other than a homestead, does not affect the SSI-related A/R's eligibility.
- An SSI-related A/R and/or the spouse may transfer the homestead, without penalty, to his/her:
- Spouse;

RESOURCES

TRANSFER OF ASSETS

- Child under the age of 21;
- Certified blind/disabled child of any age;
- Sibling who has an equity interest in the SSI-related A/R's home and has resided in the home for at least one (1) year immediately prior to the A/R's most recent institutionalization; or
- Adult child who resided in the SSI-related A/R's home for at least 2 years, immediately prior to the A/R's most recent institutionalization and who provided care to the SSI-related A/R which permitted the A/R to reside at home rather than in a medical facility. It is presumed that the child "provided care" unless there is evidence to the contrary.

The transfer of a homestead to any other person for less than fair market value may render the SSI-related A/R ineligible for Medicaid coverage of nursing facility services.

Transfer of assets penalties are not imposed against an SSI-related A/R when an asset other than the individual's home is transferred:

- to the individual's spouse, or to another for the sole benefit of the individual's spouse;
- from the individual's spouse to another for the sole benefit of the individual's spouse;
- to the individual's child who is certified blind or certified disabled; or
- to a trust established solely for the benefit of an individual under 65 years of age who is disabled.

Sole Benefit – A transfer is considered to be for the "sole benefit of the SSI-related individual's spouse" if the transfer is arranged in such a way that no individual or entity other than the spouse can benefit from the assets transferred in any way, whether at the time of the transfer or any time in the future. A remainder man is someone who will inherit property in the future (e.g., after a person's death). A transfer is not for the sole benefit of the spouse if the transferred asset has a remainder person. For example, if an SSI-related institutionalized spouse takes money that is in his/her name, purchases an annuity so that only the community spouse receives payments, and there is a designation of a remainder man (beneficiary other than the community spouse's estate), this would be evaluated as an uncompensated transfer.

RESOURCES

TRANSFER OF ASSETS

A transfer penalty is not imposed against an SSI-related A/R when a satisfactory showing is made that:

- the SSI-related A/R or the A/R's spouse intended to dispose of the asset for its fair market value or exchange it for other consideration of similar value;
- all of the assets transferred for less than the fair market value have been returned to the individual.

Assets Transferred to Purchase Life Estate Interest

If an SSI-related A/R or the A/R's spouse transfers assets to purchase a life estate interest in property owned by another individual on or after February 8, 2006, the purchase is to be treated as a transfer of assets for less than fair market value, unless the purchaser resides in the home for at least a continuous period of one year after the date of purchase.

The amount used to purchase the life estate interest is the amount to be treated as the uncompensated transfer of assets in the eligibility determination. This policy applies to applications filed on or after August 1, 2006 for nursing facility services, including requests for an increase in coverage for nursing facility services.

Assets Transferred to Purchase Loans, Promissory Notes and Mortgages

Applications filed on or after August 1, 2006 for nursing facility services, including requests for an increase in coverage for nursing facility services, if an SSI-related A/R or the A/R's spouse purchases a loan, promissory note or mortgage, the funds used are to be treated as a transfer for less than fair market value, unless the note, loan or mortgage:

- Has a repayment term that is actuarially sound;
- Provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and
- Prohibits the cancellation of the balance upon the death of the lender.

The amount of the transfer is the outstanding balance due as of the date of the individual's application for nursing facility services.

RESOURCES

TRANSFER OF ASSETS

Assets Transferred to Purchase a Personal Service Contract

A personal service contract that does not provide for the return of any prepaid monies in the event the caregiver becomes unable to fulfill his/her duties under the contract, or if the SSI-related A/R dies before his/her calculated life expectancy, must be treated as a transfer of assets for less than FMV. If a personal service contract does provide for the return of funds in the events the caregiver is unable to fulfill his/her obligation under the contract or the SSI-related A/R dies before his/her calculated life expectancy, a determination must still be made as to whether the SSI-related A/R will receive FMV in exchange for funds transferred.

If the personal service contract provides that services will be delivered on an “as needed” basis, no determination that FMV will be received and a transfer of assets penalty must be calculated.

In calculating the transfer penalty, the value of services actually received from the time the personal service contract was signed and funded through the date of the Medicaid eligibility determination must be “credited” by reducing the transferred amount before calculating the period of ineligibility.

NOTE: Credit is not allowed for services that are provided as part of the Medicaid nursing home rate.

In assessing the value of furnished services, districts must be provided with credible documentation, such as a log with dates specific services were provided and the hour(s) each service was provided. The value of the caregiver services must be commensurate with a reasonable wage scale, based on fair market value for the actual job performed and the qualifications of the caregiver. If credible documentation is not provided, no credit is deducted in calculating the uncompensated transfer amount. When a district determines that a reasonable pay rate for a job/service is less than the amount spelled out in the personal services contract, the district must use the lesser amount in calculating the amount of compensation received for the transfer.

NOTE: Assistance in evaluating job duties and pay rates may be found in the U.S. Department of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook at: <http://www.bls.gov/oco/>. This handbook includes information on training and other qualifications needed for particular jobs.

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TRANSFER OF ASSETS

The SSI-related A/R or the A/R's spouse is allowed a minimum of twenty days to present evidence that the transfer was made exclusively for a purpose other than to qualify for Medicaid coverage of nursing facility services. An SSI-related A/R's Medicaid coverage may not be restricted due to a transfer of assets without first advising the SSI-related A/R and the spouse, in writing, of the right to present evidence. Some factors suggesting that the transfer was made exclusively for another purpose include:

- The traumatic onset of a disability after the transfer (e.g., A/R has a heart attack shortly after the transfer and there was no previous record of heart disease); or
- The unexpected loss of other resources which would have precluded Medicaid eligibility.

Rebuttal Presumption of Prohibited Transfer

If an SSI-related individual transfers resources (e.g. gives them away or sells them for less than fair market value), there is a rebuttable presumption that the resources were transferred for the purpose of establishing or maintaining eligibility for Medicaid coverage of nursing facility services. The presumption is rebutted only if the SSI-related individual provides convincing evidence that the resources were transferred exclusively for a purpose other than to become or remain eligible for Medicaid. If the SSI-related individual had some other purpose of transferring the resource but an expectation of establishing and maintaining Medicaid eligibility was also a factor, the transfer will result in a period of ineligibility for Medicaid coverage of nursing facility services.

An SSI-related A/R's Medicaid coverage may not be restricted due to a transfer of assets without first advising the SSI-related A/R and the spouse, in writing, of the right to present evidence to rebut the presumption that a transfer was made in order to qualify for Medicaid coverage of nursing facility services. To meet this requirement, the "Explanation of Effects of Transfer" must be given to the applicant who is applying for Medicaid coverage of nursing facility services.

The SSI-related individual must provide convincing evidence (i.e. written documentation) that the transfer was exclusively for a purpose other than to qualify for Medicaid benefits. An individual's signed statement regarding the circumstances of the transfer should include the individual's:

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- Purpose of transferring the resource;
- Attempts if any, to dispose of the resource at fair market value (FMV);
- Reason for accepting less than FMV for the resource;
- Means or plans for self-support after the transfer;
- Relationship, if any, to the person(s) to whom the resource was transferred;
- Belief that he/she received FMV, if applicable.

NOTE: A signed statement by the SSI-related individual is not, by itself, convincing evidence. Pertinent documentary evidence includes, but is not limited to, legal documents, real estate agreements, relevant correspondence, medical reports, etc.

The following are examples of situations that while not conclusive, may indicate that the transfer was made exclusively for some purpose other than to qualify for Medicaid coverage of nursing facility services. After the transfer:

- There is a traumatic onset (e.g. traffic accident) of disability or blindness; or
- There is a diagnosis of a previously undetected disabling condition (e.g., heart attack when there was no previous record of heart disease), or
- There is an unexpected loss of other income or resources which would have precluded Medicaid eligibility.

If the SSI-related A/R is unable to present evidence that the A/R or his/her spouse intended to dispose of the asset for the fair market value, or that the asset was transferred exclusively for a purpose other than to qualify for Medicaid, the case is evaluated to determine if the restriction of Medicaid coverage would cause the SSI-related A/R “undue hardship”. Undue hardship occurs when the SSI-related A/R is otherwise eligible for Medicaid; is unable to obtain appropriate medical care without Medicaid coverage; and despite the best efforts of the A/R and/or the spouse, is unable to have the transferred assets returned or to receive fair market value for the assets. Best efforts include cooperating, as deemed appropriate by the local social services district, in the pursuit of the return of such assets.

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NOTE: Effective February 8, 2006 to meet the definition of undue hardship, the SSI-related individual must meet all of the conditions described above and be deprived of food, clothing, shelter or other necessities of life.

Uncompensated Value

The uncompensated value of a transfer is the difference between the fair market value at the time of transfer (less any outstanding loans, mortgages or other legal encumbrances on the asset) and the amount received for the asset. If the SSI-related A/R's resources are below the appropriate resource level, the amount by which the resource level exceeds the SSI-related A/R's resources must be deducted from the uncompensated value of the transfer. In addition, amounts specified in regulations for burial funds (\$1,500 for SSI-related A/Rs), but not for burial space items, must be deducted, if the SSI-related A/R does not have an irrevocable pre-need funeral agreement with \$1,500 designated for non-burial space items or a burial fund.

Example: An SSI-related applicant makes a prohibited transfer in April, 2005 of \$20,000 and applies for Medicaid coverage of nursing home care in May, 2005. The only resource the SSI-related applicant has is \$2,000 in a bank account. To determine the uncompensated value of the prohibited transfer, subtract the SSI-related applicant's countable resources from the Medicaid Resource Level for a household of one ($\$4,000 - \$2,000 = \$2,000$). If there is a remainder, subtract the remainder from the prohibited transfer amount ($\$20,000 - \$2,000 = \$18,000$). \$18,000 is the uncompensated value of the transfer.

If the SSI-related applicant also does not have an irrevocable pre-need funeral agreement with \$1,500 designated for non-burial space items or a \$1,500 burial fund, the prohibited transfer amount is further reduced by \$1,500 ($\$18,000 - \$1,500 = \$16,500$). \$16,500 is the uncompensated value of the transfer.

The uncompensated value cannot be reduced by applying it to the maximum community spouse resource allowance.

Except as provided below concerning multiple transfers, for transfers made prior to February 8, 2006 the penalty period begins on the first day of the month following the month in which the assets were transferred.

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For transfers made on or after February 8, 2006, the penalty period starts the first day of the month after assets have been transferred for less than fair market value, OR the first day of the month the otherwise eligible SSI-related institutionalized individual is receiving nursing facility services for which Medicaid would be available but for the transfer penalty, whichever is later, and which does not occur during any other period of ineligibility.

The penalty period is a period of months equal to the total uncompensated value of the transferred assets divided by the average regional rate for nursing facility services in the region where the SSI-related individual is institutionalized. There is no cap on the length of the penalty period. The regional rates are revised annually and are based on average nursing home costs in each of the seven regions of the State. (See **REFERENCE** REGIONAL RATES FOR TRANSFER OF ASSETS)

Once a penalty period has been established for an otherwise eligible SSI-related individual, the penalty period continues to run regardless of whether the individual continues to receive nursing facility services or remains eligible for Medicaid. Upon reapplication for Medicaid coverage of nursing facility services, any uncompensated transfer that still falls within the new look-back period which has already resulted in an expired penalty period, would not again be assessed a penalty. Only subsequent transfers can result in a transfer penalty period.

Partial Month Penalty Period

If the uncompensated value of the transferred assets is less than the regional rate, or the penalty period results in a partial month penalty, count the uncompensated value attributable to the partial month as part of the Net Available Monthly Income (NAMI) or, in the case of an individual receiving waiver services in the community, spenddown liability for the month.

Example: An SSI-related applicant in the Northern Metropolitan region makes an uncompensated transfer of \$29,162 in April, 2005. The uncompensated transfer amount of \$29,162, divided by \$8,332 (the 2005 Medicaid monthly regional rate for the Northern Metropolitan region), equals 3.5 months. The 3-month penalty period runs from May, 2005, the month following the month of transfer, through July, 2005, with a partial month penalty calculated for August, 2005. The calculations follow:

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\$ 8,332	Medicaid monthly regional rate (for Northern Metropolitan region)
X 3	three-month penalty period
\$24,996	penalty period amount for three full months
\$29,162	uncompensated transfer amount
<u>-24,996</u>	penalty period amount for three full months
\$ 4,166	partial month penalty amount

For August, 2005, the partial month penalty amount of \$4,166 would be added to the SSI-related institutionalized person’s NAMI.

Recalculation of Returned Assets

If all or a portion of the transferred assets is returned after the Medicaid eligibility determination, the existing penalty period is recalculated, reducing the penalty period by the amount of assets returned. For transfers made after February 8, 2006, the recalculated penalty period cannot begin before the assets retained by the individual at the time of transfer, combined with the assets transferred, and subsequently returned to the individual, have been spent down to the applicable Medicaid resource level.

Multiple Transfers

For multiple transfers during the look-back period, where assets have been transferred in amounts and/or frequency that would make the calculated penalty periods overlap, add together the uncompensated values of all the assets transferred, and divide by the Medicaid regional rate. The period of ineligibility begins with the first day of the month following the month in which that first transfer occurred.

Multiple transfers of assets for less than fair market value made on or after February 8, 2006, must be accumulated and treated as one transfer. The penalty period starts the first day of the month after assets have been transferred for less than fair market value, OR the first day of the month the otherwise eligible SSI-related institutionalized individual is receiving nursing facility services for which Medicaid would be available but for the transfer penalty, whichever is later, and which does not occur during any other period of ineligibility.

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Apportioning Penalty Periods Between SSI-related Spouses

When an SSI-related institutionalized spouse applies for Medicaid and either spouse has made a prohibited transfer and if the SSI-related institutionalized spouse is otherwise eligible, he/she is authorized with restricted coverage for a penalty period based on the full uncompensated value of the transferred resources.

If the other member of the SSI-related couple subsequently applies for Medicaid as an SSI-related institutionalized individual (both SSI-related spouses are institutionalized), prior to the expiration of the penalty period the penalty period is apportioned equally between the SSI-related spouses. If one spouse is no longer subject to a penalty (e.g., one spouse dies), the remaining penalty period for both spouses is applied to the remaining spouse.

An institutionalized SSI-related A/R who is being penalized for making a prohibited transfer may receive Medicaid coverage for ancillary services, not included in the per diem rate, if otherwise eligible. The SSI-related A/R is budgeted by deducting the SSI-related disregards, the Medically Needy Income level for a household of one. (See **REFERENCE MEDICALLY NEEDED INCOME LEVELS** and the **REFERENCE MEDICAID RESOURCE LEVEL**) An SSI-related institutionalized spouse is budgeted as if s/he was in his/her first month of permanent absence from the community. Only those resources in excess of the community spouse resource allowance (See **REFERENCE MINIMUM/MAXIMUM COMMUNITY SPOUSE ALLOWANCE**) are considered.

It is essential that the local district carefully document the actual date of any transfer. When an SSI-related A/R or spouse deeds property to another person, the effective date of the transfer is the date the deed is delivered to and accepted by the transferee/purchaser. The deed need not be recorded to complete the transfer. When a person promises to transfer a gift or resource to another person, the date the promise is made is not significant. The date of transfer is the date the resource changed ownership.

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- Verify Status:**
- (a) When the SSI-related A/R or spouse indicates that someone else pays the mortgage or property tax;
 - (b) When the SSI-related A/R or spouse indicates that s/he is provided with a home at no cost;
 - (c) When previous records indicate resources that are no longer claimed;
 - (d) When the SSI-related A/R's or spouse's financial institution accounts indicate substantial withdrawals;
 - (e) When the SSI-related A/R or spouse declares resources in the name of another person.

- Verification:**
- (a) Obtaining an appraisal by a real estate broker;
 - (b) Seeing property tax statements;
 - (c) Seeing mortgage statements;
 - (d) Seeing financial institution account statements;
 - (e) Seeing court records.

Disposition: When the local social services district becomes aware that a transfer of resources was made by an SSI-related A/R or his/her spouse, the local district determines the date on which the resources were transferred. The SSI-related A/R is notified and given a reasonable amount of time to present evidence that the transfer was not made for the purpose of qualifying for Medicaid. When a penalty period is imposed, an adequate and timely notice is sent to the SSI-related A/R.

RESOURCES TRANSFER OF ASSETS

ANNUITIES

Description: An annuity is contract with a life insurance company, designed to provide payments on a regular basis either for life or a term of years.

Policy: As a condition of eligibility, all persons applying for Medicaid coverage of nursing facility services, including requests for an increase in coverage for nursing facility services, must disclose a description of any interest he/she, or his/her spouse, may have in an annuity. The disclosure of interest in an annuity is required regardless of whether the annuity is irrevocable or counted as a resource. Additionally, for annuities purchased by an SSI-related A/R or the A/R's spouse on or after February 8, 2006, the State must be named as a remainder beneficiary in the first position for at least the amount of Medicaid paid on behalf of the institutionalized individual. In cases where there is a community spouse or minor or disabled child of any age, the State must be named the remainder beneficiary in the second position or named in the first position if such spouse or representative of such child disposes of any such remainder for less than fair market value.

NOTE: In instances where the annuity has been determined to be a countable resource, the State is NOT named a remainder beneficiary.

The social services district must require a copy of the annuity contract owned by the SSI-related A/R or the A/R's spouse in order to verify that the State has been named the remainder beneficiary. If the SSI-related A/R or the A/R's spouse fails or refuses to provide the necessary documentation, the district must treat the purchase of the annuity as a transfer of assets for less than fair market value.

Individuals who are applying for or receiving care, services or supplies pursuant to a waiver under subsection (c) or (d) of Section 1915 of the Social Security Act (SSA) are **not** subject to these requirements regarding annuities. In New York, such waiver services are provided through the Long Term Home Health Care Program (LTHHCP), Traumatic Brain Injury Waiver Program (TBI), Care at Home Program (CAH), the Office for People with Developmental Disabilities (OPWDD) Home and Community-Based Services (HCBS) Waiver, Home and Community- Based Services Waiver for Children with Serious Emotional Disturbance (Office of Mental Health [OMH]) and the Nursing Home Transition and Diversion Waiver (NHTD).

NOTE: Treatment of annuities for Partnership policy/certificate holders with Total Asset Protection OR Dollar for Dollar Asset Protection plans is discussed in **RESOURCES NEW YORK STATE PARTNERSHIP FOR LONG TERM CARE.**

**RESOURCES
TRANSFER OF ASSETS**

ANNUITIES

References:	SSL Sect.	366-a (2) 366 366-c 366-ee
	Dept. Reg.	360-2.3 360-4.4 360-4.6
	ADMs	10 OHIP/ADM-01 06 OMM/ADM-5 06 OMM/ADM-2 04 OMM/ADM-6 96 OMM/ADM-8
	GISs	09 MA/027 07 MA/020 07 MA/018 07/MA/011 06 MA/016

Interpretation: The purchase of an annuity that does not name the State as a remainder beneficiary in the first position (or in the second position as explained above) will be treated as an uncompensated transfer of assets for SSI-related A/Rs. In addition, if an annuity is purchased by or on behalf of an SSI-related A/R, the purchase will be treated as a transfer of assets for less than fair market value unless the annuity is:

- An annuity described in subsection (b) or (q) of Section 408 of the Internal Revenue Code of 1986; or
- Purchased with the proceeds from an account or trust, described in subsection (a), (c), or (p) of Section 408 of such Code; a simplified employee pension (within the meaning of Section 408 (k) of such Code); or a Roth IRA described in Section 408A of such Code; or

**RESOURCES
TRANSFER OF ASSETS**

ANNUITIES

The annuity is:

- Irrevocable and non-assignable;
- Is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration); **AND**
- Provides for payments in equal amounts during the term of the annuity with no deferral and no balloon payments made.

NOTE: These provisions apply to transactions, including purchases which occur on or after February 8, 2006. Transactions subject to these provisions include any action by the individual that changes the course of payment from the annuity or that changes the treatment of the income or principal of the annuity. These transactions include additions of principal, elective withdrawals, requests to change the distribution of the annuity, elections to annuitize the contract and similar actions.

**RESOURCES
TRANSFER OF ASSETS**

REGIONAL RATES

Policy: Regional rates are used to determine the period of restricted Medicaid coverage when a prohibited transfer is made. The districts included in each region are identified below. Districts must use the rate for the region in which the facility is located. The regional rates for persons who apply for Medicaid as an SSI-related institutionalized person on or after January 1, each year can be found in the **REFERENCE REGIONAL RATES TRANSFER OF ASSETS**. The regional rates are based on the average nursing home costs in each of the seven regions of the State.

<u>NORTHEASTERN</u>			<u>WESTERN</u>	
Albany	Fulton	Saratoga	Allegany	Orleans
Clinton	Greene	Schenectady	Cattaraugus	Wyoming
Columbia	Hamilton	Schoharie	Chautauqua	
Delaware	Montgomery	Warren	Erie	
Essex	Otsego	Washington	Genesee	
Franklin	Rensselaer		Niagara	

<u>ROCHESTER</u>		<u>NORTHERN METROPOLITAN</u>	
Chemung	Steuben	Dutchess	Westchester
Livingston	Wayne	Orange	
Monroe	Yates	Putnam	
Ontario		Rockland	
Schuyler		Sullivan	
Seneca		Ulster	

<u>CENTRAL</u>			<u>NEW YORK CITY</u>
Broome	Lewis	Tioga	Bronx
Cayuga	Madison`	Tompkins	Kings (Brooklyn)
Chenango	Oneida		NY (Manhattan)
Cortland	Onondaga		Queens
Herkimer	Oswego		Richmond (Staten Island)
Jefferson	St. Lawrence		

<u>LONG ISLAND</u>	
Nassau	Suffolk

**RESOURCES
TRANSFER OF ASSETS****REGIONAL RATES**

References:	SSL Sect.	366 366-ee
	ADMs	10 OHIP/ADM-01 96 ADM-8 06 OMM/ADM-2 05 OMM/ADM-1
	GISs	09 MA/027 07 MA/002 06 MA/001 04 MA/033

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OTHER ELIGIBILITY REQUIREMENTS

APPLICATION, CERTIFICATION AND RENEWAL

Description: The initial authorization and granting of Medicaid is based upon a written application, made on a "State-prescribed" form. The continuance of Medicaid is premised on a renewal of the recipient's eligibility for Medicaid. Department Regulations and the recipient's individual circumstances determine the frequency of recertification.

Policy: Medicaid is granted initially upon the determination of eligibility, based on a written application, made on a "State prescribed" form. An application may be made by the applicant, his/her authorized representative, or when the applicant is incompetent or incapable, by someone acting responsibly on his/her behalf, such as an adult family member, or a person or agency acting on behalf of the applicant. Continuance of Medicaid is granted upon the renewal and redetermination of the recipient's eligibility. Documentation contained in the case record is evaluated during recertification and/or reapplication.

A separate Medicaid eligibility determination is made when a Temporary Assistance (TA) case is denied or closed and the household applied for or was in receipt of Medicaid. The only exception is when the reason to deny, suspend, reduce or terminate Temporary Assistance is also a proper basis for denial, reduction or termination of Medicaid. A separate Medicaid eligibility determination is also made when a SSI recipient loses eligibility for SSI. Medicaid is continued until a separate eligibility determination can be made.

References:

SSL Sect.	366 366-a
Dept. Reg.	350.1 350.3 350.4 360-2.2 360-2.3 360-6.2
ADMs	10 OHIP/ADM-4 04 OMM/ADM-6 97 OMM/ADM-2 82 ADM-5 80 ADM-19
INF	98 OMM/INF-02

OTHER ELIGIBILITY REQUIREMENTS

APPLICATION, CERTIFICATION AND RENEWAL

Interpretation: An applicant for Temporary Assistance applies separately for Medicaid by indicating that s/he wants a Medicaid eligibility determination as well. An SSI recipient is granted Medicaid based upon his/her certification for SSI. When a Temporary Assistance or SSI case is closed, Medicaid is continued until a separate Medicaid determination is made. The only exception to this is when the reason to suspend or terminate Temporary Assistance is also a proper basis for the termination of Medicaid. In this case, a separate statement appears in the Notice of Intent advising the client of the action to be taken on his/her Medicaid case, the reasons for the action, the effective date of the action and the supporting regulations. The re-determination for Medicaid is completed by the end of the calendar month following the month in which Temporary Assistance is terminated. Similarly, for every SSI cash recipient whose case is closed, unless the closing is due to the death of the recipient or because the recipient moved out of state, a separate eligibility determination is made for Medicaid.

If an individual wishes to apply for Medicaid only, a separate application for Medicaid is filed and financial eligibility established using the standards of income and resources, as appropriate, governing the Medicaid Program. To continue and re-authorize assistance, a periodic re-determination of eligibility is completed. This section deals with the application and certification as follows:

- New application;
- Reapplication; and
- Renewal.

OTHER ELIGIBILITY REQUIREMENTS APPLICATION, CERTIFICATION AND RENEWAL

FACILITATED ENROLLERS

Description: Facilitated enrollers (FEs) assist applicants in the completion of the application. This assistance includes the following:

- Providing application assistance including:
 - seeing, copying and/or recording information about documents that verify eligibility requirements such as original identity and citizenship documents;
 - assisting in the completion of the application and
 - assisting in the collection of various documentation items;
- Screening the family for the appropriate program;
- Submitting the completed application, documentation and enrollment form to the local district;
- Counseling the applicant on managed care plan selection, where appropriate; and
- Following-up with the applicant to ensure that they complete the application process.

Policy: Effective April 1, 2010, an interview for Medicaid and FHPlus must not be required as a condition of eligibility. While an interview cannot be required, FEs are required to provide application assistance, as appropriate, to an applicant who seeks assistance in understanding the application process or with completing the application. The local district determines the applicant's eligibility for Family Health Plus, Medicaid and the Family Planning Benefit Program and is responsible for the enrollment of applicants into managed care plans as appropriate.

Persons requiring long-term care services such as nursing home care or personal care may not apply through facilitated enrollers.

References:

ADMs	10 OHIP/ADM-4 01 OMM/ADM-6
INFs	10 OHIP/INF-1
GISs	11 MA/007

Interpretation: When an FE meets with an applicant or authorized representative and provides application assistance, the FE will receive and submit the application to the appropriate LDSS. In this situation, the FE must submit the application to the LDSS for an eligibility determination within 15 days. If upon agreement between an FE or health plan and

OTHER ELIGIBILITY REQUIREMENTS APPLICATION, CERTIFICATION AND RENEWAL

FACILITATED ENROLLERS

the local department of social services the FE or health plan electronically fills out an application, the applicant may provide his/her signature on an electronic keypad which transmits the signature to the application to be printed and sent to the LDSS.

NOTE: If a recipient wants to add a child to his/her case between authorization periods, the recipient may seek application assistance at an FE. Facilitated enrollers will assist the individual in completing an application for the child and submit it to the appropriate LDSS.

When an applicant completes an application on his/her own, and then submits the application to the FE, or asks the FE to review the application, the FE must review the application to ensure that it is complete and all necessary documentation has been presented. Such applications become FE applications. The FE must have the applicant resign/date the application and collect current documentation. The FE must date stamp the application on the day he/she meets with the applicant, which will start the 15 day clock.

If the applicant goes to an FE to present his/her original documents, but does not submit the completed application to the FE, and the FE does not provide application assistance, the FE must make copies of the original documents, stamp the copy indicating the date the original was seen, add the lead name and the FE name on the copy, and return the original documents and copies to the applicant for submission to the LDSS.

NOTE: Local departments of social services may not require that individuals apply through an FE, nor may they require that the applicant seek application assistance from an FE. In addition, LDSSs cannot forward applications submitted directly by an applicant to an FE and require the FE to follow up in obtaining necessary documentation.

When an application is mailed directly to a Child Health Plus (CHPlus) plan that is not an FE, the application (whether it is complete or incomplete) will be mailed by the plan directly to the LDSS if the child appears Medicaid eligible. In this situation, the date of application is the date that a signed and dated application is received by the LDSS. Non-FE CHPlus plans will not refer these applicants to an FE for application assistance. In situations where the CHPlus plan is an FE, the plan must review the application to ensure it is complete and all necessary documentation has been provided before it is forwarded to

**OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL**

FACILITATED ENROLLERS

the LDSS. In such cases, the date of application is the date the FE receives the complete application. The FE has 15 business days from the date the application was received to get the application to the LDSS.

OTHER ELIGIBILITY REQUIREMENTS APPLICATION, CERTIFICATION AND RENEWAL

NEW APPLICATION

Description: An application for Medicaid, Family Health Plus, Child Health Plus, the Family Planning Benefit Program, Medicare Savings Program, the Medicaid Cancer Treatment Program: Breast, Cervical, Colorectal, and Prostate Cancer Treatment Programs, and/or Medicaid Buy-In Program for Working People With Disabilities (MBI-WPD) is a written, dated form prescribed by the State. The applicant, his/her authorized representative or, when the applicant is incompetent or incapacitated, by someone acting on behalf of the A/R must sign it.

Policy: An applicant requesting Medicaid, Family Health Plus, the Family Planning Benefit Program, Medicare Savings Program, Medicaid Cancer Treatment Program: Breast, Cervical, Colorectal and Prostate Cancer Treatment Programs and/or Medicaid Buy-In Program for Working People With Disabilities may make application by dropping off an application to an LDSS or by mailing the application to the local district, facilitated enroller or other designated entity.

NOTE: Access NY Health Care applications and Supplement A can be printed from the internet at:

<http://www.health.state.ny.us/nysdoh/fhplus/application.htm>.

However, such applications may not be completed or submitted online.

Applicants may request assistance in understanding the Medicaid program or completing an application.

As of June 11, 2010, ALL applicants applying for Medicaid only, including applicants seeking coverage of long-term care services or nursing home care will make application for benefits on the Access NY Health Care application (DOH-4220). However, if an LDSS receives the LDSS-2921 application for a Medicaid-only applicant, they must accept the application and cannot require that the DOH-4220 or the DOH-4495A also be completed. The LDSS-2921 should continue to be used when an individual is applying for Medicaid and another program, such as Temporary Assistance, Child Care Assistance and/or Food Stamps. Individuals who are applying for the Family Planning Benefit Program (FPBP) should use the DOH-4282, Family Planning Benefit Program Application Form. The DOH-4286 (Instructions for the Family Planning Benefit Program Application) provides guidance for completing the DOH-4282. These forms may be accessed on the DOH website, at the LDSS, or at FPBP providers. Individuals who are applying for the Medicare Savings Program (MSP) should use the DOH-4328.

**OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL**

NEW APPLICATION

NOTE: For individuals applying on the DOH-4220, county specific absent parent forms must no longer be used.

The ACCESS NY Supplement A, DOH-4495A, must be completed if anyone who is applying is age 65 or older, certified blind or certified disabled (of any age), not certified disabled but chronically ill or institutionalized and applying for coverage of nursing home care, including care in a hospital that is equivalent to nursing home care. Supplement A must be signed and dated by the applicant and/or his/her representative and if appropriate, the applicant's spouse. An S/CC or ADC-Related applicant who requires temporary nursing home care is not required to complete Supplement A. However, if such S/CC or ADC-Related applicant has a community spouse and such spouse is in a medical institution and/or nursing facility and is likely to remain in the facility for at least 30 consecutive days, Supplement A must be completed.

NOTE: Effective April 1, 2010, an LDSS can no longer require that an application interview take place.

References:

SSL Sect. 366
366-a

Chapter 58 of the Laws of 2009

Dept. Reg. 360-2.2
360-2.3
360-2.4
360-6.2

ADMs 11 OHIP/ADM-1
10 OHIP/ADM-4
04 OMM/ADM-6
04 OMM/ADM-5
03 OMM/ADM-4
01 OMM/ADM-6
97 OMM/ADM-2
95 ADM-17
93 ADM-29
93 ADM-3
91 ADM-28
90 ADM-9
88 ADM-31

**OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL**

NEW APPLICATION

INFs 10 OHIP/INF-1

GISs 08 MA/003
 07 MA/027
 07 MA/026
 96 MA/015

INFs 10 OHIP/INF-1

GISs 08 MA/003
 07 MA/027
 07 MA/026
 96 MA/015

Interpretation: An application may be made by the applicant, his/her authorized representative or, when the applicant is incompetent or incapacitated, by someone acting responsibly for him/her. The applicant or someone acting responsibly on the applicant's behalf must sign the application in ink. When both a husband and wife are applying, both spouses are required to sign the "State-prescribed form". If only one spouse is applying, the non-applying spouse cannot be required to sign the application even though information concerning his/her financial circumstances is necessary to determine eligibility for the applying spouse.

OTHER ELIGIBILITY REQUIREMENTS APPLICATION, CERTIFICATION AND RENEWAL

NEW APPLICATION

NOTE: If the applicant's representative signs the application, the LDSS must obtain a separate authorization from the applicant or a copy of legal guardianship. The applicant can identify the role of this person to: apply for and/or renew Medicaid, discuss his/her Medicaid application or case, and/or get copies of notices and agency correspondence. This authorization continues until it is revoked by the recipient; a reauthorization is not required at renewal. However, if the applicant is incompetent or incapacitated, a copy of the legal guardianship papers is not required, nor is a separate document authorizing the representative. In these situations, the LDSS is authorized to discuss the application/case and send notices and related correspondence to the responsible individual in addition to the applicant.

The date of application is the date that a signed "State-prescribed" application form, or a State-approved equivalent form or process is received by the LDSS. The application date for individuals who apply at outreach sites or facilitated enrollers is the date on which the application is started. For children under age 19 and pregnant women applying through the presumptive eligibility process, the application date is the date of the screening.

NOTE: An application is considered to be filed with the LDSS when an applicant submits a signed and dated application that includes his/her name and address. The LDSS may need more information to make a Medicaid eligibility determination, but the application date is protected.

A district cannot refuse an individual the right to apply. The applicant may be accompanied and assisted in the application process, if s/he wishes, by a person of his/her choice. The applicant may receive application assistance by an LDSS staff member, an FE, or designated staff at outreach sites such as family planning providers, providers who determine presumptive eligibility and hospitals with out-stationed workers. If requested, application assistance must be provided by the LDSS in person either as a walk-in or by appointment, over the telephone or in writing. Local departments of social services must work with the applicant or his/her representative to obtain any information missing from the application, including necessary documentation. (See **OTHER ELIGIBILITY REQUIREMENTS APPLICATION, CERTIFICATION AND RENEWAL FACILITATED ENROLLERS**)

Effective April 1, 2010, an in-person application interview with the applicant or his/her representative must not be required. Applicants for presumptive eligibility (PE) and family planning benefit program (FPBP) must be screened in person when they present at a facility for covered services by a PE provider.

OTHER ELIGIBILITY REQUIREMENTS APPLICATION, CERTIFICATION AND RENEWAL

NEW APPLICATION

The applicant must be provided material describing the program and informing the applicant or representative of: (1) the eligibility requirements for Medicaid including the different Medicaid coverage options for persons who have a resource test; (2) the responsibility of the applicant to report all facts necessary for a proper determination of eligibility; (3) the joint responsibility of the district and the applicant to explore all facts concerning eligibility and the applicant's responsibility for securing, wherever possible, records or documents supporting his/her statements; (4) the types of verification needed; (5) the fact that any investigation essential to determine eligibility will be made; (6) the fact that the A/R may be reimbursed for paid Medicaid covered medical care and services received during the three months prior to the month of application and up until the actual date of application, if otherwise eligible; (7) the fact that after the date of application the A/R must use providers who accept Medicaid and who are Medicaid approved; and (8) the applicant's responsibility to immediately notify the district of all changes in his/her circumstances. This material/information is found in: LDSS-4148A, "What You Should Know About Your Rights and Responsibilities"; LDSS-4148B, "What You Should Know About Social Services Programs" (including OHIP-0054 and as appropriate Informational Notice to Institutionalized Individuals with Real Property); LDSS-4148C, "What You Should Know if You Have an Emergency", also known as Books 1, 2 and 3. Local social services districts may either include this information with the application package that is either mailed or handed to the applicant(s), or the LDSS may send the booklets to the applicant(s) after they receive an application. However, the LDSS may not wait until eligibility is determined to send the information. If an LDSS chooses to provide the booklets in the application package, and the LDSS receives an application printed from the internet, the information must be sent to the applicant.

NOTE: As a condition of eligibility, certain referrals to other LDSS units such as referrals to the Child Support Enforcement Unit (CSEU) are necessary. Although there is no face-to-face interview requirement, such required referrals have not been waived or eliminated.

As a result of mandatory managed care, most applicants for Medicaid must choose a managed care plan. Although choosing a Medicaid managed care plan is not a condition of eligibility, failure to do so will result in the applicant being assigned to one, also known as auto-assignment.

OTHER ELIGIBILITY REQUIREMENTS APPLICATION, CERTIFICATION AND RENEWAL

NEW APPLICATION

Because FHPlus is a managed care-only product, new applicants MUST select a managed care plan AND complete a managed care enrollment form as a condition of eligibility unless the A/R resides in a district that has only ONE Family Health Plus Plan. It is strongly recommended that A/Rs complete Section K of the DOH-4220 Access NY Health Care Application or Section 19 of the LDSS-2921 or the Medicaid Managed Care and Family Health Plus enrollment form whenever possible to enable the A/R to provide primary Care provider or health center choice information. If the person fails to do so, the enrollment must be entered in accordance with procedures outlined in 01 OMM/ADM 6 Section IV. C. 3. In districts that have more than ONE Family Health Plus Plan, an application is not complete unless a plan has been selected.

Prior to making a plan selection, all Medicaid and FHPlus applicants must be informed about the managed care program, available plans in the county and optional benefits. This is known as managed care "education". Managed care education may be conducted by mail, in person, by telephone or through FEs. Applicants may be referred to managed care workers or enrollment counselors at the time they choose to come into the LDSS to conduct business such as copying documents, requesting application assistance or to bring in required documentation. Districts must provide managed care education packets that include county specific information and a managed care contact for more detailed information.

MBI-WPD recipients with income below 150% of the federal poverty level may enroll in managed care. MBI-WPD recipients with income at or above 150% of the federal poverty level cannot be enrolled in managed care.

Persons in receipt of Medicare, regardless of their categorical status or income level cannot be enrolled in Medicaid managed care with some exceptions including Managed Long Term Care and Medicare Advantage Plans.

Applications for the Medicaid Cancer Treatment Program are received and processed by State DOH/OHIP staff. (See **CATEGORICAL FACTORS** MEDICAID CANCER TREATMENT PROGRAM (MCTP))

SSI-related Medicaid applicants have the option of applying for:

1. Community Coverage without Long-Term Care which includes all Medicaid covered services except nursing facility services and

OTHER ELIGIBILITY REQUIREMENTS APPLICATION, CERTIFICATION AND RENEWAL

NEW APPLICATION

community based long-term care services. SSI-related Medicaid applicants who are not seeking coverage of long-term care services may attest to the amount of their resources rather than provide proof. (See **RESOURCES DOCUMENTATION REQUIREMENTS**)

2. Community Coverage with Community-Based Long-Term Care which includes all Medicaid covered care and services except nursing facility services. (See **RESOURCES DOCUMENTATION REQUIREMENTS**) SSI-related Medicaid applicants electing to apply for this coverage must provide proof of their current resources.
3. Medicaid coverage of all covered care and services which includes nursing facility services. SSI-related Medicaid applicants electing to apply for this coverage must provide documentation of resources for the past 60 months in accordance with transfer of resource policies. (See **RESOURCES TRANSFER OF ASSETS**)

Local districts must inform SSI-related Medicaid applicants of the available coverage options and may require the applicant to sign a "Request for Medicaid Coverage" or an approved local equivalent, indicating the coverage choice an applicant made.

It is important that the applicant understand the eligibility determination process, including the effect that the documentation of resources options have on the services the SSI-related individual may receive. The applicant must also understand that it is his/her responsibility to keep the district informed of any change in his/her income and/or resources and the need for a service which s/he does not have coverage.

If a recipient has active community coverage (with or without long term care) and subsequently is admitted to a nursing facility, Supplement A must be completed and resource and trust documentation submitted for the appropriate time period(s).

If an SSI-related recipient who attested to his/her resources subsequently requests coverage for long-term care services, the date of the request shall be treated as the date of the new application for purposes of establishing the effective date and the three-month retroactive period for increased coverage. Districts must send the recipient a "Long-Term Care Change in Need Resource Checklist" and inform the recipient of the additional documentation that is needed to determine eligibility for long-term care.

OTHER ELIGIBILITY REQUIREMENTS APPLICATION, CERTIFICATION AND RENEWAL

NEW APPLICATION

The applicant is advised of his/her right to have an agency conference or to request a fair hearing, as appropriate. The applicant is also notified of other services for which s/he may be eligible.

Verification:

All factors relating to the eligibility determination are verified. These include, but are not limited to: identity; citizenship or alien status; family composition; residence; age; income from all sources; all resources of SSI-related applicants including savings and life insurance; and medical, accident and/or health insurance.

However, Medicaid and Family Health Plus applicants whose eligibility is determined without regard to resources may attest to the amount of interest income generated by resources.

Interest income is estimated by establishing the average interest rate(s) and applying them to the resource information obtained from RFI or other third party sources. If upon review, the district finds an inconsistency between the information reported by the individual and the estimate calculated by the district, and the interest income information obtained by the district makes the individual ineligible for Medicaid or FHPlus, documentation of the interest income must be obtained from the individual. For individuals who qualify for Medicaid with a spenddown, the difference in the amount of interest income reported by the recipient must be greater than \$1.00 per month before requiring further follow-up.

Districts must continue to review RFI reports to identify resources belonging to individuals who do not have a resource test to determine when a resource identified by RFI is significant enough to generate interest that would/could affect the individual's eligibility. In such instances, the district must request documentation of the interest income and re-calculate eligibility as appropriate.

The LDSS must contact the applicant to get additional information that is required to make an eligibility determination. Options for obtaining information include: calling the applicant to get information over the phone and notating and initialing it on the application and recording a note in the case record as to the date of the telephone conversation with the Applicant; if information is missing from the various sections of the application a photocopy of the incomplete pages may be mailed to the applicant to complete and return to the agency.

If the applicant is unable to provide the district with acceptable proof of

**OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL**

NEW APPLICATION

his/her eligibility, collateral sources are used to secure verification. By signing the application, the applicant agrees to an investigation confirming any information s/he provided. However, it may be necessary, due to district procedures or requirements of outside agencies, to have a separate consent form signed by the applicant before collateral sources are contacted and information verified.

NOTE: If an SSI-related Medicaid applicant attests to his/her resources, the local social services district may continue to independently verify the accuracy of the information provided by the applicant. However, the Medicaid eligibility determination cannot be delayed pending this verification.

If the applicant claims paid or unpaid medical bills for the three-month period prior to the month of application, eligibility for that period must also be established. This three-month period is retroactive from the month in which the person applied. There is no three-month retroactive period for Family Health Plus or the Family Planning Benefit Program (FPBP). When an applicant eligible for Family Health Plus or FPBP has medical bills within the three months prior to application, the bills can only be paid if there is an agency error or delay or the A/R is financially eligible for Medicaid during the three-month retroactive period and has met his/her spenddown.

NOTE: A person does not have to be living to have unpaid medical expenses covered by Medicaid. A representative may apply on behalf of the deceased person. Medical expenses may be paid for a deceased person, provided the person was eligible at the time the medical service was rendered.

OTHER ELIGIBILITY REQUIREMENTS APPLICATION, CERTIFICATION AND RENEWAL

NEW APPLICATION

When providing application assistance to an applicant who has brought his/her application to the local department of social services, the LDSS may offer to screen the application, but may not require that the application be screened. If during the screening the LDSS finds that the case will be ineligible/denied based on income, the district must continue to process the application, request income documentation and render a decision with proper notice.

Documentation: Sufficient to establish an audit trail:

Photocopies may be used. A primary source for eligibility documentation is any previous case record.

When citing documents, the date, issuing authority, file number and such pertinent data as necessary to determine authenticity must be recorded in the applicant's file.

Applicants must show original or certified copies of documents that document identity and citizenship. These documents may be presented at the LDSS to an FE, designated staff at an outreach site including deputized workers, or to designated staff at an entity in the community with which the LDSS has established a Memorandum of Understanding (MOU) for purposes of verifying that original documents have been seen. (It is not necessary for the LDSS to enter into a separate agreement from those that currently exist with entities such as community based organizations (CBOs) or plan FEs, family planning providers, presumptive eligibility qualified entities or Article 28 prenatal care providers.) Such community organizations will not validate the authenticity of the documents, nor will they determine if the identity and/or citizenship documentation requirement has been satisfied.

Local departments of social services must allow applicants at least 10 days to provide requested documentation. If an applicant is requested to provide documentation necessary to make an eligibility determination and does not do so within the required time period and does not ask for more time or assistance in obtaining documentation, his/her application may be denied.

**OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL**

NEW APPLICATION

NOTE: If an applicant seeking Medicaid coverage of nursing facility services does not meet a request for documentation deadline and the applicant is eligible for Medicaid coverage, QMB, SLIMB, or QI the case must be opened for the coverage for which the applicant is eligible.

If an application is submitted and all necessary information is included, an application must not be denied due to the failure to provide information that is inconsequential. For example: An application must not be denied if supporting documentation of a water expense or childcare expense is not submitted if the applicant can be determined eligible without this deduction.

The determination of eligibility is made promptly, generally within 45 days of the date of application. Determinations for persons eligible under the poverty-based programs (pregnant women and children under age 19) are completed within 30 days. Determinations of eligibility based on a disability are completed within 90 days. Under certain circumstances additional time may be required, such as when there is a delay on the part of the applicant, an examining physician or because of an administrative or other emergency that could not be controlled by the district.

NOTE: If the district is waiting for essential information, the reason for the delay is noted in the record. The applicant is notified by letter of the reason for the delay in his/her eligibility determination. Although the DOH-4220 asks the applicant to list a Client Identification Number (CIN) or an identification number from a plan card, if this information is not provided, the LDSS must not deny the application or request the information from the applicant.

Disposition:

The eligibility worker reviews the application for completeness and accuracy. The LDSS must contact the applicant to obtain additional information that is needed to make an eligibility determination. If the application is being made through a facilitated enroller, the facilitated enroller does not forward the application to the district until the application is complete. (See **OTHER ELIGIBILITY REQUIREMENTS APPLICATION, CERTIFICATION AND RENEWAL FACILITATED ENROLLERS**) When the applicant fails or refuses to provide information essential to the eligibility determination, s/he is informed in writing that his/her application is denied, the reasons for the denial and his/her right to a fair hearing.

NOTE: If a community applicant who is age 65 or older, certified blind

**OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL**

NEW APPLICATION

or certified disabled, or not certified disabled is found eligible for Medicaid or FHPlus based on ADC-Related budgeting, eligibility cannot be denied based on the applicant's failure to complete Supplement A. If an S/CC applicant is chronically ill and he/she failed to comply with a disability review or did not complete Supplement A, the applicant cannot be denied coverage if otherwise eligible for Medicaid under an S/CC budget or FHPlus.

If the LDSS believes that the applicant is the fiscal responsibility of another district, the LDSS where the individual is applying may take a "courtesy application" and forward it to the district of fiscal responsibility. The agreed upon district of fiscal responsibility shall obtain any information missing from the application.

NOTE: The date the first district received the application is protected as the date of application. (See **OTHER ELIGIBILITY REQUIREMENTS DISTRICT OF FISCAL RESPONSIBILITY (DFR)**)

Exception: When an applicant claims to have a disability or when it appears that an applicant may meet the criteria for disability, the district has 90 days from the date of application to make a determination of eligibility. This 90-day period is not used as a waiting period before granting assistance, if the applicant is eligible under a different category. Coverage is authorized as soon as eligibility is established. A note is made in the record as a reminder to re-budget the recipient, adjust any spenddown amounts and claim FP coverage for the retroactive period when the A/R is certified disabled. When it is necessary to hold a potential disability case beyond the 90-day period, this is not a basis for denying Medicaid to an otherwise eligible applicant or for terminating assistance.

**OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL**

FAMILY PLANNING BENEFIT PROGRAM (FPBP) APPLICATION

Policy:

Local social services districts must determine FPBP eligibility for persons of childbearing age who are determined ineligible for Medicaid, and Family Health Plus. When a family or individual applies for Medicaid/ Family Health Plus and is determined ineligible, FPBP eligibility is determined for all applicants of child-bearing age. Children must be referred to CHPlus.

Persons can apply for the FPBP using the DOH-4282 and DOH 4286, FPBP application and instructions. When the application is for the Family Planning Benefit Program (FPBP) only, family planning providers and local county health departments can assist in the application process if the provider has a memorandum of understanding (MOU) with the district/SDOH. In addition, all Article 28 providers and others designated by the State Department of Health who have been trained must provide application assistance. Districts are encouraged to work with these entities to enter into MOUs, so that the application process can be facilitated. All applications taken by these family planning providers who have an MOU with the district will be forwarded to the local district for final eligibility determinations.

FPBP applicants must be informed, by the person who provides application assistance, of the benefits available under Medicaid, and Family Health Plus and of their right to apply for Medicaid and Family Health Plus. When the applicant's reported income is at or below the Medicaid or Family Health Plus income standards, the individual/family is encouraged to apply for these programs and the application requirements are explained. After this discussion, if the applicant chooses to apply for the FPBP only, the applicant completes the Family Planning Benefit Program application (DOH-4282) and signs the "Declination of Medicaid and Family Health Plus Eligibility Determinations" statement on the back of the application. The applicant is advised that s/he may apply for Medicaid or Family Health Plus at any time in the future.

References:

- | | |
|------|---|
| SSL | 366(1) (a) (11) |
| ADMs | 10 OHIP/ADM-4
03 OMM/ADM-2
02 OMM/ADM-7 |
| INFs | 10 OHIP/INF-1 |

**OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL**

FAMILY PLANNING BENEFIT PROGRAM (FPBP) APPLICATION

Interpretation: Persons under the age of 21 who want to apply for family planning services only, are living with their parents, and do not have their parents' financial information complete the "Family Planning Benefit Program" application. This application is available at the LDSS, on the Internet, on the DOH website, and at an FPBP provider who has an MOU. (See **INCOME FAMILY PLANNING BENEFIT PROGRAM (FPBP) BUDGETING METHODOLOGY** for budgeting guidelines.) Adults who choose not to apply for Medicaid and Family Health Plus also use the Family Planning Benefit Program application.

When the applicant requests confidentiality, the applicant is instructed to write "confidential" in the margin and circle the mailing address, if different from the applicant's residence address. However, if the application contains a different mailing address, and/or the "Yes" box is checked in answer to the question, "Do you need these services kept confidential?", the application is treated as confidential, regardless of whether the applicant circled the mailing address or wrote "confidential" in the margin. Regular procedures regarding good cause claims must be followed.

Minors receiving Child Health Plus who have confidentiality concerns about using their Child Health Plus coverage for family planning services are allowed to enroll in FPBP, if otherwise eligible.

Medicaid and Family Health Plus recipients are not eligible for FPBP. These health care programs include family planning services.

Individuals who apply for Medicaid or Family Health Plus and are determined ineligible, have their eligibility determined for FPBP. Individuals who are financially eligible for FPBP, but who choose not to participate in FPBP, must be sent the appropriate notice to the confidential mailing address the A/R has provided if confidentiality has been requested.

**OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL**

MEDICARE PART D LOW INCOME SUBSIDY APPLICATION

- Description:** Low income individuals not enrolled in Medicaid or in one of the Medicare Savings Programs (QMB, SLIMB, QI) who wish to have assistance paying Medicare Part D monthly premiums, deductibles and co-payments must apply for the federal Low Income Subsidy (LIS) Program.
- Policy:** Applications for LIS may be made with the Social Security Administration. Applicants may call the Social Security Administration or apply online at www.socialsecurity.gov. Applicants may receive assistance from the local Office for the Aging.
- References:**
- | | |
|-----------|------------------------|
| SSL Sect. | 366-2 (b) (1) |
| ADMs | 05 OMM/ADM-5 |
| GISs | 06 MA/003
05 MA/024 |
- Interpretation:** Individuals who apply for Medicaid or Medicare Savings and are found eligible will automatically be enrolled in Low Income Subsidy (LIS).

**OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL**

REAPPLICATION

Description: A reapplication for Medicaid is an application made by a former recipient whose eligibility was terminated or an applicant whose previous application was denied by the district.

Policy: A reapplication for Medicaid must be as complete and accurate as a new application for Medicaid.

When an applicant is denied and reapplies within 30 days, a new written application on the "State prescribed" form is not required. In this situation, the date of application is the date that a written request for reapplication is received.

References:

SSL Sect	366 366-a
Dept. Reg.	360-2.2 350.4(a)(5)
ADMs	04 OMM/ADM-6 93 ADM-29

Interpretation: When a reapplication is made, any previous application or record available in the local district is used for reference and documentation of eligibility factors not subject to change (e.g., date of birth). This includes verified information available through the Welfare Management Systems (WMS) in an active or closed case record. If documentation is available in the record, it can be used to verify or supplement data the applicant has available. In every case, the reapplication must be as complete and accurate as an original application, factors relating to eligibility verified and documented. If the reapplication is made within 30 days of a previous case closing, attestation rules apply.

In all instances where there is a previous record or application, a cross-reference is made to verify accuracy and consistency with the current reapplication. When inconsistencies are apparent, the worker pursues the factual data to resolve such inconsistencies.

**OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL**

REAPPLICATION

Verification/

Documentation: Needed verification and documentation are identical to that of a new application. (See **OTHER ELIGIBILITY REQUIREMENTS NEW APPLICATION**).

NOTE: The case record is a primary source for documentation. A/Rs are not asked to provide information that is contained in the case record, unless such information is subject to change (e.g., work history).

**OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL**

RENEWAL

Description: A recertification/renewal for Medicaid is a review of current eligibility factors to determine whether to continue, change or discontinue Medicaid based upon the eligibility of the recipient.

All active Medicaid cases, including those receiving both Medicaid and Temporary Assistance, are recertified periodically. Generally, the recipient must submit a written renewal (recertification) to continue Medicaid. The re-authorization period may not exceed one year.

Policy: Each month, the district/State produces reports of cases due for renewal, generally at least 60 days prior to the date coverage expires. Based on the district's entry of the appropriate code in the Client Notices System (CNS), a renewal package is produced and mailed to the recipient, or districts may opt to have the State automatically generate the renewal package through a one-time entry in the AFA field on WMS. This process is described in a WMS/CNS Coordinator Letter dated November 1, 2004.

The renewal package advises the recipient that coverage is expiring and explains the need for the recipient to provide current information and, in some cases, documentation to the local district. The deadline for returning the renewal form and the return address are included. It is the responsibility of the recipient to return the renewal form and the required documentation to the local district by the deadline provided.

Prior to September 1, 2011 the signatures of all adults applying for Medicaid/FHPlus were required on the renewal form. Effective September 1, 2011, only the signature of one applying adult is required on the renewal form.

NOTE: The renewal form for community cases, except for FPBP cases, contains pre-printed information from the Welfare Management System (WMS). It provides space for the recipient to amend the pre-printed information and provide new information, when appropriate.

Effective January 1, 2012, SSI-related single individuals and couple households with fixed incomes and whose resources are less than 85% of the Medicaid resource limit at application or last renewal whichever is later will have their case automatically renewed by the State. Such cases include SSI-related individuals or married couples 18 years of age or older with an Individual Categorical Code of Aged, Blind or Disabled, a Budget Type of SSI-related, Social Security as the only source of income and resources at or below 85% of the applicable Medicaid resource limit. Cases not included: Medicare

OTHER ELIGIBILITY REQUIREMENTS APPLICATION, CERTIFICATION AND RENEWAL

Savings Program only, nursing facility services and excess income. Neither the individual nor couple will be required to mail in a renewal form.

NOTE: Social services districts remain responsible for processing any changes reported by recipients whose case has automatically been renewed. Districts must take appropriate action based on the type of change reported.

NOTE: If an Upstate recipient wishes to add a child to his/her case between renewal periods, a separate application is not required. A recipient may simply call the LDSS and request the addition. If needed, documentation for the child must be provided and the LDSS must provide a notice of decision regarding the eligibility determination.

If an Upstate recipient wishes to add an adult to his/her case mid-renewal, a new application must be completed by the adult to be added to the case.

Children 18 to 21

Medicaid renewal for children ages 18 to 21 who are final-discharged from foster care (Chaffee Children) is done on the Chafee Medicaid renewal form.

As a passive renewal, if the renewal is not returned via United States Postal Service (USPS) eligibility must be authorized for another year, but never past the 21st birthday.

OTHER ELIGIBILITY REQUIREMENTS APPLICATION, CERTIFICATION AND RENEWAL

RENEWAL

If the renewal form is returned by the USPS with a forwarding address label that is within the district, the renewal form must be re-sent to this address. If the form is not returned as undeliverable, coverage must be re-authorized for another 12 month period, not to exceed the child's 21st birthday.

If the renewal form is returned by the USPS with a forwarding address label that is outside the district, the renewal form must be resent to the address provided by the USPS. If the renewal is returned by the child confirming the address, the case should be renewed for a 12-month period and then transferred in accordance with 08 OHIP/LCM-1. If the child has moved out of New York State or is deceased, the case may be closed.

SSI cash recipients

Individuals who receive Medicaid based on their eligibility for SSI are renewed (recertified) for Medicaid by virtue of their renewal (recertification) for SSI cash. SSI cash recipients need not be reauthorized yearly. Their authorization will be open-ended until December 31, 2049. Local districts use the SDX to confirm that an cash SSI recipient continues to be eligible for SSI and, therefore, Medicaid.

References:

SSL Sect.	366
	366-a
	366-a (2)
	366-a (5) (d)
	369-ee (2)

Chapter 58 of the Laws of 2010

Dept. Reg.	360.1
	360-2.2(e)
	360-6.2

ADMs	11 OHIP/ADM-1
	11 OHIP/ADM-9
	09 OHIP/ADM-1
	08 OHIP/ADM-4
	04 OMM/ADM-6
	03 OMM/ADM-2

**OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL**

RENEWAL

INFs	10 OHIP/INF-1
LCM	94 LCM-84
GIS	11 MA/015 11 MA/012 11 MA/002 04 MA/021

Interpretation: The period covered by a recertification may vary by category and circumstances but may not extend beyond one year. Most recipients are certified for one year; however, when a recipient is unemployed or receives variable or seasonal income, s/he may require more frequent recertification.

**Verification/
Documentation:** Renewing community Medicaid recipients who are not seeking coverage of institutional based nursing facility services all FHPlus recipients, recipients of the Medicare Savings Program (MSP), the Family Planning Benefit Program (FPBP), participants in the Medicaid Buy-In Program for Working People with Disabilities (MBI-WPD) and the Medicaid Cancer Treatment Program: Breast, Cervical, Colorectal and Prostate may, at renewal attest to the amount of their income, resources as appropriate, child/adult care expenses and to their residence, even if their address has changed since their last eligibility determination.

SSI-related recipients who are participating in the MBI-WPD program must continue to document their employment status.

All persons renewing and who do not have a resource test may attest to the amount of interest income generated by resources.

For persons other than those receiving chronic care, a reported change in circumstances may be treated as a renewal. A recipient's attestation of a change in circumstances by telephone is sufficient to re-budget the case, and a written statement documenting the change is no longer required. However, if the recipient requests to add an individual to the case, documentation requirements must be met.

OTHER ELIGIBILITY REQUIREMENTS APPLICATION, CERTIFICATION AND RENEWAL

RENEWAL

NOTE: When a recipient reports a change that does not require a new budget, such as an address change, the worker must confirm that no other changes in the household have occurred in order to consider this report as a renewal.

When the renewal is being handled by New York Health Options/the Enrollment Center and the individual reports a change within three months prior to the end of the authorization period and the LDSS is treating such report as a renewal, New York Health Options must be contacted by fax and requested to withdraw the renewal from HEART.

In counties that have combined Food Stamp (FS) and Medicaid units, renewals received for FS may also be used to renew the Medicaid case and authorize 12 months of Medicaid coverage if the A/R is found eligible for FS.

INCOME:

In lieu of income documentation, local social services districts must verify the accuracy of the income information provided by the recipient by comparing it to information to which they have access, such as RFI (Resource File Integration), the Work Number Website (TALX, used for obtaining employment and wage verification), the currently stored budget, or actual income documentation from a current Food Stamp or HEAP case. When using RFI, districts must only consider information from the most recent calendar quarter (the calendar quarter immediately preceding the current calendar quarter) as current. Information from any prior calendar quarter is to be considered a "no hit" on RFI. At any point after initial application, only Bendex and UIB may be regarded as primary sources of verification to close a case.

RESIDENCE:

Documentation of a change of address is not required at renewal unless the district has information to the contrary. If a renewal is returned to by the U.S. Postal Service with a forwarding address label, the renewal must be re-mailed to the new in-district address. No additional documentation of the address change is required. If the forwarding address label indicates the recipient lives in a different county, the renewal must be re-mailed to the new

**OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL**

RENEWAL

address. If the renewal is returned by the recipient, it must be processed by the district before the case is transitioned to the new district (See **OTHER ELIGIBILITY REQUIREMENTS STATE RESIDENCE AND RESPONSIBILITY FOR ASSISTANCE, ASSISTANCE TO PERSONS WHO CHANGE RESIDENCY**). Districts must discontinue coverage to persons who fail to respond to the renewal.

RESOURCES:

SSI-related recipients authorized for Community Coverage without Community-Based Long-Term Care and Community Coverage with Community-based Long-Term Care must itemize their current resources and attest to the value such resources. Districts must verify the accuracy of the resource information through collateral investigations. If there is an inconsistency in the information reported by the recipient and the current information obtained by the district, eligibility must be re-determined using the newly obtained information. If the SSI-related individual is found resource ineligible, eligibility must be determined for FHPlus or Medicaid under a category with no resource test. If the SSI-related individual is not eligible for FHPlus or Medicaid as a non-SSI-related recipient and further information about a resource is required to make a determination, the recipient must be notified to provide the necessary information. If the individual fails or refuses to provide such information, the case must be discontinued for failure or refusal to provide information necessary to make a determination.

INTEREST INCOME:

All community Medicaid recipients who are not seeking coverage of institutional based nursing facility services all FHPlus recipients, recipients of the Medicare Savings Program (MSP), the Family Planning Benefit Program (FPBP), participants in the Medicaid Buy-In Program for Working People with Disabilities (MBI-WPD) and the Medicaid Cancer Treatment Program: Breast, Cervical, Colorectal and Prostate may, at renewal attest to the amount of interest income generated by resources.

Interest income is estimated by establishing the average interest rate(s) and applying them to the resource information obtained from RFI or other third party sources. If upon review, the district

**OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL**

RENEWAL

finds an inconsistency between the information reported by the individual and the estimate calculated by the district, and the interest income information obtained by the district makes the individual ineligible for Medicaid or FHPlus, documentation of the interest income must be obtained from the individual. For individuals who qualify for Medicaid with a spenddown, the difference in the amount of interest income reported by the recipient must be greater than \$1.00 per month before requiring further follow-up.

Districts must continue to review RFI reports to identify resources belonging to individuals who do not have a resource test to determine when a resource identified by RFI is significant enough to generate interest that would/could affect the individual's eligibility. In such instances, the district must request documentation of the interest income and re-calculate eligibility as appropriate.

OTHER ELIGIBILITY REQUIREMENTS APPLICATION, CERTIFICATION AND RENEWAL

RENEWAL

Recipients are not required to document and verify items that remain constant, such as age and identity. However, some of the information printed on the renewal form such as a person moving into the household, health insurance premiums and new health insurance whether the premium is paid by the individual or the local social services district, and the employment of MBI-WPD participants must be documented.

If a recipient is paying a health insurance premium and fails to document the premium amount and s/he is eligible without the deduction, the case must be processed without the deduction. If the recipient needs the deduction to remain eligible OR the local department of social services is reimbursing the recipient for the premium (other than a Medicare premium), the case must be pended and the documentation requirements form (LDSS-2642) sent, allowing 10 days for the recipient to submit proof of the payment or premium. If the recipient fails to respond to the request for documentation, the case must be re-budgeted without the premium amount as a deduction and reimbursement of premiums are discontinued with appropriate notice.

Recipients who are, or expect to be participating in the excess income program will be requested to submit proof of their income (and child/adult care and third party health insurance) so that their spenddown amount can be calculated as precisely as possible. If a recipient who is eligible to participate in the Excess Income program fails to document income, eligibility must be based on the income the recipient has attested to. SSI-related Medicaid recipients who are receiving or seeking institutional based nursing facility services are required to document their income, current resources and new residence. However, if these individuals fail to submit documentation of income, new residence, resources or other required information, districts must send a documentation requirements form (LDSS-2642) requesting the missing documentation. If the recipient does not return the requested documentation within 10 days, districts must not discontinue coverage, but must authorize Community Coverage with Community-based Long-Term Care, if the individual remains otherwise eligible.

SSI-related individuals in receipt of Community Coverage without Community-Based Long Term Care OR Community Coverage with Community-Based Long Term Care who request an increase in coverage to Community Coverage with Community-Based Long Term

**OTHER ELIGIBILITY REQUIREMENTS
APPLICATION, CERTIFICATION AND RENEWAL**

RENEWAL

Care or Medicaid coverage of institutional based nursing facility services respectively, must document income and resources including resource documentation for the full transfer of assets look back period for coverage of institutional-based nursing services.

Supplemental Security Income (SSI) recipients that lose eligibility for such benefits are given an extension to allow for continued Medicaid eligibility to be determined. If the former SSI recipient is in receipt of Community-based Long-term Care services he/she must document income and resources as part of the redetermination process. At subsequent renewals, the individual is allowed to attest to income and resources.

All SSI cash recipients who enter a nursing facility and appear on the SDX with a "Pay Status Code" of EO1 (eligible - no payment) are sent a letter by the district informing them of their continued eligibility for Medicaid. In addition, the income of these individuals is reviewed to determine the amount, if any, of their net available monthly income (NAMI) to be contributed toward the cost of care.

NOTE: Documentation of income, residence and resources, as appropriate, at initial application is still required for ALL applicants.

OTHER ELIGIBILITY REQUIREMENTS**DECISION AND NOTIFICATION**

Description: A decision on an application, reapplication, or recertification is a determination that the applicant is either eligible or ineligible for Medicaid.

Policy: A decision as to the A/R's eligibility is made within specified time periods for each new application, reapplication and recertification. Upon reaching a decision, a written notification of acceptance, denial, withdrawal, discontinuance, reduction or change in the spenddown calculation is sent to the applicant.

The Notice of Intent sent to Temporary Assistance A/Rs who have also applied for Medicaid contains a separate statement concerning Medicaid eligibility. Where the reason for denying the TA case is also a valid reason for denying Medicaid, it is stated separately in the Notice of Intent.

New SSI beneficiaries will receive a letter from New York State informing them that they are automatically eligible for Medicaid. This letter also requests the A/R to supply information concerning third party health insurance, and information on paid or incurred medical bills for the three months prior to the month of application.

References:

SSL Sect.	366 366-a
Dept. Reg.	358-3.3 358-4.1 360-2.4 360-2.5 360-2.8 360-2.9
ADMs	10 OHIP/ADM-4 89 ADM-21 82 ADM-5

Interpretation: A determination of eligibility is made within a 45-day time period. A determination of eligibility for persons eligible under the poverty based programs (pregnant women and children under age 19) is completed within 30 days. The only exception to this are cases awaiting a disability determination. A 90-day time limit is applied to situations when a disability determination is being

OTHER ELIGIBILITY REQUIREMENTS

DECISION AND NOTIFICATION

made. (See **CATEGORICAL FACTORS SSI-RELATED DISABILITY**)
If the eligibility determination process for a disabled applicant takes more than 90 days, on or before the 90th day, the A/R is sent a written statement stating the reasons for the delay. When the applicant is eligible under a different category, Medicaid is authorized for the interim period.

Each applicant for Medicaid is notified in writing of the local district's decision regarding his/her application. In the written notification, the applicant is informed of: the action taken, the effective date of the action, the specific reason(s) for the action whether positive or negative, including supporting regulations or laws; his/her right to a conference with a representative of the district; and of his/her right to a fair hearing including the method by which s/he may obtain a hearing. The applicant is also advised that s/he may be represented at any conference or fair hearing by someone such as legal counsel, or by a relative, friend or other person and of the availability of community legal services (Legal Aid), if any. A fair hearing request may be made on the basis of: denial of assistance; failure to determine the applicant's eligibility within the time period specified; inadequacy of the amount or manner of assistance; discontinuance or reduction of coverage or assistance; objection to State policy as it affects the applicant; or any other grounds affecting the applicant's entitlement to assistance. If a recipient requests a fair hearing within the time period specified in the notice, Medicaid is continued unchanged until a decision is issued on the Fair Hearing.

A separate Medicaid eligibility determination is completed for every TA case closed or denied where the A/R also applied for or was in receipt of Medicaid, except for cases when the reason for closing or denying TA is also a valid reason for closing or denying Medicaid. In all situations, the client is advised in a separate statement of the status of his/her Medicaid eligibility.

This section describes decision and notification in detail. It is organized as follows:

- Acceptance;
- Denial;
- Withdrawal; and
- Discontinuance or reduction.

**OTHER ELIGIBILITY REQUIREMENTS
DECISION AND NOTIFICATION**

ACCEPTANCE

Description: When an application for Medicaid is accepted, Medicaid is authorized for a stated person(s) for a specific period of time. The applicant is notified as to who was accepted or denied and the effective date of authorization.

Policy: When an application is accepted and Medicaid is authorized, notification in writing shall be sent to the applicant.

References:

SSL Sect.	366 366-a
Dept. Reg.	358-3.3 358-4.1 360-2.4 360-2.5
ADMs	04 OMM/ADM-6 97 OMM/ADM-2 96 ADM-15 89 ADM-21 87 ADM-41

Interpretation: Written notification to the applicant includes a copy of the applicant's budget and an explanation of what care or services are authorized. If limitations are placed upon care or services, the limitations are explained in the letter. A copy of the notice is also sent to the medical provider (e.g., nursing home or hospital), as appropriate.

When only certain members of the applying household (group applying) are accepted for coverage, the coverage is explained in the notice to the applicant. The notice also advises the applicant of his/her responsibility to inform the district of any changes in his/her financial situation and/or any other changes affecting eligibility.

In addition to the standardized notice, an A/R with excess income (See **INCOME EXCESS**) is given a copy of the "Explanation of Excess Income Program" letter. When appropriate, a copy of the "Provider/Recipient Letter" and the Optional Pay-In Program for Individuals with Excess Income" (See 96 ADM-15) is sent to A/Rs with excess income. The "Provider/Recipient Letter" lists incurred medical expenses for which the A/R is responsible or partially responsible. A copy of the "Provider/Recipient Letter" is

**OTHER ELIGIBILITY REQUIREMENTS
DECISION AND NOTIFICATION****ACCEPTANCE**

also sent to the provider for billing purposes. When the medical expenses are for services from more than one provider, a separate form is completed for each provider to protect the A/R's confidentiality. When the A/R is a patient in a nursing facility or is approved for nursing home care, a letter of notification is sent to both the nursing home and the A/R clearly stating the A/R's liability toward the cost of care. When the A/R is an institutionalized spouse, the community spouse is also sent a copy of the notice.

**OTHER ELIGIBILITY REQUIREMENTS
DECISION AND NOTIFICATION**

DENIAL

Description: A denial is a determination that an applicant is not eligible for Medicaid.

Policy: When an application for Medicaid is denied, a written notification is sent to the applicant.

References:

SSL Sect.	366 366-a
Dept. Reg.	358-3.3 358-4.1 360-2.3 360-2.4 360-2.5 360-2.8 360-2.9
ADMs	10 OHIP/ADM-4 04 OMM/ADM-6 97 OMM/ADM-2 96 ADM-15 89 ADM-21 87 ADM-4
INFs	10 OHIP/INF-1
GIS	10 MA/015

Interpretation: An application for requested Medicaid coverage may be denied because the applicant is ineligible or because the applicant's eligibility cannot be determined due to his/her failure to cooperate in establishing eligibility.

When a decision is reached, a letter is sent to the applicant, including a copy of the budget, when applicable, informing him/her of the reason for the denial and of his/her right to: a conference with a representative of the local district; and a fair hearing as outlined in **OTHER ELIGIBILITY REQUIREMENTS DECISION AND NOTIFICATION**. A copy of the notice is also sent to the Medical provider (e.g., nursing home and hospital) as appropriate.

OTHER ELIGIBILITY REQUIREMENTS DECISION AND NOTIFICATION

DENIAL

When an applicant is denied due to excess income and the applicant is ADC-related, SSI-related, a pregnant woman, or under age 21, the letter explains how excess income may be utilized to "spend down" to the Medically Needy Income level. (See **INCOME MEDICALLY NEEDY INCOME LEVEL**). The letter further explains local district procedures regarding the applicant's use of the excess income, including the "Optional Pay-In Program for Individuals with Excess Income."

NOTE: If an LDSS receives an application for a child who is ineligible for Medicaid due to excess income or immigration status and a plan selection has been made, the LDSS must, on a daily basis, mail the application and documentation, including a copy of the ineligible Medicaid budget for cases denied for excess income, directly to the selected CHPlus plan. If a plan selection has not been made and there is only one CHPlus plan in the county, the application and supporting documentation is mailed directly to that plan. If a plan selection was not made and there are multiple CHPlus plans available in the county, the LDSS must send the application and supporting information to the Corning Tower, Room 1619, Empire State Plaza, Albany, New York 12237.

If an LDSS receives a Common Application (LDSS-2921) for a child under 19 years of age who is ineligible for Medicaid due to excess income or immigration status, the "Release of Information to the Child Health Plus Program" form must be signed if an eligibility determination for Child Health Plus is desired. The LDSS must mail a copy of the application (LDSS-2921), the release form, supporting documents, a copy of the denial letter and a copy of the Medicaid budget that shows ineligibility to the Community Based Organization (CBO) in their county. If there is more than one CBO the LDSS does business with, the LDSS should select the CBO that is geographically closest to the applicant's residence address.

If an LDSS receives a renewal or a request between renewal periods to add a child under 19 to a recipient's Medicaid case and the child is determined ineligible based on excess income or immigration status, the LDSS must send a manual denial notice and a blank DOH-4220 and instruct the individual to apply for CHPlus.

In all instances, if the LDSS has confirmed income information through UIB, SDX or the Child Support Collection unit, such information must be forwarded with the CHPlus application.

**OTHER ELIGIBILITY REQUIREMENTS
DECISION AND NOTIFICATION****WITHDRAWAL OF APPLICATION**

Description: After the submission of a written application, but before the applicant is notified by the local social services district of his/her eligibility determination, the applicant may withdraw his/her request for Medicaid.

Policy: When an application is withdrawn by the applicant, the district registers it as withdrawn.

References:

SSL Sect.	366 366-a
Dept. Reg.	358-3.1 358-3.3 358-4.1

Interpretation: The decision to withdraw an application can only be made by the applicant or by the person making the application on behalf of the applicant. When the withdrawal is made in person, the applicant or representative is asked to sign the application as appropriate or sign a statement declaring his/her desire to withdraw the application. When the request is by phone, a notation is made on the application. In addition, an adequate notice is issued to the applicant/representative confirming the voluntary withdrawal. No further action is taken on the application; however, the applicant may reapply at any time. Original documents, such as birth certificates, are returned to the applicant, but any photo static copies and the application remain with the district and are not returned to the applicant.

**OTHER ELIGIBILITY REQUIREMENTS
DECISION AND NOTIFICATION**

DISCONTINUANCE OR REDUCTION

- Description:** A discontinuance of Medicaid is a termination of all benefits under the program. The reduction of Medicaid is a change of benefit coverage from more extensive coverage to less extensive coverage or to an increase in the recipient's liability, i.e., a change from Community Coverage with Community-Based Long-Term Care to Community Coverage without Long-Term Care, or a change from full coverage to a spenddown.
- Policy:** A determination by the district to discontinue or reduce a recipient's Medicaid coverage is communicated to the recipient in a letter of intent to discontinue or reduce Medicaid. Generally, the notice is sent at least ten days in advance of the proposed action. Under certain circumstances, it is not necessary to send a notice of intent ten days in advance of the action. (See **OTHER ELIGIBILITY REQUIREMENTS DECISION AND NOTIFICATION**) Where the A/R is in receipt of both Medicaid and Public Assistance, any notice to discontinue or reduce Temporary Assistance also includes a statement advising the client of the status of his/her Medicaid eligibility.
- References:**
- | | |
|------------|--|
| SSL Sect. | 366
366-a |
| Dept. Reg. | 358-3.3
358-4.1
360-2.3
360-2.6
360-2.7
360-2.8
360-2.9 |
| ADMs | 04 OMM/ADM-6
97 OMM/ADM-2
89 ADM-21
83 ADM-27
81 ADM-55
80 ADM-19 |
- Interpretation:** A Medicaid case is discontinued because of the recipient's ineligibility for continued assistance, failure to cooperate, permanent removal from the district or other factors which affect continued eligibility. Generally, a letter of notification

OTHER ELIGIBILITY REQUIREMENTS DECISION AND NOTIFICATION

DISCONTINUANCE OR REDUCTION

is sent (See **OTHER ELGIBILITY REQUIREMENTS DECISION AND NOTIFICATION**), at least 10 days in advance of the proposed action, to the recipient advising him/her of: the action to be taken; the effective date of the action, the reason(s) why the action(s) is/are being taken; the supporting law or regulation; the client's right to request a conference with a representative of the district; and the right to a fair hearing. If the recipient requests a fair hearing between the date of the notification and the date of the proposed action, Medicaid is continued without reduction until the fair hearing decision is rendered.

A reduction in Medicaid coverage also requires that a letter of notification be sent at least 10 days in advance of the proposed reduction. The letter of notification advises the client: that his/her Medicaid is being reduced; the effective date of the action; the reason why the action is being taken; the supporting law or regulations; the recipient's right to a conference with a representative of the district; and the right to a fair hearing. If the recipient requests a fair hearing between the date of receiving the notice and the date of the proposed reduction, Medicaid is continued without reduction until the fair hearing decision is rendered.

When an A/R is in receipt of Temporary Assistance and Medicaid or SSI cash and the cash benefit is discontinued, a separate determination for Medicaid is completed by the end of the calendar month following the month in which cash assistance is terminated. The Notice of Intent to Discontinue Temporary Assistance contains a separate statement advising the client of the status of his/her Medicaid: continued until a separate determination can be made; discontinued and the reasons why; or continued until the next recertification. When an SSI cash benefit is discontinued, and there is adequate information in the local district's records, the recipient's eligibility is determined without contacting the recipient. The recipient is notified of the eligibility decision. When Medicaid eligibility cannot be determined due to inadequate information, the recipient is contacted and required to provide the necessary information. Medicaid is continued pending the receipt of the information. The recipient is given 30 days to provide this information.

**OTHER ELIGIBILITY REQUIREMENTS
DECISION AND NOTIFICATION
DISCONTINUANCE OR REDUCTION**

TIMELY NOTICE

Policy:

When a recipient's Medicaid coverage is terminated or reduced, the recipient is adequately notified in writing 10 days in advance of the action (See **OTHER ELIGIBILITY REQUIREMENTS DECISION AND NOTIFICATION DISCONTINUANCE OR REDUCTION**). However, if one of the following conditions has resulted in the termination or reduction of Medicaid, it is not necessary to send a notice 10 days in advance of the action. Instead, the adequate notice is sent by the date of the termination. These conditions are:

1. The recipient has provided a signed statement that s/he no longer wants Medicaid.
2. The recipient is admitted or committed to an institution that does not qualify for federal financial participation.
3. The recipient's whereabouts are unknown and his/her mail has been returned by the post office indicating no known forwarding address.

References:

Dept. Reg.	360-2.7 358-3.3(d)
ADM	89 ADM-21

OTHER ELIGIBILITY REQUIREMENTS**RETROACTIVE ELIGIBILITY PERIOD**

Description: Medicaid is granted initially upon the determination of eligibility, based on a written application made on a “State prescribed” form. Generally the date of application is the date the signed “State prescribed” application form, or a State-approved equivalent form or process is received by the LDSS. (See **OTHER ELIGIBILITY REQUIREMENTS APPLICATION, CERTIFICATION, RENEWAL NEW APPLICATION**)

Paid or unpaid medical bills for the three-month period prior to the month of application may be eligible for payment/reimbursement.

Policy: If during the three-month period prior to the month an application is filed with an LDSS, the applicant indicates that he or she has paid or unpaid medical bills, eligibility for such retroactive period must be established.

References:

ADM	10 OHIP/ADM-9
Dept. Regs.	18 NYCRR 360-7.5 (a)
GISs	03 MA/025 03 MA/019 02 MA/033 98 MA/011 95 MA/032

Interpretation: The three month retroactive period begins on the first day of the third month that precedes the month the applicant applies for assistance.

For example: If the signed application is received on April 30th, the three month retroactive period is the period between January 1st through March 31st.

When the applicant indicates that there are unpaid medical bills in the retroactive period, eligibility for that period must be established regardless of whether the applicant applies for Medicaid only or applies for Medicaid as part of his/her application for Temporary Assistance or SSI or if the applicant is found eligible for Family Health Plus or another Medicaid Program. (See **INCOME EARNED WAGES, SALARIES AND CONTRACTUAL INCOME**)

**OTHER ELIGIBILITY REQUIREMENTS
RETROACTIVE ELIGIBILITY PERIOD**

REIMBURSEMENT OF PAID MEDICAL BILLS

Description: Reimbursement of paid medical expenses may be made to Medicaid recipients or their representatives for covered care and services obtained during the recipients' retroactive eligibility periods (pre and post -application periods).

Policy: Social services districts must reimburse, at the Medicaid rate, Medicaid eligible individuals or their representative for qualifying medical expenses paid during the three-month retroactive eligibility period.

Direct reimbursement is not limited to the Medicaid rate or fee in instances where agency error or delay caused the recipient or the recipient's representative to pay for medical services which should have been paid under the Medicaid program.

NOTE: Social Services districts have the option of reimbursing eligible recipients directly or requesting the Department to make payments for expenses that the district has determined to be reimbursable.

References:

ADM	10 OHIP/ADM-9
Dept. Regs.	18 NYCRR 360-7.5 (a)
GISs	03 MA/025
	03 MA/019
	02 MA/033
	98 MA/011
	95 MA/032

New York State Fiscal Reference Manual, Volume 1 Chapter 7 and Volume 2 Chapter 5

Interpretation: Reimbursement for paid medical expenses is limited to the Medicaid rate, after application of ALL third party reimbursement, unless there was an agency error or delay which caused the recipient or his/her representative to pay for medical services that should have been paid by the Medicaid Program.

Because Family Health Plus benefits do not begin until eligibility is determined AND enrollment in a plan has occurred, there is no reimbursement available under the FHPlus program during the three-month retroactive period. However, individuals who are otherwise eligible under the Medicaid spenddown program during the three-month retroactive period through the date of enrollment in a FHPlus

OTHER ELIGIBILITY REQUIREMENTS RETROACTIVE ELIGIBILITY PERIOD

REIMBURSEMENT OF PAID MEDICAL BILLS

plan may be reimbursed for paid expenses in excess of their Medicaid spenddown.

Retroactive Period:

Reimbursement may be made to a Medicaid eligible individual or his/her representative for paid bills that are:

- incurred during the **retroactive** eligibility period, which begins on the first day of the third month prior to the month in which the individual applied for Medicaid and ends on the date the individual applies for Medicaid;
- medically necessary;
- covered by the Medicaid Program;
- within Medicaid requirements for amount duration and scope; and,
- received from providers lawfully permitted under State law or regulation to provide the care, services or supplies for which the recipient is requesting reimbursement and who has not be excluded by the Medicaid Program.

Post-Retroactive Period:

Reimbursement may be made to a Medicaid eligible individual or his/her representative for paid bills that are:

- incurred during the **post-retroactive** eligibility period, which begins on the date of application and ends on the date the individual receives a CBIC card;
- medically necessary;
- covered by the Medicaid Program ;
- within Medicaid requirements for amount duration and scope; and,
- provided by Medicaid enrolled providers.

NOTE: For new SSI recipients, reimbursement for paid medical expenses beginning three months prior to the month of application and ending on the day the recipient receives the “Dear SSI Beneficiary” letter must NOT be limited to expenses incurred from providers enrolled in the Medicaid program.

Agency Delay:

Reimbursement may be made to a Medicaid eligible individual or his/her representative for bills that are paid as a result of an LDDS’s delay and are:

OTHER ELIGIBILITY REQUIREMENTS RETROACTIVE ELIGIBILITY PERIOD

REIMBURSEMENT OF PAID MEDICAL BILLS

- incurred beginning 45 days after the date of application and before the receipt of a CBIC card; or
- incurred beginning 30 days after the date of application when the application includes a pregnant woman or child under the age of 19 and before the receipt of a CBIC card; or
- incurred beginning 90 days after the date of application when the application is based on disability and before receipt of a CBIC card; and
- medically necessary;
- covered by the Medicaid Program ;
- within Medicaid requirements for amount duration and scope; and,
- received from providers lawfully permitted under State law or regulation to provide the care, services or supplies for which the recipient is requesting reimbursement and who has not be excluded by the Medicaid Program.

FHPlus: After eligibility for FHPlus has been determined, the agency must process the plan enrollment by the 45th day following the eligibility decision if the decision was timely. If the decision was made after the proper timeframe, the agency must process the plan enrollment by the 45th day following the day the decision should have been made. When enrollment does not occur within these timeframes, the applicant is entitled to be reimbursed for reasonable out-of-pocket expenses paid from day 45 to the date enrollment is actually effective.

Agency Error:

Reimbursement may be made to a Medicaid eligible individual or his/her representative for bills that are paid as a result of an LDSS's error and are:

- incurred from the date of the social services district's incorrect determination until the date the applicant receives a CBIC card;
- medically necessary;
- covered by the Medicaid Program;
- within Medicaid requirements for amount duration and scope; and,
- received from providers lawfully permitted under State law or regulation to provide the care, services or supplies for which the recipient is requesting reimbursement and who has not been excluded by the Medicaid Program.

OTHER ELIGIBILITY REQUIREMENTS RETROACTIVE ELIGIBILITY PERIOD

REIMBURSEMENT OF PAID MEDICAL BILLS

NOTE: Reimbursement may also be available when, due to social services district delay in the provision of authorized services such as personal care services, the recipient or the recipient's representative must pay privately to obtain covered services.

FHPlus: For individuals determined eligible for FHPlus, such recipient or his/her representative may be reimbursed for reasonable out-of-pocket expenses (as defined below) paid after the date of the agency's error (as found on the Notice of Decision) through the day the individual's FHPlus enrollment is effective. The services must be those that are covered under the FHPlus plan and must be provided by an entity or individual lawfully permitted to provide the care, services or supplies for which the recipient is requesting reimbursement.

Reimbursement in cases of agency error or delay must be made for reasonable out-of-pocket expenditures. Generally, out-of-pocket expenditures that do not exceed 110% of the Medicaid rate are always considered reasonable and may be fully reimbursed. In some instances out-of-pocket expenses that exceed this threshold may be considered reasonable if the recipient or his/her representative can demonstrate and document that the services cost more due to living in a remote location or purchasing services on a holiday or other special circumstance. In such situations, reimbursement of full-out-of pocket expenses may be warranted.

To obtain reimbursement for bills paid during the retroactive periods, the recipient must document income and resources, as appropriate, in order for eligibility to be determined for the appropriate retroactive period. In all circumstances, proof that the bills for which direct reimbursement is sought were paid must be provided. Claims not supported by proof of payment with documentation such as cancelled checks or notarized affidavits are not reimbursable.

NOTE: Once a CBIC card is received, NO reimbursement may be made for expenses incurred after that date and paid by a recipient.

Social services districts must provide information concerning the policy for direct reimbursement of medical expenses to all Medicaid/FHPlus applicants, including those who apply at outreach sites and to all Temporary Assistance applicants who also apply for Medicaid. The provision of the LDSS-4148B: "What You Should Know About Social Services Programs" to such applicants fulfills this requirement.

**OTHER ELIGIBILITY REQUIREMENTS
RETROACTIVE PERIOD**

PAYMENT OF UNPAID MEDICAL BILLS

Description: Payment of unpaid medical expenses may be made to Medicaid enrolled providers for covered care and services obtained during the recipients' retroactive eligibility periods (pre and post -application periods).

Policy: Social services districts must authorize appropriate periods of eligibility for Medicaid eligible individuals who incurred qualifying medical expenses during the three-month retroactive eligibility period.

References:

ADM	10 OHIP/ADM-9
Dept. Regs.	18 NYCRR 360-7.5 (a)
GIS	03 MA/025
	03 MA/019
	02 MA/033
	98 MA/011
	95 MA/032

Interpretation: **Retroactive Period:**
Payment may be made for unpaid bills that are:

- Incurred during the **retroactive** eligibility period, which begins on the first day of the third month prior to the month in which the individual applied for Medicaid and ends on the date the individual applies for Medicaid;
- medically necessary;
- covered by the Medicaid Program ;
- within Medicaid requirements for amount duration and scope, AND
- provided by Medicaid enrolled providers.

Post-Retroactive Period:
Payment may be made for unpaid bills that are:

- incurred during the **post-retroactive** eligibility period, which begins on the date of application and ends on the date the individual receives a CBIC card;
- medically necessary;
- covered by the Medicaid Program ;
- within Medicaid requirements for amount duration and scope, AND
- provided by Medicaid enrolled providers.

OTHER ELIGIBILITY REQUIREMENTS RETROACTIVE PERIOD

PAYMENT OF UNPAID MEDICAL BILLS

NOTE: Because Family Health Plus benefits do not begin until eligibility is determined AND enrollment in a plan has occurred, there is no payment of unpaid bills available under the FHPlus program during the three-month retroactive period. However, individuals who are otherwise eligible under the Medicaid spenddown program during the three-month retroactive period through the date of enrollment in a FHPlus plan may be reimbursed for paid expenses in excess of their Medicaid spenddown.

Payment is limited to Medicaid enrolled providers, at the Medicaid rate, after application of ALL third party reimbursement.

Agency Delay:

Payment may be made for unpaid bills that are:

- incurred beginning 45 days after the date of application and before the receipt of a CBIC card; or
- incurred beginning 30 days after the date of application when the application includes a pregnant woman or child under the age of 19 and before the receipt of a CBIC card; or
- incurred beginning 90 days after the date of application when the application is based on disability and before receipt of a CBIC card; and
- medically necessary;
- covered by the Medicaid Program ;
- within Medicaid requirements for amount duration and scope; and
- provided by Medicaid enrolled providers.

Agency Error:

Payment may be made for unpaid bills that are:

- incurred from the date of the social services district's incorrect determination until the date the applicant receives a CBIC card;
- medically necessary;
- covered by the Medicaid Program;
- within Medicaid requirements for amount duration and scope; and,
- provided by Medicaid enrolled providers.

To obtain payment for bills incurred during the retroactive periods, the recipient must document income and resources, as appropriate, in order for eligibility to be determined for the appropriate retroactive period. Once eligibility has been determined, appropriate periods of eligibility are recorded in WMS to allow payment to Medicaid enrolled providers.

**OTHER ELIGIBILITY REQUIREMENTS
RETROACTIVE PERIOD**

PAYMENT OF UNPAID MEDICAL BILLS

FHPlus: For FHPlus eligible individuals, there is no mechanism to provide coverage in WMS prior to plan enrollment. Therefore, payments to providers for agency error and delay cannot be processed through eMedNY. When the LDSS has determined that it is appropriate to pay expenses, a Medicaid paper claim form that lists the proper Medicaid rates, codes and billing information must be completed by the provider and submitted to the district. Such claims are paid either by the district or the Department, consistent with the choice made by the district.

NOTE: Billing statements from enrolled providers are not acceptable for payment of claims. Providers/districts must submit actual billing forms ordinarily submitted to eMedNY for processing.

OTHER ELIGIBILITY REQUIREMENTS

FINANCIAL MAINTENANCE

Description: Financial maintenance refers to the manner in which the A/R meets basic needs and non-medical expenses. The local district evaluates the completeness and consistency of the A/R's statements regarding financial circumstances.

Policy: If monthly housing expenses exceed 60/70 percent, as appropriate, of the A/R's monthly income, the A/R must provide further information on specific monthly living expenses and an explanation as to how the expenses are being met. If the LDSS determines that based on information provided by the A/R that there are discrepancies in the A/R's statements or other evidence the LDSS has that raises questions regarding the validity or reasonableness of the A/R's statements, further information may be required.

NOTE: This does not apply to A/Rs who are applying for or are in receipt of Family Planning Benefit Program or MSP only. Financial maintenance does not apply to child-only cases or to A/R's subject to post-eligibility treatment of income.

References:	SSL Sect.	366-a.4
	Dept. Reg.	360-2.2 360-2.3(c)
	ADM	10 OHIP/ADM-6
	INFs	10 OHIP/INF-1
	GISs	11 MA/016

Interpretation: Local social services districts are responsible for determining what percentage of an A/R's income is being spent on housing expenses. When an A/R reports on the ACCESS NY Health Care application (DOH-4220), the DSS-2921 or the Medicaid, Family Health Plus and/or Family Planning Benefit Program Renewal (Recertification) form that his/her share of monthly housing expenses is in excess of: 70% of the A/R's gross monthly income if living in Bronx, Kings, Manhattan, Nassau, Putnam, Queens, Richmond, Suffolk and Westchester counties; or 60% if living in any other county, the LDSS must pursue further information to evaluate how he/she is meeting basic living expenses. Monthly living expenses include: cable, phone, heat, electricity, food, transportation, credit card payments etc.

OTHER ELIGIBILITY REQUIREMENTS

FINANCIAL MAINTENANCE

NOTE: When calculating the household income to be used in the financial maintenance assessment, ALL known income of the applying members' household, including income of any non-applying legally responsible relatives must be counted, including income otherwise exempt from the Medicaid budget such as part-time wages of a 17 year old full-time student. Other means of aid or support received by the household must also be included when calculating financial maintenance. For example, Food Stamps although not counted when determining eligibility must be included in the assessment. A parent(s) total gross monthly income must be used for a child-only application in addition to the income of a non-applying child.

In situations where the A/R's share of monthly housing expenses exceeds the 60/70% level, the LDSS must send the Financial Maintenance form (DOH-4443) to the A/R for completion. Failure to complete and return the form to the LDSS will result in a denial or discontinuation of benefits.

NOTE: An application cannot be denied for failure to provide a shelter expense.

NOTE: The DOH-4443 is never sent before a determination of financial maintenance is completed and it has been determined that the A/R's share of monthly housing expenses is in excess of the allowable amount.

Disposition:

The LDSS must compare the total reported expenses on the Financial Maintenance form to the A/R's income and determine if the A/R provided a sufficient explanation of how he/she is meeting monthly living expenses. Such explanations may include that bills are not being paid, bills are being paid with a credit card, or that someone else is paying the bill. Further information may be needed to explain any discrepancies. Documentation to support the A/R's explanation of how he/she is meeting monthly living expenses cannot be required. However, if the A/R cannot explain how he/she is paying for monthly expenses, the A/R's application/renewal will be denied/discontinued for failure to provide the required information.

NOTE: If the LDSS has information that an SSI-related A/R had assets (income and resources) on a previous application or renewal, and the SSI-related A/R cannot document how assets (income and resources) were spent, the possibility of a transfer of assets for the purpose of qualifying for Medicaid is considered. (See **RESOURCES TRANSFER OF ASSETS**)

OTHER ELIGIBILITY REQUIREMENTS

OWNERSHIP AND AVAILABILITY

Policy: The ownership and availability of income and resources are determined. Only those income and resources, as appropriate, available to and owned by the A/R or a legally responsible relative are considered when determining eligibility for Medicaid.

References: New York Estates, Powers and Trust Law 7-3.1

Mental Hygiene Law Article 81

SSL Sect. 104
366.2
366.3

Dept. Reg. 351.2
352.16
352.23
360-4.3(f)
360-4.4
360-4.6

ADMs 96 ADM-8
89 ADM-47
82 ADM-6

Interpretation: Income:

Certain income, which is not actually available to the A/R, is counted when determining eligibility for Medicaid. Generally, money deducted from income to pay court-ordered support, income taxes, FICA and New York State Disability is budgeted as available when determining Medicaid eligibility. See **INCOME UNEARNED SUPPORT PAYMENTS (VOLUNTARY AND COURT-ORDERED)** for treatment of court-ordered support when deeming; and **INCOME SSI-RELATED METHODOLOGY BLIND WORK EXPENSES** for treatment of work expenses for the blind when determining eligibility for an SSI-related A/R.

Generally, when an A/R is due income, but the income is not being paid and is not within his/her control or the control of a fiduciary owing a duty to the A/R, the income is considered unavailable and not counted when determining eligibility. However, an A/R is required to apply for entitlement benefits, which would reduce or eliminate the need for assistance and care. Unemployment Insurance (UIB) and Social Security (RSDI) are

OTHER ELIGIBILITY REQUIREMENTS

OWNERSHIP AND AVAILABILITY

examples of entitlement benefits. The local district has a responsibility to assist the A/R, as needed, in obtaining such entitlement benefits.

Garnisheed income is generally considered available and is included when determining the A/R's gross income. Local districts may assist the A/R in attempting to have a garnishment removed.

When a legally responsible relative, not living in the A/R's household, is determined able to support an A/R, the contribution is not budgeted until and unless it is actually received.

When an A/R is living with a person to whom s/he is not married, the ability and willingness of the person to support the A/R is evaluated. If the A/R is actually receiving income from this person, that income is considered.

When an A/R has a guardian, trustee, representative payee or other person/institution responsible for managing his/her funds, the local district considers the funds available for the A/R's care. If the A/R has a guardian or other fiduciary who is not meeting his/her obligations, it may be appropriate for the local district to take legal action to compel him/her to utilize funds for the A/R's medical care and services, to have him/her replaced, or to seek a money judgment against the fiduciary or an order of contempt.

Currently unavailable income from any source is reviewed to determine the likelihood of its affecting the continued eligibility of a recipient. For example, if the recipient is expected to receive income in six months, the situation is reviewed after six months.

Ownership:

In order to determine whether or not resources are available to the SSI-related A/R, it is necessary to determine who owns the resource.

When the SSI-related A/R and one or more persons jointly own a resource (financial institution accounts, real estate, stocks, bonds, etc.) the general rule is that such property is considered available to the A/R to the extent of his or her interest in the property. In the

OTHER ELIGIBILITY REQUIREMENTS

OWNERSHIP AND AVAILABILITY

absence of documentation to the contrary, it is presumed that all joint owners possess equal shares. However, there are special rules for SSI-related A/Rs concerning the availability of financial institution accounts. Generally, for such SSI-related A/Rs it is presumed that all of the funds in a joint account belong to the SSI-related A/R. (See **RESOURCES** FINANCIAL INSTITUTION ACCOUNTS)

It is not unusual for non-legally responsible relatives to own life insurance on the life of an A/R. A parent may own a policy on the life of an adult child. When someone other than the A/R owns the policy and has the redemption rights, the life insurance is not considered an available resource of the A/R. (See **RESOURCES** LIFE INSURANCE)

Availability:

All resources owned by the SSI-related Medicaid A/R are considered available unless there is a legal impediment that precludes liquidation. If there is a legal impediment to the disposal of the resources, the resources are not counted in determining resource eligibility until the legal impediment does not exist.

A legal impediment exists when an A/R is legally prohibited from, or lacks the authority to liquidate the resource. For example, a legal impediment exists when an A/R needs the consent of a co-owner of a jointly owned resource in order to sell the resource, and the co-owner refuses to give consent.

When an SSI-related A/R is living with a legally responsible relative (LRR), the LRR's income and resources are generally considered available to the A/R.

When an A/R is residing in the community with an LRR and the LRR asserts that his/her income/resources are not available to the A/R, the eligibility determination depends on whether: (a) the LRR provides financial information; or (b) the LRR refuses to provide the requested financial information.

- (a) When the LRR provides information, but refuses to make his/her income/resources available to the A/R, eligibility for the A/R is determinable. When completing a budget, only the income/resources, as appropriate actually available to an A/R are counted.

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- (b) When the LRR refuses to provide financial information, eligibility is generally indeterminable. However, if the A/R provides complete information concerning his/her own income and resources, as appropriate, including any jointly held resources, eligibility is determined based on the available information. If an LRR refuses to make his/her income and/or resources available for the A/R's medical care a dollar amount is budgeted for any non-medical needs that the LRR is meeting. For example, the LRR may be providing the A/R with food, shelter, and clothing. The value of these items would be considered income. The non-contributing LRR is not included in the household size.

As appropriate the resources of a legally responsible relative, residing with the A/R, are considered in the eligibility process. However, if the legally responsible relative refuses to make his/her resources available to the A/R, Medicaid is provided to the SSI-related A/R, if s/he is otherwise eligible. The provision of assistance to such persons creates an implied contract with the legally responsible relative and the local social services district may initiate legal action to recover the cost of medical care provided. (See **OTHER ELIGIBILITY REQUIREMENTS OWNERSHIP AND AVAILABILITY**)

For married couples, at the time of initial eligibility, when one is an institutionalized spouse (See **INCOME CHRONIC CARE BUDGETING METHODOLOGY FOR INSTITUTIONALIZED SPOUSES**), all countable resources are combined and considered available to the institutionalized spouse, regardless of which spouse owns the resource. The community spouse is allowed to retain resources up to the maximum community spouse resource allowance. The resources, which comprise the community spouse resource allowance are then transferred to the community spouse. These resources are no longer considered available to the institutionalized spouse. After the month eligibility is established for the institutionalized spouse, none of the community spouse's resources are considered available to the institutionalized spouse.

When the value of an A/R's countable resources exceed the appropriate resource level, the A/R is ineligible for Medicaid. (See **RESOURCES EXCESS RESOURCES**)

OTHER ELIGIBILITY REQUIREMENTS

OWNERSHIP AND AVAILABILITY

Generally, no grant or loan to an undergraduate student for educational purposes is considered an available resource. There are some variations on this policy according to the category of the A/R. (See **INCOME LIF DISREGARDS**, **ADC-RELATED DISREGARDS**, **SSI-RELATED DISREGARDS** and **S/CC DISREGARDS**)

When an SSI-related A/R has a guardian, trustee, representative payee or other person/institution responsible for managing his/her funds, the local district reviews the terms of the trust or other agreements/documents to assure that the SSI-related A/R's resources are actually available for his/her care. If a trust was created from the A/R's funds, and, if the trustee has any discretion to expend any of the trust income for the benefit of the A/R, then all of the trust principal which could be expended in any way to benefit the A/R is considered available. In instances where the client has a formal fiduciary and the fiduciary is uncooperative, the local district commences a recovery proceeding under SSL 104.

If an A/R is alleged to be incapable of managing his/her own finances and there is no one with the legal authority to make decisions concerning the A/R's income/resources, the A/R's income and resources, as appropriate, are considered unavailable from the time a petition to appoint a guardian is filed until the court appoints a guardian. The income and resources, as appropriate, are considered unavailable to the A/R prospectively and for a retroactive period of three months.

Where there is a question of availability, the local social services district documents why the resource is not considered available and any actions taken to secure the resource for the SSI-related A/R.

If an SSI-related A/R jointly owns a home, but s/he is out of the home due to an informal separation and the spouse in the home refuses to sell, the A/R's share is an unavailable resource.

Verify Status:

- (a) When the A/R indicates that s/he has a joint financial institution account;
- (b) When the A/R indicates joint ownership of assets;
- (c) When the A/R indicates that an LRR has available assets;

OTHER ELIGIBILITY REQUIREMENTS**OWNERSHIP AND AVAILABILITY**

- (d) When a child in the household has assets in his/her own name;
- (e) When someone other than the A/R pays the mortgage.

Documentation: Sufficient to establish an audit trail:

Copies of financial institution account statements from the bank, mortgagor or insurer, or statements of availability from the LRR.

All efforts to obtain unavailable income and/or resources, as appropriate, are documented in the case record.

OTHER ELIGIBILITY REQUIREMENTS

AUTHORIZATION

Description: Medicaid is granted to an eligible person on the basis of a signed authorization. The authorization is initiated by the district. In addition to initial eligibility determination, authorizations are required for recertifications, reauthorizations, changes and closings.

Policy: An authorization is initiated for all persons determined eligible for Medicaid. A reauthorization is initiated to continue Medicaid previously authorized. No authorization or reauthorization, except those done for SSI recipients, may exceed a period of one year beyond the date of application or recertification. When retroactive coverage is appropriate, a case may be authorized for up to 15 months, 3 months retroactive and 12 months prospective.

References:

SSL Sect.	366.1(a)
Dept. Reg.	360-6.2 354.1
ADM	10 OHIP/ADM-8
GISs	02 MA/012 98 MA/041

Interpretation: An authorization is completed for all persons determined eligible for Medicaid. Common Benefit Identification Cards or rosters are issued for all eligible individuals. Authorizations are initiated to grant Medicaid and affect changes, such as suspension or termination of Medicaid and changes in information affecting eligibility.

Most children under age 19 are guaranteed Medicaid coverage for 12 months. Each time eligibility is determined (i.e., initial determination, and at every renewal or re-determination), children under age 19, who are found fully eligible for Medicaid, are authorized for 12 months continuous coverage regardless of any changes in income or circumstances. This period of continuous coverage applies to all children who are eligible under Low Income Family (LIF) or expanded eligibility budgeting. It also applies to children in families who are on Temporary Assistance cases receiving LIF Medical Assistance, Non IV-E Foster Care children and IV-E Foster Care children, including children in the custody of the Office of Children and Family Services in IV-E eligible settings.

However, if the child or his/her representative fails to provide a social security number (SSN), provides a fraudulent SSN or the child fails to

OTHER ELIGIBILITY REQUIREMENTS**AUTHORIZATION**

“pass” the SSA citizenship verification and/or subsequently fails to provide proof of citizenship and identity coverage is discontinued prior to the end of the 12-month continuous coverage period.

When an authorization is used to change eligibility information, such as family composition, marriage, change of name, death of a member of a family, living arrangements, address or limitations on care or services, it is not necessary to use more than one authorization to make changes which take place at the same time. For example, at renewal, a case can be reauthorized for another year and an address change made on the same form.

In all situations, the authorization is signed and a copy kept in the record.

OTHER ELIGIBILITY REQUIREMENTS**CARD ISSUANCE**

Description: There are three types of Common Benefit Identification Cards (CBIC): permanent plastic photo; permanent plastic non-photo; and temporary paper replacement. A temporary Medicaid Authorization (DSS-2831A) form may also be issued in cases of immediate medical need. Any of these cards may be presented to a medical care provider for the purpose of verifying eligibility and coverage.

Policy: Photo and non-photo cards are plastic and issued on a permanent basis. A recipient generally uses the same card for his/her entire period of eligibility. Adults applying for or in receipt of Medicaid must comply with CBIC photo requirements unless specifically exempted.

The following Medicaid A/Rs are exempt from the photo CBIC requirements:

1. All cash SSI recipients;
2. All children under age 21 living with a responsible relative (including foster parents, guardians and KinGAP relatives);
3. All persons who apply at a location other than an LDSS authorized by the Department until the district's next contact with the person;
4. Homebound persons including those receiving personal care, home health care, or long-term home health care;
5. All persons in nursing facilities or a foster care child placed in an authorized child care agency;
6. Person residing in living arrangements operated by the Office of Mental Health (OMH), or residing in living arrangements certified or operated by the Office for People with Developmental Disabilities (OPWDD);
7. Person enrolled in the OPWDD Home Community Based Services Waiver (HCBS Waiver);
8. Persons who have their Medicaid eligibility determined by OMH or OPWDD in conjunction with the NYS Department of Health (i.e., districts 97 and 98);
9. Persons applying for the Family Planning Benefit Program (FPBP). Any individual who is currently ineligible for cash assistance or Medicaid due to noncompliance with photo requirements may be eligible for FPBP; and
10. Persons eligible for Family Health Plus.

OTHER ELIGIBILITY REQUIREMENTS

CARD ISSUANCE

When two or more adults reside in the same household, each receives his/her own card.

When an applicant is determined eligible and has an immediate medical need the district may issue a temporary Medicaid authorization (DSS-2831A) pending his/her receipt of a permanent CBIC. The DSS-2831A is intended for use between the time of determination and actual delivery of the permanent card, and is valid only for a specific number of days.

References:	ADMs	10 OHIP/ADM-4 02 OMM/ADM-7 01 OMM/ADM-6
	GISs	10 MA/004 09 MA/009

Interpretation: A CBIC is issued to each: (1) individual in receipt of SSI; (2) needy child in foster care; (3) individual determined eligible for Medicaid or Family Health Plus; or (4) individuals determined eligible as a Qualified Medicare Beneficiary (QMB). Cards are not issued for periods of retroactive coverage. Certain recipients, such as those in nursing homes or voluntary childcare institutions which receive Medicaid per diem payments do not receive a CBIC. Rather, their names are placed on a roster of eligible individuals. Rosters are generated from principal provider codes and sent to each facility.

Effective with new or replacement cards requested on or after December 12, 2009 the sequence number that appears on the card will be randomly assigned. A Date and Time stamp is included on all new and replacement cards to help recipients, providers and local district workers identify the most recently issued CBIC card.

Disposition: Persons, who are required to have a photo CBIC, but fail or refuse, may not be denied or discontinued from Medicaid for failure to obtain such photograph. Individuals must not be called into the LDSS solely to obtain a CBIC photograph, but should be photographed at the next time there is an in-person contact. If the individual must come to the LDSS to meet a referral requirement, such as a IV-D interview, a CBIC photo may be obtained at that time.

All photo identification cards must be signed. A card may be signed by the recipient, the recipient's authorized representative, the recipient's caretaker relative, or an authorized representative of the

OTHER ELIGIBILITY REQUIREMENTS**CARD ISSUANCE**

local social services agency. Children, age 13 and older, may sign their own cards.

OTHER ELIGIBILITY REQUIREMENTS**RECIPIENT RESTRICTION PROGRAM (RRP)**

Policy: When an individual's utilization of Medicaid services is considered excessive, following a NYS claims review, the A/R is restricted to only primary providers. The individual is given the opportunity to select which physician, clinic, or pharmacy, etc., s/he wishes to use.

References: SSL Sect. 366
Dept. Reg. 360-6

Interpretation: Through the RRP, certain Medicaid recipients are restricted to one physician, dentist, inpatient hospital, pharmacy and/or clinic for receipt of medical care or services. A provider inquiring on the Electronic Medicaid Eligibility Verification System (EMEVS), concerning a recipient's Medicaid coverage, will be informed of any limitations including the recipient's restriction status. Information in the EMEVS provider manual expands on this information. The restriction message on EMEVS will change each time a recipient either enters the RRP or is removed from the program. Further information on the RRP may be obtained from the individual in your district who administers the program or from the State Department of Health.

OTHER ELIGIBILITY REQUIREMENTS**CO-PAY**

Description: Medicaid and Family Health Plus recipients age 21 or older may be asked to pay part of the cost of some medical care/items. This is called a Co-payment or Co-pay.

Policy: Health care providers may ask for a co-payment for certain services from Medicaid and Family Health Plus recipients age 21 or older. There is a maximum of \$200.00 per Medicaid recipient per year for all co-payments. The co-payment year begins on April 1 each year and ends on March 31 of the following year. Once the maximum has been reached, no co-payments will be required until the new benefit year begins. There is no maximum for Family Health Plus recipients. There is no copayment for family planning treatment, services and supplies for individuals enrolled in Medicaid or Family Health Plus. There is no copayment for any treatment, services or supplies for individuals enrolled in an FPBP case. The provider cannot refuse to give medical services or goods because the recipient indicates that s/he is unable to pay the co-payment.

References:

SSL Sect.	366 369ee
Dept. Reg.	360-7.12
	Chapter 58 Laws of 2005
GISs	05 MA/026 05 MA/006

Interpretation: A Medicaid or Family Health Plus recipient age 21 or older may be asked to pay part of the cost of some medical care/items as identified below. Recipients in Managed Care plans are only required to pay prescription drug co-payments. The amounts for each are identified in **REFERENCE CO-PAYMENT**.

OTHER ELIGIBILITY REQUIREMENTS

CO-PAY

<u>SERVICE</u>	<u>FFS</u>	<u>MC</u>	<u>FHP</u>	<u>FPBP</u>
Inpatient Hospital	YES	NO	YES	NO
Outpatient Hospital & Clinic	YES	NO	YES	NO
Non-emergency/Non-urgent ER	YES	NO	YES	NO
Prescription drugs * (brand name) (generic)	YES	YES	YES	NO
Over-the-Counter Drugs**	YES	YES	YES	NO
Enteral/Parenteral Formulae/Supplies	YES	NO	YES	N/A
Covered Medical/Surgical Supplies ***	YES	NO	YES	NO
Laboratory	YES	NO	YES	NO
X-ray ****	YES	NO	YES	NO
Dental services	NO	NO	YES	N/A
Physician services	NO	NO	NO	NO
Family Planning services and supplies	NO	NO	NO	NO

* One co-payment charge for each new prescription and each refill

** Covered OTC e.g. smoking cessation products, insulin

*** Covered medical supplies e.g. diabetic supplies such as syringes, lancets, test strips, enteral formula

**** Radiology services e.g. diagnostic x-rays, ultrasound, nuclear medicine & oncology services

Recipients exempt from co-payment include the following:

Recipients under the age of twenty-one (21)

Pregnant women (This exemption continues for 2 months after the month in which the pregnancy ends.)

Recipients institutionalized in a medical facility who are required to spend all of their income, except for a personal needs allowance, on medical care. This includes all recipients in nursing facilities and Intermediate Care Facilities for the Developmentally Disabled (ICF/DD).

Recipients enrolled in Medicaid Managed Care Plans (with the exception of pharmacy co-payments and OTC).

Recipients enrolled in FPBP only cases or who receive FPBP only coverage (Coverage Code 18) in an MA case.

OTHER ELIGIBILITY REQUIREMENTS**CO-PAY**

Residents of Adult Care Facilities licensed by DOH or OMH and OPWDD certified community residences and recipients enrolled in a Comprehensive Medicaid Care Managed Program (CMCM), in an OPWDD Home and Community Based Services (HCBS) waiver program, or in a DOH HCBS waiver program for Persons with Traumatic Brain Injury (TBI).

Services Exempt from Co-Payment include the following:

Emergency Services

Family planning services, supplies, and treatment

Tuberculosis Directly Observed Therapy

Methadone Maintenance Treatment Programs, mental health clinic services, mental retardation clinic services, and alcohol and substance abuse clinic services

Drugs to treat tuberculosis, and birth control.

Psychotropic drugs

Prescription drugs for a resident of an Adult Care Facility licensed by the DOH.

NOTE: Co-payments are not charged by private physicians and dentists enrolled in Medicaid or, for home health and personal care services. Private physicians and dentists in Family Health Plus may charge a co-payment.

OTHER ELIGIBILITY REQUIREMENTS**MEDICAID BUY-IN PROGRAM FOR
WORKING PEOPLE WITH DISABILITIES (MBI-WPD) PREMIUM PAYMENT**

Policy: MBI-WPD participants with net (earned and unearned) income at least 150% and at or below 250% of the federal poverty level are required to pay a monthly premium for Medicaid. Individuals with net income below 150% of the federal poverty level pay no premium.

NOTE: A moratorium on premium payments has been instituted until such time as systems support for automated premium collection and tracking is available.

References: SSL Sect. 366(1)(a)(12)&(13)
ADMs 04 OMM/ADM-5
03 OMM/ADM-4

OTHER ELIGIBILITY REQUIREMENTS

STATE RESIDENCE AND RESPONSIBILITY FOR ASSISTANCE

Description: The state of residence of an A/R is where s/he is domiciled. A person's domicile, or legal residence, is the principal and permanent home to which the person, wherever temporarily located, always intends to return.

Policy: Medicaid is provided to otherwise eligible persons domiciled in New York State, regardless of the length of their residence. Local districts rely on a person's intent in determining the state of legal residence, unless the person's actions are inconsistent with that intent.

References:

SSL Sect.	62
Dept. Reg.	349.4(b) 360-3.2(g)
ADMs	OMM/ADM 97-1 93 ADM-34 87 ADM-22

Interpretation: An A/R's State of residence is determined by a preponderance of factors, including, but not limited to: the address where the A/R is currently residing; the address from which s/he is registered to vote; his/her mailing address; the abandonment of any prior residence; and his/her health when s/he entered the district. The state that is responsible for providing Medicaid is the state where the A/R is domiciled.

Generally, when an SSI cash recipient enters New York State with the intent to remain, the district where s/he resides is responsible for providing him/her with Medicaid beginning with the date s/he entered New York State (provided the recipient was not placed in New York by another state). When an SSI recipient moves into New York State and continues to be eligible for SSI, the Social Security Administration (SSA) will change the state responsible for making state supplement payments to the recipient. The date of this change is the first of the month following the month in which the recipient moved. The date of the change will appear on the SDX in field 74 "Date Residency Began".

If an SSI recipient incurs a bill after entering New York State, but prior to the date in field 74 "Date Residency began" Medicaid is provided by the local district where the recipient resides. Medicaid coverage begins on the first of the month prior to the month of the

OTHER ELIGIBILITY REQUIREMENTS

STATE RESIDENCE AND RESPONSIBILITY FOR ASSISTANCE

"Date of Residency". The SDX is adequate documentation for determining when the recipient became a resident of the State. When an SSI recipient indicates that s/he moved to New York State prior to the first of the month preceding the "Date of Residency" further investigation is required. If the SSI recipient can document that s/he became a resident of New York State at an earlier date, Medicaid is authorized from that date.

Children who are adopted or receive foster care under Title IV-E of the Social Security Act receive Medicaid from the state in which the adoptive or foster parents reside. When a family including a IV-E eligible child moves to a different state, the new state become responsible for providing Medicaid. Families of IV-E adopted children must bring documentation of IV-E eligibility to the new state of residence for Medicaid to be authorized.

Transfer of Medicaid for IV-E foster care children is accomplished with the assistance of the State's IV-E Foster Care Compact Coordinator. When a IV-E foster care child is placed in another state, once the new placement is approved by the new state, that state opens up a Medicaid case. Until the new state of residence approves the foster care placement, New York State is responsible for arranging Medical care. While a New York State Medicaid case may remain open, Children and Family Services is responsible for working with foster parents in arranging for medical care out of state.

Specific residence topics are considered in detail in the following sections:

Persons Temporarily In the State;

District of Fiscal Responsibility; and

Persons Temporarily Out of State.

**OTHER ELIGIBILITY REQUIREMENTS
STATE RESIDENCE AND RESPONSIBILITY FOR ASSISTANCE**

DISTRICT OF FISCAL RESPONSIBILITY (DFR)

Policy: Generally, each local social services district is responsible for furnishing Medicaid to otherwise eligible A/Rs who are residents of New York State (NYS) and who reside within the district.

References:

SSL Sect.	62.5 365.5
Dept. Reg.	311.3 311.4 360-3.5 360-3.6
ADMs	08 OHIP/ADM-5 08 OHIP/ADM-3 OMM/ADM 97-1 94 ADM-20 90 ADM-9 86 ADM-40 80 ADM-4
LCM	08 OHIP/LCM-1
INFs	06 INF-34 06 INF-22 90 INF-45
GISs	02 MA/010 02 MA/006 02 MA/001 00 MA/018 97 MA/028

Interpretation: Where Found Rule

When a person enters New York State with the intent to remain permanently or indefinitely and has a need for medical care, before a living arrangement is established, the local district where the person is found is responsible for providing Medicaid, if the A/R is otherwise eligible.

**OTHER ELIGIBILITY REQUIREMENTS
STATE RESIDENCE AND RESPONSIBILITY FOR ASSISTANCE**

DISTRICT OF FISCAL RESPONSIBILITY (DFR)

When a person has not abandoned his/her residence in another state, but is unable to return to the home state due to illness, eligibility for benefits from the home state is explored. If the home state does not agree that the individual is a resident of that state for Medicaid purposes, the local district where s/he is found at the time that the person can no longer return to his/her home state is the district responsible for providing Medicaid, regardless of where the applicant is found at the time of application. If the A/R subsequently is moved to a medical facility in another district, the first district remains responsible.

OTHER ELIGIBILITY REQUIREMENTS

DISTRICT OF FISCAL RESPONSIBILITY (DFR)

For example: While visiting his sister in Essex County from another state, Mr. Smith becomes ill and cannot return to his home state. He is hospitalized in Clinton County. While in Clinton County, Mr. Smith's sister applies on his behalf for Medicaid in Essex County. If the home state does not agree that the individual is a resident of that state for Medicaid purposes, Mr. Smith is authorized for Medicaid by Essex County. Subsequently Mr. Smith is moved to a nursing facility in Franklin County. Essex County remains fiscally responsible for Mr. Smith's Medicaid.

When a person applies for Medicaid while in a district other than his/her local district of residence, the local district in which the person is found contacts the local district of residence before assuming that district will accept and process an application. The district where the A/R is found assists in processing the application as a courtesy. This acknowledgment of fiscal responsibility is confirmed and noted in the record, prior to forwarding the courtesy application. Without such an agreement, the district in which the applicant is found accepts and processes the application. If otherwise eligible, Medicaid is authorized by the district where the applicant is found. The district may then request a fair hearing to determine the district of responsibility.

All individuals who have been determined eligible for SSI cash payments by the Social Security Administration, or who are in receipt of such payments (federal benefits and/or State Supplements) are the district of fiscal responsibility of the "where found" district. The only exceptions that apply to SSI cash recipients and eligibles include:

- Children in receipt of, or eligible for, SSI cash assistance who are in the care and custody of the Commissioner of the Local Department of Social Services remain the fiscal responsibility of the Commissioner who has custody of the child.
- Medicaid SSI eligible's and recipients who are the responsibility of the Office of Mental Health (District 97/OMH) or the Office for People with Developmental Disabilities (District 98/OPWDD), who move to another district may remain the responsibility of OMH or OPWDD depending on the living arrangement of the individual. OMH and OPWDD will retain responsibility for

OTHER ELIGIBILITY REQUIREMENTS

DISTRICT OF FISCAL RESPONSIBILITY (DFR)

determining whether the Medicaid SSI recipient gains residence in another district following a move or remains the responsibility of the State. OMH or OPWDD will transfer a Medicaid SSI case to the new district when appropriate.

- Medicaid-only recipients who move to an adult care facility in another district are the fiscal responsibility of the former district. However, if the individual becomes eligible for SSI, the SSI recipient gains residence in the new district and a Medicaid case must be opened in the new district following the closing of the Medicaid case in the former district.
- SSI recipients who enter a medical facility in another district and remain eligible for SSI but for whom no SSI payment is being made (SDX Payment Status Code E01 "Eligible but no Payment") gain residence in the new district.
- SSI cash recipients who move to a medical facility in another district prior to October 20, 2008 are the fiscal responsibility of the former district. . Should the individual subsequently move and remain in receipt of SSI the district of fiscal responsibility becomes the where found district.

EXCEPTIONS TO THE "WHERE FOUND" RULE (other than SSI cash recipients/eligible's)

NOTE: Unless one of the following exceptions applies, the "where found" district is fiscally responsible for the A/R. The burden of proof is on the "where found" district to establish that an exception applies.

Temporary Absence from Legal Residence

The local social services district where a person has his or her legal residence continues to be responsible for providing Medicaid when the person is temporarily absent from the district. A person's legal residence, or domicile, is the principal and permanent home to which the person, wherever temporarily located, always intends to return. Districts rely on a person's expression of intent in determining the district of legal residence, unless the person's actions are inconsistent with the expressed intent. When a person capable of indicating intent leaves his/her district of legal residence, the person will be considered to be temporarily absent from such district if:

OTHER ELIGIBILITY REQUIREMENTS**DISTRICT OF FISCAL RESPONSIBILITY (DFR)**

- (a) the person enters another district for a specific purpose (such as rehabilitation for alcohol or substance abuse, training, schooling, or vacation); and
- (b) the person intends to return to the “from” district when the specific purpose is accomplished; and
- (c) the person’s actions are not inconsistent with this purpose. In this situation, the “from” district continues to be responsible for providing Medicaid as long as the recipient continues to engage in the activity which prompted the temporary absence.

This responsibility continues only until the temporary purpose ends. At that point, the recipient:

- returns to his/her district of legal residence; or
- is considered to have established a new legal residence and is transitioned from the “from” district to the “where found” district; or
- becomes a transient (a homeless person without a legal residence) and immediately becomes the responsibility of the “where found” district.

When an A/R chooses to receive care or treatment in a medical facility outside his/her district of residence, the district of residence retains responsibility for the cost of the A/R's care.

Transition Rule

When a non-institutionalized recipient moves from one district to another, the district from which the recipient moved must follow the rules in **OTHER ELIGIBILITY REQUIREMENTS, STATE RESIDENCY, ASSISTANCE TO PERSONS WHO CHANGE RESIDENCY.**

OTHER ELIGIBILITY REQUIREMENTS

DISTRICT OF FISCAL RESPONSIBILITY (DFR)

Medical Facility Rule

The local district of legal residence continues to be responsible for providing Medicaid to a person who has entered a medical facility in another district if the person is in need of Medicaid upon admission to the facility, or becomes in need during the inpatient stay, or upon discharge from the facility. This responsibility continues indefinitely until there is a break in the recipient's need for Medicaid.

When applying these provisions to a Title XIX facility operated or certified by OMH or OPWDD, regardless of where the facility is located, the district of legal residence ("from district") remains responsible until there is a "break in need".

A "break in need" is defined as one calendar month without financial eligibility. As long as an individual remains financially eligible for Medicaid, there is no break in need. If the individual has excess income and submits paid or incurred expenses totaling the amount of excess or pays the excess directly to the district, there is no break in need. If in any month, the SSI-related individual becomes resource ineligible and is unable to spend down the excess resources or does not meet an excess income liability, there is a break in need. When a break in need occurs, the district of fiscal responsibility may close the case with adequate and timely notice.

District Placement Rule

When the A/R's district of residence arranges or participates actively in arranging for care in another local district, that district is assuming responsibility for the continuing care of that A/R, regardless of the type of facility the person enters. The A/R's district of legal residence continues to be, or becomes responsible for providing Medicaid when: a district (either the local district of legal residence or any other district) was involved in placing the eligible person into a formal residential care setting in another district. District involvement in a placement includes both direct and indirect involvement by any county agency or official governmental entity of the county including courts, mental health departments, probation departments, etc.

OTHER ELIGIBILITY REQUIREMENTS

DISTRICT OF FISCAL RESPONSIBILITY (DFR)

Homeless Rule

When a district places a homeless individual/family in temporary housing in another district, the placing district continues to be responsible for providing Medicaid during the individual/family's stay in the temporary housing. If the homeless recipient subsequently moves into permanent housing, the placing district follows the procedures found in **OTHER ELIGIBILITY REQUIREMENTS, STATE RESIDENCE, ASSISTANCE TO PERSONS WHO CHANGE RESIDENCY.**

NOTE: When a homeless A/R relocates from one district to another and does not wish to return to the first district, s/he is treated as any other A/R moving from one district to another (See **OTHER ELIGIBILITY REQUIREMENTS, STATE RESIDENCE, ASSISTANCE TO PERSONS WHO CHANGE RESIDENCY.**

Domestic Violence

When an eligible person enters an approved Shelter for Victims of Domestic Violence located in another district following an incident of domestic violence, the district in which the person legally resided at the time of the incident is fiscally responsible for that person while s/he resides in the approved shelter. This rule applies to persons who had been receiving Medicaid prior to the incident as well as to persons who become eligible due to lack of available income and resources while residing in the approved shelter.

This responsibility continues until the person leaves the approved shelter. If the recipient chooses not to return to the former district of legal residence, such district must follow the procedures in **OTHER ELIGIBILITY REQUIREMENTS, STATE RESIDENCE, ASSISTANCE TO PERSONS WHO CHANGE RESIDENCY.**

Adult Care Facility

When an individual enters an adult care facility (Congregate Care Level II-adult home, enriched housing program or residence for adults) in another district and is or becomes in need of care, the district of fiscal responsibility from which the individual was admitted to the adult care facility is responsible for providing assistance and care. This responsibility continues until there is a "break in need".

OTHER ELIGIBILITY REQUIREMENTS

DISTRICT OF FISCAL RESPONSIBILITY (DFR)

This DFR rule does not apply to OMH, OPWDD or OASAS certified community residences, residential substance abuse treatment programs or residential care centers for adults.

A/R under age 21

The DFR for a child under age 21, is the district “where found”, unless one of the current DFR exceptions applies. Districts should rely on a person’s expression of intent in determining the district of legal residence, unless the person’s actions are inconsistent with the expressed intent.

The district of fiscal responsibility for a child under the age of 21, who has been adjudicated incompetent, remains the district of legal residence of the parent(s) or legal guardian.

NOTE: The DFR of a newborn surrendered for adoption and not yet placed in an adoptive home is the DFR of the birth mother.

Medical Parole

The DFR for an inmate released on medical parole is the district from which the inmate was sentenced. This responsibility continues indefinitely until there is a break in need.

Non-medical Parole

The DFR for non-medical parolees who are mandated as a condition of parole to live in a particular district in a non-medical residential setting, such as a half-way house, is the district where the non-medical parolee legally resided immediately prior to incarceration. This responsibility continues until there is a break in need. Once the mandate is ended or parole is completed, and the individual regains his/her freedom to exercise intent, the rules in **OTHER ELIGIBILITY REQUIREMENTS STATE RESIDENCY, ASSISTANCE TO PERSONS WHO CHANGE RESIDENCY** would apply.

See **OTHER ELIGIBILITY REQUIREMENTS MAINTAINING MEDICAID ELIGIBILITY FOR INCARCERATED INDIVIDUALS** for an explanation of residency rules at reinstatement.

OTHER ELIGIBILITY REQUIREMENTS

DISTRICT OF FISCAL RESPONSIBILITY (DFR)

Infants Residing with Incarcerated Mothers

The DFR for an infant residing with an incarcerated mother is the mother's district of legal residence prior to incarceration.

Children Eligible for Continuous Medicaid Coverage

A child who has lost eligibility, but is in a period of continuous coverage, who moves to another district will not have his/her coverage transitioned to the new district of residence. Continuous coverage will be provided by the former district of residence.

If a child turns age 19 during a period of continuous eligibility, the guarantee of continuous eligibility will end as of the last day of the month of the child's nineteenth birthday. However, if the child is receiving medically necessary inpatient services at that time, Medicaid coverage continues through the end of the hospitalization.

Disposition:

When the district of fiscal responsibility for the A/R has been established, that district authorizes Medicaid, if the A/R is otherwise eligible.

If a dispute based on residency occurs between local districts for an otherwise eligible A/R, either district may request a fair hearing to determine the district of fiscal responsibility. The district where the A/R is found provides Medicaid until the fair hearing decision is rendered. The district found to be responsible, if necessary, reimburses the district that assumed responsibility for the A/R prior to the fair hearing decision.

Generally, a person cannot gain residence in a district while receiving care in a Title XIX facility or a public institution.

When a pregnant woman is determined presumptively eligible for Medicaid, the district she states is her residence is fiscally responsible for care provided during the period of presumptive eligibility. Her documented district of residence may be different when a full eligibility determination is completed.

**OTHER ELIGIBILITY REQUIREMENTS
STATE RESIDENCE AND RESPONSIBILITY FOR ASSISTANCE**

ASSISTANCE TO PERSONS WHO CHANGE RESIDENCY

Description: Medicaid recipients who notify their district of residence of a change in residency to another district in New York State will have their Medicaid case transitioned to the new district.

Policy: Medicaid recipients who report their move from one district to another within the State will be provided coverage by their originating district for the month in which the move is reported and the following month. Coverage will be established in the new district of residence effective the first day of the second month following the month the move was reported. Eligibility will continue for the duration of the originating county's authorization period, or four months, whichever is greater. If a recipient advises the district of a move, in advance of his or her actual relocation, the originating district is responsible for providing coverage through the month of the actual move and the following month.

References:

SSL Sect.	62.5 (a)
ADMs	10 OHIP/ADM-8 09 OHIP/ADM-1 99 OMM/ADM -3 OMM/ADM 97-1 95 ADM-5 89 ADM-2
Dept. Reg.	360-1.4 (j)
LCM	08 OHIP/LCM-1
GISs	09 MA/004 02 MA/006 02 MA/001

Interpretation: Recipients in Case Types 20 (Medicaid), 24 (Family Health Plus), and recipients who receive Medicaid through a Temporary Assistance (TA) Case (Case Types 11, 12, 16 or 17) who notify their district of a move to another county, and provide their new address in writing will have their Medicaid case transitioned to the new district of residence without the need for a new application.

NOTE: This policy does not apply to Medicaid recipients who are institutionalized in a medical facility as defined in Department

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ASSISTANCE TO PERSONS WHO CHANGE RESIDENCY

Regulations at 18 NYCRR, Section 360-1.4 (j). This means that eligibility will not be transitioned for individuals who relocate to another district from a hospital, nursing home, Intermediate Care facility, inpatient psychiatric center or inpatient alcohol treatment facility.

When a Supplemental Security Income (SSI) recipient reports a move to another district, it is important that the move be reported to the Social Security Administration following the instructions in 95 ADM-5. Districts must coordinate any closing for an SSI recipient with the opening of a case in the new district.

For recipients who report their move and provide the address in the new district in advance of his or her actual relocation, the district is responsible for providing coverage through the month of the actual move and the following month and coverage is established in the new district the first day of the succeeding month.

If a district discovers a recipient has moved out of county (the recipient has reported the move), coverage must be provided for the month of and the month following the move at which time the case must be closed.

Recipients who do not report their move in advance of his or her actual relocation will have their coverage provided by the originating district for the month in which the move is reported and the following month. Coverage is established in the new district effective the first day of the second month following the month the move was reported.

NOTE: The District of Fiscal Responsibility (DFR) rules, with the exception of the Transition Rule, remain unchanged.

CONSIDERATIONS:

Changes in Circumstances- In situations where the recipient reports their move AND other changes relative to eligibility and the information is sufficient to complete a re-determination before the case is transitioned, such re-determination should be made. Changes that result in ineligibility should be handled in accordance with existing procedures, including the discontinuance or change of coverage as appropriate. However, in no instance should a district

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ASSISTANCE TO PERSONS WHO CHANGE RESIDENCY

delay the transition of coverage pending receipt of further information regarding items that may change as a result of the individual's reported relocation (i.e. a change of job, which may result in a change in earned income).

Cases for which the district has not completed the eligibility determination, (i.e. a pregnant woman authorized for Presumptive Eligibility) must have such determination of eligibility completed prior to the transition of the case to the new district of residence.

Similarly, if the case is in the process of being renewed, the district must complete the renewal before transitioning the case to the new district of residence.

NOTE: For procedures for renewing children age 18 and up to 21 who are receiving Medicaid as final discharges from foster care (Chaffee provisions) that have moved, see: **OTHER ELIGIBILITY REQUIREMENTS APPLICATION, CERTIFICATION AND RENEWAL.**

Not All Case Members Moving- The eligibility of the moving household members must be determined. If determined ineligible, they must be closed, and the case is not transitioned. If eligibility continues, a new case must be opened for them and transitioned to the new district of residence. Eligibility for the remaining household members must be re-determined and appropriate action taken.

Returned Agency Correspondence Out of District Moves- Returned correspondence, including the Medicaid/FHP renewal that is returned to the district by the U.S. Postal Service with a change of address must be re-mailed to the new address with a copy of Attachment VII of 08 OHIP/LCM-1 which will provide the individual the opportunity to confirm the new address. Individuals who respond in the prescribed time frame (minimally 10 days) to the follow-up correspondence shall be considered to have reported their re-location and new address and will have their case transitioned after continued eligibility is determined. Individuals who do not respond to the follow-up correspondence will have their case discontinued having failed to renew or comply with a request for additional information.

Returned Agency Correspondence In District Moves- Correspondence returned by the U.S. Postal Service (USPS) for a recipient, including the Medicaid /FHP renewal, with a change of address, the district must

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make an effort to confirm the new address. In order to get confirmation from the recipient of the new address, Attachment I of GIS 09 MA/004 must be included when the returned mail is forwarded to the individual. However, if the individual fails to return Attachment I of GIS 09 MA/004 verifying the new address after an established period of time (a minimum of ten days should be given) and the mail is not returned by the USPS, the LDSS will conclude that the recipient is living at the new address and must update WMS to reflect the new address.

If the district receives correspondence returned by the USPS without a forwarding address, but staff learns of an updated address within the county, e.g., associated with the recipient's food stamp case, the returned mail and Attachment I of GIS 09 MA/004 must be forwarded to the individual at the updated address. However, if the individual fails to return Attachment I of GIS 09 MA/004 verifying the new address after the established period of time and the mail is not returned by the USPS, the LDSS will conclude that the recipient lives at the address and must update WMS to reflect the new address. In accordance with the managed care contract, if a Managed Care Contractor informs the local district of a new address, this is sufficient information to update the address in WMS.

Children in Continuous Coverage Status- A child who has lost eligibility, but is in a period of continuous coverage, who moves to another district will not have his/her coverage transitioned to the new district of residence. Continuous coverage will be provided by the former district of residence.

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ASSISTANCE TO PERSONS WHO CHANGE RESIDENCY

Individuals who Notify County B of their Re-location- In situations where the recipient notifies the new district of residence of their move, the new district of residence must direct the individual to put the new address in writing. The new district must forward the new address to the district currently providing coverage so that such district may take necessary action to transition the case.

If the individual wishes to make an application in the new district of residence, all aspects of the application process must be adhered to, including documentation requirements. If the applicant(s) is found eligible, coordination in opening and closing the cases must occur between the two districts to avoid duplicate coverage.

NOTE: The Medicaid coverage of a TA case will be transitioned to the new district of residence in the event of a reported move. However, the individual must re-apply for TA in the new district of residence. If the individual also applies for Medicaid with the TA application and the determination is made prior to the transition of the Medicaid coverage, the TA/Medicaid case should be authorized.

Homeless Individuals- Homeless individuals who report a move to another district must have their case transitioned, even though they do not have a permanent address.

Admissions to District 97 (Office of Mental Health, (OMH)) and 98 (Office for People with Developmental Disabilities, (OPWDD)) Living Arrangements- Individuals who are admitted to certain District 97 and 98 living arrangements will not have their cases transitioned. When a district is contacted by a Patient Resource Office (OMH), or a Revenue Support Office (OPWDD) and advised that an individual has been admitted to a specified OMH or OPWDD living arrangement, the district must use manual notice OHIP-0014 to inform the individual that his or her Medicaid case is being transferred to District 97 or 98, effective with the date of admission to the facility.

When an individual is discharged from a specified OMH or OPWDD living arrangement, the district will be sent the Relocation Referral Form and accompanying documentation from the appropriate Patient Resource Office or Revenue Support Office. The District of Fiscal Responsibility

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must establish uninterrupted coverage for the case, and send notice OHIP-0015.

COVERAGE CONSIDERATIONS:

Managed Care- If available, individuals who have moved to a new district should be re-enrolled in the same managed care plan in their new district of residence.

If the same managed care plan is not available, the Managed Care disenrollment should be coordinated with the last date of coverage in the former district. Consideration may be made to disenroll the individual earlier if the individual has moved out of the plan's service area and cannot access services. Such disenrollment would enable the individual to receive fee-for-service coverage in order to access services. Future managed care enrollment should proceed according to local district requirements.

Family Health Plus (FHPlus) - If available, individuals who have moved to a new district should be re-enrolled in the same managed care plan in their new district of residence.

Individuals who have moved to a district where only one FHPlus plan is available must be enrolled in that plan. If the FHPlus plan is not the same plan as the individual was enrolled previously, the county must take necessary steps to insure the enrollment is effective by the first day of the month following the closing in the former district of residence. This may include notifying the plan in writing if the enrollment is not processed by pull down dates.

If the same FHPlus plan is not available and more than one FHPlus plan exists in the new county of residence, the former county of residence must disenroll the individual effective the first day of the month following the second month in which the closing transaction is made. The new district of residence must provide the individual with plan selection information as soon as possible. In some instances, the former district of residence may need to delete a disenrollment to allow the new district of residence to process an enrollment.

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STATE RESIDENCE AND RESPONSIBILITY FOR ASSISTANCE**

ASSISTANCE TO PERSONS WHO CHANGE RESIDENCY

NOTE: Managed Care and FHPlus recipients who are receiving Guaranteed Coverage (Coverage Codes 31 and 36 respectively) have been determined to be ineligible for Medicaid. If such an individual reports a move to another district, the individual is entitled ONLY to the balance of the six month guarantee from the original county of residence.

Third Party and Medicare- When a case opens in the new district of residence, any commercial insurance, Medicare coverage and Medicare Savings Program information must be reflected on eMedNY.

If the former district of residence has been paying a commercial health insurance premium, all necessary information regarding the payment of the premium must be forwarded to the new district of residence and annotated on the Relocation Referral Form.

The new district of residence should verify that the commercial policy remains in effect. Any changes to coverage or providers should be entered in the eMedNY Third Party subsystem and the district should assume the responsibility of making the premium payments. This should be done timely to ensure the commercial health insurance coverage is not jeopardized.

CITIZENSHIP DOCUMENTATION-

For cases where the Social Security citizenship verification match confirmed citizenship, the worker must note this on the "Relocation Referral Form" which is forwarded to the new district. If the worker verified citizenship through documentation provided by the A/R or a referral to Vital Records, a copy of the verification received shall be forwarded to the new district. If an individual has not yet provided citizenship documentation or authorization for the district to confirm birth information with Vital Records, the case must be transferred to the new district, and the new district must pursue such documentation/authorization. The originating district shall note any outstanding issues concerning a recipient's citizenship/identity documentation on the referral form sent to the new district.

Disposition: Local Social Services Districts must ensure that individuals who report their move to a new district and are otherwise eligible have their Medicaid/Family Health Plus case transitioned to such new district. Appropriate and timely transactions in the Welfare Management System (WMS) must be made, and coordinated between the new and former districts to ensure appropriate access to Medicaid and Family Health Plus coverage.

**OTHER ELIGIBILITY REQUIREMENTS
STATE RESIDENCE AND RESPONSIBILITY FOR ASSISTANCE**

ASSISTANCE TO PERSONS TEMPORARILY ABSENT

Policy: Medicaid may be authorized for a resident of the New York State who is temporarily absent from NYS if the A/R remains in the United States (including Puerto Rico, the Virgin Islands, Northern Mariana Islands, or Guam) or in Canada, and s/he meets one of the following conditions:

- (1) the residents of the A/R's district customarily use medical facilities in another state or Canada; or
- (2) there are limited medical services available in the A/R's local district and the local social services district gives prior approval; or
- (3) an emergency situation arises.

References:

SSL Sect.	62 365
Dept. Reg.	360-3.2(g) 360-3.5
ADM	OMM/ADM 97-1

Interpretation: An A/R is temporarily absent from the State, if before the absence s/he: was a resident of the district; has an intent to return to the State; and has not shown an intent to establish a permanent residence elsewhere.

Residents of New York State may be eligible for Medicaid coverage of medical services provided in another state if residents of the A/R's district customarily use the medical facilities in another state, or if the type of medical service required is not available in New York State and the local social services district has given prior approval. Medicaid coverage may also be authorized, if while temporarily in another state, the A/R requires emergency medical attention. The assistance of that state is sought in the application process.

NOTE: New York Medicaid will only make payment to out-of-state providers who are enrolled in New York's Medicaid program. For situations involving medical expenses incurred/paid during the three month period prior to the month of application see **OTHER ELIGIBILITY REQUIREMENTS APPLICATION, CERTIFICATION AND RENEWAL NEW APPLICATION**.

**OTHER ELIGIBILITY REQUIREMENTS
STATE RESIDENCE AND RESPONSIBILITY ASSISTANCE**

ASSISTANCE TO PERSONS TEMPORARILY ABSENT

If an individual is placed in a medical institution in another state, the district which placed him/her continues to be responsible for all covered necessary medical expenses incurred outside the state, since the local district arranged for the placement in a medical institution. If, however, an individual voluntarily placed him/herself in a chronic care facility in another state, abandoning his/her former residence, s/he may be considered a resident of the state to which s/he moved.

NOTE: Generally, in cases involving a question of state residence, the intent of the client to establish a permanent dwelling is the primary consideration, as long as the A/R's action is consistent with his/her intent.

Disposition: When an A/R is found to have established a legal residence (domicile) outside of New York State, a timely and adequate notice is sent to the A/R that s/he is no longer eligible for Medicaid in New York State and that s/he should apply for assistance in the State to which s/he moved.

**OTHER ELIGIBILITY REQUIREMENTS
STATE RESIDENCE AND RESPONSIBILITY FOR ASSISTANCE**

ASSISTANCE TO PERSONS TEMPORARILY IN THE STATE

Policy: The state of residence is fiscally responsible for providing Medicaid to otherwise eligible A/Rs.

When an application is made by a person temporarily in New York State (NYS), the local district in which s/he is found assists the appropriate agency in the applicant's state of residence with the investigation to determine eligibility and make arrangements for care.

However, if the Medicaid available to the client in his/her state of residence is limited in scope and duration, NYS may authorize care after the A/R utilizes any Medicaid available from his/her home state, providing the A/R did not enter the NYS for the purposes of obtaining such care and s/he is otherwise eligible.

Persons who are placed in medical institutions in NYS by another state remain the responsibility of that State which made the placement.

References:	SSL Sect	365.1(b) 366.1(b)
	Dept. Reg.	360-3.2(g) 360-3.6
	ADM	OMM/ADM 97-1
	LCM	93 LCM-12

Interpretation: When an A/R is temporarily absent from his/her state of residence, that state continues to be responsible for the A/R's Medicaid (See **OTHER ELIGIBILITY REQUIREMENTS STATE RESIDENCE AND RESPONSIBILITY FOR ASSISTANCE** for a discussion of state of residence). If the state of residence does not agree that the individual is the responsibility of that state for Medicaid purposes, then NYS Medicaid is authorized for an otherwise eligible A/R provided that the A/R did not enter NYS for the purpose of obtaining medical care.

When a person is found in NYS and is medically unable to return to his/her home state, the district where the person is found at the time s/he becomes unable to return to his/her home state is

**OTHER ELIGIBILITY REQUIREMENTS
STATE RESIDENCE AND RESPONSIBILITY FOR ASSISTANCE**

ASSISTANCE TO PERSONS TEMPORARILY IN THE STATE

responsible for providing his/her Medicaid, if the person is otherwise eligible and assistance is denied by the home state because of residency.

When to Verify: When an applicant indicates a recent entry or an address outside NYS, the local district establishes the client's actual State of residence. If s/he has recently entered New York State, the local district establishes that the entry was not for the purpose of receiving medical care.

Verification: When there is a question as to the A/R's state of residence, a determination of residence is based on a preponderance of the following factors: (1) the address from which s/he is registered to vote; (2) his/her mailing address; (3) the abandonment of any prior residence; and (4) his/her health.

NOTE: When there is a question as to the A/R's state of residence, generally the intent of the A/R to establish a permanent residence is the primary consideration, as long as the A/R's actions are consistent with his/her intent.

Disposition: When an A/R entered New York State for the purpose of obtaining medical care, his/her application is denied. If the A/R is a resident of another state, the local district in which s/he is found assists the state of residence in the investigation of his/her eligibility and/or the arrangement for his/her care. (See **OTHER ELIGIBILITY REQUIREMENTS STATE RESIDENCE AND RESPONSIBILITY FOR ASSISTANCE**)

OTHER ELIGIBILITY REQUIREMENTS

LIVING ARRANGEMENTS

Description: This section describes where Medicaid may be provided. A recipient may reside in his/her own home or a medical institution/facility. Medicaid may also be given to residents of certain public institutions/facilities. Federal reimbursement is not always available, however.

Policy: Care and services under Medicaid may be provided to an otherwise eligible A/R residing in: his/her own home; a general or chronic disease hospital; or an institution used primarily for the care of the mentally ill, when the A/R is under age 21, under age 22 if the A/R turned age 21 while residing in the institution, or is age 65 or over. Generally a person residing in a public institution may not receive Medicaid unless the public institution is: a medical facility; a community residence, not on the grounds of a major institution, serving 16 or fewer residents; a child care institution for 25 or fewer children; an emergency shelter for the homeless; a home for adults operated by a local social services district; or an OMH residential care center for adults (RCCA).

References:

SSL Sect.	365 366
Family Court Act 454	
Dept. Reg.	360-3.4 360-6.6
ADMs	OMM/ADM 97-1 90 ADM-18 89 ADM-2 88 ADM-50 86 ADM-23

Interpretation: The term his/her own home is broad in scope. Such living arrangement may include the person's own house or apartment, a private home for adults, an approved home for the aged or blind, a residential facility not located on the grounds of a major institution, a child care institution; and congregate care living arrangements. Persons in family care or foster care are living in their own home for Medicaid purposes. See **OTHER ELIGIBILITY REQUIREMENTS LIVING IN OWN HOME** for a discussion of the A/R living in his/her home.

OTHER ELIGIBILITY REQUIREMENTS

LIVING ARRANGEMENTS

An approved medical institution or facility includes the following, when operated according to Public Health Law or other applicable law:

- a private proprietary or non-profit nursing home ;
- the infirmary section of a home for the aged;
- a public home infirmary or similar public facility for the chronically ill;
- a hospital or nursing home section of a public institution operated for the care of persons with developmental disabilities;
- a State hospital for the mentally disabled operated by the Department of Mental Hygiene (OMH);
- a residential treatment facility for mentally disabled children certified by the Department of Mental Hygiene (OMH);
- an intermediate care facility for the developmentally disabled; and
- a hospital, other than one caring primarily for the mentally disabled.

NOTE: These definitions are NOT to be used for the purpose of determining the district of fiscal responsibility (See OMM/ADM 97-1).

Medicaid is available to otherwise eligible persons receiving inpatient psychiatric services while residing in an institution primarily for the care of the mentally ill when: the A/R is under age 21; the A/R turns age 21 during the course of his/her institutionalization, (in which case the A/R may receive assistance until s/he reaches the age of 22); the A/R is age 65 or over; or, the A/R is an FNP refugee or Cuban-Haitian entrant (in which case Medicaid may be authorized for eight months following the date of entry).

Medicaid may be provided to otherwise eligible prisoners or individuals in the detention process or to residents of another

OTHER ELIGIBILITY REQUIREMENTS

LIVING ARRANGEMENTS

public institution during the month they enter and/or leave the institution but for only that part of the month in which they are in the community. A public institution is one that is the responsibility of a government unit or over which a governmental unit exercises administrative control. Jails, prisons, secure detention facilities and half-way houses operated by the government are types of public institutions.

Children placed in secure detention facilities may receive Medicaid (if otherwise eligible) during the month they enter or leave the facility, but only for the part of the month that they reside in the community. Children placed in Office of Family and Children Services Group Homes, Foster Homes and Contract Homes, who are otherwise Medicaid eligible, may receive full Medicaid coverage and a Common Benefit Identification Card.

This section outlines living arrangements where Medicaid may be given as follows:

Living in Own Home;

Medical Facilities; and

Public Institutions.

**OTHER ELIGIBILITY REQUIREMENTS
LIVING ARRANGEMENTS**

LIVING IN OWN HOME

Description: An A/R is living in his/her own home when s/he is living alone, living with friends or relatives, living in a congregate care situation or living in foster care.

Policy: Medicaid may be given to an otherwise eligible person living in his/her own home.

References:

SSL Sect.	365 366 371 374
Dept. Reg.	360-6.6(a)
ADMs	92 ADM-15 90 ADM-18
LCMs	93 LCM-89

Interpretation: For Medicaid purposes, "home" indicates a type of residence where Medicaid may be received. The term commonly used is "community based".

An A/R may live with friends and/or legally responsible relatives and be eligible for Medicaid "in his/her own home". When an applicant is living in a communal situation, the arrangement should be investigated. When the communal arrangement represents itself as an organization, whether religious or fraternal, the status of the organization is determined. If the applicant made a commitment to the organization in return for the organization agreeing to meet his/her needs, a determination is made as to whether or not this includes medical needs. In such an agreement, resources may be held in common.

An individual is living in his/her own home when s/he is living in a congregate care situation. Some examples of congregate situations are foster care for children and adult care facilities such as family type homes for adults, shelters for adults and residences for adults. These adult care facilities provide shelter for adults who, though not requiring continual medical or nursing care, are, by reason of physical or mental disability associated with age or other factors, unable to live independently.

**OTHER ELIGIBILITY REQUIREMENTS
LIVING ARRANGEMENTS**

MEDICAL FACILITIES

Description: Medical facilities are hospitals, skilled nursing facilities and intermediate care facilities which have an operating certificate issued to them by the New York State Department of Health or the Department of Mental Hygiene and have a Medicaid Provider agreement issued by the State Medicaid agency.

Policy: Medicaid may be given to an otherwise eligible person in an approved medical facility.

NOTE: This definition is NOT to be used for the purpose of determining the district of fiscal responsibility. (See OMM/ADM 97-1 and **OTHER ELIGIBILITY REQUIREMENTS DISTRICT OF FISCAL RESPONSIBILITY**)

References:

SSL Sect.	365 366
	Public Health Law, Article 28 Mental Hygiene Law, Article 31 Mental Hygiene Law, Article 16
Dept. Reg.	360-6.6(b) - (f)
ADM	OMM/ADM 97-1
INF	88 INF-15
LCM	93 LCM-89

Interpretation: An approved medical institution or facility includes the following when operated in accordance with the provisions of the Public Health Law, Mental Hygiene Law or other applicable law:

- a private proprietary, public or non-profit nursing home;
- the approved infirmary section of a home for the aged;
- a public home infirmary or other similar public facility for the chronically ill;
- an approved hospital or nursing home section of a public institution operated for the care of persons with developmental disabilities;

**OTHER ELIGIBILITY REQUIREMENTS
LIVING ARRANGEMENTS**

MEDICAL FACILITIES

- a general or chronic disease hospital; an institution operated primarily for the care of the mentally disabled, for individuals under age 22 if the A/R turned age 21 while residing in the institution or is age 65 or over or under age 21; or the A/R is an FNP refugee or Cuban-Haitian entrant in which case s/he receives Medicaid (if otherwise eligible) for eight months following the date of entry; and,

- an ICF for the developmentally disabled.

Medicaid may be provided to inpatients in public, voluntary or proprietary hospitals in New York State which: are in possession of a valid operating certificate issued in accordance with the provisions of Article 28 of the Public Health Law; are enrolled in the New York State Medicaid program including possession of a provider agreement, and have in effect a hospital utilization review plan.

NOTE: Medicaid may be provided in a hospital located outside New York State if the hospital: is in compliance with such legislation and requirements established by the official agency in the state in which that care is received; has a Medicaid provider agreement; and is enrolled in the New York State Medicaid program.

**OTHER ELIGIBILITY REQUIREMENTS
LIVING ARRANGEMENTS**

PUBLIC INSTITUTIONS

Description: A public institution is a non-medical facility that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. Public institutions do not include a community residence serving 16 or less residents; or a child care institution serving 25 or less residents.

Policy: Medicaid cannot be provided to residents of non-medical public institutions, except when the public institution is:

- a shelter for homeless adults operated by a social services district, regardless of size;
- a correctional facility nursery. An infant/child residing in a correctional facility nursery while the mother is serving a prison term may receive Medicaid (See **OTHER ELIGIBILITY REQUIREMENTS PUBLIC INSTITUTIONS INFANTS RESIDING WITH INCARCERATED MOTHERS**);
- a public emergency shelter for homeless adults. Persons residing in a public emergency shelter for homeless adults may be eligible for Medicaid when the A/R is: in receipt of or eligible for S/CC; over the age of 18 and otherwise eligible; or SSI-related. However, an SSI-related A/R may be claimed FP for only six (6) months during a nine (9) month stay within 12 consecutive months. When the six months of federal participation expires, the SSI-related A/R may be claimed FNP. Persons residing in a family shelter are not subject to such categorical restrictions; or,
- a public home operated by a county. Residents of a county-operated public home may be eligible for Medicaid, without federal reimbursement.

References:

SSL Sect.	365 366
Dept. Reg.	360-3.4(a)(1) 491.1-4 500.2 500.1

**OTHER ELIGIBILITY REQUIREMENTS
LIVING ARRANGEMENTS**

PUBLIC INSTITUTIONS

ADMs	95 ADM-04
	94 ADM-20
	88 ADM-50
	86 ADM-23
	81 ADM-10
	79 ADM-87

Interpretation: Except as listed above, Medicaid is not available to residents of non-medical public institutions.

In any month an otherwise eligible Medicaid recipient enters or leaves a public institution (in which Medicaid is not available), Medicaid may be authorized for only that portion of the month the individual is residing in the community (except as listed above).

**OTHER ELIGIBILITY REQUIREMENTS
LIVING ARRANGEMENTS
PUBLIC INSTITUTIONS**

INFANTS RESIDING WITH INCARCERATED MOTHERS

Description: Certain correctional facilities operate nurseries for infants born to inmates. Children, born to women serving prison sentences, may live in the nursery for up to eighteen (18) months. This includes a standard twelve (12) month stay plus a possible 6 month extension if there is a reasonable probability that the mother will be released within the 18 months. In the event that the mother is not released within the allotted time, the child is placed in foster care or with relatives.

Policy: Infants and children residing in correctional facilities (where their mothers are incarcerated) are not considered "inmates" of a public institution and therefore may be eligible for Medicaid.

The child is an individual under age 21 and fulfills the requirements of one of the categories. (See **CATEGORICAL FACTORS UNDER AGE 21**) The child is budgeted as a household of one, residing in the community. After allowing appropriate disregards, the child's income is compared to the Medically Needy Income Level or Medicaid Standard (and MBL Living Arrangement Chart as appropriate), whichever is most beneficial.

The district in which the mother resided at the time of her sentencing is the district of fiscal responsibility for the child. The district of fiscal responsibility designates a person to review the application. The designated person may be a district employee or the district's Commissioner may enter into a Memorandum of Understanding (MOU) with the Superintendent of the facility, designating a correctional facility employee.

The mother of the child or the mother's representative must complete an application (See **OTHER ELIGIBILITY REQUIREMENTS APPLICATION, CERTIFICATION AND RENEWAL**) and submit it to the designated person at the correctional facility. The designated person reviews the application and forwards the application packet to the district of fiscal responsibility. The district of fiscal responsibility processes the application and determines the child's Medicaid eligibility.

The date of application is the date that a signed State-prescribed application form, a State-approved equivalent form or process is

**OTHER ELIGIBILITY REQUIREMENTS
LIVING ARRANGEMENTS
PUBLIC INSTITUTIONS**

INFANTS RESIDING WITH INCARCERATED MOTHERS

received by the designated person. Eligibility may be established for up to three (3) months prior to the month of application. (See **OTHER ELIGIBILITY REQUIREMENTS AUTHORIZATION**) However, Medicaid cannot be authorized for the period prior to the child's birth.

References:

SSL Sect. 65
366

Dept. Regs. 369.1 & .2
360-2.2

ADMs OMM/ADM 97-1
95 ADM-04

Interpretation:

Completed applications are forwarded to the district of fiscal responsibility by the designated person at the correctional facility.

The child's eligibility is determined as if s/he resided in the community, as a household of one.

OTHER ELIGIBILITY REQUIREMENTS**MAINTAINING MEDICAID ELIGIBILITY FOR INCARCERATED INDIVIDUALS**

Description: Medicaid coverage must be suspended for recipients incarcerated in a New York State Department of Correctional Services or local correctional facility and reinstated at the time of release from such facility.

Policy: An inmate of a State Department of Correctional Services or local correctional facility that was in receipt of Medicaid immediately prior to incarceration shall have eligibility maintained during incarceration. In addition, Medicaid coverage must be reinstated upon release from the correctional facility.

References:

SSL Sect.	366 (1-a)
Dept. Regs.	360-3.4 (a) (1) 360-3.4 (c)
ADMs	08 OHIP/ADM03
LCMs	08 OHIP/LCM-1
GISs	11 MA/20 11 MA/010 09 MA/010

Interpretation: Suspension of Medicaid:

Medicaid must be suspended for Case Type 20 (MA) recipients and single individuals in a Case Type 22 who are expected to be incarcerated for at least 30 days and who at the time of incarceration have one of the following Coverage Codes: 01 (Full), 02 (Outpatient), 06 (Provisional), 10 (Ancillary Coverage Due to Prohibitive Transfer), 11 (Legal Alien), 15 (Perinatal), 18 (Family Planning Services Only), 19 (Community Coverage With Community-Based Long-Term Care), 20 (Community Coverage Without Long-Term Care), 22 (Outpatient Coverage Without Long-Term Care), 21 (Outpatient Coverage With Community-Based Long-Term Care), 23 (Outpatient Coverage With No Nursing Facility Services), 24 (Community Coverage Without Long-Term Care, Legal Alien During Five-year Ban, NYC only), and 30 (Pre-paid Capitation Plan). Also, Family Health Plus (FHPlus) coverage will be suspended for Case Type 24 (FHPlus) recipients who at the time of incarceration have Coverage Code

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06 (Provisional, not yet enrolled, Upstate only), Coverage Code 20 (Community Coverage Without Long-Term Care) or 34 (FHPlus).

NOTE: Districts are advised to call their local district liaison for further instructions when an individual with Coverage Code 10 or 23 becomes incarcerated.

In situations where the incarcerated individual was part of a multi-person household, a determination of the remaining household's ongoing eligibility must be performed utilizing the following guidelines:

- Permanent Absence- When a recipient is incarcerated in a New York State Department of Correctional Services (DOCS) facility, the individual shall be considered permanently absent from the household.
- Temporary Absence- When a recipient is incarcerated in a local correctional facility (jail), the individual shall be considered temporarily absent unless the district has information that the absence will be permanent.

NOTE: Medicaid will be suspended for Case Type 22 recipients (MA-SSI) by the State utilizing information from the New York State Department of Corrections and Community Supervision and the New York State Division of Criminal Justice Services.

Incarcerated individuals whose Medicaid or FHPlus has been suspended and who are subsequently released to a New York State local correctional facility, an Office of Mental Health (OMH) facility or Office of Children and Family Services (OCFS), formerly known as the Division for Youth (DFY), facility or other agency must have their eligibility for Medicaid continued in suspend status.

Discontinuation of Medicaid:

1. At incarceration MA Coverage must be discontinued for recipients with Coverage Code 07 (Emergency Services Only).
2. In addition, individuals with Coverage Code 31 or 36 (Active for Guarantee Coverage Only) must have their managed care guarantee coverage discontinued with appropriate notice.
3. At incarceration, Medicaid coverage and the premium payment must be discontinued for Case Type 20 and single Case Type 22 recipients

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MAINTAINING MEDICAID ELIGIBILITY FOR INCARCERATED INDIVIDUALS

who are expected to be incarcerated at least 90 days who at incarceration have Coverage Code 09 (Medicare Savings Program) or Coverage Code 17 (COBRA, AHIP and third-party health insurance), because Medicaid payment of these premiums is not cost effective. However, Case Type 20 (MA) recipients with Coverage Code 09 who are participating in the spenddown program must have their case suspended and their premium payment discontinued.

NOTE: It may not be appropriate to discontinue health insurance premium payments if the policy covers other household members.

Medicaid and FHPlus must be discontinued with appropriate notice for recipients who are incarcerated out-of-state or in a federal penitentiary within New York State.

Incarcerated individuals who are released to the federal government, other state law enforcement, immigration or who are deceased must have their Medicaid discontinued with appropriate notice.

Re-Instatement of Medicaid

Upon notification from DOCS or a Local Correctional Facility that an individual whose Medicaid or FHPlus authorization had been placed in suspend status, and is being released to Parole or has completed his/her sentence without community supervision, Medicaid coverage must be re-instated in the district where the releasee had coverage immediately prior to incarceration. Coverage will begin on the first day of the release month and continue for the following four months.

Released to the Community Without Supervision

If a formerly incarcerated recipient who has been released to the community without supervision contacts the LDSS with a change of address, the LDSS must update the recipient's address on WMS to ensure that the renewal packet will be mailed to the correct address. If the new address is in another district, the case must **not** be transferred to the new district until the five-month reinstatement period has expired, the renewal process has been

OTHER ELIGIBILITY REQUIREMENTS

MAINTAINING MEDICAID ELIGIBILITY FOR INCARCERATED INDIVIDUALS

completed and a determination of ongoing eligibility is made pursuant to 08 OHIP/LCM-1, "Continued Medicaid Eligibility for Recipients Who Change Residency (Luberto v. Daines)".

The LDSS where the former inmate had coverage immediately prior to the incarceration must issue the mail-in renewal packet to the former inmate at the address on WMS. For recipients who have been released from a New York State Department of Correctional Services (NYS DOCS) facility to the community without supervision, the address listed on WMS will be a NYS DOCS facility. If the recipient has not contacted the LDSS with an updated address, the mail-in renewal packet must be mailed to the former inmate at NYS DOCS facility address found on WMS.

Released to the Community With Parole Supervision

The address of parolees released from a NYS DOCS facility will automatically be posted to WMS as that of his/her parole officer. If a parolee informs the LDSS of a change of address, the LDSS may record the address change in the case record but must **not** update the recipient's address on WMS or transfer the case (if there is an out of county move) until the five-month reinstatement period has expired, the renewal process has been completed and the recipient is determined to be eligible.

The LDSS where the former inmate had coverage immediately prior to the incarceration must issue the mail-in renewal packet to the former inmate at the address of his/her Parole Officer listed on WMS. Such Parole Officer will provide the mail-in renewal packet to the parolee as soon as possible.

Mail-In Renewal Returned to District With Out-of County Address

In cases where the mail-in renewal is returned to the district with an out-of-county address, the district must determine ongoing eligibility for the former inmate, and if eligible, the district will authorize coverage for the usual 12 month period. Once coverage has been authorized, the district may transfer the case to the new district of residence pursuant to procedures outlined in 08 OHIP/LCM-1.

If the district determines the individual is ineligible for Medicaid or FHPPlus as a result of the renewal the coverage shall be discontinued with appropriate notice.

OTHER ELIGIBILITY REQUIREMENTS**MAINTAINING MEDICAID ELIGIBILITY FOR INCARCERATED INDIVIDUALS****Releasee Residing with Family Members**

In situations where the releasee is residing with family members, his/her ongoing eligibility shall be redetermined at renewal, after the five month reinstatement period, as a member of the household. If the releasee is a member of a currently eligible Medicaid/FHP household, eligibility for the other household member(s) shall also be reviewed.

OTHER ELIGIBILITY REQUIREMENTS

MAINTAINING MEDICAID ELIGIBILITY FOR INDIVIDUALS ADMITTED TO A PSYCHIATRIC CENTER

Description: Generally, Medicaid coverage must be suspended for recipients age 21-64 admitted to a psychiatric center and reinstated at the time of release from such facility.

Policy: When a district is notified that a Medicaid recipient age 21-64 is a resident of a psychiatric center, the district must suspend Medicaid coverage, barring certain exceptions. Upon notification of discharge from the psychiatric center, Medicaid coverage must be reinstated in the district of fiscal responsibility immediately prior to admission.

NOTE: Districts will be notified of admissions and discharges from State Operated Psychiatric Centers by the State Department of Health in conjunction with the Office of Mental Health (OMH). However, should a district become aware that an individual age 21-64 has entered a private (non-state operated) psychiatric hospital, Medicaid coverage must also be suspended and re-instated.

References:

SSL Sect.	365.2 (a) & (b) 366 (1) (c) & (d)
Dept. Regs.	360-3.4 (a) (2)
ADMs	11 OHIP/ADM-3
INFs	89 INF-43

Interpretation: Suspension of Medicaid:

On a monthly basis DOH will run a file provided by OMH to identify individuals age 21-64 who have been in a State psychiatric center for at least 30 days and have an active Medicaid/FHPlus case.

Medicaid must be suspended for Case Type 20 (MA) recipients with one of the following Coverage Codes: 01 (Full), 02 (Outpatient), 06 (Provisional), 10 (All Services Except Nursing Facility Services), 11 (Legal Alien), 15 (Perinatal), 18 (Family Planning Services Only), 19 (Community Coverage With Community-Based Long-Term Care), 20 (Community Coverage Without Long-Term Care), 22 (Outpatient Coverage Without Long-Term Care), 21 (Outpatient Coverage With Community-Based Long-Term Care), 23 (Outpatient Coverage With No Nursing Facility Services), 24 (Community Coverage Without Long-Term Care, Legal Alien During Five-year Ban, NYC only), and 30 (Pre-paid Capitation Plan). Also, Family Health Plus (FHPlus) coverage will

OTHER ELIGIBILITY REQUIREMENTS**MAINTAINING MEDICAID ELIGIBILITY FOR INDIVIDUALS ADMITTED TO A PSYCHIATRIC CENTER**

be suspended for Case Type 24 (FHPlus) recipients who at the time of admission have Coverage Code 06 (Provisional, not yet enrolled, Upstate only), Coverage Code 20 (Community Coverage Without Long-Term Care) or 34 (FHPlus).

In situations where the individual was part of a multi-person household, a determination of the remaining household's ongoing eligibility must be performed. The psychiatric center resident shall remain in the household count unless the district receives notification from OMH that the resident's stay is other than temporary.

Medicare Part A and /or B premium payments and payments for third-party health insurance coverage must be discontinued and the Buy-In closed. If the individual is enrolled in a managed care plan, he/she must be dis-enrolled. NOTE: It may not be appropriate to discontinue payment of third-party health insurance premiums which cover other Medicaid/FHPlus household recipients.

Medicaid coverage will not be suspended for Temporary Assistance (TA)/Medicaid recipients if the individual continues to receive TA benefits based on the individual's temporary admission to a psychiatric center. For these individuals, Medicaid coverage will continue. Also, Supplemental Security Income (SSI) beneficiaries will continue to receive Medicaid coverage based on the receipt of SSI.

Exceptions to Suspension:

1. Medicaid Coverage must be discontinued for recipients with Coverage Code 07 (Emergency Services Only).
2. Individuals with Coverage Code 31 or 36 (Active for Guarantee Coverage Only) must have their managed care guarantee coverage discontinued with appropriate notice.
3. Individuals authorized for Medicare Savings Program (coverage code 09) must have their coverage discontinued.
4. Individuals with coverage code 17, Health Insurance Continuation Only- COBRA, AHIP must have their coverage discontinued. **NOTE:** If the COBRA/AHIP policy covers other eligible household members, it may not be appropriate to discontinue payment of health insurance premiums.

OTHER ELIGIBILITY REQUIREMENTS**MAINTAINING MEDICAID ELIGIBILITY FOR INDIVIDUALS ADMITTED TO A PSYCHIATRIC CENTER**

5. Case Type 20 (MA) recipients with Coverage Code 09 who are participating in the spenddown program must have their case suspended and their premium payment discontinued. Recipients who have been authorized for MSP-only must have their MSP Buy-in span end-dated in eMedNY.

Re-Instatement of Medicaid

Upon notification from DOH/OMH that an individual whose Medicaid or FHPlus authorization had been placed in suspend status is being discharged from the psychiatric center such individual must have their Medicaid coverage reinstated with the coverage they had immediately prior to their admission to the psychiatric center. Medicaid coverage must be reinstated for five months (the month of discharge, plus four months) with appropriate notice at the individual's current address.

In situations where the releasee is residing with family members who are not in receipt of Medicaid or FHPlus, his/her ongoing eligibility shall be redetermined at renewal as a member of the household, after the five month reinstatement period. If the releasee is a member of a currently eligible Medicaid/FHP household, eligibility for the other household member(s) must be reviewed at renewal.

Exceptions to Re-Instatement

1. Medicaid eligibility must be redetermined for individuals who are being discharged to an SNF. While a new application is not required, Supplement A to the DOH-4220 is required if resource information must be captured.
2. Coverage for individuals who are being discharged to the custody of the United States Immigration and Customs Enforcement (ICE) must be discontinued.
3. Individuals who are being discharged to a NYS or local correctional facility will continue to have their coverage suspended.
4. Coverage must be discontinued for individuals who are being discharged to another state's law enforcement.
5. Coverage for individuals who are being discharged to the Federal Bureau of Prisons must have their coverage discontinued.

OTHER ELIGIBILITY REQUIREMENTS**MAINTAINING MEDICAID ELIGIBILITY FOR INDIVIDUALS ADMITTED TO A PSYCHIATRIC CENTER**

6. Coverage for individuals who are being discharged to an OMH operated living arrangement (i.e. a State operated family care home, community residence or residential care center for adults) must be discontinued. Once the county case is closed, OMH will open a case in District 97.
7. Coverage must be discontinued for individuals who have died in the psychiatric center.
8. The DFR prior to admission to the psychiatric center must discontinue coverage for individuals who turn 65 and remain in the psychiatric center. Once the district closes its case, OMH will determine eligibility for the individual.
9. Coverage for an individual discharged to an Office for People with Developmental Disabilities (OPWDD) must be discontinued. Once the district has closed its case, OPWDD will open a case in District 98.
10. Medicaid and FHPlus must be discontinued for individuals who have moved to another state.
11. Medicaid and FHPlus must be discontinued for individuals who are discharged to an out-of-state psychiatric center.

OTHER ELIGIBILITY REQUIREMENTS

LEGALLY RESPONSIBLE RELATIVES (LRRs)

Description: A legally responsible relative is a person who is legally responsible for the support and care of one or more relatives.

Policy: For Medicaid purposes, a legally responsible relative is:

- a spouse of a Medicaid A/R; or
- a parent of a child under the age of 21. However, the income and resources of a parent will not be considered in the determination of eligibility of a pregnant minor. In addition parental income/resources are not considered in the determination of eligibility of a certified blind or certified disabled child who is:
 - 18 years of age or older;
 - under the age of 18, but expected to be living separately from the parental household for 30 days or more; or
 - participating in one of the home and community-based waived programs provided pursuant to Section 1915(c) of the Social Security Act where the income/resources of the parents or step-parents are not considered in the determination of eligibility for the child.

References:	SSL Sect.	101 366
	Dept. Reg.	360-1.4(h) 360-4.3(f)
	ADMs	OMM/ADM 97-2 89 ADM-47
	GISs	00 MA/021 91 MA/007

OTHER ELIGIBILITY REQUIREMENTS**LEGALLY RESPONSIBLE RELATIVES (LRRs)**

Interpretation: When an A/R is living with a legally responsible relative (LRR), the LRR's income and resources are generally considered available to the A/R.

When an A/R is residing in the community with an LRR and the LRR asserts that his/her income/resources are not available to the A/R, the eligibility determination depends on whether: (a) the LRR

OTHER ELIGIBILITY REQUIREMENTS

LEGALLY RESPONSIBLE RELATIVES (LRRs)

provides financial information; or (b) the LRR refuses to provide the requested financial information.

- (a) When the LRR provides information, but refuses to make his/her income/resources available to the A/R, eligibility for the A/R is determinable. When completing a budget, only the income/resources, as appropriate, actually available to an A/R are counted.
- (b) When the LRR refuses to provide financial information, eligibility is generally indeterminable. However, if the A/R provides complete information concerning his/her own income and resources, as appropriate, including any jointly held resources, eligibility is determined based on the available information.

A dollar amount is budgeted for any non-medical needs that the LRR is meeting. For example, the LRR may be providing the A/R with food, shelter, and clothing. The value of these items would be considered income. The non-contributing LRR is not included in the household size.

If Medicaid is provided because of the failure or refusal of an LRR to make income and resources available, an implied contract is created with the non-contributing LRR. Recovery for the cost of any care provided may be pursued through legal channels.

NOTE: The income/resources of parents are not considered in the eligibility determination for their pregnant daughters (of any age), regardless of where the pregnant daughter resides.

**OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)**

SPOUSE

Description: A spouse is an A/R's legal husband or wife. (See definitions in the **GLOSSARY**) A spouse is a legally responsible relative (LRR). A spouse may be of either sex.

Policy: The spouse of an individual in need of Medicaid, if of sufficient financial ability, is responsible for that person's medical needs. (See **RESOURCES** THIRD PARTY RESOURCES for utilization of third party health insurance benefits.)

References:

SSL Sect.	101 366(3)(a)
Dept. Reg.	360-1.4(h) 360-4.3(f) 360-4.10 360-7.11(b)(ii)
ADMs	OMM/ADM 97-2 91 ADM-37 91 ADM-31 90 ADM-29 89 ADM-47 82 ADM-20 82 ADM-6
GISs	08 MA/024 08 MA/023

Interpretation: Spouses Living Together

When an A/R is **living with** his/her spouse, the spouse's income and resources are generally considered available to the A/R (See **OTHER ELIGIBILITY REQUIREMENTS** HOUSEHOLD COMPOSITION and OWNERSHIP AND AVAILABILITY for budgeting methodologies and availability).

When the spouse asserts that his/her income/resources are not available to the A/R, the eligibility determination depends on whether: (a) the spouse provides financial information; or (b) the spouse refuses to provide the requested financial information. In both instances, at a minimum, a notation is entered into the case record. (See **OTHER ELIGIBILITY REQUIREMENTS** LEGALLY RESPONSIBLE RELATIVES for general treatment of legally responsible relatives.

**OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)**

SPOUSE

Spouses Living Apart in the Community

When an A/R is residing in the community apart from his/her spouse who is also residing in the community, the spouse may be requested to contribute toward the cost of medical care provided to the A/R. The amount of the requested contribution depends on the spouse's financial ability to support and the category of the A/R.

To determine the amount of the requested contribution from a spouse residing in the community, but not in the A/R's household:

- when there is a child in the household under the age of 21, the case is referred to the Child Support Enforcement Unit (IV-D);
- when the A/R is S/CC, local district Public Assistance procedures determine the contribution; or
- when the A/R is SSI-related, the spouse is requested to contribute twenty-five percent (25%) of his/her otherwise available income which exceeds the minimum monthly maintenance needs allowance (MMMNA), plus any family member allowance(s). (See **RESOURCES PERSONS IN MEDICAL FACILITIES COMMUNITY SPOUSE** and **RESOURCES FAMILY MEMBER ALLOWANCE**)

The local district requests the LRR other than a community spouse to contribute any excess resources, as appropriate, to the support of the Medicaid A/R. Only the income/resources, as appropriate, actually received from a spouse not residing in the A/R's household are counted when determining eligibility.

When the spouse asserts that his/her income/resources are not available to the A/R, at a minimum, a notation is entered into the case record.

Institutionalized Spouse with a Community Spouse

When an A/R is an institutionalized spouse and his/her spouse is a community spouse, spousal budgeting rules determine the

**OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)**

SPOUSE

treatment of the couple's income and resources. See **INCOME PERSONS IN MEDICAL FACILITIES ASSESSMENT/ DETERMINATION OF INCOME AVAILABLE FOR THE COST OF CARE** for the full explanation of the assessment and budgeting of income/resources.

If Medicaid is provided, in the instance of failure or refusal, an implied contract is created with the non-contributing spouse. Recovery of the cost of any care provided may be pursued through legal channels.

Both Spouses Institutionalized

When both spouses are institutionalized they are treated as two separate households, whether or not they share a room.

Institutionalized Waiver Participant with a Community Spouse

When one spouse is a waiver participant and his/her spouse is a community spouse, spousal budgeting rules as specified in **INCOME PERSONS IN MEDICAL FACILITIES BUDGETING FOR INSTITUTIONALIZED SPOUSES IN SPECIFIED HOME AND COMMUNITY BASED WAIVERS (HCBS)** are applied.

**OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)**

PARENTS AND CHILDREN

Description: A child is a person under the age of 21. Generally, parents are legally responsible for their children under the age of 21.

Policy: A parent of a child under the age of 21 is legally and financially responsible for his/her child. However, the income and resources of a parent will not be considered in the determination of eligibility of a pregnant minor. In addition parental income/resources are not considered in the determination of eligibility of a certified blind or certified disabled child who is:

- 18 years of age or older;
- under the age of 18 but expected to be living separately from the parental household for 30 days or more; or
- participating in one of the home and community-based waived programs provided pursuant to Section 1915(c) of the Social Security Act where the income/resources of the parents or step-parents are not considered in the determination of eligibility for the child.

References:	SSL Sect.	101 366
	Dept. Reg.	360-1.4(h) 360-4.3(f)
	ADMs	OMM/ADM 97-2 82 ADM-6
	LCM	95 LCM-106
	GIS	91MA007

Interpretation: Generally, parents, including adoptive and step-parents (See **OTHER ELIGIBILITY REQUIREMENTS LEGALLY RESPONSIBLE RELATIVES PARENTS AND CHILDREN STEP-PARENTS**), are financially and legally responsible for their children under the age of 21. However, the income/resources of the parent or step-parent are not considered in the eligibility determination if the child is pregnant. In addition parental income/resources are not considered in the determination of eligibility of a certified blind or certified disabled child who meets one of the criteria specified above.

**OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)**

PARENTS AND CHILDREN

The income/resources of parents are counted in the determination of eligibility for certified blind/disabled child(ren) under the age of 18, unless the child is living or expected to be living separate and apart from the parent(s) for 30 days or more. Even though the child returns to the household in less than 30 days, if s/he was expected to be absent for 30 days, the income/resources of his/her parents are not considered in the eligibility determination for the child during the entire 30 days s/he was expected to be absent.

The income/resources of parents are considered in the eligibility determination for their certified blind/disabled child(ren). If the child is participating in one of the home and community-based waived programs provided pursuant to Section 1915(c) of the Social Security Act the income/resources of the parents or step-parents are not considered in the determination of eligibility for the child.

The income/resources of parents are not considered in the eligibility determination for their pregnant daughters (of any age), regardless of where the child resides.

When the child's parent is absent from the household, a referral is made to the Child Support Enforcement Unit (IV-D). IV-D will pursue the absent parent for medical support and paternity establishment as appropriate.

Only the income/resources, as appropriate, actually received (from his/her absent parent) by an A/R are counted when determining eligibility.

See **OTHER ELIGIBILITY REQUIREMENTS LEGALLY RESPONSIBLE RELATIVES (LRRs)** for the general treatment of legally responsible relatives.

See **OTHER ELIGIBILITY REQUIREMENTS OWNERSHIP AND AVAILABILITY** for treatment of a non-cooperative parent residing with the A/R.

See **OTHER ELIGIBILITY REQUIREMENTS LEGALLY RESPONSIBLE RELATIVES PARENTS AND CHILDREN STEP-PARENTS** when the child has a step-parent.

Verify Status: When there is a certified blind/disabled or pregnant child in the household.

**OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)**

PARENTS AND CHILDREN

- Documentation:**
- (a) Certificate of blindness/disability.
 - (b) Proof of absence or expected absence of a certified blind/disabled child, such as a doctor's statement.
 - (c) Statement from a medical provider that the minor is pregnant.
 - (d) Participation in a home and community-based waiver program where parental income/resources are not considered in the determination of eligibility.

**OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)
PARENTS AND CHILDREN**

ABSENT PARENTS

Description: Absent parents are legally responsible for their children under the age of 21.

Policy: Generally, the income of parents is considered in the eligibility determination of children under the age of 21. The income/resources of the parents of a pregnant minor are not considered in the determination of eligibility regardless of where the pregnant minor resides.

References:

SSL Sect.	101 366
Dept. Reg.	360-1.4(h) 360-4.3(f) 360-7.11(b)(iii)
ADMs	OMM/ADM 97-2 89 ADM-47
INFs	07 OHIP/INF-1

Interpretation: The income actually contributed by an absent parent is considered in the determination of eligibility. A referral is made to the Child Support Enforcement Unit (IV-D) to determine the amount of any contribution, medical support, paternity and any appropriate recovery.

In situations of evenly shared (physical and legal) custody of a child(ren) the child's eligibility is determined using the parental income of the applying household and the child's own income, if any. Child support payments count as income to the applying household that is in receipt of the payment and the payment is subject to the \$100 child support disregard. If the child(ren) would be eligible in both parent's separate households, the child's Medicaid is authorized in the case of the household that applies first.

**OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)
PARENTS AND CHILDREN**

EMANCIPATED MINOR

Description: For Medicaid purposes, an emancipated minor is a person who: is age 16 or over; has completed his/her compulsory education; is living separate and apart from his/her family; and not in receipt of or in need of foster care.

Policy: Medicaid may be authorized for an emancipated minor who is otherwise eligible.

References: Dept. Reg. 349.5

Interpretation: When a child leaves his/her family household to live on his/her own, the child, if otherwise eligible, may receive Medicaid on his/her own behalf. This child must fulfill the requirements of an emancipated minor by being age 16 or over, having completed compulsory education, and living away from home and not in need of foster care.

The parents of an emancipated minor are legally responsible relatives for him/her. The parental liability for support should be established (See **OTHER ELIGIBILITY REQUIREMENTS LEGALLY RESPONSIBLE RELATIVES PARENTS AND CHILDREN IV-D REQUIREMENTS**) by an appropriate referral to the Child Support Enforcement Unit (IV-D) for medical support and paternity establishment as appropriate.

**OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)
PARENTS AND CHILDREN**

IV-D REQUIREMENTS

Description: Title IV Section D (IV-D) of the Social Security Act was established to: secure and enforce child support and medical support from absent parents; establish paternity when necessary; and to provide a parent locator service. For more detailed information regarding IV-D refer to the Public Assistance Source Book, Section VIII-T.

Policy: Generally, a Medicaid household including a child under the age of 21, whose parent is absent from the home, must as a condition of eligibility meet the requirements to secure medical support and establish paternity, unless good cause not to cooperate exists OR they are otherwise exempt. Not all IV-D requirements apply to the Medicaid program; pursuit of cash support is not a requirement for Medicaid A/Rs.

NOTE: In situations of equally (50-50) shared custody of a child(ren) a referral to the Child Support Enforcement Unit (CSEU) should be made except when good cause is established, they are otherwise exempt, or instances where medical support/health insurance is already being provided. The referral would be made for the parent that does not reside in the household in which the child receives Medicaid unless they are otherwise exempt.

Cases to refer to IV-D:

- MA cases that include a child under the age of 21 with an absent parent, and/or for whom paternity has not yet been established, provided the case does not meet the exemption criteria, shall be referred to the CSEU. At no time during a women's pregnancy shall a referral be made for the pregnant woman or her children. Referrals are made after the end of the month of the 60 day post-partum period.

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Cases exempt from referral to IV-D:

- Child-only MA cases for all children under the age of 21, including children living on their own and children in receipt of SSI;
- Parents or step-parents who already provide health insurance and/or cash medical support for the child for whom paternity has already been established regardless of living arrangements;

**OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)
PARENTS AND CHILDREN**

IV-D REQUIREMENTS

- Intact households in which both parents (married or unmarried) reside together with their common children; however, a referral may be made for the establishment of paternity;
- Transitional medical assistance (TMA) recipients; deceased absence parent;
- A child released for or pending adoption;
- When good cause is claimed by the A/R at any time during the application, determination or authorization period, until the final good cause determination is completed. If good cause is found to exist, the non-referral status continues until the reason for good cause no longer exists; and
- Any case where the parents' income and resources are not used in determining eligibility for the child, such as:
 - A child participating in one of the community-based waiver programs;
 - A pregnant minor
 - A certified blind or certified disabled child 18 years of age or older, or if under age 18, expected to be living separately from the parents' household for at least 30 days;
 - A child who chooses to apply for, and/or is in receipt of family planning benefits only (coverage code 18); or
 - IV-E adoption children.

**OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)
PARENTS AND CHILDREN**

IV-D REQUIREMENTS

Under the Family Court Act (FCA), support orders must require legally responsible relatives to make use of any health insurance coverage available to cover the child on whose behalf a child support petition is brought. The cost of providing such health insurance for the child is prorated between the parents.

If neither parent has health insurance available, the FCA requires the court to direct the custodial parent to apply for Medicaid or Child Health Plus for the child. If the child is eligible for one of those programs, the parents' obligation is to pay the cost of any required premium or family contribution, such as co-payments, that are the responsibility of the recipient under the Medicaid or Child Health Plus programs, which cost shall be prorated between the parents. The court also has the ability to order cash medical support when no health insurance is available by applying a formula.

A direction by the court to seek Medicaid or Child Health Plus for the child does not eliminate the parents' obligation to utilize for the child's benefit any health insurance coverage that may subsequently become available.

References:	SSL Sect.	111 366.3 366.4(h) 367-a.2(b)
	Dept. Reg.	369.2(b) 360-4.3(f) 360-7.11 441.2

**OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)
PARENTS AND CHILDREN**

IV-D REQUIREMENTS

ADMs	99 ADM-5 92 ADM-40 89 ADM-47 89 ADM-23
INFs	07 OHIP/INF-1 90 INF-45
GIS	08 MA/031

Interpretation: The eligible parent or other caretaker/relative of a child under the age of 21 whose parent is absent from the home must meet the following IV-D requirements, for medical support only unless it is a child-only MA case:

Cooperate in good faith with the State and the local social services district to establish the paternity of a child born out of wedlock, to locate any absent parent or putative father and to establish, modify, and enforce support orders.

The term "cooperation" includes providing information for the A/R to complete the DSS-2860, Child Support Referral form and, if required, appearing at the local Child Support Enforcement Unit (CSEU) to be interviewed. A Medicaid applicant who is not pregnant or in the 60 day postpartum period or otherwise exempt must assist in completing the DSS-2860 appear at the CSEU, as necessary, and cooperate with the CSEU unless good cause not to cooperate is found to exist.

A Medicaid recipient's continued cooperation with the CSEU is prerequisite to his or her ongoing eligibility to receive Medicaid. An A/R's Medicaid eligibility is not delayed or denied, however, if the A/R is complying but, through no fault of the client, the IV-D process has not been completed.

**OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)
PARENTS AND CHILDREN**

IV-D REQUIREMENTS

The local district:

- (1) mails or provides all client books at application and recertification, including Client Information Book I (DSS-4148A), which addresses clients' rights and responsibilities regarding child support;
- (2) advises all Medicaid-Only A/Rs in writing via the DOH-4220 (ACCESS NY application), unless they are otherwise exempt, that, as a condition of initial and ongoing eligibility, they will be required to cooperate in:
 - (a) obtaining third party health insurance (TPHI) and medical payments for themselves and any other individuals for whom the Medicaid-Only A/R can legally assign rights;
 - (b) establishing paternity of a child born out of wedlock for whom the Medicaid-Only A/R can legally assign rights; and
 - (c) obtaining medical support for their children (unless it is a child-only MA case).

NOTE: Pregnant women should not be referred to the CSEU until after the 60-day post partum period. To the extent possible, prior to such referral, local districts continue to pursue the availability of TPHI. If a pregnant minor does not want her parents contacted, however, TPHI is not pursued. All other Medicaid-Only A/R's must cooperate in establishing paternity and securing medical support.

An A/Rs failure, without good cause or other exemption, to cooperate renders such person ineligible for Medicaid. Their children under age 21, however, are authorized to receive Medicaid if they are otherwise eligible;

**OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)
PARENTS AND CHILDREN**

IV-D REQUIREMENTS

- (3) Medicaid worker or an appropriate designee determines whether an A/R who claims to have good cause for refusing to cooperate does have good cause that can be verified.
- (4) refers to the CSEU cases which include a non-pregnant child under age 21 whose paternity has not been established or whose parent(s) are absent from the home unless they are in a child-only MA case. Mails or provides the DSS-2860 form and informs A/Rs who are required to appear in the CSEU that they must bring the completed DSS-2860 to their CSEU interview. Applicants are referred to the CSEU prior to their eligibility determination or, if practicable, prior to their eligibility interview;
- (5) obtains necessary documentation from A/Rs;
- (6) takes appropriate action (notices and procedures) when notified by CSEU via the DSS-2859, Child Support Information Transmittal that an A/R who is not pregnant has failed to cooperate.. The A/R's children are not denied or discontinued from Medicaid for this reason;
- (7) takes appropriate action in Medicaid cases reported in the IV-D/Medicaid Interface Report and in DSS-2859 referrals from the CSEU. The weekly IV-D/IV-A Interface Report provides information to Medicaid workers about status changes in child support cases, including location of absent parents, paternity establishment, support order actions and third party health insurance coverage;

**OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)
PARENTS AND CHILDREN**

IV-D REQUIREMENTS

- (8) responds to CSEU requests for Medicaid eligibility and payment information via the OHIP-0030, Medicaid Medical Support Transmittal;
- (9) at recertification and other client contacts, asks recipients for new and changed information about absent parents, forwards information to the CSEU via the OHIP-0030 form; and
- (10) budgets child support as unearned income in a Medicaid-Only case with the \$100 child support disregard.

The local district informs the A/R that s/he has a right to claim good cause as an exception to the cooperation requirement. The A/R may refuse to meet any or all of the IV-D requirements when s/he has good cause to do so. The following circumstances are considered good cause:

- (1) when cooperation may be against the best interests of the child. Cooperation in establishing paternity or seeking support is deemed to be against the best interest of the child only if the A/R's cooperation in establishing paternity or securing support is reasonably anticipated to result in:
 - physical harm to the child for whom support is sought;
 - emotional harm to the child for whom support is sought;
 - physical harm to the parent or caretaker relative with whom the child is living;
 - emotional harm to the parent or caretaker relative with whom the child is living;
- (2) the child for whom support is sought was conceived as a result of incest or forcible rape;
- (3) legal proceedings for the adoption of the child are pending before a court of competent jurisdiction; or

**OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)
PARENTS AND CHILDREN**

IV-D REQUIREMENTS

the A/R is currently being assisted by an authorized agency (LDSS or a voluntary agency) to resolve the issue of whether to parent the child or place him/her for adoption,

- (4) and discussions have not gone on for more than three months.

If an A/R refuses to meet the IV-D requirements and s/he cannot show good cause, s/he is denied Medicaid.

Documentation: An A/R who claims good cause must provide corroborative evidence within 20 days from the day the claim was made. A district may extend this 20 day period when the A/R has difficulty obtaining evidence.

Statement from a medical provider that the A/R is pregnant including the EDC (due date).

**OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)
PARENTS AND CHILDREN**

STEP-PARENTS

Description: A step-parent is the spouse of an A/R's parent, including an adoptive parent. For Medicaid purposes step-parents are legally responsible for their step-children under the age of 21.

Policy: A step-parent of a child under the age of 21 is legally and financially responsible for his/her child. However, the income of a step-parent will not be considered in the determination of eligibility of a pregnant minor. In addition parental income/resources are not considered in the determination of eligibility of a certified blind or certified disabled child who is:

- 18 years of age or older;
- under the age of 18 but expected to be living separately from the parental household for 30 days or more; or
- participating in one of the home and community-based waived programs provided pursuant to Section 1915(c) of the Social Security Act where the income/resources of the parents or step-parents are not considered in the determination of eligibility for the child.

References:

SSL Sect.	101 366
Dept. Reg.	360-4.3(f) 360-7.11
ADMs	91 ADM-8 82 ADM-6 75 ADM-21

Interpretation: Generally, step-parents are responsible for their step-children under the age of 21. However, the income/resources of step-parents are not considered in the determination of eligibility when the child is pregnant; age 18 or over and certified blind/disabled or participating in a home and community-based waiver program.

The income/resources of step-parents are not considered in the determination of eligibility for their certified blind/disabled step-child age 18 or older, regardless of where the child resides. The

**OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)
PARENTS AND CHILDREN**

STEP-PARENTS

income/resources of step-parents are considered in the determination of eligibility for their certified blind/disabled step-child under the age of 18, unless the child is living or expected to be living separate and apart from the step-parent for 30 days or more. Even though the child returns to the household in less than 30, days, if s/he was expected to be absent for 30 days his/her step-parent's income/resources are not considered in the eligibility determination for the child during the entire 30 days s/he was expected to be absent.

The income/resources of a step-parent are not considered in the eligibility determination of a child participating in a home and community-based waiver program pursuant to Section 1115 of the Social Security Act.

Although step-parents are financially responsible for their step-children under Social Services Law, a local district may not presume that the step-parent's income/resources, as appropriate, are available to the child. The step-parent must actually be contributing to the support of the child for the step-parent's income/resources, as appropriate, to be considered when determining eligibility for the child. If a step-parent refuses to support the child for whom s/he is responsible, care is provided to the child, if s/he is otherwise eligible. The district may take action to recover the cost of care from the legally responsible step-parent.

When a step-parent is divorced from the child's parent, there is no longer an obligation on his/her part to support the step-child. In case of abandonment or desertion on the part of the step-parent, the obligation to support the child still exists under Social Services Law.

Verify Status: When the A/R indicates there is a step-parent in the household.

When there is a certified blind/disabled child in the household.

Documentation:

- (a) Marriage certificate, birth certificate.
- (b) Certificate of blindness/disability.
- (c) Proof of absence or expected absence of a certified blind/disabled child, such as a doctor's statement.

**OTHER ELIGIBILITY REQUIREMENTS
LEGALLY RESPONSIBLE RELATIVES (LRRs)
PARENTS AND CHILDREN**

STEP-PARENTS

- (d) Statement from a medical provider that the minor is pregnant.
- (e) Participating in a home and community-based waiver program under Section 1115 of the Social Security Act wherein the income/resources of the parent or step-parent are not considered in the determination of eligibility of the child.

OTHER ELIGIBILITY REQUIREMENTS**HOUSEHOLD COMPOSITION**

Description: Household composition is defined as the individuals included in the Medicaid household. Certain individuals are required to be included in the Medicaid household whether or not they are applying for Medicaid (i.e., LRRs living in the household). The household composition varies depending on the category of the individuals for whom eligibility is being determined.

Policy: Medicaid may be given to an otherwise eligible individual, household, or a portion of the applying household. A Medicaid household's size determines which income and resource, as appropriate, levels are used in the determination of eligibility.

References:

SSL Sect.	365 366
Dept. Reg.	360-4.2
ADMs	OMM/ADM 97-2 82 ADM-6
INFs	07 OHIP/INF-1

Interpretation: This section discusses the following household compositions:

- Low Income Families (LIF), ADC-related, Pregnant Women and Children, family/household size
- SSI-related household size
- Singles/Childless Couples (S/CC) household size

OTHER ELIGIBILITY REQUIREMENTS HOUSEHOLD COMPOSITION

LOW INCOME FAMILIES (LIF), ADC-RELATED, PREGNANT WOMEN AND CHILDREN

Description: For applicants in the Low Income Families (LIF) and ADC-related categories and pregnant women and children, the household/family size:

Must include:

- The applicant and applying family members
- Legally responsible relatives
 - Parents- The household of a parent with joint (equally shared) physical custody of their child who applies with his or her child(ren) includes both the parent and the child(ren). If the other parent in the second household with equally shared physical custody also applies for Medicaid, that household includes that parent and his or her children as well.
 - Stepparents when the stepparent has acknowledged that s/he is supporting the child. (See **OTHER ELIGIBILITY REQUIREMENTS LEGALLY RESPONSIBLE RELATIVES PARENTS AND CHILDREN STEP-PARENTS** for more information on stepparents.)
 - Spouses

May include:

- Non applying siblings
- Non applying related children
- Applying related children (e.g. nieces)
- Applying care taker relatives (e.g. aunts, uncles, grandparents) if there is no parent in the household AND the designated caretaker relative has taken a parental role for the child. The caretaker relative must be applying and if there is more than one person eligible to be designated as a caretaker relative in the household, only one can be designated as the caretaker for Medicaid purposes (See **CATEGORICAL FACTORS ADC-RELATED RELATIONSHIP OF CHILD TO CARETAKER RELATIVE**).
- Unwed father of an unborn if paternity has been established AND he is making his income available to the pregnant woman
- Children under the age of 21 of applying adults
- Children eligible under Chaffee provisions
- Children in receipt of an adoption subsidy

**OTHER ELIGIBILITY REQUIREMENTS
HOUSEHOLD COMPOSITION**

LOW INCOME FAMILIES (LIF), ADC-RELATED, PREGNANT WOMEN AND CHILDREN

Must not include:

- Children and siblings over the age of 21
- SSI cash recipients
- Family Assistance/Safety Net Assistance cash recipients
- Unrelated foster care children
- Parents of pregnant minors
- Non-legally responsible relatives over age 21
- Unrelated household members (e.g. roommates)

Determining eligibility is a two-step process:

1. Count as many persons in the household as possible. If the child or the person seeking eligibility is not found eligible;
2. Remove the “May Counts” from the household of the applicant(s) and determine eligibility.

Policy:

Medicaid may be authorized for an entire household or the portion of a household that is determined eligible. All persons in a household may apply on the same application, regardless of whether or not their eligibility is determined in the same budget/household. A child(ren) in receipt of an adoption subsidy may be removed from the household for budgeting purposes if the child(ren) makes the rest of the family ineligible. Federal law mandates states provide Medicaid coverage for adopted IV-E children.

References:

SSL Sect.	365 366
Dept. Reg.	360-4.2
ADMs	OMM/ADM 97-2 91 ADM-8 90 ADM-9 82 ADM-6
INFs	07 OHIP/INF-1 90 INF-45
LCMs	95 LCM-106
GISs	00 MA/021 00 MA/007

**OTHER ELIGIBILITY REQUIREMENTS
HOUSEHOLD COMPOSITION**

LOW INCOME FAMILIES (LIF), ADC-RELATED, PREGNANT WOMEN AND CHILDREN

Interpretation: When determining eligibility, initially include all the Must counts and May counts in the household. In the event that the applicant(s) are not found eligible, the May Counts should be removed from the household. This option must be explained to the applicant. It is the A/R's choice of who is applying and who of the May Counts are counted in the household size.

A child who is eligible for and receiving Adoption Assistance payments is automatically eligible for Medicaid.

A single individual under age 21 living separate and apart from his/her parents is a one-person household.

Disposition: Families with children under age 21 residing in the household, persons under age 21 living alone, and pregnant women may all be eligible under LIF. This group includes families without a deprivation factor as well as families with a deprivation.

The household size of a pregnant woman is increased by one to account for the additional needs associated with pregnancy regardless of the number of expected births.

Children not found eligible for Medicaid, must be referred to Child Health Plus for an eligibility determination.

**OTHER ELIGIBILITY REQUIREMENTS
HOUSEHOLD COMPOSITION**

SSI-RELATED

- Description:** For adults (age 18 or over) who are aged, certified blind or certified disabled, a Medicaid household is the aged, blind or disabled person and his/her spouse who lives with him/her if the spouse is: (1) also aged, certified blind or certified disabled; or (2) has remaining income after allocations which is equal to or greater than the difference between the medically needy income level for one, and the medically needy income level for two.
- For other aged, certified blind or certified disabled adults who live with their spouses, a Medicaid household consists of one person for income purposes, but consists of two persons for resource purposes.
- For all other aged, certified disabled or certified blind A/Rs, a Medicaid household consists of one person.
- Policy:** Medicaid may be given to an otherwise eligible individual, household or a portion of the applying household.
- References:**
- | | |
|------------|---------------------------------------|
| SSL Sect. | 365
366 |
| Dept. Reg. | 360-4.2 |
| ADMs | OMM/ADM 97-2
91 ADM-27
82 ADM-6 |
- Interpretation:** A person who is SSI-related (at least age 65, certified disabled or certified blind) is only a household of two when residing with a spouse who:
- is also SSI-related; or
 - has remaining income after allocations (See **INCOME SSI-RELATED BUDGETING METHODOLOGY ALLOCATION**) which is equal to or greater than the difference between the medically needy income level for one, and the medically needy income level for two.

**OTHER ELIGIBILITY REQUIREMENTS
HOUSEHOLD COMPOSITION****SINGLES/CHILDLESS COUPLES (S/CC)**

Description: An S/CC household is comprised of an individual or married couple who are (1) at least age 21 but not yet 65; (2) not certified blind or disabled; (3) not pregnant; and (4) not caretaker relatives of children under age 21.

Policy: Medicaid may be given to an otherwise eligible individual; household; or a portion of the applying household.

References: SSL Sect. 365
366

Dept. Reg. 360-4.2

ADMs OMM/ADM 97-2

Interpretation: The S/CC household includes the individual and his/her spouse residing with him/her.

If a spouse living in the household refuses to make his/her income available, eligibility for Medicaid must be determined by counting only the applicant's income (household of one).

OTHER ELIGIBILITY REQUIREMENTS**IDENTITY**

Policy: All A/Rs, as a condition of eligibility for Medicaid, must be identified.

References:

SSL Sect.	366
Dept Reg.	351.11(b)(2)(ii)(a) 351.2(a) 360-2.3
INF	08 OHIP/INF-1
ADM	93 ADM-29
GIS	08 MA/028 08 MA/009

Interpretation: It is the responsibility of the applicant to establish his/her identity. When the A/R's name changes due to marriage, divorce or legal proceedings, the local district documents the change as appropriate.

Effective July 1, 2006, the Deficit Reduction Act of 2005 (DRA) amended federal Medicaid statute to require that all United States (U.S.) citizens applying for or renewing Medicaid coverage provide "satisfactory documentary evidence" of their U.S. citizenship and identity.

NOTE: The provisions of the DRA do not apply to immigrants. Individuals with satisfactory immigration status can continue to receive Medicaid in New York State as described in OMM 04 ADM-07.

For individuals who present other than primary documents, including birth certificates, LDSS must obtain additional proof of identity, such as a driver's license. If no other identity document is available for a child under age 16, a parent or guardian may certify to the child's identity, as long as an affidavit has not been used to document citizenship.

Verification: Identity documents presented by applicants/recipients (A/Rs) must be originals or copies certified by the issuing agency. Districts may copy or scan the documents for the LDSS files. The worker should make photocopies of any original documents and annotate on the copy that she or he saw the original or a document certified by the issuing agency.

OTHER ELIGIBILITY REQUIREMENTS

IDENTITY

The DRA requires all states to obtain documentary evidence from citizen A/Rs and maintain this documentation in their case files, or risk losing federal matching funds. The federal government has stated that a U.S. passport book/card, or a Certificate of Naturalization (N-550 or N-570), or a Certificate of U.S. Citizenship (N-560 or N-561) issued by the United States Department of Homeland Security is considered a "primary" document. A New York State Enhanced Driver's License (EDL) or Native American Tribal Document is also considered a primary document. If an individual states they do not have one of these documents, LDSS may and should continue to accept birth certificates as proof of U.S. citizenship, however, an additional identity document is required from the identity section in the attached desk aid.

Documentation: An A/R who uses a primary document, such as a U.S. passport book/card, to establish citizenship is not required to submit a second document to prove identity. All other A/R's must establish their identity by providing a document from the following list or as otherwise specified below:

- Driver's license issued by a State or Territory either with a photograph of the individual or other identifying information such as name, age, sex, race, height, weight or eye color. Canadian driver's licenses may not be used.
- School identification card with a photograph of the individual.
- U.S. military card or draft record.
- Identification card issued by the Federal, State or local government with the same information included on a driver's license.
- Military dependent's identification card.
- Certificate of Degree of Indian Blood or other United States Native American/Alaska Native Tribal document with a photograph or other personal identifying information relating to the individual, such as age, weight, height, race, sex and eye color.
- U.S. Coast Guard Merchant Mariner card.

OTHER ELIGIBILITY REQUIREMENTS

IDENTITY

- A cross-match with a Federal or State government, public assistance, law enforcement, or corrections agency's data system. Some examples are (but not limited to): State Data Exchange (SDX), Beneficiary Data Exchange (BENDEX) and State Online Query (SOLQ).
- If none of the above identity documents is available, a combination of three or more corroborating documents that, when taken as a whole, reasonably verify the A/R's identity. Acceptable documents include marriage certificates, divorce decrees, employer identification cards, high school and college diplomas from accredited institutions (including general education and high school equivalency diplomas) and/or property deeds or titles. Voter registration cards are not acceptable. All corroborating documents must contain consistent identifying information. None of the documents may have been used to establish the A/R's citizenship. This method of proving identity may be used only when the A/R submitted second or third level evidence of citizenship.

SPECIAL RULES FOR CHILDREN YOUNGER THAN AGE 16

Children who are younger than age 16 may have their identity documented through other means:

- Clinic, doctor or hospital record.
- School records, including report card or nursery or daycare record. The LDSS must verify the records with the issuing school.
- If no other documents are available, an affidavit signed under penalty of perjury by a parent, guardian or caretaker relative may be used. An identity affidavit should not be used if a citizenship affidavit was used. Affidavits need not be notarized. Identity affidavits may be used for children under age 18 when a school ID card or driver's license is not available to the child until she or he is 18 years of age.

OTHER ELIGIBILITY REQUIREMENTS

IDENTITY

SPECIAL RULES FOR DISABLED INSTITUTIONALIZED INDIVIDUALS

The LDSS may accept an identity affidavit signed under penalty of perjury by the director or administrator of a nursing facility or other residential care facility in which a disabled A/R resides. The LDSS should first pursue all other means to verify identity before accepting such an affidavit. The affidavit need not be notarized.

HOMELESS INDIVIDUALS

Homeless individuals often need assistance from the eligibility worker in obtaining acceptable proof of identity, citizenship or immigration status. When the applicant is a homeless individual, it may be difficult for him/her to establish his or her identity, citizenship or immigration status. However, just because an individual is homeless, she/he still must be identified. Proving one's identity is a requirement of the Medicaid program.

The eligibility worker may accept any of the aforementioned documents listed in the Identity section of the attached desk aide, as proof of identity for the homeless individual. If none of the identity documents listed above or in the desk aid is available, a combination of three or more corroborating documents may be used.

NOTE: If an individual is unable to verify his or her identity, citizenship or immigration status, workers should not assume she/he is therefore eligible for coverage of an emergency medical condition. The provisions of the DRA do not apply to immigrants applying for the treatment of an emergency medical condition. However, verification of identity is a requirement for this coverage and all other covered services.

“JOHN/JANE DOE”

A Medicaid application submitted by a “John/Jane Doe” individual (i.e., an individual who is unable to verify his or her identity) should be evaluated in the same manner as any other Medicaid applicant, that is, these individuals are required to meet the same documentation requirements as any other Medicaid applicant. A true “John/Jane Doe” individual is not eligible for Medicaid coverage for the treatment of an emergency medical condition. Verification of identity is a requirement for this coverage and all other covered services.

OTHER ELIGIBILITY REQUIREMENTS**IDENTITY****Desk Guide:**

The desk aid/chart entitled "Documents Establishing U.S. Citizenship and Identity" reflects the final federal regulations on acceptable documentation for citizenship and identity and is attached on the next page.

DOCUMENTS ESTABLISHING U.S. CITIZENSHIP AND IDENTITY

Ver: 11/19/07

PRIMARY CITIZENSHIP DOCUMENTS

Primary Documents	Explanation: Highest reliability; proves U.S. citizenship and identity. No other document required.
United States passport	The Department of State issues this document. A U.S. passport does not have to be currently valid to be accepted as evidence of U.S. citizenship. Note: Spouses and children were sometimes included on one passport through 1980. U.S. passports issued after 1980 show only one person. Consequently, the citizenship and identity of the included person can be established when one of these passports is presented.
Certificate of Naturalization (DHS Forms N-550 or N-570)	Department of Homeland Security (DHS) issues for naturalization.
Certificate of U.S. Citizenship (DHS Forms N-560 or N-561)	Department of Homeland Security (DHS) issues certificates of citizenship to individuals who derive citizenship through a parent.

SECONDARY CITIZENSHIP DOCUMENTS

Secondary Documents	Explanation: Districts should attempt to obtain the most reliable document available. Satisfactory reliability when a primary document not available; also requires an identity document.
A U.S. public birth certificate showing birth in: <ul style="list-style-type: none"> • One of the 50 U.S. States; • District of Columbia; • American Samoa; • Swain's Island; • *Puerto Rico (if born on or after January 13, 1941); • *Virgin Islands of the U.S. (on or after January 17, 1917); • *Northern Mariana Islands (after November 4, 1986 (NMI local time); or • Guam (on or after April 10, 1899) 	The birth record document may be issued by the State, Commonwealth, territory or local jurisdiction. It must have been issued before the person was five years of age. Note: If the document shows the individual was born in Puerto Rico, the Virgin Islands of the U.S., or the Northern Mariana Islands before these areas became part of the United States, the individual may be a collectively naturalized citizen. Collective naturalization occurred on certain dates listed for each of the territories. * See additional requirements for Collective Naturalization, on page 5.
Certification of Report of Birth issued by the Department of State (DS-1350)	The Department of State issues a DS-1350 to U.S. citizens in the U.S. who were born outside the U.S. and acquired U.S. citizenship at birth, based on the information shown on the FS-240. When the birth was recorded as a Consular Report of Birth (FS-240), certified copies of the Certification of Report of Birth Abroad (DS-1350) can be issued by the Department of State in Washington, D.C. The DS-1350 contains the same information as that on the current version of Consular Report of Birth FS-240. The DS-1350 is not issued outside the U.S.

DOCUMENTS ESTABLISHING U.S. CITIZENSHIP AND IDENTITY continued Ver: 11/19/07

SECONDARY DOCUMENTS (continued)

Secondary Documents continued	Explanation:
A Report of Birth Abroad of a U.S. Citizen (FS-240)	Satisfactory reliability when a primary document not available; also requires an identity document. The Department of State consular office prepares and issues this document. A Consular Report of Birth can be prepared only at an American consular office overseas while the child is under the age of 18. Children born outside the U.S. to U.S. military personnel usually have one of these.
Certification of birth issued by Department of State (Forms FS-545 or DS-1350)	Before November 1, 1990, Department of State consulates also issued Form FS-545 along with the prior version of the FS-240. In 1990, U.S. consulates ceased to issue Form-545. Treat an FS-545 the same as the DS-1350.
United States Citizen Identification Card (I-197 or prior version I-179)	The former Immigration and Nationality Services (INS) issued the I-179 from 1960 until 1973. It revised the form and renumbered it as Form I-197. INS issued the I-197 from 1973 until April 7, 1983. INS issued Form I-179 and I-197 to naturalized U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossings. Although neither form is currently issued, either form that was previously issued is still valid.
Northern Mariana Identification Card (I-873)	The former INS issued the I-873 to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before November 4, 1986. The card is no longer issued, but those previously issued are still valid.
American Indian Card (I-872)	DHS issues this card to identify a member of the Texas Band of Kickapoos living near the U.S./Mexican border. A classification code "KIC" and a statement on the back denote U.S. citizenship.
Final adoption decree	The adoption decree must show the child's name and U.S. place of birth. In situations where an adoption is not finalized and the State in which the child was born will not release a birth certificate prior to final adoption, a statement from a State approved adoption agency that shows the child's name and U.S. place of birth is acceptable. The adoption agency must state in the certification that the source of the birth information is an original birth certificate.
Evidence of civil service employment by the U.S. government	The document must show employment by the U.S. government before June 1, 1976.
Official Military record of service showing U.S. place of birth	The document must show a U.S. place of birth (for example a DD-214 or similar official document showing a U.S. place of birth).
Evidence of qualifying for U.S. citizenship under the Child Citizenship Act of 2000	Evidence of meeting the automatic criteria for U.S. citizenship outlined in the Child Citizenship Act of 2000 (P.L. 106-395). Applies to adopted or biological children born outside the U.S.

THIRD LEVEL DOCUMENTS

Third Level Documents	Explanation:
Extract of hospital record on hospital letterhead established at the time of the person's birth that was created at least 5 years before the initial application date and that indicates a U.S. place of birth	Satisfactory reliability when a primary or secondary document is not available; also requires an identity document DO NOT ACCEPT a souvenir "birth certificate" issued by the hospital. Note: For children under 16, the document must have been created near the time of birth or 5 years before the date of application.

DOCUMENTS ESTABLISHING U.S. CITIZENSHIP AND IDENTITY continued Ver: 11/19/07

THIRD LEVEL DOCUMENTS (continued)

Third Level documents continued	Explanation: Satisfactory reliability when a primary or secondary document is not available; also requires an identity document
Life, health or other insurance record showing a U.S. place of birth that was created at least 5 years before the initial application date	Life, health or other insurance records may show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth. Note: For children under 16, the document must have been created near the time of birth or 5 years before the date of application.
Religious record recorded in the U.S. within 3 months of birth showing a U.S. place of birth	Religious record recorded in the U.S. within 3 months of birth showing a U.S. place of birth and either the date of birth or the individual's age at the time the record was made. The record must be an official record recorded with the religious organization. Entries in a family bible are not considered religious records.
Early school record showing U.S. place of birth	Early school record showing date of admission, a U.S. place and date of birth and names and places of birth of the applicant's parents. School records must be verified with the school's administration.

FOURTH LEVEL DOCUMENTS

Fourth Level Documents	Explanation: Satisfactory reliability when a primary, secondary or third level document is not available; should be used only in the rarest of circumstances; also requires an identity document.
Federal or State census record showing U.S. citizenship or a U.S. place of birth (Generally for persons born 1900 through 1950)	The census record must also show the applicant's age. Note: Census records from 1900 through 1950 contain certain citizenship information. To secure this information the applicant, recipient or social services district should complete a Form BC-600, Application for Search of Census Records for Proof of Age. Add in the remarks portion "U.S. citizenship data requested." Also add that the purpose is for Medicaid eligibility. This form also requires a fee.
Other documents as listed in the explanation column that were created at least 5 years before the application for Medicaid (For children younger than 16, near the time of birth or 5 years before the application)	This document must be one of the following and show a U.S. place of birth: <ul style="list-style-type: none"> • Seneca Indian tribal census record; • Bureau of Indian affairs tribal census records of the Navajo Indians; • U.S. State Vital Statistics official notification of birth registration; • Delayed U.S. public birth record that was recorded more than 5 years after the person's birth; • Statement signed by the physician/midwife who was in attendance at the time of birth; or • Bureau of Indian Affairs Roll of Alaska Natives.

DOCUMENTS ESTABLISHING U.S. CITIZENSHIP AND IDENTITY continued Ver: 11/19/07

FOURTH LEVEL DOCUMENTS (continued)

<p>Fourth Level Documents continued</p>	<p>Explanation: Satisfactory reliability when a primary, secondary or third level document is not available; should be used only in the rarest of circumstances; also requires an identity document.</p>
<p>Institutional admission papers from a nursing facility, skilled care facility or other institution (created at least 5-years before the application date) showing a U.S. place of birth</p>	<p>Admission records generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth.</p>
<p>Written Affidavit</p>	<p>Affidavits should ONLY be used in rare circumstances. The affidavit must contain the following information under the following circumstances:</p> <ul style="list-style-type: none"> • There must be at least two affidavits by two individuals who have personal knowledge of the event(s) establishing the applicant's or recipient's claim of citizenship. • The two affidavits can be combined in a joint affidavit. • At least one of the individuals making the affidavit cannot be related to the applicant or recipient. • The person(s) making the affidavit must be able to provide proof of his or her own citizenship and identity for the affidavit to be accepted. • The affidavit must also be signed under penalty of perjury by the person making the affidavit, but need not be notarized. • A separate affidavit from the applicant/recipient or other knowledgeable individual (guardian or representative) explaining why documentary evidence does not exist or cannot be readily obtained must also be obtained.

DOCUMENTS ESTABLISHING U.S. CITIZENSHIP AND IDENTITY (continued) Ver: 11/19/07

When primary evidence of citizenship is not available, a document from the list of Secondary, Third, or Fourth Level Documents may be presented and must be accompanied by an identity document the list below.

IDENTITY DOCUMENTS

Documents to Establish Identity	Explanation: This section includes a list of acceptable documents that establish identity when a primary document is not available:
	<ul style="list-style-type: none"> • A driver’s license issued by State or Territory either with a photograph of the individual or other identifying information of the individual such as name, age, sex, race, height, weight or eye color. Do not accept a Canadian driver’s license; • School identification card with a photograph of the individual; • U.S. military card or draft record; • Identification card issued by Federal, State, or local government with the same information included on the driver’s license; • Military dependent’s identification card; • Certificate of Degree of Indian Blood, or other U.S. Native American/Alaska Native Tribal document with photo or other identifying information; • U.S. Coast Guard Merchant Mariner card; • A cross-match with a Federal or State governmental, public assistance, law enforcement, or corrections agency’s data system; • If none of the above identity documents is available, a combination of three or more corroborating documents such as marriage certificates, divorce decrees, high school or college diplomas, employer ID cards or property deeds/titles. Voter registration cards are not acceptable; • Disabled individuals in residential care facilities may have their identity attested to by the facility director or administrator, on behalf of the individual in the facility when the individual does not have or cannot get any document listed above. This affidavit must be signed under penalty of perjury, but need not be notarized. • Children under age 16 may have their identity documented using other means: <ul style="list-style-type: none"> ○ Clinic, doctor or hospital record; ○ School records including report card, day care or nursery school record. Records must be verified with the issuing school; ○ If no other documents are available, an affidavit signed under penalty of perjury by a parent, guardian or caretaker relative may be used. An identity affidavit should not be used if a citizenship affidavit was used. Affidavits need not be notarized. Identity affidavits may be used for children under 18 when a school ID card or driver’s license is not available to the child until she or he is 18 years of age.

DOCUMENTS ESTABLISHING U.S. CITIZENSHIP AND IDENTITY (continued)

Ver: 11/19/07

COLLECTIVE NATURALIZATION

Territories	Explanation:
Puerto Rico	<p>Evidence that establishes U.S. citizenship for collectively naturalized individuals.</p> <ul style="list-style-type: none"> • Evidence of birth in Puerto Rico on or after April 11, 1899 and the applicant's or recipient's statement that he or she was residing in the U.S., a U.S. possession or Puerto Rico on January 13, 1941; or • Evidence that the applicant/recipient was a Puerto Rican citizen and the applicant's/recipient's statement that he or she was residing in Puerto Rico on March 1, 1917 and that he or she did not take an oath of allegiance to Spain.
U.S. Virgin Islands	<ul style="list-style-type: none"> • Evidence of birth in the U.S. Virgin Islands, and the applicant/recipient's statement of residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927; or • The applicant/recipient's statement indicating residence in the U.S. Virgin Islands as a Danish citizen on January 17, 1917 and residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927, and that he or she did not make a declaration to maintain Danish citizenship; or • Evidence of birth in the U.S. Virgin Islands and the applicant/recipient's statement indicating residence in the U.S., a U.S. possession or territory or the Canal Zone on June 28, 1932).
Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Island [TTPI])	<ul style="list-style-type: none"> • Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. territory or possession on November 3, 1986 (NMI local time) and the applicant/recipient's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); • Evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration prior to January 1, 1975 and the applicant/recipient's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); or • Evidence of continuous domicile in the NMI since before January 1, 1974 and the applicant/recipient's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time). <p>NOTE: If a person entered the NMI as a nonimmigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile and the individual is not a U.S. citizen.</p>

OTHER ELIGIBILITY REQUIREMENTS

CITIZENSHIP AND IMMIGRATION STATUS

Policy:

Medicaid is provided to otherwise eligible residents of the United States who are citizens, nationals, or individuals in satisfactory immigration status (i.e. qualified or persons Permanently Residing in the United States Under Color of Law (PRUCOL). Medicaid coverage is limited to coverage for the treatment of emergency medical conditions for otherwise eligible individuals who are not qualified (i.e. temporary non-immigrants, short term visa holders, foreign students, etc.) or who are not in satisfactory immigration status (i.e., undocumented).

Citizens, nationals, qualified immigrants and PRUCOL immigrant applicants for Medicaid must provide appropriate documentation of their citizenship or satisfactory immigration status. Such individuals must also sign a declaration, under penalty of perjury, that they are citizens, nationals or immigrants with satisfactory immigration status and must provide or apply for a Social Security Number.

Individuals who are initially eligible for Medicaid as a “deemed” newborn are considered to have provided satisfactory documentation of citizenship and identity, by virtue of being born in the United States, and will not be required to further document citizenship or identity at any subsequent Medicaid eligibility redetermination/renewal.

NOTE: Special provision is made for individuals who are not qualified, but who, on August 4, 1997, were residing in certain residential facilities or were diagnosed with AIDS (as defined by the Centers For Disease Control) and receiving Medicaid based on a determination that they were “permanently residing in the United States under color of law” (PRUCOL). Such individuals will continue to receive full Medicaid benefits if they are otherwise eligible.

NOTE: Citizenship and immigration status are not considered when determining Medicaid eligibility for a pregnant woman. A pregnant woman does not need to document her citizenship/immigration status until the month following the month in which the 60-day postpartum period ends.

References:

- SSL Sect 122
 131-k

- Dept Reg. 349.3
 351.1
 351.2
 360-3.2(j)

OTHER ELIGIBILITY REQUIREMENTS**CITIZENSHIP AND IMMIGRATION STATUS**

ADMs	04 ADM 07 97 ADM-23 88 ADM-22 88 ADM-4 82 ADM-24
INFs	07 OHIP/INF-2 06 OMM/INF-5
GISs	10 MA/006 08 MA/009 04 MA/014 02/MA/016 02 MA/002 01 MA/033 01 MA/030 01 MA/026

OTHER ELIGIBILITY REQUIREMENTS**CITIZENSHIP AND IMMIGRATION STATUS**

This section deals with the following groups:

Citizens:

Nationals;
Native Americans;

Satisfactory Immigration Status:

Qualified;

Battered;

Veterans and Active Duty Exceptions;

Victims of Trafficking;

PRUCOL (permanently residing in the United States under color of law);

Temporary Protected Status (TPS);

Visa Statuses:

Temporary non-immigrants (immigrants admitted on a temporary basis); and

Special non-immigrants (immigrants admitted on a K, S, V, U visa); and

Undocumented/illegal:

Treatment of an Emergency Medical Condition

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS**

CITIZENS

Description: A citizen is a person who was born in the United States or who has been naturalized.

Policy: Medicaid may be given to citizens of the United States who are residents of New York State and who are otherwise eligible. The Deficit Reduction Act of 2005 (DRA) amended federal Medicaid Statute to require that all United States citizens applying for or renewing Medicaid coverage provide “satisfactory documentary evidence” of their citizenship. For applications submitted after October 1, 2010 individuals declaring to be U.S. citizens and presenting a valid SSN will have their citizenship confirmed via the Social Security Administration (SSA) citizenship verification process.

NOTE: Naturalized citizens will not have their citizenship verified through the SSA process.

Applicants/recipients (A/Rs) declaring to be U.S. citizens, who are eligible for or enrolled in Medicare or receiving Supplemental Security Income (SSI) are exempt from documenting both citizenship and identity. These individuals have already established their citizenship and identity to the Social Security Administration (SSA).

The Tax Relief and Health Care Act of 2006 (PL 109-432) amended the DRA further to exempt A/Rs in receipt of Social Security Disability Insurance (SSDI) and children under Title IV-B on the basis of being a child in foster care and IV-E on the basis of adoption or receiving foster care assistance.

The provisions of Section 211 of the Children’s Health Insurance Program Reauthorization Act (CHIPRA) of 2009 also eliminates citizenship documentation requirements for deemed newborns.

References:

SSL Sect.	122 131-k
Public Law	109-432
Dept. Reg.	349.3 360-3.2(f)
ADM	10 OHIP/ADM-8
INF	08 OHIP/INF-1

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS**

CITIZENS

GIS 10 MA/006

Interpretation:

Natural born citizens and individuals who acquire citizenship through naturalization and who are residents of the State of New York may receive Medicaid, if otherwise eligible. For the Medicaid program, identity, citizenship and/or satisfactory immigration status must be documented. For the purposes of qualifying as a United States citizen, the United States includes the 50 states, the District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands and the Northern Mariana Islands. Nationals from American Samoa or Swain's Island are also regarded as United States citizens for the purpose of Medicaid eligibility.

All persons who were born in the United States are, with rare exception, United States citizens. United States citizenship can also be acquired by naturalization or acquired by persons who are born in another country and whose parent(s) are citizens of the United States. Lengthy residence in this country or marriage to a U.S. citizen does not by itself bestow citizenship.

Individuals who are initially eligible for Medicaid as a "deemed" newborn are considered to have provided satisfactory documentation of citizenship and identity, by virtue of being born in the United States, and will not be required to further document citizenship or identity at any subsequent Medicaid eligibility redetermination/renewal.

Newborns processed through the existing newborn process are excluded from being sent for citizenship verification.

Applicants declaring to be U.S. citizens do not have to provide proof of citizenship as a condition of initial eligibility. The response from SSA will be displayed in the Welfare Management System as a Birth Verification Indicator (BVI). A BVI value of "1" is generated when a recipient's allegation of citizenship is consistent with SSA data. No further action is required and no additional documentation of citizenship, identity or date of birth is required. If the SSA verification process fails to confirm citizenship and identity and the LDSS is unable to resolve any inconsistency, the A/R must be given 90 days to either authorize the LDSS to obtain verification of birth from Vital Records and provide the LDSS with identity documentation or provide the district with original documentary evidence to support their declaration of citizenship and identity.

OTHER ELIGIBILITY REQUIREMENTS CITIZENSHIP AND IMMIGRATION STATUS

CITIZENS

A/Rs may also bring their original documents or certified copies to a Facilitated Enroller (FE) or other qualified entity designated by the LDSS for this purpose. If the FE processed the original application, the FE will forward the verified copies to the LDSS. Otherwise, the facilitator will photocopy the original documents and notate on the copies that the originals or certified copies were seen, and return the documents to the recipient. The recipient must send the copies to the LDSS.

During the 90 day period, the individual remains enrolled in Medicaid. After 90 days, if documentary evidence has not been provided to verify citizenship and identity, the district must discontinue Medicaid for the individual with timely notice. However, the recipient continues to be eligible for any remaining months in a six-month managed care guarantee enrollment period. **NOTE:** If a parent or caretaker relative does not comply with providing citizenship and identity documentation to the district for an applying child under the age of twenty-one when the SSA match fails, **ONLY** the child's Medicaid eligibility can be discontinued.

Naturalized citizens are required to show documentary proof of their acquired citizenship by presenting their original or certified copy of the Certificate of Naturalization or their US Passport to the LDSS, FE or qualified entity designated by the LDSS. These individuals are allowed 90 days from the date of notification to supply their original or certified copy of naturalization document or US Passport. **NOTE:** Medicaid coverage must not be delayed pending receipt of such documentation if the individual is otherwise eligible.

Once a person's citizenship is documented, it need not be re-documented unless that person's citizenship becomes questionable.

However, individuals who re-apply after their declaration of citizenship did not validate and who did not comply with the request to provide proof of citizenship and identity, will not be forwarded to SSA for citizenship verification. These individuals will be required to provide documentation of identity and U.S. citizenship or immigration status at reapplication.

Documentation: If the SSA verification process fails to confirm citizenship and identity and the LDSS is unable to resolve any inconsistency, original documentary evidence to support their declaration of citizenship and identity must be obtained.

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS**

CITIZENS

The following are examples of items which constitute primary documentation of U.S. citizenship:

Documents which Establish both Citizenship and Identity

- U.S. passport book/card;
- Certificate of Naturalization (N-550 or N-570);
- Certificate of U.S. Citizenship (N-560 or N-561);
- NYS Enhanced Driver's License (EDL); Or
- Native American Tribal Document

Secondary Documents which Establish Citizenship but also require one identity document from the Identity Documentation list below:

- U.S. Birth Certificate showing birth in one of the 50 U.S. States, District of Columbia, American Samoa, Swain's Island, Puerto Rico (if born on or after 4/11/1899), Virgin Islands of the U.S. (on or after 2/25/1927), Northern Mariana Islands (after 11/3/1986 [NMI local time]), or Guam (on or after 4/10/1899);
- Certification of Report of Birth issued by the Department of State (DS-1350) ;
- Report of Birth Abroad of a U.S. Citizen (FS-240);
- Certification of birth issued by Department of State (Forms FS-545 or DS-1350);
- U.S. Citizen Identification Card (I-197 or I-179);
- Northern Mariana Identification Card (I-873);
- American Indian Card with classification code of "KIC" (I-872);
- Final adoption decree showing U.S. place of birth;

OTHER ELIGIBILITY REQUIREMENTS CITIZENSHIP AND IMMIGRATION STATUS

CITIZENS

- Evidence of U.S. civil service employment before 6/1/1976;
- Military record of service showing U.S. place of birth (i.e., DD-214); or
- Evidence of qualifying for U.S. citizenship under the Child Citizenship Act of 2000.

Third Level Documents which Establish Citizenship but are less reliable than Secondary Documents (Also requires an identity document)

- Extract of hospital record on hospital letterhead. The record must have been established at the time of birth and the extract must have been created at least 5 years before the Medicaid application date (or, for children younger than 16, near the time of birth) and must show a U.S. place of birth;
- Life, health or other insurance record, if it shows a U.S. place of birth and was created at least 5 years prior to the application date (or, for children younger than 16, near the time of birth);
- Religious record recorded in the U.S. within 3 months of birth showing a U.S. place of birth and either the date of birth or the individual's age at the time the record was made; or
- Early school record showing date of admission, a U.S. place and date of birth and names and places of birth of the applicant's parents.

Fourth Level Documents which Establish Citizenship but are the least reliable and should only be used in rarest of circumstances (Also requires an identity document)

- Federal or State census record showing U.S. citizenship or a U.S. place of birth; or
- The following other documents are acceptable if they indicate a U.S. place of birth and were created at least 5 years prior to the application date (or, for children younger than 16, near the time of birth):
 - Medical (clinic, doctor, or hospital) record;
 - Seneca Indian tribal census;
 - Bureau of Indian Affairs tribal census records of the Navajo Indians;
 - U.S. State Vital Statistics official notification of birth registration;
 - Delayed U.S. public birth record that is recorded more than 5 years after the person's birth;

OTHER ELIGIBILITY REQUIREMENTS CITIZENSHIP AND IMMIGRATION STATUS

CITIZENS

- Statement signed by the physician/midwife who was in attendance at the time of birth; or
- Bureau of Indian Affairs Roll of Alaska Natives;
- Institutional admission papers from a nursing facility, skilled care facility or other institution (created at least 5 years before the application date) showing a U.S place of birth; or
- Written affidavit (to be used only in rare instances). The affidavit must contain the following information under the following circumstances:
 - There must be at least two affidavits by two individuals who have personal knowledge of the event(s) establishing the applicant's or recipient's claim of citizenship.
 - The two affidavits can be combined in a joint affidavit.
 - At least one of the individuals making the affidavit cannot be related to the applicant or recipient.
 - The person(s) making the affidavit must be able to provide proof of his or her own citizenship and identity for the affidavit to be accepted.
 - The affidavit must also be signed under penalty of perjury by the person making the affidavit, but need not be notarized.

A separate affidavit from the applicant/recipient or other knowledgeable individual (guardian or representative) explaining why documentary evidence does not exist or cannot be readily obtained must also be obtained.

Evidence that Establishes U.S. Citizenship for Collectively Naturalized Individuals

Puerto Rico

- Evidence of birth in Puerto Rico on or after 4/11/1899 and the applicant's or recipient's (A/R's) statement that he or she was residing in the U.S., a U.S. possession or Puerto Rico on 1/13/1941; or
- Evidence that the A/R was a Puerto Rican citizen and the A/R's statement that he or she was residing in Puerto Rico on 3/1/1917 and that he or she did not take an oath of allegiance to Spain.

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS**

CITIZENS

U.S. Virgin Islands

- Evidence of birth in the U.S. Virgin Islands, and the A/R's statement of residence in the U.S., a U.S. possession or the U.S. Virgin Islands on 2/25/1927; or
- The A/R's statement indicating residence in the U.S. Virgin Islands as a Danish citizen on 1/17/1917 and residence in the U.S., a U.S. possession or the U.S. Virgin Islands on 2/25/1927, and that he or she did not make a declaration to maintain Danish citizenship; or
- Evidence of birth in the U.S. Virgin Islands and the A/R's statement indicating residence in the U.S., a U.S. possession or territory or the Canal Zone on 6/28/1932.

Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands [TTPI])

- Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. territory or possession on 11/3/1986 (NMI local time) and the A/R's statement that he or she did not owe allegiance to a foreign state on 11/4/1986 (NMI local time); or
- Evidence of TTPI citizenship, continuous residence in the NMI since before 11/3/1981 (NMI local time), voter registration prior to 1/1/1975 and the A/R's statement that he or she did not owe allegiance to a foreign state on 11/4/1986 (NMI local time), or
- Evidence of continuous domicile in the NMI since before 1/1/1974 and the A/R's statement that he or she did not owe allegiance to a foreign state on 11/4/1986 (NMI local time). If a person entered the NMI as a non-immigrant and lived in the NMI since 1/1/1974, this does not constitute continuous domicile and the individual is not a U.S. citizen.

OTHER ELIGIBILITY REQUIREMENTS CITIZENSHIP AND IMMIGRATION STATUS

CITIZENS

HOMELESS INDIVIDUALS

Homeless individuals often need assistance from the eligibility worker in obtaining acceptable proof of identity, citizenship or immigration status. When the applicant is a homeless individual, it may be difficult for him/her to establish his or her identity, citizenship or immigration status. However, just because an individual is homeless, she/he still must be identified. Proving one's citizenship is a requirement of the Medicaid program.

The eligibility worker may accept any of the aforementioned documents listed in the citizenship section above or in the attached desk aide, as proof of citizenship for the homeless individual.

NOTE: If an individual is unable to verify his or her identity, citizenship or immigration status, workers should not assume she/he is therefore eligible for coverage of an emergency medical condition.

“JOHN/JANE DOE”

A Medicaid application submitted by a “John/Jane Doe” individual (i.e., an individual who is unable to verify his or her identity) should be evaluated in the same manner as any other Medicaid applicant, that is, these individuals are required to meet the same documentation requirements as any other Medicaid applicant. A true “John/Jane Doe” individual is not eligible for Medicaid coverage for the treatment of an emergency medical condition. Verification of identity is a requirement for this coverage and all other covered services.

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS**

CITIZENS

**Documentation Guide
Citizenship and Immigrant Eligibility for Health Coverage in
New York State**

Category 1: U.S. Citizens

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
<p>United States Citizen: (Includes the 50 U.S. States, the District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands, and American Samoa, Swain's Island and the Northern Mariana Islands for purposes of Medicaid eligibility.)</p> <p>Note: Listed are the most common documents used to prove U.S. citizenship. The list is not exhaustive and there are other documents that can establish U.S. citizenship.</p> <p>CITIZENSHIP REMINDERS: A birth certificate can no longer be accepted as proof of both citizenship and identity. If the birth certificate is presented as proof of citizenship, the worker must obtain another form of identity document from the Identity documentation list, such as a driver's license. All documents must be originals or copies certified by the issuing agency. Workers are required to photocopy the original/certified copy and annotate the copy with their initials and the date of the review.</p>	<p>Primary Documents (No other document required)</p> <ul style="list-style-type: none"> ▶ U.S. Passport; ▶ Certificate of Naturalization (N-550 or N-570); or ▶ Certificate of U.S. Citizenship (N-560 or N-561). <hr/> <p>Secondary Documents (When a primary document is unavailable, a secondary document may be used, but also requires ONE identity document from the identity documentation list below.)</p> <ul style="list-style-type: none"> ▶ U.S. Birth Certificate showing birth in one of the 50 U.S. States, District of Columbia, American Samoa, Swain's Island, Puerto Rico (if born on or after 1/13/1941), Virgin Islands of the U.S. (on or after 1/17/1917), Northern Mariana Islands (after 11/4/1986 [NMI local time]), or Guam (on or after 4/10/1899); ▶ Certification of Report of Birth issued by the Department of State (DS-1350); ▶ Report of Birth Abroad of a U.S. Citizen (FS-240); ▶ Certification of birth issued by Department of State (Forms FS-545 or DS-1350); ▶ U.S. Citizen Identification Card (I-197 or I-179); ▶ Northern Mariana Identification Card (I-873); ▶ American Indian Card with classification code of "KIC" (I-872); ▶ Final adoption decree showing U.S. place of birth; ▶ Evidence of U.S. civil service employment before 6/1/1976; ▶ Military record of service showing U.S. place of birth (i.e., DD-214); or ▶ Evidence of qualifying for U.S. citizenship under the Child Citizenship Act of 2000. 	<p>C</p>	<p>YES</p>	<p>A SSN is an eligibility requirement for all citizens applying for Medicaid or FHP.</p> <p>Note: Pregnant women are excluded from this requirement.</p>

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS**

CITIZENS

Category 1: U.S. Citizens continued

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
<p>U.S. Citizen (Includes the 50 U.S. States, the District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands, and American Samoa, Swain's Island and the Northern Mariana Islands for purposes of Medicaid eligibility.)</p>	<p>Third Level Documents (When a primary or secondary document is not available; also requires an identity document.) ▶ Extract of hospital record on hospital letterhead. The record must have been established at the time of birth and the extract must have been created at least 5 years before the Medicaid application date (or, for children younger than 16, near the time of birth) and must show a U.S. place of birth; ▶ Life, health or other insurance record, if it shows a U.S. place of birth and was created at least 5 years prior to the application date (or, for children younger than 16, near the time of birth); (When a primary or a secondary document is not available: also requires ONE identity document.) ▶ Religious record recorded in the U.S. within 3 months of birth showing a U.S. place of birth and either the date of birth or the individual's age at the time the record was made; or ▶ Early school record showing date of admission, a U.S. place and date of birth and names and places of birth of the applicant's parents.</p>	<p>C</p>	<p>YES</p>	<p>A SSN is an eligibility requirement for all citizens applying for Medicaid or FHP.</p> <p>Note: Pregnant women are excluded from this requirement.</p>

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS**

CITIZENS

Category 1: U.S. Citizens continued

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
<p>U.S. Citizen (Includes the 50 U.S. States, the District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands, and American Samoa, Swain's Island and the Northern Mariana Islands for purposes of Medicaid eligibility.)</p>	<p>Fourth Level Documents (Are the least reliable and should only be used in rarest of circumstances; also requires an identity document.)</p> <ul style="list-style-type: none"> ▶ Federal or State census record showing U.S. citizenship or a U.S place of birth; or ▶ The following other documents are acceptable if they indicate a U.S. place of birth and were created at least 5 years prior to the application date (or, for children younger than 16, near the time of birth): <ul style="list-style-type: none"> ▪ Medical (clinic, doctor, or hospital) record; ▪ Seneca Indian tribal census; ▪ Bureau of Indian Affairs tribal census records of the Navajo Indians; ▪ U.S. State Vital Statistics official notification of birth registration; ▪ Delayed U.S. public birth record that is recorded more than 5 years after the person's birth; ▪ Statement signed by the physician/midwife who was in attendance at the time of birth; or ▪ Bureau of Indian Affairs Roll of Alaska Natives; ▶ Institutional admission papers from a nursing facility, skilled care facility or other institution (created at least 5 years before the application date) showing a U.S. place of birth; or ▶ Written affidavit (to be used only in rare instances). The affidavit must contain the following information under the following circumstances: <ul style="list-style-type: none"> • There must be at least two affidavits by two individuals who have personal knowledge of the event(s) establishing the applicant's or recipient's claim of citizenship. • The two affidavits can be combined in a joint affidavit. • At least one of the individuals making the affidavit cannot be related to the applicant or recipient. • The person(s) making the affidavit must be able to provide proof of his or her own citizenship and identity for the affidavit to be accepted. • The affidavit must also be signed under penalty of perjury by the person making the affidavit, but need not be notarized. <p>A separate affidavit from the applicant/recipient or other knowledgeable individual (guardian or representative) explaining why documentary evidence does not exist or cannot be readily obtained must also be obtained.</p>	<p>C</p>	<p>YES</p>	<p>A SSN is an eligibility requirement for all citizens applying for Medicaid or FHP.</p> <p>Note: Pregnant women are excluded from this requirement.</p>

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS**

CITIZENS

Category 1: U.S. Citizens continued

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
<p>Collectively Naturalized</p> <p>Evidence that establishes U.S. Citizenship for Collectively Naturalized individuals.</p>	<p>Puerto Rico</p> <ul style="list-style-type: none"> ▶ Evidence of birth in Puerto Rico on or after 4/11/1899 and the applicant's or recipient's (A/R's) statement that he or she was residing in the U.S., a U.S. possession or Puerto Rico on 1/13/1941; or ▶ Evidence that the A/R was a Puerto Rican citizen and the A/R's statement that he or she was residing in Puerto Rico on 3/1/1917 and that he or she did not take an oath of allegiance to Spain. <p>U.S. Virgin Islands</p> <ul style="list-style-type: none"> ▶ Evidence of birth in the U.S. Virgin Islands, and the A/R's statement of residence in the U.S., a U.S. possession or the U.S. Virgin Islands on 2/25/1927; or ▶ The A/R's statement indicating residence in the U.S. Virgin Islands as a Danish citizen on 1/17/1917 and residence in the U.S., a U.S. possession or the U.S. Virgin Islands on 2/25/1927, and that he or she did not make a declaration to maintain Danish citizenship; or ▶ Evidence of birth in the U.S. Virgin Islands and the A/R's statement indicating residence in the U.S., a U.S. possession or territory or the Canal Zone on 6/28/1932. <p>Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands [TTPI])</p> <ul style="list-style-type: none"> ▶ Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. territory or possession on 11/3/1986 (NMI local time) and the A/R's statement that he or she did not owe allegiance to a foreign State on 11/4/1986 (NMI local time); or ▶ Evidence of TTPI citizenship, continuous residence in the NMI since before 11/3/1981 (NMI local time), voter registration prior to 1/1/1975 and the A/R's statement that he or she did not owe allegiance to a foreign State on 11/4/1986 (NMI local time); or ▶ Evidence of continuous domicile in the NMI since before 1/1/1974 and the A/R's statement that he or she did not owe allegiance to a foreign State on 11/4/1986 (NMI local time). If a person entered the NMI as a nonimmigrant and lived in the NMI since 1/1/1974, this does not constitute continuous domicile and the individual is not a U.S. citizen. 	<p>C</p>	<p>YES</p>	<p>A SSN is an eligibility requirement for all citizens applying for Medicaid or FHP.</p> <p>Note: Pregnant women are excluded from this requirement</p>

Category 1: U.S. Citizens continued

Category	Identity Documents (One identity document must be used with secondary, third or fourth level citizenship documentation).	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
<p>U.S. Citizen (Includes the 50 U.S. States, the District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands, and American Samoa, Swain's Island and the Northern Mariana Islands for purposes of Medicaid eligibility.)</p>	<p>▶ A driver's license issued by State or Territory either with a photograph of the individual or other identifying information of the individual such as name, age, sex, race, height, weight or eye color. Canadian driver's licenses may not be used;</p> <p>▶ School identification card with a photograph of the individual;</p> <p>▶ U.S. military card or draft record;</p> <p>▶ Identification card issued by Federal, State, or local government with the same information included on the driver's license;</p> <p>▶ Military dependent's identification card;</p> <p>▶ Certificate of Degree of Indian Blood, or other U.S. Native American/Alaska native tribal document with photo or other identifying information;</p> <p>▶ U.S. Coast Guard Merchant Mariner card;</p> <p>▶ A cross-match with a Federal or State governmental, public assistance, law enforcement, or corrections agency's data system;</p> <p>▶ If none of the above identity documents is available, a combination of three or more corroborating documents such as marriage certificates, divorce decrees, high school or college diplomas, employer ID cards or property deeds/titles. Voter registration cards are not acceptable;</p> <p>▶ Disabled individuals in residential care facilities may have identity attested to by the facility director or administrator, on behalf of the individual in the facility, when the individual does not have or cannot get any document listed above. This affidavit must be signed under penalty of perjury but need not be notarized.</p> <p>▶ Children under age 16 may have their identity documented using other means:</p> <ul style="list-style-type: none"> ▪ Clinic, doctor or hospital record; ▪ School records including report card, day care or nursery school record. Records must be verified with the issuing school; ▪ Affidavit signed under penalty of perjury by a parent, guardian or caretaker relative stating the date and place of the child's birth, if no other documents are available. An identity affidavit should not be used if a citizenship affidavit was used. Affidavits need not be notarized. Identity affidavits may be used for children under 18 when a school ID card or driver's license is not available to the child until he or she is 18 years of age. 	<p>C</p>	<p>Not applicable to identity documents</p>	<p>Not applicable to identity documents</p>

OTHER ELIGIBILITY REQUIREMENTS CITIZENSHIP AND IMMIGRATION STATUS

NATIVE AMERICANS

Policy:

Native Americans born in the United States are citizens of the United States and will have the same types of documentation of citizenship as do other U.S. citizens.

Native Americans born outside the U.S. are eligible for Medicaid without regard to immigration status restrictions, if they reside in New York State and are:

- ▶ A non-citizen member of a federally recognized tribe; or
- ▶ A Native American, who is at least fifty percent American Indian blood and was born in Canada;

A Native American born in Canada may freely enter and reside in the U.S. and is considered to be lawfully admitted for permanent residence if s/he is of at least one-half American Indian blood. As such, s/he is considered a U.S. citizen for the purposes of Medicaid eligibility and coding. This does not include a non-citizen whose membership in an Indian tribe or family is created by adoption unless such person is at least fifty percent Indian blood.

NOTE: The tribal membership card demonstrates membership in a U.S. Federally recognized Indian Tribe. For the purposes of Medicaid eligibility, Medicaid will accept a tribal membership card, with a date of birth, as proof of age, identity and citizenship status.

References:

SSL Sect.	122 131-k
Dept. Reg.	349.3 360.3.2(j)
ADM	04 OMM/ADM-7
GIS	08 MA/009 05 MA/ 028

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS**

NATIVE AMERICANS

Documentation: The following items can be used to verify Native American status or membership in a federally recognized tribe

NOTE: Tribal documents are considered to be as reliable as a U.S. passport and are to be treated as “primary” documents. Additional identity documentation is not required.

Native American Indians born in Canada:

- ▶ I-94 coded “S1-3”;
- ▶ I-551 Permanent Resident Card stamped “S1-3”;
- ▶ Temporary I-551 stamp in a Canadian passport coded “S1-3”;
- ▶ Tribal Record or document certifying at least 50% American Indian blood, as required by Section 289 of the INA;
- ▶ Birth or Baptismal Certificate issued on a reservation or other satisfactory evidence of birth in Canada;

Member of federally recognized Native American tribe born outside of the U.S:

- ▶ A membership card or other tribal document demonstrating membership in a federally recognized Indian Tribe under Section 4 (e) of the Indian Self-determination and Education Assistance Act [25 U.S.C. §450b (e) and satisfactory evidence of birth outside the U.S].

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS**

NATIVE AMERICANS

Category	Documentation	WMS ACI CODE	Federal Financial Participation	SSN Requirement
Native Americans born outside the U.S. who belong to a federally recognized tribe	<ul style="list-style-type: none"> ▶ A membership card or other tribal document demonstrating membership in a federally recognized Indian Tribe under Section 4 (e) of the Indian Self-determination and Education Assistance Act [25 U.S.C. §450b (e)] and satisfactory evidence of birth outside the U.S. 	C	YES	YES
Canadian born Native Americans	<ul style="list-style-type: none"> ▶ I-94 coded "S1-3"; ▶ I-551 Alien Registration Card stamped "S1-3"; ▶ Temporary I-551 stamp coded S1-3 in a Canadian passport; ▶ Tribal Record or document certifying at least 50% American Indian blood, as required by Section 289 of the INA; and satisfactory evidence of birth in Canada, such as a birth certificate or baptismal Certificate issued on a reservation; 	C	YES	YES
Native Americans born in Canada	<ul style="list-style-type: none"> ▶ I-94 coded "S1-3"; ▶ I-551 Permanent Resident Card stamped "S1-3"; ▶ Temporary I-551 stamp coded S1-3 in a Canadian passport; ▶ Tribal Record or document certifying at least 50% American Indian blood, as required by Section 289 of the INA; and satisfactory evidence of birth in Canada, such as the following: <ul style="list-style-type: none"> -a Birth certificate or Baptismal Certificate issued on a reservation; -Letter from Canadian Department of Indian Affairs; or -School Records. 	C	YES	<p>For the purpose of Medicaid, Native Americans are classified as U.S. citizens.</p> <p>A SSN is an eligibility requirement for all citizens applying for Medicaid of FHP.</p> <p>Note: Pregnant women are excluded from this requirement.</p>
Native Americans belonging to a Federally recognized Tribe born outside the U.S.	<ul style="list-style-type: none"> -Membership card or other tribal document demonstrating (i.e., tribal card), membership in U.S. federally recognized Indian tribe under Section 4(e) of the Indian Self-Determination and Education Assistance Act and satisfactory evidence of birth outside the U.S. 	C	YES	

OTHER ELIGIBILITY REQUIREMENTS

SATISFACTORY IMMIGRATION STATUS

Description: Immigrants in satisfactory immigration status are otherwise eligible for Medicaid, Family Health Plus (FHPlus) and Child Health Plus (CHPlus) and include qualified aliens and persons permanently residing in the United States under color of law (PRUCOL).

Policy: All immigrants in satisfactory immigration status regardless of the date they physically entered into the United States can be eligible for Medicaid provided they meet all other eligibility requirements. The only difference is that Federal Financial Participation (FFP) should be claimed for some groups but must not be claimed for others or must not be claimed until the individual has resided in the United States as a qualified alien for five years (i.e., the Federal five-year ban).

- Qualified aliens who entered the U.S. prior to August 22, 1996 receive full Medicaid coverage with Federal Financial Participation (FFP);
- Certain qualified aliens who entered the U.S. on or after August 22, 1996 receive Medicaid coverage with FFP; and
- Certain qualified aliens who entered the U.S. on or after August 22, 1996, receive Medicaid coverage with State and local funds (FNP) until they have resided in the U.S. as a qualified alien for five years (five year ban).
- Persons permanently residing in the United States under color of law (PRUCOL) are eligible for Medicaid, provided they meet all other eligibility requirements. There is no Federal Financial Participation for this group. This means the federal government will not pay a share of their Medicaid costs. The shares are generally split 50% State/50% local. (Refer to the PRUCOL section of this document)

References:

Public Law	P.L. 100-202
SSL Sect.	122 131-k
Dept. Reg.	349.3 351.1 351.2 360-3.2(j)
ADMs	04 ADM 07 97 ADM-23 92 ADM-10

OTHER ELIGIBILITY REQUIREMENTS

SATISFACTORY IMMIGRATION STATUS

- 88 ADM-47
- 88 ADM-22
- 82 ADM-24

- INF 06 OMM INF-5

- GISs 09 MA/028
- 09 MA/009
- 98 MA/21
- 97 TA/DC022

Interpretation: Medicaid eligibility is based on whether the immigrant is in satisfactory immigration status and meets all the other requirements of the Medicaid program(s). Immigrants who are not in a satisfactory immigration status may be eligible for the treatment of an emergency medical condition.

Individuals who file United States Citizen Immigration Services (USCIS) applications and/or petitions at certain facilities have the option to receive an e-mail and/or text message informing them that USCIS has accepted their application or petition. The E-Notification does not constitute official notice of application acceptance; the A/R will receive an official notice of application acceptance (I-797) through the U.S. Postal Service. The e-mail or text message does not grant any type of immigration status or benefit and cannot be accepted or used as evidence that USCIS has granted the individual any immigration status or benefit. Receipt of the transmission cannot be used as supporting evidence of satisfactory immigration status for any Medicaid benefit.

SPECIAL NOTE: HOMELESS INDIVIDUALS

Homeless individuals often need assistance from the eligibility worker in obtaining acceptable proof of identity, citizenship or satisfactory immigration status. When the applicant is a homeless individual, it may be difficult for him/her to establish his or her identity, citizenship or immigration status. However, just because an individual is homeless, she/he still must be identified. Proving one's identity is a requirement of the Medicaid program. (See **OTHER ELIGIBILITY REQUIREMENTS IDENTITY**).

NOTE: If an individual is unable to verify his or her identity, citizenship or satisfactory immigration status, workers should not assume she/he is therefore eligible for coverage of an emergency medical condition.

OTHER ELIGIBILITY REQUIREMENTS**SATISFACTORY IMMIGRATION STATUS****“JOHN/JANE DOE”**

A Medicaid application submitted by a “John/Jane Doe” individual (i.e., an individual who is unable to verify his or her identity) should be evaluated in the same manner as any other Medicaid applicant, that is, these individuals are required to meet the same documentation requirements as any other Medicaid applicant. A true “John/Jane Doe” individual is not eligible for Medicaid coverage for the treatment of an emergency medical condition. Verification of identity is a requirement for this coverage and all other covered services. (See **OTHER ELIGIBILITY REQUIREMENTS** IDENTITY).

**OTHER ELIGIBILITY REQUIREMENTS
SATISFACTORY IMMIGRATION STATUS**

QUALIFIED ALIENS

Description: Immigrants considered “Qualified aliens” include the following:

- Persons lawfully admitted for permanent residence;
- Persons admitted as refugees;
- Persons granted asylum;
- Persons granted status as Cuban and Haitian entrants;
- Persons admitted as Amerasian immigrants;
- Persons whose deportation has been withheld;
- Persons paroled into the United States for at least one year;
- Persons granted conditional entry;
- Persons determined to be battered or subject to extreme cruelty in the United States by a family member;
- Victims of trafficking; or
- Veterans or persons on active duty in the Armed Forces and their immediate family members.

Policy: **QUALIFIED ALIENS WHO ENTERED THE U.S. PRIOR TO AUGUST 22, 1996:**

A qualified alien who entered the United States prior to August 22, 1996, may receive all care and services available under the Medicaid program, provided he or she is determined to be otherwise eligible. This provision includes individuals who attained qualified immigrant status subsequent to August 22, 1996, and who can demonstrate to the district’s satisfaction that they continuously resided in the United States until attaining qualified alien status. Federal Financial Participation (FFP) should be claimed for Medicaid provided to these qualified aliens.

QUALIFIED ALIENS WHO ENTERED THE U.S. ON OR AFTER AUGUST 22, 1996 AND ARE IN CERTAIN CATEGORIES EXEMPT FROM THE FEDERAL FIVE YEAR BAN ON MEDICAID:

The following qualified aliens who entered the United States on or after August 22, 1996, may receive all care and services available under the Medicaid program, provided they are determined to be otherwise eligible.

- Persons who have been granted asylum under Section 208 of the INA;

OTHER ELIGIBILITY REQUIREMENTS SATISFACTORY IMMIGRATION STATUS

QUALIFIED ALIENS

- Persons for whom deportation has been withheld under Section 243(h) or 241 (b) (3) of the INA;
- Cuban/Haitian entrants, as defined in Section 501(e) of the Refugee Education Assistance Act of 1980 (P.L. 96-422);
- Qualified immigrants lawfully residing in the State who are on active duty in the armed forces, or who have received an honorable discharge from the armed forces and their spouses and unmarried dependent children, who are also qualified aliens.

NOTE: Non-citizen veterans and Active Duty Military personnel and their spouses and children are exempt from most of the immigration status related restrictions under the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). For example they are eligible for Supplemental Security Income (SSI) and Food Stamps and are exempt from the five year ban.

- Refugees under Section 207 of the INA (including Amerasian immigrants admitted under the provisions of Public Law 100-202).
- Victims of a severe form of trafficking are qualified aliens who receive Medicaid to the same extent as refugees. A comprehensive discussion of this group is in the section “Victims of Trafficking” of this Reference Guide. Federal Financial Participation (FFP) should be claimed for Medicaid provided to these qualified aliens.

ALL OTHER QUALIFIED ALIENS WHO ARE NOT IN THE ABOVE TWO GROUPS:

This group of qualified aliens may receive all care and services available under the Medicaid program, provided s/he is determined to be otherwise eligible. However, for these individuals the date they physically entered the United States will determine whether or not Federal Financial Participation (FFP) is available. This date is called the “Date Entered Country” (DEC). During their first five years in the U.S. with a status as qualified alien, FFP is not available. The cost of their Medicaid coverage will be born solely by State and local shares (50% State/50% local). Once a qualified alien in this group has resided in the United States as a qualified alien for a period of five years, FFP will become available. This means the federal government will pay a share of their Medicaid costs.

Qualified aliens in this group include the following:

**OTHER ELIGIBILITY REQUIREMENTS
SATISFACTORY IMMIGRATION STATUS**

QUALIFIED ALIENS

- Persons lawfully admitted for permanent residence (i.e. LPRs-“green card holders”) under the Immigration and Nationality Act (INA);
- Persons paroled into the United States under Section 212(d)(5) of the INA for a period of at least one year;
- Persons granted conditional entry pursuant to Section 203(a)(7) Immigration and Nationality ACT (INA); and
- Persons who have been determined by the social services district to be in need of Medicaid as a result of being battered or subject to extreme cruelty in the United States by a spouse, parent, or by a member of the spouse’s or parent’s family residing in the same household as the alien family member at the time of the battering or extreme cruelty. (Refer to the section of this Reference Guide entitled “Battered Qualified Alien”)

References:	SSL Sect	122 131-k
	Dept Reg.	349.3 351.1 351.2 360-3.2 (j)
	ADMs	04 ADM 07 97 ADM 23 88 ADM 22 88 ADM 4 82 ADM 24
	INFS	06 INF-5

Interpretation: Applicants who meet the criteria above are considered to be in satisfactory immigration status and, if otherwise eligible, may receive all care and services provided by the Medicaid program.

Documentation: The following chart indicates examples of acceptable USCIS forms/documentation for qualified aliens who are in satisfactory immigration status.

**OTHER ELIGIBILITY REQUIREMENTS
SATISFACTORY IMMIGRATION STATUS¹**

QUALIFIED ALIENS

Category 2: Qualified Aliens

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
Native Americans born in Canada	<ul style="list-style-type: none"> ▶ I-94 coded "S1-3"; ▶ I-551 Permanent Resident Card stamped "S1-3"; ▶ Temporary I-551 stamp coded S1-3 in a Canadian passport; or ▶ Tribal Record or document certifying at least 50% American Indian blood, as required by Section 289 of the INA; and satisfactory evidence of birth in Canada, such as the following: <ul style="list-style-type: none"> - Birth certificate or Baptismal Certificate issued on a reservation; -Letter from Canadian Department of Indian Affairs; or -School Records. 	C	YES	<p>For the purposes of Medicaid, Native Americans are classified as U.S. citizens.</p> <p>An SSN is an eligibility requirement for all citizens applying for Medicaid or FHP.</p> <p>Note: Pregnant women are excluded from this requirement.</p>
Native Americans belonging to a Federally recognized Tribe born outside the U.S.	-Membership card or other tribal document demonstrating (I.E., tribal card), membership in federally recognized Indian tribe under Section 4(e) of the Indian Self-Determination and Education Assistance Act and satisfactory evidence of birth outside the U.S.	C	YES	
Refugees	<ul style="list-style-type: none"> ▶ I-94 or foreign passport with annotation "Section 207" of the INA or "Refugee" RE1, RE2, RE3, or RE4; ▶ I-551 coded R8-6, RE6, RE-7, RE-8, or RE-9; ▶ I-571 Refugee Travel Document; ▶ I-688B Employment Authorization Card annotated 8 C.F.R. 274a.12(a)(3); or ▶ I-766 Employment Authorization Document annotated "A3". 	R	YES	<p>Immigrants with or without work authorization are required to apply for a Social Security Number.</p> <p>LDSS must provide Immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility requirements for federal or state benefits, except for having an SSN. (08 OHIP INF-2)</p>
Asylees	<ul style="list-style-type: none"> ▶ I-94 or foreign passport annotated "granted Asylum under Section 208" of the INA, "Section 208" or "Asylee"; ▶ I-551 coded AS1, AS2, AS3, AS6, AS7 or AS8; ▶ I-571 Refugee Travel Document; ▶ I-688B Employment Authorization Card annotated 8 C.F.R. 274a.12(a)(5); ▶ I-766 Employment Authorization Document annotated "A5"; or ▶ Grant letter/order from the USCIS² Asylum Office or Immigration judge granting asylum. 	A	YES	<p>Note: Pregnant women are excluded from this requirement.</p>

**OTHER ELIGIBILITY REQUIREMENTS
SATISFACTORY IMMIGRATION STATUS
QUALIFIED ALIENS**

Category 2: Qualified Aliens continued

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
<p>Persons granted withholding of deportation or removal (Non-citizens whose deportation or removal has been withheld based on a finding that the person's life or freedom is threatened in the country of deportation based on race, religion, nationality, or membership in a particular social group or political opinion.)</p>	<ul style="list-style-type: none"> ▶ I-94 or foreign passport stamped "Section 243(h)" or "Section 241(b)(3)"; ▶ I-766 Employment Authorization Document annotated "A10"; ▶ Order issued by an immigration judge, the Board of Immigration appeals or a federal court showing the date that deportation was withheld under Section 243(h) of the INA, as in effect prior to April 1, 1997, or removal withheld under Section 241 (b)(3) of the INA. 	J	YES	<p>Immigrants with or without work authorization are required to apply for a Social Security Number.</p> <p>LDSS must provide Immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility requirements for federal or state benefits, except for having an SSN. (08 OHIP INF-2) Note: Pregnant women are excluded from this requirement.</p>
<p>Cuban/Haitian Entrants</p>	<ul style="list-style-type: none"> ▶ I-94 with annotation "Cuban-Haitian Entrant" Section 212(d)(5) of the INA, or CU6, CU7 or any other notation indicating "parole" under 212 (d)(5) on or after 10/10/80; and satisfactory evidence that the parolee has been a citizen of Cuba or Haiti; ▶ I-551 coded CU6, CU7, CH6, CN-P, LB-2, LB-6 or LB-7; ▶ Temporary I-551 stamp coded "CU-6" or "CU-7" in a foreign passport; ▶ I-688B Employment Authorization Card annotated 8 C.F.R. 274a.12(c)(8), and satisfactory evidence that the parolee has been a citizen of Cuba or Haiti; ▶ I-766 Employment Authorization Document annotated "C8" and satisfactory evidence that the parolee has been a citizen of Cuba or Haiti;; ▶ Order to Show Cause (OSC), I-221S, or Notice to Appear (NTA), I-862, indicating pending exclusion, removal or deportation proceedings and satisfactory evidence that the parolee has been a citizen of Cuba or Haiti; or ▶ Any document indicating pending asylum application or filing of I-589 Application for Asylum with satisfactory evidence on the document that the person has been a citizen of Cuba or Haiti 	H	YES	<p>Immigrants with or without work authorization are required to apply for a Social Security Number.</p> <p>LDSS must provide Immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility requirements for federal or state benefits, except for having an SSN (08 OHIP INF-2) Note: Pregnant women are excluded from this requirement.</p>

**OTHER ELIGIBILITY REQUIREMENTS
SATISFACTORY IMMIGRATION STATUS
QUALIFIED ALIENS**

Category 2: Qualified Aliens continued

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
Amerasians	<ul style="list-style-type: none"> ▶ I-94 Arrival/Departure Record of Vietnamese passport or exit visa stamped "AM1, AM2, AM3, AM6, AM7, or AM8"; ▶ I-551 Permanent Resident Card coded "AM1, AM2, AM3, AM6, AM7, or AM8"; ▶ Temporary I-551 stamp in Vietnamese passport "AM1, AM2, AM3, AM6, AM7, or AM8"; or ▶ I-571 Refugee Travel Document. 	R	YES	<p>Immigrants with or without work authorization are required to apply for a Social Security Number.</p> <p>LDSS must provide Immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility requirements for federal or state benefits, except for having an SSN. (08 OHIP INF-2)</p>
Victims of a Severe Form of Human Trafficking	<ul style="list-style-type: none"> ▶ I-94 Arrival/Departure Record coded T1, T2, T3, T4 or T5 stating admission under Section 212(d)(5) of the INA if status is granted for at least one year; ▶ Certification letter (for adults) or eligibility letter (for children) from the Office of Refugee Resettlement. Must call 1-866-401-5510 for verification; or ▶ I-797 Notice of Action acknowledging receipt of I-914, Application for T non-immigrant status. 	D Upstate R NYC	YES	<p>Note: Pregnant women are excluded from this requirement.</p>
Veterans (Immediate family members: documentation of relationship to veteran.)	<ul style="list-style-type: none"> ▶ DD Form 214 showing "Honorable" discharge; or ▶ Original or notarized copy of the veteran's discharge papers. 	V	YES	
Persons on active duty in the Armed Forces and their immediate family members	<ul style="list-style-type: none"> ▶ Military I.D. card -DD Form 2 (active); ▶ Original or notarized copy of current orders showing the person is on full-time duty in U.S. Armed Forces; <p>(Immediate family members must show documentation of relationship to the person on active duty.)</p>	M	YES	

**OTHER ELIGIBILITY REQUIREMENTS
SATISFACTORY IMMIGRATION STATUS
QUALIFIED ALIENS**

Category 2: Qualified Aliens continued

Please note: **Qualified Aliens who are Eligible for State Medicaid until becoming Eligible for Federal Medicaid after a 5 Year Waiting Period:** Qualified aliens listed below, who entered the U.S before August 22, 1996, are eligible for federal Medicaid, if otherwise eligible. However, qualified aliens in these four categories who entered the U.S. on or after August 22, 1996, are subject to the federal five year ban. This means that they are *not* eligible for federally funded Medicaid until they have resided in the U.S. for five years in a qualified alien status. Until becoming eligible for federally funded Medicaid, these qualified aliens are eligible for State funded Medicaid coverage of all medically necessary care and services, if they meet the program's other eligibility requirements. Districts must enter the appropriate State/federal charge codes to assure proper claiming of federal and State shares. For these individuals the date they physically entered the U.S. will determine whether or not Federal Financial Participation (FFP) is available. This date is called the "Date Entered Country" (DEC). During their first five years in the U.S the cost of their Medicaid coverage will be born solely by the State and local share (50% State/50% local). Once a qualified alien in this group has resided in the United States as a qualified alien for a period of five years, FFP will become available. This means the federal government will pay a share of their Medicaid costs.

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
Lawful Permanent Residents (LPRs or "green card" holders)	<ul style="list-style-type: none"> ▶ I-94 Arrival/Departure Record or foreign passport stamped I-551; ▶ I-551 Lawful Permanent Resident Card "green card"; ▶ I-327 Re-entry permit; or ▶ I-181 Memorandum of Creation of Record of Lawful Permanent Residence with approval stamp. 	K (without 40 quarters) S (with 40 quarters)	YES After 5 yrs in a qualified status	Immigrants with or without work authorization are required to apply for a Social Security Number. LDSS must provide Immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility requirements for federal or state benefits, except for having an SSN. (08 OHIP INF-2)
Parolees admitted into the U.S. for at least one year (Non-citizen who have been allowed to come into the U.S. for humanitarian or public interest reasons.)	<ul style="list-style-type: none"> ▶ I-94 Arrival/Departure Record with annotation "Paroled Pursuant to Section 212(d)(5)" or "parole" or "PIP" or "public interest" with the date of entry and date of expiration indicating at least one year; ▶ I-688B Employment Authorization Card annotated " 8 C.F.R. 274a.12(a)(4) or 274a.12(c)(11)"; or ▶ I-766 Employment Authorization Document annotated "A4" or "C11". 	G	YES After 5 yrs in a qualified status	Note: Pregnant women are excluded from this requirement.
Conditional Entrants (Status granted to refugees before 1980.)	<ul style="list-style-type: none"> ▶ I-94 Arrival/Departure Record stamped Section 203(a)(7), or otherwise indicating status as a conditional entrant;; ▶ I-688B Employment Authorization Card annotated "8 C.F.R. 274a.12(a)(3)"; or ▶ I-766 Employment Authorization Document annotated "A3". 	F	YES After 5 yrs in a qualified status	

**OTHER ELIGIBILITY REQUIREMENTS
SATISFACTORY IMMIGRATION STATUS**

QUALIFIED ALIENS

Category 2: Qualified Aliens continued

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
<p>Victims of Battery/Abuse</p> <p>The term “battered qualified alien” includes the following immigrants described at 8 U.S.C. §1641(c):</p> <ul style="list-style-type: none"> • an alien who has been battered or abused in the U.S. by a spouse or parent, or by a member of the spouse’s or parent’s family residing in the same household as the alien; or • the parent of a battered or abused child; or • the child of a battered or abused parent. <p>A substantial connection must also exist between the battery or abuse and the need for public benefits such as Medicaid. The alien must no longer be living with the batterer or abuser.</p>	<p>A variety of documents provide evidence that an alien meets this definition.</p> <ul style="list-style-type: none"> ▶ I-797 Notice of Action indicating that the alien has an <u>approved</u> I-360 self petition (Do NOT refer to DVL); ▶ I-797 Notice of Action indicating that the alien has a pending I-360 self petition that has established a prima facie case (Do NOT refer to DVL); ▶ Order from the Executive Office for Immigration Review (“EOIR”) granting or finding a prima facie case for granting, suspension of deportation or cancellation of removal. (Do NOT refer to DVL); or ▶ I-797 Notice of Action indicating that the alien has a pending I-360 self petition AND credible evidence of battery or abuse (Request permission to refer to DVL); or ▶ I-797 Notice of Action indicating the alien is the beneficiary of a <u>pending or approved</u> I-130 petition and credible evidence of battery and/or abuse (Request permission to refer to DVL); or ▶ I-94 coded K3, K4, V1, V2 or V3 and credible evidence of battery or abuse (Request alien’s permission to refer to DVL); or ▶ Any other USCIS document indicating the alien has a K or V visa and a pending or approved I-130 petition with credible evidence of battery or abuse. (Request permission to refer to DVL); or 	<p>B</p>	<p>YES</p> <p>After 5 yrs in a qualified status</p>	<p>Immigrants with or without work authorization are required to apply for a Social Security Number.</p> <p>LDSS must provide Immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility requirements for federal or state benefits, except for having an SSN. (08 OHIP INF-2)</p> <p>Note: Pregnant women are excluded from this requirement.</p>

Continued on next page

**OTHER ELIGIBILITY REQUIREMENTS
SATISFACTORY IMMIGRATION STATUS**

QUALIFIED ALIENS

Category 2: Qualified Aliens continued

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
(from previous page)	(from previous page) ► I-94 or Foreign passport annotated CR1, CR2, CR6, CR7 with credible evidence of battery and/or abuse (Request permission to refer to DVL); or; ► I-688B Employment Authorization Card annotated:274a.12(a)(9)-spouse/children of USC or LPR (K or V visa); 274a.12(a)(15)-spouses and dependents of LPR (K or V visa); 274a.12(c)(10)-applicant for suspension of deportation with credible evidence of battery or abuse (Request alien’s permission to refer to DVL); or ; ► I-766 Employment Authorization Document annotated A9, A15 or C10 with credible evidence of battery and/or abuse (Request alien’s permission to refer to DVL).			

NOTE: Referral to a domestic violence liaison (DVL): Medicaid-only offices may refer alien applicants and recipients who must demonstrate that they are credible victims of domestic violence to be considered qualified for Medical assistance as “battered aliens” to the DVL for a credibility assessment. Those applicants and recipients who cannot document eligibility in any other category and cannot document that the United States Citizenship and Immigration Services (USCIS) or immigration court has determined the alien has in fact been subject to battery or extreme cruelty will need to see the district/s DVL for a credibility determination. If districts are unable to verify that an acceptable immigration document has been filed with USCIS, districts can accept the alien’s written attestation and then refer the alien to an immigration attorney or legal services for assistance. The DVL does not have the authority to determine eligibility for assistance.

REVISED 03/03/08

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS
QUALIFIED ALIENS**

BATTERED QUALIFIED ALIENS

Description: An immigrant who, or whose child or parent, has been battered or subjected to extreme cruelty in the United States by a U.S. citizen or lawful permanent resident spouse or parent can be considered a qualified alien. An immigrant whose child has been battered/abused by the child's U.S. citizen or lawful permanent resident other parent is similarly eligible, as are immigrant children, whose parent has been abused by the parent's U.S. citizen or lawful permanent resident spouse residing in the same household. The immigrant can be considered a qualified alien when it is determined that there is substantial connection between the battery, abuse or cruelty and the need for benefits.

Policy: Battered immigrants are considered qualified aliens and are said to be in satisfactory immigration status.

References:

SSL	Sect. 122 131-k
Dept Reg.	349.3 351.1 351.2 360-3.2(j)
ADMs	04 ADM-7 97 ADM-23 92 ADM-10 88 ADM-47 88 ADM-22 88 ADM-24
INFs	06 OMM-INF-5
GISs	08 MA/009

Interpretation: Battery or extreme cruelty is defined as including, but not limited to, being a victim of any act or threatened act of violence, including forceful detention, which results or threatens to result in physical or mental injury or psychological or sexual abuse or exploitation, including rape, molestation, incest, or forced prostitution.

**OTHER ELIGIBILITY REQUIREMENTS
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QUALIFIED ALIENS**

BATTERED QUALIFIED ALIENS

Immigrant victims of battery/abuse can be treated as a “qualified alien” for Medical Assistance benefit purposes if they meet the following four requirements:

1. Be a credible victim of battery/abuse or extreme cruelty, who or who’s child or parent has been battered, abused or subject to extreme cruelty in the U.S., by a spouse or a parent, or by a member of the spouse’s or parent’s family residing in the same household; and
2. Be able to show a substantial connection between the need for benefits sought and the battery or extreme cruelty; and
3. No longer resides in the same household as the abuser, and
4. Have an appropriate immigration status including a pending or approved I-130 petition for a alien relative (K or V visa status), a pending or approved I-360 self petition, or Notice of Prima Facie Case determination (I-797 Notice of Action), or an Executive Office for Immigration Review (EOIR) order/letter granting suspension or cancellation under 8 U.S.C 1229b(b)(2) and 8 U.S.C. 1254(a)(3) or evidence that an application for suspension of deportation/cancellation of removal has been made with evidence that sets forth a prima facie case.

EVIDENCE OF ABUSE:

An applicant who has an approved petition or court order granting him/her protection from the abuser has already shown battery or extreme cruelty and a new determination should not be made by the eligibility worker. Other evidence of battery/abuse that immigrants may present includes, but is not limited to: reports or affidavits from police, judges, court officials, medical personnel, school officials, clergy, social workers; counseling or mental health personnel; proof of a domestic violence conviction, and proof of seeking safe-haven in a battered shelter.

SUBSTANTIAL CONNECTION:

There must be a substantial connection between the battery/abuse or extreme cruelty to which the immigrant, immigrant's child, or immigrant child's parent has been subjected to and the need for the medical assistance. The following list demonstrates circumstances in which a substantial connection exists between the battery and the need for medical assistance benefits:

- where the benefits are needed to enable the immigrant, immigrant's child, or an immigrant child's parent to become self-sufficient following separation from the abuser;

**OTHER ELIGIBILITY REQUIREMENTS
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BATTERED QUALIFIED ALIENS

- where the benefits are needed to enable the immigrant, immigrant's child, or an immigrant child's parent to escape the abuser and/or the community in which the abuser lives and to ensure safety;
- where the benefits are needed due to a loss of financial support resulting from the immigrant's separation from the abuser;
- where the benefits are needed because the battery/abuser or extreme cruelty, separation from the abuser, work absences, or lower job performance resulting from the abuse or court-related proceeding cause the immigrant, the immigrant's child, or immigrant child's parent to leave or lose employment;
- where the benefits are needed because the battery/abuse or extreme cruelty has caused the immigrant, the immigrant's child, or immigrant child's parent to require medical attention/counseling or become disabled;
- where the benefits are needed because of the loss of a dwelling or source of income or because fear of the battery/abuse after separation diminishes the immigrant's, or immigrant child's parent's ability to care for the children;
- where the benefits are needed to alleviate nutritional risks and needs following battery/abuse and/or after separation;
- where the benefits are needed to provide medical care during pregnancy resulting from sexual assault or the relationship with the abuser; and
- where medical coverage or health care services for the immigrant, the immigrant's child, or immigrant child's parent are needed to replace the services provided while living with the abuser.

NON-RESIDENCY WITH THE BATTERER:

The following examples will serve as credible evidence to support the claim of non-residency with the batterer and include, but are not limited to:

- a civil protection order requiring the batterer to stay away from the battered immigrant, immigrant child, or immigrant child's parent;

**OTHER ELIGIBILITY REQUIREMENTS
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QUALIFIED ALIENS**

BATTERED QUALIFIED ALIENS

- an eviction notice removing the batterer from the immigrant's residence;
- employment records;
- utility receipts;
- school records;
- hospital or medical bills;
- rental records from a building or property manager;
- affidavit from a staff member at a battered or homeless shelter
- affidavits from witnesses, including landlords and neighbors; and
- any other records establishing that the immigrant, immigrant's child, or immigrant child's parent no longer resides with the abusive abuser.

NOTE: Districts should be cautioned that they should not contact the abuser for any verification or documentation of living arrangements or other factors of eligibility.

Information with respect to victims of domestic violence must not be released to any outside party or other governmental agencies unless the information is required to be disclosed by law, or unless authorized in writing by applicant/recipient. Districts need to be concerned about how information is shared (i.e., insure that information pertaining to good cause or domestic violence is mailed to the victims' homes). Notices and other information may be mailed to an alternate mailing address (i.e., shelter) or held at district office. The client must decide the safest way to obtain the information.

REFERRAL TO A DOMESTIC VIOLENCE LIAISON (AVL):

Battered Immigrants are "qualified aliens" and may receive Medical Assistance benefits if all of the following criteria are met, including financial requirements: A battered qualified alien must be:

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS
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BATTERED QUALIFIED ALIENS

- an alien who has been battered or subjected to extreme cruelty (“abused”) in the U.S. by a spouse or parent or by a member of the spouse’s or parent’s family residing in the same household as the alien; or
- the parent of a battered or abused child; or
- the child of a battered or abused parent.

Applicants and recipients who cannot document that the United States Citizenship and Immigration Services (USCIS) or immigration court has determined the immigrant has in fact been subject to battery/abuse or extreme cruelty will need to see the district’s DVL for a credibility determination. These individuals must demonstrate that they are credible victims of domestic violence in order to be considered qualified for Medical Assistance as a “battered qualified alien”. If districts are unable to verify that an acceptable immigration document has been filed with USCIS, districts can accept the alien’s written attestation and then refer the alien to an immigration attorney or legal services for assistance. The DVL does not have the authority to determine eligibility for assistance.

VERIFICATION OF IMMIGRATION STATUS:

Battered or abused aliens will typically possess one or more of the following documents:

- I-797 Notice of Action indicating that the alien has an approved I-360 self-petition (entitled Petition for Amerasian, Widow(er) or Special Alien) under the Violence Against Women Act (VAWA) to obtain lawful permanent residence status as the battered or abused spouse or child of a U.S. citizen or lawful permanent resident [Do not refer to the domestic violence liaison (DVL)]; or
- I-797 Notice of Action indicating that the alien has a pending I-360 self-petition under VAWA that has established the alien’s prima facie eligibility for obtaining lawful permanent resident status as the battered or abused spouse or child of a U.S. citizen or lawful permanent resident (Do not refer to the DVL); or
- Order from the Executive Office for Immigration Review (EOIR) granting or finding a prima facie case for granting, suspension of deportation or cancellation of removal based on battery or abuse by a U.S. citizen or lawful permanent resident spouse or parent (Do not refer to the DVL); or
- I-797 Notice of Action indicating that the alien has a pending I-360 self-petition under VAWA to established lawful permanent resident status as the battered or abused spouse or child of a U.S. citizen or lawful permanent resident and credible evidence of battery or abuse (Request alien’s permission to refer to the DVL); or

**OTHER ELIGIBILITY REQUIREMENTS
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BATTERED QUALIFIED ALIENS

- I-797 Notice of Action indicating that the alien is the beneficiary of a pending or approved I-130 Petition for Alien Relative as the battered or abused spouse or child of a U.S. citizen or lawful permanent resident **and** credible evidence of battery or abuse (Request alien's permission to refer to the DVL); **or**
- I-94 Arrival/Departure Record stamped "K3", "K4", "V1", "V2", or "V3" and credible evidence of battery or abuse (Request alien's permission to refer to the DVL); **or**
- Any other USCIS document indicating that the alien has a "K" or "V" visa and a pending or approved I-130 Petition for Alien Relative and credible evidence of battery or abuse (Request alien's permission to refer to the DVL); **or**
- I-94 Arrival/Departure Record or foreign passport stamped "CR-1", "CR-2", "CR-6" or "CR-7" **and** credible evidence of battery or abuse (Request alien's permission to refer to the DVL); **or**
- I-688B Employment Authorization Card coded "274a.12(a)(9)," "274a.12(a)(15)" or "274a.12(c)(10)" **and** credible evidence of battery or abuse (Request alien's permission to refer to the DVL); **or**
- I-766 Employment Authorization Document coded "A9", "A15" or "C10" **and** credible evidence of battery or abuse (Request alien's permission to refer to the DVL).

Districts must determine if the USCIS or the EOIR has approved an applicant's I-360 self-petition or has found that an applicant's pending petition set-forth a prima facie case by reviewing the applicant's documents.

- The worker must carefully examine the documents provided by the immigrant applicant.
- If based on the documentation provided to show citizenship, immigration or qualified alien status the worker can conclude that the applicant is not a "qualified alien" (i.e. the applicant presents documents such as a tourist visa or other documents that do not make them eligible for Medical Assistance), the worker does not need to verify the applicant's status.
- If the documentation provided does not appear on its face to be genuine or does not appear to relate to the person presenting it, this should not serve as a basis to conclusively deny benefits without first checking with the USCIS. (Through SAVE or by filing a G-845 "Verification Request" [non-SAVE agencies] with USCIS. Refer to 04 ADM-7).

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS
QUALIFIED AIENS**

BATTERED QUALIFIED ALIENS

- If the USCIS notifies the applicant that they have an immigration status that makes him/her a qualified alien the eligibility worker should accept the USCIS verification and proceed to determine whether the applicant satisfies the remaining program requirements. If the USCIS notifies the applicant that she/he does not have immigration status that makes him/her a qualified alien, the worker should notify the applicant of her appeal rights.

If the applicant is a battered immigrant and the documentation provided does not appear on its face to be genuine or does not appear to relate to the person presenting it, the worker should contact the Immigration Court that is handling the case or the USCIS Vermont Service Center at 75 Lower Welden Street, Saint Albans, Vermont, 05479.

THE FIVE YEAR BAN TO BENEFITS ACCESS:

Battered immigrants who first entered the United States after 8/22/96 and become "qualified aliens" are not eligible to receive federal Medical Assistance benefits until they have attained five years in a qualified alien status. This is called the federal "five year bar." This bar applies to all immigrants who entered the United States after 8/22/96.

New York State covers "battered" qualified aliens with State only funds until the five-year ban expires.

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS
QUALIFIED ALIENS**

BATTERED QUALIFIED ALIENS

SOCIAL SECURITY NUMBERS (SSNs) FOR BATTERED QUALIFIED ALIENS:

The Social Security Administration (SSA) does not routinely assign new SSNs. However, SSA will do so when evidence shows the immigrant is being harassed, a victim of family violence, abused or their life is endangered.

Qualified aliens must provide a social security number. If they do not have a SSN, they must apply for one. An exception applied to pregnant women. Pregnant women are not required to provide or apply for a SSN for the duration of the pregnancy and the sixty-day period that begins on the last day of the pregnancy and including, but not exceeding, the last day of the month in which the sixty-day post-partum period ends.

If a qualified alien applies for a SSN, but is denied a SSN based on immigration status, the alien is not required to reapply for a SSN until his or her status changes. In these situations districts are to use WMS Social Security Code N, "State Benefits Eligible Alien".

ALIEN NUMBER (A#) REQUIREMENT FOR BATTERED QUALIFIED ALIENS:

Providing an alien registration number is no longer an eligibility requirement for Public Assistance, Medical Assistance or Food Stamp Assistance for battered aliens (ACI Code "B"). This change is a result of MKB litigation.

Although not required, if an alien number is presented by the applicant/recipient, the alien number should be entered into the Welfare Management System (WMS).

BATTERED QUALIFIED ALIENS DESK AID

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
<p>Victims of Battery/Abuse</p> <p>The term “battered qualified alien” includes the following immigrants described at 8 U.S.C. §1641(c):</p> <ul style="list-style-type: none"> ▪ an alien who has been battered or abused in the U.S. by a spouse or parent, or by a member of the spouse’s or parent’s family residing in the same household as the alien; or • the parent of a battered or abused child; or • the child of a battered or abused parent. <p>A substantial connection must also exist between the battery or abuse and the need for public benefits such as Medicaid. The alien must no longer be living with the batterer or abuser.</p>	<p>A variety of documents provide evidence that an alien meets this definition.</p> <ul style="list-style-type: none"> ▶ I-797 Notice of Action indicating that the alien has an approved I-360 self petition (Do not refer to DVL); ▶ I-797 Notice of Action indicating that the alien has a pending I-360 self-petition that has established a prima facie case (Do not refer to DVL); ▶ Order from the Executive Office for Immigration Review (“EOIR”) granting or finding a prima facie case for granting, suspension of deportation or cancellation of removal (Do not refer to DVL); or ▶ I-797 Notice of Action indicating that the alien has a pending I-360 self petition AND credible evidence of battery or abuse (Request alien’s permission to refer to DVL); or ▶ I-797 Notice of Action indicating the alien is the beneficiary of a pending or approved I-130 petition and credible evidence of battery and/or abuse (Request alien permission to refer to DVL); or ▶ I-94 coded, K3, K4, V1 V2 or V3 and credible evidence of battery or abuse (Request alien’s permission to refer to DVL); or ▶ Any other USCIS document indicating the alien has a K or V visa and a pending or approved I-130 petition with credible evidence of battery or abuse (Request alien’s permission to refer to DVL); or ▶ I-94 or Foreign passport annotated CR1, CR2, CR6, CR7 with credible evidence of battery or abuse (Request alien’s permission to refer to DVL); or ▶ I-688B Employment Authorization Card annotated 274a.12(a)(9)-spouse/children of USC or LPR (K or V visa), 274a.12(a)(15)-spouses and dependents of LPR (K or V visa), 274a.12(c)(10)-applicant for suspension of deportation with credible evidence of battery or abuse (Request alien’s permission to refer to DVL); or ▶ I-766 Employment Authorization Document annotated A9, A15 or C10 with credible evidence of battery or abuse (Request alien’s permission to refer to DVL). 	<p>B</p>	<p>YES</p> <p>After 5 yrs in a qualified status</p>	<p>Immigrants with or without work authorization are required to apply for a Social Security Number.</p> <p>LDSS must provide immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility requirements for federal or state benefits, except for having an SSN. (08 OHIP INF-2)</p> <p>Note: Pregnant women are excluded from this requirement.</p>

NOTE: Referral to a domestic violence liaison (DVL): Medicaid-only offices must refer alien applicants and recipients who must demonstrate that they are credible victims of domestic violence to be considered qualified for medical assistance as “battered aliens” to the DVL for a credibility assessment. Those applicants and recipients who cannot document eligibility in any other category and cannot document that the United States Citizenship and Immigration Services (USCIS) or immigration court has determined the alien has in fact been subject to battery or extreme cruelty will need to see the district’s DVL for a credibility determination. If districts are unable to verify that an acceptable immigration document has been filed with USCIS, districts can accept the alien’s written attestation and then refer the alien to an immigration attorney or legal services for assistance. The DVL does not have the authority to determine eligibility for assistance.

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS
QUALIFIED ALIENS**

REFUGEE MEDICAL ASSISTANCE (RMA)

Description: A refugee is an individual who comes to the United States because he/she faces persecution or fear of persecution in his/her home country. New York State provides the services of resettlement agency case workers to help refugees in applying for short-term cash and medical assistance upon arrival in the United States. The program under which this service/support is provided is known as Refugee Cash Assistance (RCA) and Refugee Medical Assistance (RMA).

Policy: The Refugee Medical Assistance (RMA) Program is primarily limited to refugees who are single or childless couples (S/CCs) who are not living with a dependent child, are not pregnant, or certified blind or disabled and who:

- Are eligible for or receiving Safety Net Assistance (SNA); or
- Are financially ineligible for Medicaid Under the S/CC category of assistance or FHPlus; and
- Meet immigration status and identification requirements set forth below; and
- Provide the name of the resettlement agency which resettled them, if he/she is a refugee or entrant; and
- Are not full-time students in an institution of higher education, except where such enrollment is expected to be approved as part of an individual employability plan.

References:

SSL Sect.	358 (3)
Dept. Reg.	373-2
ADMs	05 OTDA/ADM-01
INFs	10 OHIP/INF-2 06 OMM/INF-5

Interpretation: The term refugee includes the following groups: Refugees, Asylees, Cuban and Haitian Entrants and Amerasians. Aliens who are considered “refugees” for the purpose of Medicaid eligibility also include federally certified victims of a severe form of human trafficking, certain family members of certified trafficking victims, and Special Immigrant Visa Holders (SIV) from Afghanistan and Iraq.

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS
QUALIFIED ALIENS**

REFUGEE MEDICAL ASSISTANCE (RMA)

Eligibility for RMA is based on the applicant's income on the date of application. The LDSS must NOT average income prospectively for the application-processing period to determine income eligibility for RMA. A sponsor's income (solely because the person is serving as a sponsor), in-kind services and shelter provided to an applicant by a sponsor or resettlement agency and any cash grant received by the applicant from the United States Department of State or Department of Justice during the initial 30-day Reception and Placement Program period are exempt in determining the applicant's eligibility. All other Medicaid rules and regulations apply in determining eligibility under RMA.

NOTE: Match grants provided to an applicant by a voluntary agency under direct agreement with the Office of Refugee Resettlement (ORR) must be counted in determining eligibility. However, a Match grant should not cause the individual to be ineligible for Medicaid.

Eligibility is first determined for S/CC. If the individual is not eligible as an S/CC, then eligibility under FHPlus is determined. If the applicant is not eligible as an S/CC or under FHPlus, an ADC budget is performed and the S/CC is allowed to spend-down to the Medically Needy Income Level.

If a refugee who is receiving RMA receives new or increased earnings from employment after eligibility for RMA has been determined, the increased earning will not affect his/her continued RMA eligibility.

If during the initial eligibility period an individual who is receiving "regular" Medicaid becomes ineligible for "regular" Medicaid due to increased earnings, the individual must be transferred to RMA without an RMA eligibility re-determination. This includes refugees receiving Medicaid through Family Assistance (FA) Program or under Low Income Family (LIF) category of assistance. However, before transferring the individual to RMA, the case must first be evaluated for eligibility under Transitional Medical Assistance (TMA).

Should earnings/income decrease during the initial eligibility period, eligibility must be redetermined. If the individual is now eligible under regular Medicaid or FHPlus, authorize coverage as appropriate. If the individual continues to be ineligible under regular Medicaid or FHPlus, as an S/CC, but the decrease in earnings/income results in a decrease

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS
QUALIFIED ALIENS**

REFUGEE MEDICAL ASSISTANCE (RMA)

in the excess income amount under the ADC-related budget, notify the individual of his/her decrease in excess income.

NOTE: Refugee families with children can receive RMA during their first eight months in the U.S. only if they become ineligible for the State's "regular" State Plan Medicaid Program.

Disposition: The following refugees are eligible for RMA for the time periods specified:

- Refugees, Cuban/Haitian entrants and Amerasian immigrants are eligible for eight months from the date of arrival into the United States.
- Asylees are eligible for eight months from the date that asylum status is granted.
- Trafficking victims are eligible for RMA benefits for eight months from the date indicated in the certification letter (for adults) or eligibility letter (for children) issued by the ORR.
- Certain family members of victims of a severe form of human trafficking are eligible for eight months from the date they acquired the Derivative T-Visa status:
 - For family members who received the Derivative T-Visa in the United States, the date of eligibility for RMA benefits is the notice date found on the I-797 Notice of Action.
 - For family members who enter the United States with a Derivative T-Visa, the date of eligibility is the date the individual entered the country which is stamped on the individual's passport or I-94 Arrival/Departure Record.
- Iraqi/Afghan Special Immigrant Visa Holders' eligibility continues for eight months from the date they entered the U.S. or, if already in the U.S., for eight months from the date that they acquired their Special Immigrant Status.

Documentation: RMA applicants must provide proof of his/her immigration status including, as appropriate, Arrival/Departure Record (I-94), Permanent Resident Card (I-551), or a USCIS Notice of Action (I-797). The various immigration statuses that may be found on the immigration documents include:

- Admitted as a conditional entrant under Section 203 (a) (7) of the Immigration and Nationality Act (INA).
- Admitted as a refugee under Section 207 of the INA.

**OTHER ELIGIBILITY REQUIREMENTS
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QUALIFIED ALIENS**

REFUGEE MEDICAL ASSISTANCE (RMA)

- Granted asylum under Section 208 of the INA.
- Any national of Cuba or Haiti granted parole status as a Cuban/Haitian Entrant (status pending) or granted any other special status subsequently established under the immigration laws for nationals of Cuba or Haiti, regardless of the status of the individual at the time assistance or services are provided.
- Any other national of Cuba or Haiti who:
 - Was paroled into the U.S. and has not been given any other status under the INA; or is facing exclusion or deportation proceedings under the INA; or has an application for asylum pending with the USCIS; and
 - With respect to whom a final, non-appealable, and legally enforceable order of deportation or exclusion has not been entered.
- Amerasian immigrants (aliens who were born in Vietnam after January 1, 1962 and before January 1, 1976, and whose fathers were U.S. citizens and such alien's spouses or minor children) who are admitted to the U.S. as immigrants pursuant to Section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988 (as contained in Section 101 (d) of Public Law 100-202 and as amended by Public Law 100-461).
- Adjusted to permanent resident status from one of the previously held eligible statuses described above.
- Office of Refugee Resettlement documentation for trafficking victims, as described in 06 OMM/INF-5. There are two categories of trafficking victims:
 - Adult (18 years of age or older) victims of a severe form of human trafficking who are certified by ORR of the Federal Department of Health and Human Services. These individuals must submit the original certification letter to the LDSS. This letter is used instead of USCIS documents; and
 - Children younger than 18 years of age do not have to be certified but are issued an eligibility letter by the ORR stating that they are eligible for benefits as victims of a severe form of human trafficking.

The ORR certification or eligibility letter is proof of the alien's immigration status. However, the Medicaid worker must call the Trafficking Verification Line (1-866-401-5510) to verify the document(s).

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS
QUALIFIED ALIENS**

REFUGEE MEDICAL ASSISTANCE (RMA)

Certain family members of victims of a severe form of trafficking are also eligible for RMA benefits and services to the same extent as refugees. These individuals will have either a T-2, T-3, T-4 or T-5 visa, which is referred to as a Derivative T-Visa. Derivative T-Visas may be issued while the immigrant is in the U.S. or an individual may be issued a Derivative T-Visa upon entering the U.S.

- Iraqi and Afghan Special Immigrant Visa Holders (SIV) category/code "SI" will be stamped in the foreign passport or appear on the I-551-Lawful Permanent Resident Card ("green card").

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS
QUALIFIED ALIENS**

**U.S. ARMED FORCES
ACTIVE DUTY AND VETERANS**

Description: Qualified aliens who are on active military duty or who are veterans are eligible for Medical Assistance, if they are otherwise eligible.

Policy: Medicaid may be authorized for a qualified alien who is on active duty or who is a veteran of the U.S. Armed Forces, provided that s/he is otherwise eligible.

References: Balanced Budget Act of 1997

SSL Sect. 122

Dept Reg. 349.3
351.1
351.2
360-3.2(j)

ADMs 04 ADM-7

INF 06 INF-5

GISs 08 MA/009

Interpretation: Active Military Duty-The individual must be on full-time duty in the Army, Navy, Air Force, Marine Corps, or Coast Guard. Active Duty for training and full time National Guard duty are not included in this interpretation.

Medicaid is also provided to the immigrant's spouse and unmarried dependent children who are qualified aliens.

Veterans - The veteran's discharge must have been characterized as "honorable", and not because of his or her immigration status. Medicaid is also provided to the veteran's qualified alien's spouse, including his or her un-married surviving spouse if the veteran is deceased, and any unmarried dependent children of the veteran who are qualified aliens.

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS
QUALIFIED ALIENS**

**U.S. ARMED FORCES
ACTIVE DUTY AND VETERANS**

NOTE: The Balanced Budget Act of 1997 provided that Hmong and other Highland Lao veterans who fought on behalf of the Armed Forces of the United States during the Vietnam conflict and have been lawfully admitted to the United States for permanent residence are to be considered veterans for the purpose of this provision.

Documentation: U.S. ARMED FORCES-ACTIVE DUTY AND VETERANS

Category 2: Qualified Aliens Continued

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
Veterans (Immediate family members: documentation of relationship to veteran or person on active duty)	<ul style="list-style-type: none"> ▶ DD Form 214 showing "Honorable" discharge; or ▶ Original or notarized copy of the veteran's discharge papers. 	V	YES	YES Immigrants with or without work authorization are required to apply for a Social Security Number. LDSS must provide immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility requirements for federal or state benefits, except for having an SSN. (08 OHIP INF-2) Note: Pregnant women are excluded from this requirement.
Persons on active duty in the Armed Forces and their immediate family members	<ul style="list-style-type: none"> ▶▶ Military I.D. card – DD Form 2 (active); ▶ Original or notarized copy of current orders showing the person is on full-time duty in U.S. Armed forces; <p>(Immediate family members must show documentation of relationship to the person on active duty.)</p>	M	YES	

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS
QUALIFIED ALIENS**

VICTIMS OF TRAFFICKING

Description: The federally eligible immigration category, “victims of a severe form of trafficking”, Section 107(b) of The Trafficking Victims Protection Act of 2000 (P.L. 106-386) makes victims of “a severe form of trafficking in persons” eligible for Medicaid and other benefits (if otherwise eligible) to the same extent as an alien who is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act (INA).

Policy: Victims of “a severe form of trafficking in persons” (VOTs) are eligible for Medicaid and other benefits (if otherwise eligible) to the same extent as an alien who is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act. Individuals with letters of certification or eligibility as victims of severe forms of trafficking are eligible for medical assistance. They retain this eligibility for seven years from the date of certification contained in the letter.

References:	The Trafficking Victims Protection Act of 2000	Sect.107(B) P.L. 106-386
	The Trafficking Victims Reauthorization Protection Act of 2003	P.L. 108-193
	Chapter 74 of the Laws of 2007	
	Dept. Regs.	360.3.2 (j)
	ADMs	09 ADM-01(OTDA) 04-OMM/ADM-7 03-ADM-1(OTDA)
	INF	06 OMM INF-5
	GIS	10 MA/002 08 MA/009

Interpretation: A “victim of a severe form of trafficking in persons” means a person:

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS
QUALIFIED ALIENS**

VICTIMS OF TRAFFICKING

- 1) Who has been subjected to a “severe form of trafficking in persons,” which is defined as “sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; or the recruitment, harboring, transportation, provision, or obtaining a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery”; and
- 2) Who has not attained the age of 18 years or who is the subject of a certification issued by the federal government pursuant to Section 107(b)(1)(E) of the Act.

For individuals who meet the above criteria, the Office of Refugee Resettlement (ORR) will issue the certification letters for adults and the eligibility letters for children. To receive a certification or a letter, a victim of trafficking must be willing to assist with the investigation and prosecution of trafficking cases AND either:

- (1) Have made a bona fide application for a “T” visa that has not been denied. **OR**
- (2) Be an individual whose continued presence the Attorney General is ensuring to effectuate a Trafficking prosecution.

When a victim of trafficking applies for Medicaid, local districts must follow their normal procedures for establishing Medicaid eligibility for refugees. Local districts must also:

1. Accept the certification letter for adults, or eligibility letter for children in place of USCIS documentation. **Please note, as of November 6, 2001, certification letters for adults and eligibility letters for children no longer contain an eight-month expiration date.** Victims of severe forms of trafficking do not need to provide any other documentation of their immigration status. The local district must call the trafficking verification line at 1-866-401-5510 to verify the validity of the documentation.
2. Use the certification date as the “Date of Status” (DOS) for Medicaid purposes. The certification date is in the body of the certification letter or the eligibility letter for children.
3. Issue benefits to the same extent as other refugees, provided the victim of a severe form of trafficking meets other program eligibility criteria (e.g., income levels).

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS
QUALIFIED ALIENS**

VICTIMS OF TRAFFICKING

4. Upstate WMS: Districts should use citizenship/alien code (ACI) "D"-Victim of Human Trafficking.
5. New York City WMS: Workers should use ACI code "R"- Person Admitted as a Refugee" for Victim of Human Trafficking.

For purposes of Medicaid/Family Health Plus and/or Child Health Plus eligibility, victims of a severe form of trafficking, (holders of a T-visa/T-1, and holders of T-2, T-3, T-4 and T-5 ["Derivative" T-visas]) who are the minor children, spouses and in some cases the parents and siblings of victims of severe forms of trafficking in persons, may receive Medicaid benefits to the same extent as refugees. Recipients of a "T" visa are eligible for employment authorization. "T" visa recipients also may, if eligible, adjust their status to that of lawful permanent resident after three years. Victims may also apply for other immigration benefits such as an "S" visa (See section on **OTHER VISA STATUSES**) or asylum.

New York State "*Confirmed*" Victims of Human Trafficking:

Effective November 1, 2007 human trafficking was established as a crime in New York State. Under the law, a process to "*confirm*" victims of human trafficking as a means of providing assistance to such victims was established. State "*confirmed*" human trafficking victims who are citizens or aliens with a satisfactory immigration status who are otherwise eligible, are eligible for Medicaid benefits and services to the same extent as any other citizen or alien with satisfactory immigration status.

State "*confirmed*" human trafficking victims who do not have a satisfactory immigration status who are otherwise eligible for Medicaid may receive coverage and care necessary for the treatment of an emergency medical condition. (See **OTHER ELIGIBILITY REQUIREMENTS CITIZENSHIP AND IMMIGRATION STATUS UNDOCUMENTED/ILLEGAL ALIENS TREATMENT OF AN EMERGENCY MEDICAL CONDITION**) When the State "*confirmed*" adult or minor victim is an alien without satisfactory immigration status, local districts must contact the Office of Temporary and Disability Assistance (OTDA), Bureau of Refugee and Immigration Affairs (BRIA) Anti-Trafficking Program Coordinator. BRIA will refer the victim to a specific regional case management agency and/or other local resources that may be able to assist the victim.

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS
QUALIFIED ALIENS**

VICTIMS OF TRAFFICKING

At the time of application, the “*confirmed*” adult victim should have received a letter from OTDA indicating that she/he is a state “*confirmed*” victim of human trafficking. Each “*confirmed*” adult victim must present evidence of confirmation. Should the victim not present the letter to the intake worker or she/he does not appear to have a letter, or if additional information about the case is needed, the local district must contact the BRIA Anti-Trafficking Program Coordinator.

Minor children who are State “*confirmed*” trafficking victims who are otherwise eligible, may be provided medical coverage without regard to immigration status under the Child Health Plus program. BRIA will notify the LDSS by telephone and follow-up letter of any minor victims of human trafficking whether “*confirmed*” or “*not confirmed*”, and whether a “victim” or “possible victim” of human trafficking.

State “*confirmed*” human trafficking victims who are pregnant and otherwise eligible may be provided Medicaid at any time without regard to immigration status.

NOTE: State “*confirmed*” victims of human trafficking are not to be confused with the federally “*certified*” alien victims of human trafficking. Federally “*certified*” adults will have a Certification Letter from the Office of Refugee Resettlement (ORR). Children victims of human trafficking (under age 18) will have a letter of eligibility from ORR.

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS
QUALIFIED ALIENS**

VICTIMS OF TRAFFICKING

Documentation: Victims of Trafficking will have the following documentation:

Category 2: Qualified Immigrants Continued

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
Victims of Trafficking	<ul style="list-style-type: none"> ▶ I-94 Arrival/Departure Record coded T1, T2, T3, T4, or T5 stating admission under Section 212(d)(5) of the INA if status is granted for at least one year; ▶ Certification letter (for adults) or eligibility letter (for children) from the Office of Refugee Resettlement. Must call 1-866-401-5510 for verification; or ▶ I-797 Notice of Action acknowledging receipt of I-914, Application for T non-immigrant status. 	<p align="center">D- Upstate</p> <p align="center">or</p> <p align="center">R-NYC</p>	<p align="center">YES</p>	<p>Immigrants with or without work authorization are required to apply for a Social Security Number.</p> <p>LDSS must provide immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility benefits, except for having an SSN. (08 OHIP INF-2)</p> <p>Note: Pregnant women are excluded from this requirement.</p>

OTHER ELIGIBILITY REQUIREMENTS CITIZENSHIP AND IMMIGRATION STATUS

PRUCOL

Description: The United States Citizenship and Immigration Services (USCIS) (formerly the Immigration and Naturalization Services [INS]), or Immigration and Customs Enforcement (ICE), under the umbrella of the Department of Homeland Security (DHS), and/or the Executive Office for Immigration Review (EOIR), under the Department of State, are collectively referred to in this document as “the federal immigration agency” or “agency”.

PRUCOL is an acronym for persons Permanently Residing Under Color Of Law. The federal immigration agency does not determine whether an alien is PRUCOL and does not grant PRUCOL status. This is because PRUCOL is not a federal immigration status. Rather, PRUCOL is a public benefits eligibility status. Immigrants who are PRUCOL for Medicaid eligibility purposes and who may be eligible for Medicaid are any immigrants who are permanently residing in the United States with the knowledge and permission or acquiescence of the federal immigration agency and whose departure from the United States the federal immigration agency does not contemplate enforcing.

An immigrant will be considered as one whose departure the agency does not contemplate enforcing if:

- a. Based on all the facts and circumstances in that particular case, it appears that the federal immigration agency is otherwise permitting the immigrant to reside in the United States indefinitely; or
- b. It is the policy or practice of the federal immigration agency not to enforce the departure of immigrants in a particular category.

Policy: The Medicaid eligibility worker must determine whether the alien is PRUCOL based upon the documentation that the alien, or the alien’s representative, presents. An alien who establishes that he or she is PRUCOL is eligible for State Medicaid and FHPlus benefits if the alien meets the programs’ financial and other eligibility requirements, regardless of the date the immigrant entered the U.S. (Aliessa v. Novello, 06/01). There is no longer a five-year waiting period.

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS**

PRUCOL

Previously, Section 122 of the Social Services Law (SSL) provided an exception for certain PRUCOL immigrants who, on August 4, 1997, were residing in certain residential settings or who were diagnosed with AIDS and receiving Medicaid. Such individuals will continue to be provided Medicaid coverage to the extent they are otherwise eligible. The settings included are:

- Residential health care facilities licensed by the NYS Department of Health;
- Residential facilities licensed, operated or funded by the NYS Office of Mental Health (OMH), including psychiatric centers; residential treatment facilities; family care; community residences; teaching family homes; family based treatment; and residential care centers for adults; and
- Residential facilities licensed, operated or funded by the NYS Office for People with Developmental Disabilities (OPWDD), including: developmental centers and small residential units; intermediate care facilities for the developmentally disabled; family care; community residences; individual residential alternatives; and OPWDD certified schools for the mentally retarded.

References:	SSL Sect.	122 131-k
	Dept. Reg.	360-3.2(j)(1)(ii)
	ADM	04 OMM/ADM-7
	INFs	07 OHIP INF-2 08 OHIP INF-4
	GISs	08 MA/009 04 MA/014 04 MA/002 02 MA/016 02 MA/002 01 MA/033 01 MA/030 01 MA/026

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS**

PRUCOL

Interpretation: Some aliens are PRUCOL because the federal immigration agency has granted them a particular immigration status or relief. These aliens are permanently residing in the U.S. with the “knowledge and permission” of the federal agency. Examples include, but are not limited to, aliens paroled (admitted) into the U.S. for less than one year, aliens residing in the U.S. under an order of supervision, aliens granted an indefinite stay of deportation and aliens granted voluntary departure, deferred action or temporary protected status. A more complete list is included in the “Documentation Guide to Citizenship and Immigrant Eligibility for Health Coverage in New York State,” pages 9-10, issued on March 26, 2008, as part of GIS 08 MA/009. Each of these aliens will have a form of documentation, as listed in this desk guide, issued by the federal immigration agency that shows that the agency has granted the alien a particular status or relief.

Other aliens may be PRUCOL because they have applied for or otherwise requested a particular immigration status or relief from removal and are awaiting the federal immigration agency’s decision. The federal agency has received their application or request for relief and has not yet approved or denied the request. Under certain circumstances, and as further explained in this document, these aliens are PRUCOL pending the federal immigration agency’s determination. Until the agency has adjudicated the application or request, these aliens are residing in the U.S. with the “knowledge and acquiescence” of the federal immigration agency.

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS**

PRUCOL

Verification: PRUCOL CATEGORIES

- a. Immigrants Paroled into the United States pursuant to Section 212 (d)(5) of the Immigration and Nationality Act (INA) showing status for less than one year, except Cuban/Haitian entrants.
 - (1) Immigrants in this category are admitted to the United States for similar reasons as a refugee, i.e. humanitarian. However, this category, unlike refugee, does not grant legal residence status.
 - (2) Parole status allows the immigrant temporary status until a USCIS determination of his/her admissibility has been made, at which time another status may be granted.
 - (3) Immigrants in this category will have an Arrival/Departure Record (Form I-94) indicating that the bearer has been paroled pursuant to Section 212 (d)(5) of the INA. Possession of a properly annotated Form I-94 constitutes evidence of permanent residence in the U.S. under color of law, regardless of the date the Form I-94 is annotated.
- b. Immigrants residing in the United States pursuant to an Order of Supervision.
 - (1) Immigrants in this category have been found deportable; however, certain factors exist which make it unlikely that the federal immigration agency would be able to remove the immigrant. Such factors include age, physical condition, humanitarian concerns, and the availability of a country to accept the deportee.
 - (2) Immigrants in this category are required to report to USCIS periodically; if the factors preventing deportation are eliminated one of the federal immigration agencies will initiate action to remove the immigrant.
 - (3) Immigrants in this category will have USCIS Form I-94 or I-120B.
- c. Deportable immigrants residing in the United States pursuant to an Indefinite Stay of Deportation.
 - (1) Immigrants in this category have been found to be deportable, but the federal immigration agency may defer deportation indefinitely due to humanitarian reasons.

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- (2) Immigrants in this category will have a letter and/or a Form I-94 showing that the immigrant has been granted an indefinite stay of deportation.
- d. Immigrants residing in the United States pursuant to an Indefinite Voluntary Departure.
- (1) Immigrants in this category will have a letter and/or Form I-94 indicating that the immigrant has been granted voluntary departure for an indefinite time period.
- e. Immigrants in this category on whose behalf an Immediate Relative Petition (Form I-130) has been approved and their families covered by the petition, who are entitled to voluntary departure and whose departure the agency does not contemplate enforcing.

NOTE: An immediate relative for USCIS purposes is: husband, wife, father, mother, or child (unmarried and under age 21).

- (1) Immigrants in this category are the immediate relatives of a United States citizen or lawful permanent resident (LPR) and have had filed on their behalf a Form I-130 petition for issuance of an immigrant visa.
- (2) If this petition has been approved, a visa will be prepared, which will allow the alien to remain in the United States permanently.
- (3) Immigrants in this category may have a Form I-94 and/or Voluntary Departure Letter (I-210 Letter). These documents, or others, indicate that the immigrant is to depart on a specified date (usually 3 months from date of issue); however, USCIS expects the immigrant's visa to be available within this time. If it is not, extensions may be granted until the visa is ready.

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS**

PRUCOL

- f. Immigrants who have filed applications for Adjustment of Status pursuant to section 245 of the INA that USCIS has accepted as “properly filed” or has granted and whose departure the agency does not contemplate enforcing.
 - (1) Immigrants in this category have filed for lawful permanent resident status.
 - (2) Immigrants in this category may have Form I-94 or Memorandum of Creation of Record of Lawful Permanent Residence (Form I-181). Form I-181 or their passports will be stamped with either of the following: “Adjustment application” or “employment authorized during status as adjustment applicant.”
- g. Immigrants granted Stays of Deportation by court order, statute or regulation, or by individual determination of the federal immigration agency pursuant to section 243 of the INA whose departure the agency does not contemplate enforcing.
 - (1) Immigrants in this category have been found to be deportable, but the agency may defer deportation for a specified period of time due to humanitarian reasons.
 - (2) Immigrants in this category will have a letter or copy of the court order and/or a Form I-94.
- h. Immigrants granted Voluntary Departure pursuant to section 242(b) of the INA whose departure the agency does not contemplate enforcing.
 - (1) Immigrants in this category are awaiting a visa.
 - (2) Such immigrants are provided Forms I-94 and/or Form I-210 which indicate a departure within 60 days. This may be extended if the visa is not ready within the time allotted.
- i. Immigrants granted Deferred Action Status pursuant to agency operating policy. Immigrants in this category will have a Form I-210 or a letter indicating that the immigrant’s departure has been deferred.

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- j. Immigrants who entered and have Continuously Resided in the United States since before January 1, 1972. Immigrants in this category are presumed by the federal immigration agency to meet certain criteria for lawful permanent residence. Obtain any documentary proof establishing entry and continuous residence.
- k. Immigrants granted Suspension of Deportation pursuant to section 244 of the INA whose departure the federal immigration agency does not contemplate enforcing.
- (1) Immigrants in this category have been found deportable, have met a period of continuous residence and have filed an application for the agency to suspend deportation, which has been granted.
 - (2) Immigrants in this category will have a letter/order from an immigration judge and a Form I-94 showing suspension of deportation granted. After lawful permanent residence is granted, the immigrant will have a Lawful Permanent Resident Card (Form I-551 "green card").
- l. Any other immigrant living in the U.S. with the knowledge and permission or acquiescence of the federal immigration agency and whose departure that agency does not contemplate enforcing.
- (1) Immigrants in this category may be in a status not listed above. But, based on a determination by one of the federal immigration agencies or documentation supplied by the immigrant or his or her representative that indicates the immigrant is present in the U.S. with the knowledge of the federal immigration agency and with the permission or acquiescence of the agency, local districts may find them to be PRUCOL. Examples include, but are not limited to:
 - Applicants for adjustment of status to Lawful Permanent Residence (LPR), asylum, suspension of deportation or cancellation of removal or requesting deferred action; or
 - Deferred Enforced Departure (DED) due to conditions in their home country; or
 - Permanent non-immigrants, pursuant to P.L. 99-239 (applicable to citizens of the Federated States of Micronesia and the Marshall Islands); or
 - Persons granted Temporary Protected Status (TPS); or
 - Applicants for Temporary Protected Status; or
 - Persons having a "K", "V", "S" or "U" visa.

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DETERMINING PRUCOL STATUS

The following paragraphs describe the Department's policy regarding the PRUCOL status of aliens who:

1. have filed official applications with the federal immigration agency, typically USCIS or EOIR, for a particular immigration status or to obtain other relief; or
2. have submitted letters or other correspondence to the federal immigration agency, typically ICE, for relief, such as deferred action, for which no official application form exists.

I. Applications filed on federal immigration agency forms

There are many types of immigration statuses or relief for which an alien may apply by submitting an official application to the federal immigration agency on its application forms. Examples include applications to USCIS for adjustment of status to that of a lawful permanent resident (Form I-485), asylum and withholding of removal (Form I-589), or temporary protected status (Form I-821). An alien in removal proceedings may also apply to EOIR for suspension of deportation (EOIR-40), cancellation of removal (EOIR-42A) and for certain other forms of relief. It is the Department's understanding that the federal immigration agency generally confirms its receipt of an official application by issuing an I-797 Notice of Action.

It is the Department's policy, as stated in 04 OMM/ADM-7, 07 OHIP/INF-2, and 08 OHIP/INF- 4 that the alien is PRUCOL during the period of time that the federal agency is determining whether to approve the application by granting the requested immigration status or other relief. Local departments of social services should continue to follow the procedures described in these directives when the alien, or the alien's representative, presents documentation that an application has been submitted to the federal immigration agency on the agency's forms. In particular, the district should

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attempt to verify whether the application remains pending or whether the federal immigration agency has adjudicated the application by granting or denying the requested status or relief. There are a few ways that the district can verify the current status of an application. The alien may have an I-797 Notice of Action, employment authorization document or other federal immigration agency document that contains a 13 character receipt number. If so, the district worker can access the USCIS website at www.uscis.gov and follow the instructions for checking the case status online. This on-line search can confirm the accuracy of the information in the document as well as whether the agency has approved the request.

However, if the alien does not have a document with a receipt number, or the district worker does not have access to the USCIS website, the worker should send a Document Verification Request, Form G-845, (also known as a Systematic Alien Verification for Entitlements (SAVE) request) to USCIS. The worker should include copies of all documentation that the alien has submitted to, or received from, the federal immigration agency, and request that it verify the alien's current status. As a general rule, the district worker should also send a G-845 Document Verification Request when the documentation does not clearly indicate a particular immigration status, the alien has presented expired documents or the worker has reason to believe that the documentation may be questionable in any respect.

The Medicaid worker should find the alien to be PRUCOL if the alien's application remains pending with the federal immigration agency, not having yet been approved or denied, unless contradictory evidence indicates that the federal immigration agency is contemplating enforcing the alien's departure from the U.S.

The alien would be PRUCOL from the date that the federal immigration agency received the application. The I-797 Notice of Action indicates the date of receipt. If the alien does not have an I-797 Notice of Action, the date of receipt can be verified from a U.S. Postal Service return receipt, a "signature confirmation" or a "delivery confirmation."

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If the federal immigration agency denies the application or otherwise indicates that it is not permitting the alien to remain in the U.S., the alien is not PRUCOL. The alien would be eligible only for Medicaid coverage for the treatment of an emergency medical condition, if otherwise eligible.

II. Other letters or requests for relief from removal

There are various forms of relief from removal or deportation for which no formal application form or process exists. Two examples are deferred action and voluntary departure.

An alien whom the federal immigration agency would regard as illegal, and thus subject to removal, may still, under certain circumstances, be PRUCOL for purposes of eligibility for State Medicaid benefits and Family Health Plus (FHPlus).

DEFERRED ACTION/VOLUNTARY DEPARTURE

Deferred action is a form of relief that the Department of Homeland Security, in its' discretion, may afford to an otherwise removable alien whom DHS has decided not to prosecute for removal before the immigration courts, whether for humanitarian or administrative reasons. According to DHS estimates, the vast majority of cases in which deferred action is granted involve medical grounds. The former INS had operating instructions for making deferred action determinations under which the INS would consider the age or physical condition affecting an alien's ability to travel as well as the presence of sympathetic factors. Although the INS withdrew these operating instructions in 1997, deferred action continues to be available, according to DHS.

Voluntary departure permits an otherwise removable alien to depart the U.S. at his or her own expense, thus avoiding the stigma of being subjected to a removal proceeding. It is available both during and prior to removal proceedings. An alien may request voluntary departure to return to his or her home country or another country, if he or she can secure entry there.

Because no formal application process exists for these types of relief, the federal immigration agency might not timely respond to, or even acknowledge receipt of, the alien's letter requesting relief. Several months may pass before the agency responds to the informal request, if it responds at all. It is also

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more difficult for local departments of social services to verify the current status of the federal immigration agency's review of a request for deferred action or other relief made by letter rather than the current status of a formal application filed on official USCIS or EOIR application forms. However, an alien who has made a letter request for deferred action or other relief from removal may still be PRUCOL under certain circumstances.

Sections A through C of this document, which follow, present guidelines for local departments of social services to apply when determining the PRUCOL status of an otherwise removable alien who has requested, by informal letter, the federal immigration agency to grant relief from removal including, but not limited to, deferred action, voluntary departure or any other relief that may reasonably be construed as humanitarian relief.

A. Initial contact with the federal immigration agency

The letter or other correspondence to the federal immigration agency must clearly state the type of relief sought, which must be a recognized form of relief from removal or a recognized immigration status. The letter should summarize pertinent facts and circumstances of the alien's case that would support the granting of the relief. For example, if the alien is requesting deferred action or other humanitarian relief from removal based on the alien's medical condition, this information would include such factors as the following: date of birth and nationality; address in the U.S.; family ties in the U.S., if any; immigration history; criminal history, if any; and, in particular, the alien's current medical condition with a rationale for why the federal immigration agency should grant deferred action relief based on the alien's medical condition. If the alien is requesting voluntary departure, the alien must be capable of departing the U.S. if the federal immigration agency grants voluntary departure under the applicable federal regulations at 8 C.F.R. § 240.25 or § 1240.26. If the alien is represented by an attorney, the attorney should include an executed copy of the "Notice of Appearance as Attorney or Representative."

The alien, or the alien's representative, must present documentation sufficient to show that the letter was mailed to, and received by, the federal immigration agency. There is more than one way to establish mailing and receipt. A letter sent via the U.S. Postal Service by certified mail proves that the letter was mailed on a certain date. A

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certified letter, return receipt requested, is proof not only of mailing but also of receipt. A U.S. Postal Service “signature confirmation” or “delivery confirmation” also verifies receipt. In addition, a letter that is properly addressed, stamped and mailed by regular first-class mail is presumed to have been received, although this presumption can be rebutted.

B. Affording the federal immigration agency a “reasonable period of time” to adjudicate the request for relief

The alien is not considered PRUCOL immediately upon mailing of the initial letter requesting relief. Before the alien may be considered PRUCOL, the federal immigration agency must be afforded a “reasonable period of time” to consider and act upon the request. This is consistent with 04 OMM/ADM-7, in which the Department stated that an alien may be PRUCOL when the federal immigration agency, despite having been notified of the alien’s presence in the U.S., fails after “a reasonable period of time” to respond to the alien’s letter requesting relief or fails to take any action to enforce the alien’s departure from the U.S.

Under federal law, the federal immigration agency is required to conclude matters presented to it “within a reasonable time” (5 U.S.C. § 555). There is no hard and fast rule that defines a “reasonable time.” What is “reasonable” depends on all the facts and circumstances of a case. However, local departments of social services may consider that a “reasonable period of time” is six months. This six-month period is measured from the date that the alien, or the alien’s representative, mailed to the federal immigration agency the initial letter requesting relief.

C. Subsequent contacts with the federal immigration agency within the six-month period

A single letter or other piece of correspondence requesting relief from the federal immigration agency does not establish PRUCOL status. (An exception applies to applications to USCIS or EOIR that are filed on official application forms, as previously discussed.) It is reasonable to expect that any alien who has submitted a good faith request for relief to a federal immigration agency would take steps to follow-up on the status of the original request. The same principle applies here.

The Medicaid applicant, or the applicant’s representative, must make reasonable efforts to follow-up with the federal immigration agency on

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the status of the request for deferred action or other relief. These efforts to monitor the status of the initial request must occur during the six-month period that begins with the date that the alien, or the alien's representative, mailed to the federal immigration agency the initial letter requesting relief. If the applicant, or the applicant's representative, fails to make any effort to follow-up on the request within this period, this indicates that the request was not a "good faith" effort to seek relief.

This policy is consistent with court cases that have found otherwise removable aliens to be PRUCOL when the federal immigration agency was made aware on numerous occasions of the alien's presence in the U.S. but neither responded to the alien's letters nor took any action to enforce the alien's departure.

Applying these guidelines, local departments of social services should determine that the alien is PRUCOL when, based on all the facts and circumstances of the particular case, it appears that the federal immigration agency is acquiescing, at least for now, to the alien's presence in the U.S. Three examples of circumstances in which the local department of social services should conclude that federal acquiescence to the alien's presence exists, and the alien is thus PRUCOL, are illustrated below:

1. The federal immigration agency does not respond to the alien's initial or subsequent letters within six months after mailing and made no effort within that six-month period to enforce the alien's departure from the U.S.

In this example, the alien would be PRUCOL effective on the date that is six months after the alien, or the alien's representative, mailed the initial letter requesting relief provided that the alien, or the alien's representative, made reasonable and good faith efforts to follow-up on the status of the initial request during this six-month period. An exception applies if other evidence indicates that the federal immigration agency contemplates enforcing the alien's departure from the U.S.

2. The federal immigration agency responded to the alien's initial letter within six months after mailing by referring the matter to another entity and the entity to which the letter was referred did not respond within that same initial six-month period.

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For example, ICE responded to the alien's initial letter within six months of the date it was mailed by referring the matter to another wing of the Department of Homeland Security, namely USCIS, and USCIS did not respond within that same initial six-month period.

In this example, the alien would be PRUCOL effective on the date that is six months after the alien, or the alien's representative, mailed the initial request that was then referred to another entity. This presumes, however, that the alien, or the alien's representative, made reasonable and good faith efforts to follow-up on the status of the request for relief during this six month period. Again, an exception applies if other evidence indicates that the federal immigration agency is contemplating enforcing the alien's departure from the U.S.

3. The federal immigration agency responds to the alien's initial letter within six months of mailing and the agency's response can be reasonably interpreted as indicating that the agency does not contemplate enforcing the alien's departure from the U.S. at this time.

In this example, the federal immigration agency has responded within six months after the alien, or the alien's representative, mailed the initial letter. If the agency had granted the alien's request for relief, the alien would be PRUCOL effective on the date of the agency's response. However, the alien may still be PRUCOL if the agency's response, although not granting the requested relief, also does not show that the agency intends to enforce the alien's departure from the U.S. For example, the federal immigration agency may have responded that the alien is not in any form of formal expulsion proceedings or is not under a final order of removal and that the agency is returning the request for deferred action or other relief without adjudicating the request; that is, without determining whether to grant or deny the requested relief. In that example, the alien would be PRUCOL effective on the date of the federal immigration agency's response.

NOTE: As a general rule, the Medicaid worker should determine that an alien is not PRUCOL when the federal immigration agency denies the alien's request for relief from removal or indicates that it is not permitting or acquiescing to the alien's continued presence in the U.S. or, from all the facts and circumstances of the particular case, it appears that the agency is contemplating enforcing the alien's departure from the U.S.

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For example, the federal agency might respond to an alien's letter seeking deferred action or other relief by stating that the alien has been placed in formal removal proceedings or is under a final order of removal. In that case, the alien is not PRUCOL and is eligible only for Medicaid coverage for the treatment of an emergency medical condition, if financially and otherwise eligible.

Also as a general rule, Medicaid applicants are responsible for providing information and documentation necessary to establish their eligibility for Medicaid. This obligation includes providing information and documentation necessary to establish eligibility for Medicaid as a PRUCOL alien. Among other factors, an applicant who asserts that the federal immigration agency has a policy or practice of not enforcing the departure of aliens in a particular category, and that he or she falls within that category, is responsible for establishing that the federal immigration agency has such a policy or practice.

The desk aids that follow this section describe the documentation that a PRUCOL individual may present.

Category 3: Persons who are Permanently Residing in the U.S. Under Color of Law (PRUCOL)*

*PRUCOL is not an immigration status. PRUCOL is not granted by the federal immigration agency. PRUCOL is a public benefits eligibility category.

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
a. Persons paroled into the U.S. for less than a year. (Non-citizens allowed to come into the U.S. without being granted admission.)	<ul style="list-style-type: none"> ▶ I-94 Arrival/Departure Record with annotation "Paroled Pursuant to Section 212(d)(5)" of the INA or "parole" or "PIP"; ▶ I-688B Employment Authorization Card annotated 8 C.F.R. 274a.12(a)(4) or 274a.12(c)(11); or ▶ I-766 Employment Authorization Document annotated "A4" or "C11". 	T	NO	Immigrants with or without work authorization are required to apply for a Social Security Number. LDSS must provide immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility requirements for federal or state benefits, except for having an SSN. (08 OHIP INF-2)
b. Persons under an Order of Supervision. (Non-citizens who have been found deportable; however certain factors exist which make it unlikely that they will be deported.)	<ul style="list-style-type: none"> ▶ I-94 Arrival/Departure Record annotated "Order of Supervision"; ▶ I-220B Order of Supervision; ▶ I-688B Employment Authorization Card annotated 8 C.F.R. 274a.12 (c)(18); or ▶ I-766 Employment Authorization Document annotated "C18". 	O	NO	
c. Persons granted indefinite stay of deportation (Non-citizens who have been found deportable, but deportation is deferred indefinitely due to humanitarian reasons.)	<ul style="list-style-type: none"> ▶ I-94 Arrival/Departure Record coded 106 "granted Indefinite Stay of Deportation"; or ▶ Letter/order from the immigration agency, immigration judge or a federal court granting indefinite stay of deportation. 	O	NO	
d. Persons granted indefinite voluntary departure (Status that was granted before April, 1997 to non-citizens who have been found deportable, but deportation is deferred indefinitely due to humanitarian reasons.)	<ul style="list-style-type: none"> ▶ I-94 Arrival/Departure Record or letter/order from the immigration agency or immigration judge granting voluntary departure for an indefinite time period. 	O	NO	
e. Persons on whose behalf an immediate relative petition has been approved and family members covered by the petition. (Non-citizens who are immediate relatives (spouse, father, mother, or unmarried child under 21) of a U.S. citizen/LPR who has filed an I-130 Relative Petition on their behalf.)	<ul style="list-style-type: none"> ▶ I-94 Arrival/Departure Record or I-210 indicating departure on a specified date, however, the USCIS expects the non-citizen's visa will be available within this time; or ▶ I-797 indicating I-130 Relative Petition has been approved. 	O	NO	

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Category 3: PRUCOL continued

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
<p>f. Persons who have filed applications for adjustment of status to lawful permanent resident under Section 245 of the INA that the USCIS has accepted as “properly filed”. (Non-citizens who filed for legal permanent resident status.)</p>	<p>► I-94 Arrival/Departure Record or foreign passport with annotation “adjustment application” or “employment authorized during status as adjustment applicant”; ► I-688 Temporary Resident Card or I-688A Employment Authorization Card annotated “245A”; ► I-688B Employment Authorization Card annotated 8 C.F.R. 274a.12 (c)(22); or ► I-766 Employment Authorization Document annotated “C22”.</p>	O	NO	Immigrants with or without work authorization are required to apply for a Social Security Number.
<p>g. Persons granted stays of deportation (Non-citizens who have been found deportable, but the federal immigration agency may defer deportation for a specified period of time due to humanitarian reasons.)</p>	<p>► I-94 Arrival/Departure Record or letter/order from the immigration agency, immigration judge or court granting stay of deportation.</p>	O	NO	LDSS must provide immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility requirements for federal or state benefits, except for having an SSN. (08 OHIP INF-2)
<p>h. Persons granted voluntary departure under Section 242(b). (This section of the INA has been repealed.)</p>	<p>► I-797 Notice or form showing grant of extended voluntary departure; ► I-688B Employment Authorization Card annotated 274a.12(a)(11); or ► I-766 Employment Authorization Document annotated A11.</p>	O	NO	LDSS must provide immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility requirements for federal or state benefits, except for having an SSN. (08 OHIP INF-2)
<p>i. Persons granted deferred action status.</p>	<p>► I-797 or any document from the federal immigration agency granting deferred action status; ► I-688B Employment Authorization Card annotated 8 C.F.R 274a.12 (c)(14); or ► I-766 Employment Authorization Document annotated “C14”.</p>	O	NO	LDSS must provide immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility requirements for federal or state benefits, except for having an SSN. (08 OHIP INF-2)
<p>j. Persons who entered and continuously resided in the U.S. before January 1, 1972. (Non-citizens are presumed by the USCIS to meet certain criteria for legal permanent residence.)</p>	<p>► Any documentary proof establishing entry and continuous residence; or ► I-688B or I-766 coded 274a.12(c)(16) or C16; or ► I-797, letter/notice from the USCIS or court indicating registry application is pending.</p>	O	NO	Note: Pregnant women are excluded from this requirement.
<p>k. Persons granted suspension of deportation pursuant to Section 244 of the INA; the USCIS does not contemplate enforcing departure (Non-citizens in this category have been found deportable, have met a period of continuous residence and have filed an application for the USCIS to suspend deportation, which has been granted.)</p>	<p>► I-797, letter/notice from an immigration judge or court; and ► I-94 Arrival/Departure Record showing suspension of deportation granted. (After Lawful Permanent Residence is granted the person will have a “green Card” Form I-551).</p>	O	NO	

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Category 3: PRUCOL continued

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
<p>I. Other persons living in the U.S. with the knowledge and permission or acquiescence of the federal immigration agency and whose departure the agency does not contemplate enforcing: Examples include, but are not limited to: ► Applicants for adjustment of status to LPR¹, asylum², suspension of deportation or cancellation of removal³ or requesting deferred action; or ► Persons granted Deferred Enforced Departure (DED)⁴ due to conditions in their home country; or ► Permanent non-immigrants, pursuant to P.L. 99-239 (applicable to citizens of the Federated States of Micronesia and the Marshall Islands⁵; ► Persons granted Temporary Protected Status⁶; or ► Applicants for Temporary Protected Status⁷ (TPS); or ► Persons having a K, V, S or U Visa.⁸</p>	<p>► I-94 Arrival/Departure Record coded K1, K2, K3, K4, V1, V2, or V3, U, or S; ► I-688B Employment Authorization Card annotated 8 C.F.R.274a.12(c)(9)¹, 274a.12(c)(8)², 274a.12(c)(10)³, 274a.12(a)(11)⁴, 274a.12(a)(8)⁵, 274a.12(a)(12)⁶ or 274a.12(c)(19)⁷, 274a.12(a)(9)⁸, 274a.12(a)(13)⁸, 274a.12(a)(15)⁸, 274a.12(c)(21)⁸, and 274a.12(c)(24)⁸ ► I-766 Employment Authorization Document annotated C9¹, C8², C10³, A11⁴, A8⁵, A12⁶, C19⁷, A9⁸, A13⁸, A15⁸, C21⁸ or C24⁸. ► I-797 indicating the USCIS has received an application or petition or request for change of status; or ► Postal Return Receipt addressed to the federal immigration agency* or a copy of a cancelled check to the federal immigration agency, and a copy of the application, petition or request submitted to the federal immigration agency. (* USCIS-United States Citizenship and Immigration Services; ICE-Immigration and Customs Enforcement; EOIR-Executive Office of Immigration Review.)</p>	<p>O</p>	<p>NO</p>	<p>Immigrants with or without work authorization are required to apply for a Social Security Number. LDSS must provide immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility requirements for federal or state benefits, except for having an SSN. (08 OHIP INF-2) Note: Pregnant women are excluded from this requirement.</p>

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**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS**

PRUCOL

DOCUMENTATION GUIDE FOR PRUCOL ALIEN CATEGORIES rev. 09/15/08

PRUCOL: (Permanently Residing in the United States Under Color Of Law) are any aliens who are residing in the United States with the knowledge and permission or acquiescence of the federal immigration agency (formerly the Immigration and Naturalization Services [INS]), now the United States Citizenship and Immigration Services (U.S.C.I.S.), or the United States Immigration and Customs Enforcement (I.C.E) or the Executive Office of Immigration Review (EOIR) and whose departure from the United States the agency does not contemplate enforcing.

ALIEN CATEGORIES	GENERAL INFORMATION		DOCUMENTATION/FORMS
a) Aliens paroled into the United States pursuant to Section 212(d)(5) of the INA showing status for less than one year, except for Cuban/Haitian entrants.	Aliens in this category are admitted to the United States for similar reasons as a refugee, i.e., humanitarian. However, this category, unlike refugee status, does not grant legal residence status.	Parole status allows the alien temporary status until USCIS determination of his/her admissibility has been made; at which time another status may be granted.	Aliens in this category will have a FORM I-94 indicating that the bearer has been paroled pursuant to Section 212 (d)(5) of the INA. Possession of a properly annotated Form I-94 constitutes evidence of permanent residence in the U.S. under color of law, regardless of the date the Form I-94 is annotated.
b) Aliens residing in the United States pursuant to an Order of Supervision.	Aliens in this category have been found deportable; however, certain factors exist which make it unlikely that the federal immigration agency would be able to remove the alien. Such factors include age, physical condition, humanitarian concerns, and the availability of a country to accept the deportee.	Aliens in this category are required to report to the federal immigration agency periodically; if the factors preventing deportation are eliminated, the agency will initiate action to remove the alien.	Aliens in this category will have an USCIS Form I-94 or I-220B.
c) Deportable aliens residing in the United States pursuant to an indefinite stay of deportation.	Aliens in this category have been found to be deportable, but the federal immigration agency may defer deportation indefinitely due to humanitarian reasons.		Aliens in this category will have a letter and/or FORM I-94 showing that the alien has been granted an indefinite stay of deportation.
d) Aliens residing in the United States pursuant to an indefinite voluntary departure.			Aliens in this category will have a letter and/or Form I-94 indicating that the alien has been granted departure for an indefinite time period.
e) Aliens on whose behalf an immediate relative petition has been approved and their families covered by the petition, who are entitled to voluntary departure and whose departure the federal immigration agency does not contemplate enforcing.	NOTE: An immediate relative for USCIS purposes is: husband, wife, father, mother, or child (unmarried and under 21). Aliens in this category are the immediate relatives of an American citizen/LPR and have had filed on their behalf a Form I-130 petition for issuance of an immigration visa.	If this petition has been approved, a visa will be prepared, which will allow the alien to remain in the United States permanently.	Aliens in this category may have a Form I-94 and/or I-210 letter. These documents, or others, indicate that the alien is to depart on a specified date (usually 3 months from date of issue), however, USCIS expects the alien's visa to be available within this time. If it is not, extensions may be granted until the visa is ready.

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS**

PRUCOL

DOCUMENTATION GUIDE FOR PRUCOL ALIEN CATEGORIES continued

ALIEN CATEGORIES	GENERAL INFORMATION		DOCUMENTATION/FORMS
f) Aliens who have filed applications for adjustment of status pursuant to Section 245 of the INA that USCIS has accepted as "properly filed" or has granted and whose departure the federal immigration agency does not contemplate enforcing.	Aliens in this category have filed for lawful permanent resident status.		Aliens in this category may have Form I-94 or Form I-181 or their passports will be stamped with either of the following: "adjustment application" or "employment authorized during status as adjustment applicant".
g) Aliens granted stay of deportation by court order, statute or regulation, or by individual determination of the federal immigration agency pursuant to Section 243 of the INA whose departure BCIS does not contemplate enforcing.	Aliens in this category have been found to be deportable, but the federal immigration agency may defer deportation for a specified period of time due to humanitarian reasons.		Aliens in this category will have a letter or copy of the court order and/or a Form I-94.
h) Aliens granted voluntary departure pursuant to Section 242(b) of the INA whose departure the federal immigration agency does not contemplate enforcing.	Aliens in this category are awaiting a visa.	NOTE: N/A SECTION 242 (b) OF THE INA HAS BEEN REPEALED	Such aliens are provided Forms I-94 and/or I-210 which indicate a departure within 60 days. This may be extended if the visa is not ready within the time allotted.
i) Aliens granted deferred action status pursuant to the federal immigration agency's operating policy.			Aliens in this category will have Form I-210 or a letter indicating that the alien's departure has been deferred.
j) Aliens who entered and have continuously resided in the United States since before January 1, 1972.	Aliens in this category are presumed by the federal immigration agency to meet certain criteria for lawful permanent residence.		Obtain any documentary proof establishing entry and continuous residence.
k) Aliens granted suspension of deportation pursuant to Section 244 of the INA whose departure the federal Immigration agency does not contemplate enforcing.	Aliens in this category have been found deportable, have met a period of continuous residence and have filed an application for the federal immigration agency to suspend deportation, which has been granted.		Aliens in this category will have a letter/order from an immigration judge and a Form I-94 showing suspension of deportation granted. After lawful permanent residence is granted the alien will have a Form I-551.

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS**

PRUCOL

DOCUMENTATION GUIDE FOR PRUCOL ALIEN CATEGORIES continued

ALIEN CATEGORIES	GENERAL INFORMATION		DOCUMENTATION/FORMS
<p>I) Any other aliens living in the U.S. with the knowledge and permission or acquiescence of the federal immigration agency and whose departure that agency does not contemplate enforcing.</p>	<p>Aliens in this category may be in a status not listed above, but based on a determination by the federal immigration agency or documentation supplied by the alien or his or her representative that indicates the alien is present in the U.S. with the knowledge of the agency and with the permission or acquiescence of the agency, local districts may find them to be PRUCOL.</p>	<p>Examples include, but are not limited to:</p> <p>Applicants for adjustment of status to LPR, asylum, suspension of deportation or cancellation of removal or requesting deferred action; or Persons granted Deferred Enforced Departure (DED) due to conditions in their home country; or</p> <p>Permanent non-immigrants, pursuant to P.L. 99-239 (applicable to citizens of the Federated States of Micronesia and the Marshall Islands);</p> <p>Persons granted Temporary Protected Status; or Applicants for Temporary Protected Status (TPS); or Persons having a K, V, S or U Visa.</p>	<p>Aliens in this category may have: I-94 Arrival/Departure Record; or I-688B Employment Authorization Card; or</p> <p>I-766 Employment Authorization Document; or</p> <p>I-797 "Notice of Action" indicating the USCIS has received an application or petition or request for change of status; or a Postal Return Receipt addressed to the federal immigration agency* or a copy of a cancelled check to the federal immigration agency, and a copy of the application, petition or request submitted to the federal immigration agency.</p> <p>(* USCIS-United States Citizenship and Immigration Services; ICE-Immigration and Customs Enforcement; EOIR-Executive Office of Immigration Review.)</p>

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS
TEMPORARY PROTECTED STATUS (TPS)**

Description: “Temporary protected status (TPS)” is a temporary immigration status granted under federal law at 8 U.S.C. 1254a to aliens who are physically present in the United States and who are from certain countries designated by the U.S. Secretary of Homeland Security as unsafe to accept their return because of ongoing environmental disasters or other extraordinary and temporary conditions. At present, the following countries have TPS designation: Angola, Burundi, El Salvador, Honduras, Liberia, Montserrat, Nicaragua, Sierra Leone, Somalia, and Sudan. [A list of countries designated for TPS is located at the United States Citizenship and Immigration Services’ (USCIS) (formerly the Immigration and Naturalization Service-INS), website, at: <http://www.uscis.gov>]

NOTE: The Department of Homeland Security (DHS) has designated Haiti for Temporary Protected Status beginning January 21, 2010 and ending January 18, 2011. TPS will apply only to those Haitians who were in the United States on or before January 12, 2010, even if such individuals were illegally in the United States. TPS protects these individuals from deportation until January 18, 2011 and allows them to work in the U.S. Haitians who attempt to travel into the U.S. after January 12, 2010, will not be eligible for TPS.

Policy: Immigrants who have been granted Temporary Protected Status (“TPS”) may be eligible for Medicaid, Family Health Plus (FHP) or Child Health Plus (CHPlus) based on their status as permanently residing in the United States under color of law (PRUCOL), if they meet such programs’ requirements.

Immigrants who have applied for TPS may also be considered to be PRUCOL and may thus be eligible for Medicaid, Family Health Plus or Child Health Plus, if otherwise eligible.

References:

ADMs	04 ADM-7
GISs	10 MA/019
	10 MA/005
	08 MA/009

Interpretation: Immigrants Granted Temporary Protected Status (TPS): These immigrants should be treated as PRUCOL for purposes of their eligibility for Medicaid, FHP or CHPlus “Persons granted TPS are authorized to remain in the United States for a specific limited period; the U. S. Secretary of Homeland Security can extend it for a further specified period. Prior to 1990, a similar status called “Extended Voluntary Departure” was used in the same way to provide relief to

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS
TEMPORARY PROTECTED STATUS (TPS)**

particular nationalities.

Immigrants who have been granted TPS will have the following documentation:

- Form I-688B; or
- Form I-766 EAD coded 274a.12(a) (12) or A12; or
- A letter, verification or correspondence from USCIS, such as a Notice of Action (I-797) indicating temporary protected status has been granted.

Immigrants who have *applied* for Temporary Protected Status (TPS): These immigrants should be treated as PRUCOL for purposes of their eligibility for Medicaid, Family Health Plus or Child Health Plus if it reasonably appears, based on all the facts and circumstances of the case, that they are present in the United States with the **knowledge** and **permission** or the acquiescence of the federal immigration agency and that such agency is not presently contemplating deporting them. Social services districts should request proof from the immigrant that he or she filed the Application for Temporary Protected Status (Form I-821) and the Application for Employment Authorization (Form I-765) to the USCIS or its predecessor, the INS. For example, the immigrant may have a receipt or letter from the federal immigration agency that shows that such agency received these documents. However, the immigrant does not need to have written confirmation from the federal immigration agency acknowledging its receipt of these documents. An immigrant can be considered PRUCOL if the immigrant can prove that he or she mailed these documents to the federal immigration agency on a certain date. When the federal immigration agency has not acted on the application after a reasonable period of time after mailing, the district may reasonably presume that the applicant is PRUCOL.

Documentation: Immigrants applying for temporary protected status will have one of the following types of documentation:

- Receipt or notice showing filing of Form I-821 (Application for Temporary Protected Status) and Form I-765 (Application for Employment Authorization); or
- Form I-688B; or
- Form I-766 EAD codes 274a.12 (c) (19) or C19; or
- Any letter, verification or correspondence from USCIS or a U.S. Postal Return Receipt.

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS**

TEMPORARY PROTECTED STATUS (TPS)

Category 3: Persons who are Permanently Residing Under Color of Law (PRUCOL)*

***PRUCOL is not an immigration status. PRUCOL is not granted by the USCIS. PRUCOL is a public benefits eligibility category.**

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
<p>I. Other persons living in the U.S. with the knowledge and permission or acquiescence of the USCIS and whose departure the USCIS does not contemplate enforcing: Examples include, but are not limited to:</p> <ul style="list-style-type: none"> ▶ Applicants for adjustment of status to LPR¹, asylum², suspension of deportation or cancellation of removal³ or requesting deferred action; or ▶ Persons granted Deferred Enforced Departure (DED)⁴ due to conditions in their home country; or ▶ Permanent non-immigrants, pursuant to P.L. 99-239 (applicable to citizens of the Federated States of Micronesia and the Marshall Islands⁵); ▶ Persons granted Temporary Protected Status⁶; or ▶ Applicants for Temporary Protected Status⁷ (TPS); or ▶ Persons having a K, V, S or U visa.⁸ 	<ul style="list-style-type: none"> ▶ I-94 Arrival/Departure Record coded K1, K2, K3, K4, V1, V2, or V3, T, U, or S; ▶ I-688B Employment Authorization Card annotated 8 C.F.R.274a.12(c)(9)¹, 274a.12(c)(8)², 274a.12(c)(10)³, 274a.12(a)(11)⁴, 274a.12(a)(8)⁵, 274a.12(a)(12)⁶ or 274a.12(c)(19)⁷, 274a.12(a)(9)⁸, 274a.12(a)(13)⁸, 274a.12(a)(15)⁸, 274a.12(c)(21)⁸, and 274a.12(c)(24)⁸ ▶ I-766 Employment Authorization Document annotated C9¹, C8², C10³, A11⁴, A8⁵, A12⁶, or C19⁷, or A9⁸, A13⁸, A15⁸, C21⁸ and C24⁸. ▶ I-797 indicating the USCIS has received an application or petition or request for change of status; or ▶ Postal Return Receipt addressed to federal immigration agency* or a copy of a cancelled check to the federal immigration agency, and a copy of the application, petition or request submitted to the federal immigration agency. <p>(* USCIS-United States Citizenship and Immigration Services; ICE-Immigration and Customs Enforcement; EOIR-Executive Office of Immigration Review.)</p>	O	NO	<p>Immigrants with or without work authorization are required to apply for a Social Security Number.</p> <p>LDSS must provide immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility requirements for federal or state benefits, except for having an SSN. (08 OHIP INF-2)</p> <p>Note: Pregnant women are excluded from this requirement.</p>

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS**

OTHER VISA STATUSES

Visa Statuses: K, S, T, U, and V

There have been several new visa categories issued by the United States Citizenship and Immigration Services (USCIS) [formerly the Immigration and Naturalization Services (INS)] over the past several years.

Some categories of non-immigrant status allow the status (visa) holder to work and eventually adjust to lawful permanent residence. These categories allow the individual to apply for adjustment to Lawful Permanent Resident (LPR) status after he or she has had the nonimmigrant status for a period of time.

Such visa statuses include, for example:

- K status: For the spouse, child, or fiancé (e) of a U.S. citizen
- S status: For informants providing evidence for a criminal investigation. Also known as the "Snitch Visa".
- T status: For victims of Trafficking.*
- U status: For victims or witnesses of specified crimes (who have suffered substantial physical or mental abuse and agrees to cooperate with the government)
- V status: For spouses and children of LPR's whose visa petitions have been pending for at least three years.

[Law found at 8 U.S.C. section 1101 (a)(15)(K), (S), (T), (U), and (V).]

*Victims of Trafficking receive benefits to the same extent as refugees (06 OMM INF-5). (See **OTHER ELIGIBILITY REQUIREMENTS VICTIMS OF TRAFFICKING**)

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS**

“NON-IMMIGRANTS”
NON-IMMIGRANTS ADMITTED ON A TEMPORARY BASIS

Medicaid coverage for the care and the treatment of an emergency medical condition only. Such non-immigrants may receive this coverage, provided that they have not entered the State for the purpose of obtaining medical care.

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS**

**“NON-IMMIGRANTS”
NON-IMMIGRANTS ADMITTED ON A TEMPORARY BASIS**

Verification: Non-immigrants admitted on a temporary basis will have the following types of documentation:

Category 4: Temporary Non-Immigrants

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
<p>Temporary Non-immigrants include but are not limited to the following visa types: A – Foreign government representatives on official business; B-1 or B-2 – Visitors for business or pleasure; D – Crewmen on shore leave; E – Treaty Traders and investors; F – Foreign students; G – Representatives of international organizations; H – Temporary workers (including agricultural workers); I – Members of the foreign press; J – Exchange visitors, L- Intra-company transferee; O – Persons with extraordinary ability or achievement; P – Artists, Entertainers and Athletes; Q – Cultural Exchange Visitors; and R – Religious workers.</p>	<p>► I-94 Arrival/Departure record or foreign passport stamped with non-immigrant code; ► I-185 Canadian Border Crossing Card*; ► I-586 Mexican Border Crossing Card*; ► I-444 Mexican Border Visitor’s Permit; or ► I-95A Crewmen’s Landing Permit. ► I-688B Employment Authorization Card ► I-766 Employment Authorization Document *B-1/B-2 Visa/Border Crossing Card (BCC) is now issued in place of these documents</p> <p>(Temporary non-immigrants are lawfully admitted to the U.S. for a temporary or specified period of time.)</p>	<p align="center">E</p> <p>Only eligible for the treatment of an Emergency medical condition</p>	<p align="center">YES</p>	<p align="center">NOT Required</p> <p>However, may be assigned an SSN if USCIS/DHS has granted permission to work.</p>

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS**

“SPECIAL NON-IMMIGRANT”

Description: **SPECIAL NON-IMMIGRANT:** Some categories of “special” non immigrant statuses allow the status (visa) holder to work in the United States and eventually adjust to Lawful Permanent Resident (LPR) status. These categories allow the individual to apply for adjustment to Lawful Permanent Resident (LPR) status after he or she has had the non-immigrant status for a period of time. These statuses are included in the category defined as: “other persons living in the U.S. with the knowledge and permission and acquiescence of USCIS and whose departure USCIS does not contemplate enforcing.”

Such statuses include, for example:

K status: For the spouse, child, or fiancé(e) of a U.S. citizen.

S Status: For informants providing evidence for a criminal investigation. Also known as the “Snitch Visa”.

U Status: For victims or witnesses of specialized crimes (who have suffered substantial physical or mental abuse and agrees to cooperate with the government).

V Status: For spouses and children of LPR’s whose visa petitions (Form I-130) have been pending for at least three years.

Policy: Immigrants granted a “K”, “V”, “S”, or “U” visa category, if otherwise eligible should be authorized for Medicaid, Family Health Plus and Child Health Plus as a person who is Permanently Residing in the U.S. Under Color of Law (PRUCOL).

Interpretation: Non-immigrant visas V (Visa codes V-1, V-2 and V-3) and K (Visa codes K-3 and K-4) are two new categories of “special” non-immigrant visas that were created by the Legal Immigration and Family Equity Act (LIFE Act) and are issued to persons intending to live permanently in the United States. The V visa may be issued to alien spouses and minor children of lawful permanent residents whose family petitions (the I-130) have been pending for some time. The V visa is intended to permit family reunification while the immigration cases of the lawful permanent resident’s spouse and children are pending. The K visa allows the spouse and minor children of United States citizens to enter the United States legally and obtain work authorization. Individuals issued any of these visas may enter the United States as non-immigrants to complete the immigration process.

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS**

“SPECIAL NON-IMMIGRANT”

Holders of the S (Visa codes S-5, S-6 and S-7) or U visas (Visa codes U-1, U-2, U-3, and U-4) are considered PRUCOL and, if otherwise eligible, may receive Medicaid, FHPlus or CHPlus.

The S visa status is given to aliens who assist U.S. law enforcement to investigate and prosecute crimes and terrorist activities. S visa holders are allowed to adjust status to permanent resident under Section 245(j) of the Immigration and Nationality Act.

The U visa status is given to aliens who are victims and/or witnesses of certain crimes who are assisting an investigation or prosecution. This status allows the non-immigrant to remain in the U.S. and to work. After three years in this status, a U status holder can apply to adjust their status.

With respect to the U visa status, the USCIS has directed that individuals who satisfactorily demonstrate to USCIS that they are eligible for a U visa are to be granted Deferred Action status. As such, holders of U visas are to be considered PRUCOL and, if otherwise eligible, may receive Medicaid, FHPlus or CHPlus.

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS**

“SPECIAL NON-IMMIGRANT”

Category 4: Special Non-Immigrants

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
<p>Special Non-immigrants:</p> <p>Some categories of non-immigrant status allow the status holder to work and eventually adjust to lawful permanent residence. These categories allow the individual to apply for the adjustment to LPR status after he or she has had the non-immigrant status for a period of time. As SPECIAL NON-IMMIGRANTS, (K), (S), (T)*, and (V) visa holders are PRUCOL and are eligible for Medicaid/FHPlus/CHPlus.</p> <p>* Victims of Trafficking (T visas) receive benefits to the same extent as refugees (04 OMM/ADM-7).</p>	<ul style="list-style-type: none"> ▶ I-94 Arrival/Departure Record coded K3, K4, V1, V2, or V3, T*, U, or S; ▶ I-797 indicating the USCIS has received, taken action on or approved an application or petition; ▶ Postal Return Receipt addressed to the USCIS or copy of cancelled check to the USCIS and a copy of the of the enclosed documents submitted to the USCIS, or ▶ Correspondence to or from the USCIS, showing that the person is living in the U.S. with the knowledge and permission or acquiescence of the USCIS, and the USCIS does not contemplate enforcing the person’s departure from the U.S. 	<p align="center">O PRUCOL*</p> <p>*Except for Victims of Trafficking</p>	<p align="center">NO</p>	<p>LDSS must provide immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility requirement for federal or state benefits, except for having an SSN.</p> <p>(08 OHIP INF-2)</p> <p>Note: Pregnant women are excluded from this requirement</p>

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS
UNDOCUMENTED/ILLEGAL ALIENS**

TREATMENT OF AN EMERGENCY MEDICAL CONDITION

Description: An immigrant is here illegally or is undocumented if s/he entered the United States in a manner or in a place so as to avoid inspection, or was admitted on a temporary basis (certain non-immigrants) and the period of authorized stay has expired.

Policy: Medicaid shall be provided for the care and services necessary for the treatment of emergency medical conditions to otherwise eligible illegal or undocumented aliens.

References:

SSL Sect	122 131-k
Dept. Reg.	360.3.2(f)(2)
ADMs	04 ADM-7 92 ADM-10 88 ADM-47 88ADM-22 88 ADM-4 88ADM-1
GISs	10 MA/012 08 MA/009 07 MA/ 017

Interpretation: If otherwise eligible, an A/R cannot be denied Medicaid coverage for treatment of an emergency medical condition because of his/her immigration status.

The term emergency medical condition is defined as: “a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- (a) placing the patient’s health in serious jeopardy;
- (b) serious impairment to bodily functions; or
- (c) serious dysfunction of any bodily organ or part.”

Care and services related to an organ transplant procedure are not included in the federal definition of treatment for an emergency medical condition.

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS
UNDOCUMENTED/ILLEGAL ALIENS**

TREATMENT OF AN EMERGENCY MEDICAL CONDITION

Medicaid is available for emergency services provided to undocumented/illegal or certain non-immigrants from the time that the individual is first given treatment for an emergency medical condition until such time as the medical condition requiring emergency care is no longer an emergency. If an eligible individual receives treatment for an emergency medical condition and continues to receive care after the emergency ceases, Medicaid coverage for such care is not available.

When an enrollee is eligible for Emergency Services Only, Medicaid no longer covers the costs for or the transportation to rehabilitation services (including physical, occupational and speech therapies). This is because these services do not fall under the definition of treatment of an emergency medical condition.

NOTE: Until formally notified to do otherwise, chemotherapy and radiation therapy are to be considered as emergency medical services.

Current Medicaid policy states that certain types of care provided to chronically ill persons are beyond the intent of the federal and State laws which allow Medicaid to pay for the treatment of medical emergencies. Such care includes:

- alternate level of care in a hospital,
- nursing facility services, and
- home-care (including but not limited to, personal care services, home health services and private duty nursing).

NOTE: A women with a medically verified pregnancy is not required to document citizenship or immigration status for the duration of her pregnancy, through the last day of the month in which the 60-day postpartum period ends.

Verification:

Temporary non-immigrants and undocumented aliens applying for coverage for the treatment of an emergency medical condition must complete the appropriate MEDICAID APPLICATION and sign the DOH 4471, "Certification of Treatment of Emergency Medical Condition".

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS
UNDOCUMENTED/ILLEGAL ALIENS**

TREATMENT OF AN EMERGENCY MEDICAL CONDITION

The DOH-4471 certification form must be signed by the A/R. If the A/R is unable to sign, his or her authorized representative may sign on the behalf of the A/R. The form is not valid without the required signature of the A/R or his/her authorized representative. Signing the form authorizes the local department of social services to request information regarding the emergency medical treatment. It also gives the physician or facility permission to provide such information.

The treating physician must complete the DOH-4471 and sign and date the form. The physician must, in all cases, make the decision as to whether or not the medical treatment is for an emergency medical condition. The physician must complete the entire form, sign and date the certification and return it to the local department of social services.

The local district maintains this certification form in the applicant's case record, the local district notifies the provider of the acceptance/denial of the application, and furnishes the provider with the individual's CIN number when appropriate.

The DOH-4471 has space to accommodate up to four coverage periods ("FROM____TO____ Date(s)" of Treatment/Hospital Stay) that may be entered by the provider. A new DOH-4471 certification form must be completed, dated and signed by the A/R, or the A/R's authorized representative, and by the treating physician and submitted for subsequent or continuing treatment of an emergency medical condition.

Each person's "emergency" is unique and the coverage period under the definition of emergency medical condition is limited and date specific. Therefore, Medicaid coverage for the emergency care must be a specific period of time in the past (i.e., at least one day prior to the initial Medicaid application date or one day prior to the Transaction Date for recipients in need of continuing care for the treatment of the emergency medical condition).

Medicaid payment for emergency services is limited to the day treatment was initiated and the following period of time in which the necessity for emergency services exists (e.g., the date of admission through the date of discharge from the hospital).

**OTHER ELIGIBILITY REQUIREMENTS
CITIZENSHIP AND IMMIGRATION STATUS
UNDOCUMENTED/ILLEGAL ALIENS**

TREATMENT OF AN EMERGENCY MEDICAL CONDITION

The DOH-4471 form has space to accommodate up to four coverage periods (From-To Date(s) of Treatment/Hospital Stay). Each “From-To” date(s) must be entered in the Welfare Management System (WMS) as a separate coverage period, and each coverage period requires a separate Client Notification System (CMS) note (upstate). For any subsequent treatment/hospital stay or continuing treatment for an emergency medical condition, a new DOH-4471, form must be completed, dated, and signed by the A/R, or the A/R’s authorized representative, and by the treating physician.

The maximum period of time for which “emergency treatment” (coverage code “07”) may be entered from one submission of the DOH-4471 is 90 days. This can be a combination of retroactive, current, and prospective coverage. A new DOH-4471 must be obtained from a physician at least once 90 days, in order to continue the Medicaid coverage. Future (prospective) coverage may not exceed 60 days.

Category 5: Undocumented Aliens

Category	Documentation	WMS ACI code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
Undocumented Aliens: (Undocumented aliens do not have the permission of the USCIS to remain in the U.S. They may have entered the United States legally but have violated the terms of their status, e.g. over-stayed a visa, or they may have entered without documents.)	Undocumented aliens are unable to provide documentation of immigration status; therefore, absent any documentation they are eligible only for the treatment of an emergency medical condition. Undocumented children may be eligible for CHPlus. Undocumented pregnant women continue to be eligible for pre-natal care.	<p align="center">E</p> Only eligible for treatment of an emergency medical condition	<p align="center">YES</p>	<p align="center">NOT Required</p>

OTHER ELIGIBILITY REQUIREMENTS**RECOVERIES**

Description: Recovery is the repayment or taking back of funds expended for Medicaid.

Policy: A recovery may be made:

- from the estate (including non-probate assets) of a permanently institutionalized individual of any age;
- from the estate (including non-probate assets) of an individual who was 55 years of age or older when s/he received Medicaid;
- from a personal injury award or settlement;
- based upon a court judgment, for Medicaid incorrectly paid (including Family Health Plus);
- from a legally responsible relative who fails or refuses to make his/her income and resources, as appropriate, available to the Medicaid recipient (See **OTHER ELIGIBILITY REQUIREMENTS OWNERSHIP AND AVAILABILITY**);
- from the sale of real property of a permanently institutionalized individual (See **RESOURCES PERSONS IN MEDICAL FACILITIES TREATMENT OF REAL PROPERTY**) when a lien had been placed against the real property of such person pursuant to SSL 369(2)(a)(ii); or
- from a non-custodial parent who has a court order to pay cash medical support to the LDSS.

A recipient may elect to voluntarily reimburse a district for Medicaid correctly or incorrectly paid.

References: SSL Sect. 366(3)(a)
369

NYS Finance Law 18 (4&5)

General Business Law 453

Social Security Act 1917(b)

OTHER ELIGIBILITY REQUIREMENTS

RECOVERIES

Dept. Reg.	360-1.4 360-4.4 360-4.7 360-7.2 360-7.4 360-7.11
ADMs	09 OHIP/ADM-3 02 ADM-03 96 ADM-08 94 ADM-17 92 ADM-53 92 ADM-45 89 ADM-47 89 ADM-45
LCMs	94 LCM-89
GISs	10 MA/008 08 MA/031 06 MA/018 06 MA/022

Interpretation: Medicaid paid on behalf of a recipient age 55 or older or a permanently institutionalized individual of any age is recoverable from the recipient's estate (including non-probate assets) with certain exceptions (See **OTHER ELIGIBILITY REQUIREMENTS RECOVERIES ESTATE RECOVERIES**).

Medicaid/Family Health Plus which has been paid for an ineligible recipient is incorrectly paid and may be recovered. This may be done by:

- requesting voluntary repayment from the recipient for any incorrect payment; or.
- going to court to obtain a judgment that the payment was incorrectly made.

The amount of Medicaid/Family Health Plus incorrectly paid is calculated from the first day the recipient became ineligible for Medicaid, (including any Medicaid paid during the notice period, and pending a fair hearing decision). Medicaid paid prior to the day the

OTHER ELIGIBILITY REQUIREMENTS

RECOVERIES

recipient became ineligible is Medicaid correctly paid.

For federally-participating (FP) individuals, when Medicaid has been incorrectly paid because the recipient had excess income and, in the case of SSI-related individuals excess resources, that were not considered in the eligibility determination, the amount of Medicaid incorrectly paid is limited to the amount of the recipient's excess income/resources liability. The overpayment is restricted to the amount of the spenddown liability. In any event recovery cannot exceed the amount that Medicaid paid.

The overpayment for federally non-participating (FNP) individuals is the total amount of Medicaid payments (fee-for-service or Managed care premiums) expended. The overpayment for Family Health Plus recipients is the total amount of premiums paid during the period of ineligibility.

When Medicaid is provided to a person with a legally responsible relative (LRR) who refuses or fails to make his/her income available to the A/R, an implied contract is created with the non-contributing LRR. The LRR may be responsible for Medicaid paid. Recovery for Medicaid paid may be pursued through court action. The LRR can be offered the opportunity to voluntarily reimburse the district before a court action is initiated. By clearly explaining the district's procedures, a court action may be avoided.

NOTE: Recoveries are not pursued from the parents of: children participating in one of the home and community-based waiver programs; pregnant minors; certified blind or certified disabled children who are 18 years of age or older; children under age 18 who are expected to be living separately from their parents' household for at least 30 days; and from the parents of a disabled child for Medicaid furnished for school-based medical care and services provided to such child under the IDEA as part of a free and appropriate education.

If a district has a legal basis for making a Medicaid recovery from a recipient of his or her estate, it may commence a court action pursuant to the Debtor and Creditor Law to undo transfers of assets by the recipient and have those assets returned to the recipient or his/her estate so that sufficient assets will be available to satisfy the district's claim. The Debtor and Creditor Law cannot be used to attempt to have assets returned to a Medicaid recipient for the purpose of making the recipient ineligible for Medicaid prospectively.

OTHER ELIGIBILITY REQUIREMENTS**RECOVERIES**

The cost effectiveness of pursuing recoveries for Medicaid paid must be determined. Cost effectiveness is based on a variety of factors, including but not limited to: the administrative cost of a court action; the amount of overpayment; the availability of income or assets from which to recover; and previous experience with the court.

Cash medical support court ordered to be paid by the non-custodial parent to the LDSS can be recovered from the non-custodial parent by using the Non-custodial Parent Billing Notice, OHIP-0029. Such recovery can be made administratively through the accounting or Medicaid unit. The Medicaid Medical Support Transmittal, OHIP-0030 must be sent to the CSEU for further action. Additional court appearances to recover money may be indicated if cost-effective.

See **OTHER ELIGIBILITY REQUIREMENTS RECOVERIES LIENS** for a discussion of recovery from the real property of an institutionalized individual. An institutionalized individual is an inpatient in a nursing facility, intermediate care facility for the

OTHER ELIGIBILITY REQUIREMENTS

RECOVERIES

mentally retarded, or other medical institution, who is not reasonably expected to be discharged from the medical institution to return home.

Limitations on recoveries from Personal Injury Settlements/Awards (effective for recoveries made on or after May 1, 2006):

- Only the portion of the personal injury settlement or award specifically allocated to compensate the Medicaid recipient for past medical expenses arising out of the personal injury is available to satisfy a 104-b lien. Any portion allocated to compensate the Medicaid recipient for pain and suffering, lost wages, and other non-medical damages is not available to satisfy a 104-b lien. A minor's personal injury settlement or award is also subject to this policy.
- To the extent that the lien amount exceeds the portion of the personal injury award or settlement specifically allocated to repayment of past medical expenses, the district's recovery of the lien will be reduced.
- 104-b liens are paid prior to funds being transferred to a supplemental needs trust for the benefit of the Medicaid recipient, insofar as the lien is partially or fully satisfied out of the portion of the personal injury settlement or award specifically allocated to compensate the Medicaid recipient for past medical expenses. Any other amounts of the settlement or
- awards are the Medicaid recipient's personal property and should be evaluated in accordance with resource and supplemental needs trust policies.

Medicaid Managed Care and Family Health Plus capitation payments made during a time after a recipient has either reported a change that makes him/her ineligible or requests his/her case closed may be recovered ONLY if the recipient accessed services from the managed care plan during that time.

NOTE: The extent to which liens may be imposed and recoveries pursued with respect to Medicaid recipients who are Qualified Partnership Policyholders (QPPs) depends on the type of plan chosen by the QPP.

OTHER ELIGIBILITY REQUIREMENTS

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Total Asset Protection Plans (TAP) - No liens may be imposed against the real property of a permanently institutionalized individual who is a TAP QPP nor may recoveries made from the estate of a TAP QPP.

Dollar-for-Dollar Asset Protection (DDAP) Plans- Since homes of DDAP QPPs must be evaluated for their exempt/countable status, a lien shall be placed on the real property of the permanently institutionalized individual DDAP QPP in an amount equivalent to his/her unprotected resources, if any.

The sections that follow discuss these forms of recoveries:

- Estate Recoveries
- Confinement and Pregnancy Related Expenses
- Liens; and
- Voluntary Repayments.

OTHER ELIGIBILITY REQUIREMENTS**RECOVERIES**
ESTATE RECOVERIES

Description: Estate recovery is when the cost of Medicaid provided to an individual who was after age 55 or older, or when the recipient was permanently residing in a medical institution, is recovered from the assets in the recipient's estate.

Policy: Medicaid correctly paid for any recipient who was age 55 or older, or regardless of age, was permanently institutionalized, is recoverable from the estate of the recipient. Non-probate assets of the recipient that generally pass directly to another individual upon death, including: jointly owned financial institution accounts, jointly held real property, life estate interests, interests in certain trusts and annuities regardless of whether there is a named beneficiary or right of survivorship are considered part of the decedent's estate.

References:

SSL Sect. 366(3)(a)
369

Social Security Act 1917(b)

NYS Finance Law 18 (4&5)

General Business Law 453

Dept. Reg. 360-1.4
360-4.4
360-4.7
360-7.2
360-7.4
360-7.11

ADMs 11 OHIP/ADM-8
09 OHIP/ADM-3
02 ADM-03
96 ADM-08
94 ADM-17
92 ADM-53
92 ADM-45
89 ADM-47
89 ADM-45

LCMs 94 LCM-89

OTHER ELIGIBILITY REQUIREMENTS**RECOVERIES**
ESTATE RECOVERIES

GISs 10 MA/008
 08 MA/031
 06 MA/018
 06 MA/022

Interpretation: Effective September 8, 2011 assets subject to estate recovery include all property in which the deceased Medicaid recipient has any legal interest including jointly owned real and personal property, retained life estates, interests in trusts and other assets.

Medicaid Recoveries are prohibited:

- During the lifetime of the surviving spouse, or at any time when the recipient has a surviving child who is under age 21 or a child of any age who is certified blind or certified disabled. This prohibition applies to all assets of the recipient including those that pass directly upon the recipient's death to individuals other than a surviving spouse or minor child, or blind or disabled child.
- From the income, resources and property belonging to an American Indian or Alaskan Native.
- From government reparation payments paid to special populations.
- From Workers' Compensation, volunteer firemen's benefits, Social Security, SSI or other such benefits.
- From the recipient's personal injury action that was filed against a nursing home. This prohibition runs for the lifetime of the recipient.
- From the personal account of a veteran who died in a Veteran's Administration (VA) nursing facility. If a veteran was transferred from a non-VA facility to a VA facility (e.g. a VA hospital) for treatment and died while in the VA facility no recovery from the personal account maintained by the non-VA facility is pursued. Similarly if the VA contracted for the care of a veteran in a private nursing facility at VA expense recovery is not sought from the personal account maintained by the private nursing facility.
- From payments made through the Office of Mental Health Comprehensive Outpatient Program (COPs).

Medicaid Recoveries involving a homestead are prohibited:

- When a sibling with an equity interest in the home of a

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RECOVERIES ESTATE RECOVERIES

deceased Medicaid recipient lived in the home for at least one year immediately before the recipient was institutionalized and who has lawfully resided in the home continuously since that time;

- When an adult child who lived in the home of a deceased Medicaid recipient for at least two years immediately before the recipient was institutionalized, who provided care that may have delayed the recipient's institutionalization and who has lawfully resided in the home continuously since that time;
- From the real property of a permanently institutionalized individual if the value of the property when counted in determining eligibility results in the applicant having to spend down excess resources. An example is a permanently institutionalized individual who does not intend to return home and does not have a relative that would allow the homestead to be exempt from recovery (as described above). In such instances, the home is treated as a countable resource.

If the prohibited period ends (e.g., the spouse dies or a minor child reaches the age of 21) or in the case of a decedent's home, the sibling or adult child no longer resides in the home or the property is to be sold, a recovery can then be pursued.

Recoveries and Liens-Qualified Partnership Policy Holders

The extent to which liens may be imposed and recoveries pursued with respect to Medicaid recipients who are Qualified Partnership Policyholders (QPPs) depends on the type of plan chosen by the QPP.

- Total Asset Protection Plans (TAP) - No liens may be imposed against the real property of a permanently institutionalized individual who is a TAP QPP nor may recoveries be made from the estate of a TAP QPP.
- Dollar-for-Dollar Asset Protection (DDAP) Plans- Since homes of DDAP QPPs must be evaluated for their exempt/countable status, a lien shall be placed on the real property of the permanently institutionalized individual DDAP QPP in an amount equivalent to his/her unprotected resources, if any.

Recovery of Expanded Probate Assets

- Jointly Owned Bank Accounts and Securities - the Medicaid

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recipient's per capita interest in a joint bank account as well as jointly owned securities (e.g., stocks, bonds, mutual funds) at the time of his/her death is subject to recovery from the person(s) who is named as the joint owner on the account.

NOTE: If the case record does not contain evidence that rebuts the presumption of 100% ownership by the decedent or the decedent was not subject to a resource test for Medicaid eligibility purposes and the joint owner claims the funds in the joint account were not wholly assets of the decedent, the joint account owner must be allowed the opportunity to provide documentation of his/her interest in the account through verifiable deposits and withdrawals.

- Jointly Held Real Property - real property owned jointly by a Medicaid recipient and one or more other individuals may not have been considered available as a resource during the eligibility process. Whether the property was considered available or unavailable, recovery must be pursued against the deceased recipient's interest in such property. A post death lien must be filed.

Life Estate Interest - A life estate interest that was created by a recipient or his/her spouse in property in which the recipient or spouse held interest at the time the life estate was created, or a life estate interest that was created for the benefit of a recipient or the recipient's spouse in property in which the recipient or spouse held any interest within five years prior to the creation of the life estate is subject to estate recovery. The value of the life estate interest is an actuarial computation based on the age of the recipient and the fair market value (FMV) of the property immediately prior to the recipient's death. Effective September 08, 2011, the Internal Revenue Service (IRS) actuarial table, "Table S, Single Life Factors", in accordance with the most recent mortality table, "Table 2000CM", and interest rates under IRS code 7520, "Section 7520 Interest Rates", must be used for this computation. These tables and rates are found on the IRS website.

Example:

Step 1. Determine the IRS code 7520 interest rate that applies to the month and year of the recipient's death.

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Step 2. Determine the interest rate factor from “Table S”.

Step 3. Multiply the FMV of the property by the interest rate factor from “Table S” to arrive at the life estate value.

NOTE: If the life estate was jointly owned by the recipient, the district must file a post death lien on the real property using the “Notice of Post Death Medical Assistance Lien”.

- Trusts - Any interest the recipient had in a living trust at the time of death must be included in the estate recovery.
 - Revocable living trusts – when created by the recipient or the recipient’s spouse, the entire value of the principal and accumulated interest is considered an available resource at the time of death and is included in the individual’s estate for purposes of estate recovery.
 - Irrevocable trusts – when funded in whole or in part with the assets of the recipient or the recipient’s spouse, any principal and accumulated interest that was required to be paid to or for the benefit of the recipient are included in the decedent’s estate for recovery.

NOTE: Exception trusts created for the benefit of a certified disabled individual under age 65, and exception trusts created for the benefit of a certified disabled individual of any age (pooled trusts) are disregarded as available income and resources when determining eligibility. However, these trusts must include provisions giving the Medicaid program a remainder interest of all amounts remaining in the trust, or in the case of a pooled trust, all amounts not retained by the trust, up to the total value of all Medicaid paid on behalf of the disabled individual, payable at the time of the recipient’s death.

- Annuities - The remaining balance or income distribution from an annuity purchased by or with assets of the decedent or the decedent’s spouse is included in the Medicaid recipient’s estate and is subject to recovery regardless of a designated beneficiary. A “payable on death” clause does not alter the status of these funds from being subject to estate recovery as the investment is considered an asset of the recipient at the time of death.

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An annuity purchased on or after February 8, 2006 by an SSI-related Medicaid recipient is required to have the State named as the remainder beneficiary if the annuity is not treated as a countable resource (considered countable income only).

- Life Insurance – Generally, life insurance policies are not part of a decedent's estate. However, if the beneficiary of the policy is the estate, or there are no surviving beneficiaries, the payout is recoverable as part of the estate.

Hardship

No recovery of Medicaid correctly paid will be pursued against any portion of an estate if it will result in undue hardship. Examples of undue hardship include:

- the sole income-producing asset of the beneficiary (ies), such as the family farm or family business and income produced by the asset is limited, or
- real property of modest value (i.e., having a value no higher than 50% of the average selling price in the county where the home is located, as of the decedent's date of death) and the home is the primary residence of the beneficiary (ies), or
- other complying circumstances.

Undue hardship is not considered to exist based on the inability of the beneficiaries to maintain a pre-existing lifestyle or when the alleged hardship is the result of Medicaid or estate planning methods involving divestiture of assets.

Waiver of Estate Recovery

The estate claim may be waived in whole or in part if the recovery against the decedent's interest in the asset will result in undue hardship as described above.

Deferral of Estate Recovery

Recovery against a deceased Medicaid recipient's estate must be deferred:

- during the lifetime of the recipient's surviving spouse; or
- during any period in which the recipient has a surviving child under 21 years of age; or
- during the lifetime of a recipient's surviving child of any age who is certified blind or certified disabled; or

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- with respect to the home of a deceased Medicaid recipient, when one of the relatives, adult child or sibling as described above, is lawfully residing in the home.

Upon the death of the surviving spouse, or blind or disabled child, or upon the minor child reaching 21 years of age, or in the case of a decedent's home, upon the adult child or sibling ceasing to reside in the home or the home being put up for sale, the estate claim against the estate that was previously prohibited must be pursued. The claim against such individual for the receipt of such property by distribution or survival is limited to the value of the property received from the estate of the deceased Medicaid recipient or the amount of medical assistance otherwise recoverable, whichever is less.

Deferral of estate recovery on real property is subject to a post death lien if:

- undue hardship has not been found to exist;
- the heir or survivor has lawfully and continuously resided in the real property, beginning prior to the deceased Medicaid recipient's death, and is unwilling to sell the real property;
- the Medicaid claim cannot be paid in full unless the property is liquidated;
- the heir or survivor is able to demonstrate the inability to obtain financing to pay the estate claim; AND
- a written agreement has been entered into between the Medicaid program and the dependent, heir or survivor whereby the Medicaid program holds a lien on such real property and the dependent, heir or survivor agrees to pay the amount of the claim in accordance with a reasonable payment schedule, subject to reasonable interest.

When such deferrals of estate recovery are made, a lien must be filed in the county clerk's office in the county where the property is located and remain on file to protect the interest of the Medicaid program to the extent of the claim against the recipient's estate, less any payments actually received toward such claim. Recovery is deferred until:

- the death of the dependent, heir or survivor; or
- the sale, refinance, transfer or change in title of the real property; or
- the determination by the Medicaid program that the dependent, heir or survivor is in breach of the repayment agreement.

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Amount of the Lien

A claim may be asserted against the estate of a deceased Medicaid recipient for the amount of Medicaid paid from the date the recipient reached 55 years of age or the date of permanent institutionalization, whichever occurs first.

Effective January 1, 2010, Medicaid payments for Medicare cost sharing expenses made on behalf of any individual receiving benefits through the Medicare Savings Program, including: Medicare Part A and Part B premiums; Medicare deductibles, coinsurance and co-payments are exempt from estate recovery. Medicaid payments for all other services not related to Medicare cost sharing continue to be subject to estate recovery. In addition, Medicare cost sharing payments made on behalf of individuals who are not enrolled in the Medicare Savings Program continue to be subject to estate recovery.

If a recipient who is not permanently institutionalized (non PI) was 65 years of age prior to October 1, 1993, a claim may be made against the estate for the amount of Medicaid paid from the date the recipient became 65 until his/her death. If such recipient was less than 65, but more than 55 years of age as of October 1, 1993 then a claim may be made against the estate for the amount of Medicaid paid from the date the recipient became 55 years old or October 1, 1993, whichever is later

The local social services district is a preferred creditor of the estate. After the payment of funeral and burial expenses, the recovery of Medicaid is subject to the funds remaining in the estate including: probate assets, non-probate assets, excess revocable burial funds and payments for burial space items that are not used after the payment of funeral. After all debts of the estate are satisfied, including Medicaid, the remainder goes to the beneficiary or beneficiaries designated by will or by law if no will exists.

Social services districts must notify affected heirs when an estate claim is made and give the individuals an opportunity to request an undue hardship waiver.

Districts must evaluate the cost effectiveness of pursuing Medicaid recoveries. Cost effectiveness is based on factors including but not

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limited to: the administrative cost of court action, the amount of Medicaid paid, the availability of assets from which to recover, and previous experience with the court.

Notice of Claim

Upon notification of the death of the Medicaid recipient or the surviving spouse of such individual, the local department of social services shall issue "Notice of Claim-Non Probate Assets" reproduced on district letterhead, "Medicaid Estate Recovery Questionnaire", and "Important Information Regarding Medicaid Estate Recovery" to the fiduciary of the decedent's estate, and, if applicable, to the person in possession of property or assets in which the decedent had any legal title or interest at the time of death.

NOTE: For estates with a fiduciary, the district should file its claim within seven months from the date the fiduciary is first appointed to probate the decedent's will. If the district files its claim after this seven month period, the fiduciary will not be liable if he or she has in good faith paid other claims or distributed the estate.

OTHER ELIGIBILITY REQUIREMENTS RECOVERIES

CONFINEMENT AND PREGNANCY RELATED EXPENSES

Policy:

Confinement recoveries are not pursued during a woman's pregnancy, during the 60-day period beginning on the last day of the pregnancy or during the remainder of the calendar month in which the 60th day occurs.

The father's liability for confinement expenses depends on his legal relationship with the mother and child and on the father's financial circumstances as described in below:

When the father is married to the mother, he is not liable for payment of confinement expenses for the mother and child if:

1. the father's income was considered available in determining the pregnant woman/mother's Medicaid eligibility; or
2. the father's income was at or below Medicaid standards at the time of birth of the child; or
3. the father was in receipt of TANF or Medicaid at the time of birth of the child.

If any of the above circumstances apply, the father is not liable for confinement expenses.

When the father is not married to the mother, his liability for the mother's confinement expenses may be determined by the court at a hearing to establish paternity and support. However, no confinement expenses are pursued when the local district determines that the father currently has income at or below the applicable Medicaid standard or is currently in receipt of TANF or Medicaid. When paternity and responsibility for prospective medical support have already been established and the father's financial circumstances do not warrant pursuit of confinement expenses, the A/R is not referred to Child Support Enforcement Unit (CSEU).

Where the father, regardless of marital status, is not in receipt of Medicaid or TANF and his income is unknown and cannot be determined for the relevant period of time, the local district may pursue confinement expenses. This allows the court to conduct an inquiry into the father's financial circumstances.

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RECOVERIES**

CONFINEMENT AND PREGNANCY RELATED EXPENSES

When the father is not married to the mother his liability for the child's expenses is evaluated in the same manner as explained in (1) through (3).

- References:** LCM 04 OMM/LCM-4
GIS 08 MA/031

Interpretation: The following chart summarizes the legal relationship of the father to the mother and the time period for which the father's income is considered.

Marital status:	Expenses of:	When ability to pay measured:
Married	Mother	Time of Birth
Married	Child	Time of Birth
Unwed	Mother	Time of Hearing
Unwed	Child	Time of Birth

NOTE: This chart only deals with the recovery of Medicaid furnished for the mother's confinement expenses and the child's birth related expenses paid for the child before the child leaves the hospital. Regardless of marital status, there is legal authority to pursue an order of medical support prospectively against the absent father of a child receiving Medicaid.

Documentation: When an eligibility worker refers a case to the CSEU for reasons that include recovery of confinement or pregnancy related expenses, the referral includes documentation of such expenses in a format that is acceptable as evidence to the court. When testimony is needed to establish liability for, or the amount of, confinement costs, the local district arranges for qualified staff to testify regarding the Medicaid expense records. These Medicaid expense records are not needed to establish paternity or pursue prospective medical support.

OTHER ELIGIBILITY REQUIREMENTS RECOVERIES

LIENS

Description: A lien is a legally filed claim against property as security for the payment of a debt.

Policy: Generally a lien may be placed against a recipient's:

- exempt real property if the individual is permanently institutionalized; and
- personal injury claim or suit for Medicaid expenditures related to the injury.

A claim may be placed against a recipient's:

- estate including non-probate assets, if the deceased recipient was 55 years of age or older when he or she received Medicaid; and
- estate including non-probate assets, if the deceased recipient of any age was permanently institutionalized.

References:

SSL Sect.	104 106 366.3(a) 369
Dept. Reg.	360-7.11
ADMs	11 OHIP/ADM-8 09 OHIP/ADM-3 02 ADM-03 92 ADM-53

Interpretation: When a recipient is permanently institutionalized and has an interest in real property that is exempt for purposes of Medicaid eligibility, is anticipating a court award, settlement, or claim that resulted from a personal injury or has died and left an estate, a lien is placed against the exempt real property, award, settlement, claim or estate. An award, settlement or claim may result from, but is not limited to insurance payments and lawsuits. Generally, liens against real property and estates are for the amount of Medicaid correctly paid on behalf of the individual, while liens for personal injury are for the cost of medical care provided to treat the personal injury.

Incorrectly paid Medicaid is any Medicaid furnished to a recipient at a

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LIENS

time when s/he was ineligible. Only by instituting a court action pursuant to SSL Section 369 (2)(a)(i) can a district place a lien on a recipient's real property to recover Medicaid incorrectly paid.

NOTE: If an institutionalized individual is discharged and returns to the community, any liens against his/her real property are removed. If the individual wants to continue Medicaid coverage, his/her eligibility is determined based on his/her new circumstances.

Liens May Not Be Imposed

- Against an A/R's homestead
 - When a sibling with an equity interest in the home of a Medicaid recipient lived in the home for at least one year immediately before the recipient was institutionalized and who has lawfully resided in the home continuously since that time;
 - When an adult child who lived in the home of a Medicaid recipient for at least two years immediately before the recipient was institutionalized, who provided care that may have delayed the recipient's institutionalization and who has lawfully resided in the home continuously since that time;
 - Against the real property of a permanently institutionalized individual if the value of the property when counted in determining eligibility results in the applicant having to spend down excess resources. An example is a permanently institutionalized individual who does not intend to return home and does not have a relative that would allow the homestead to be exempt from a lien (as described above). In such instances, the home is treated as a countable resource.

Institutionalized individuals are given an opportunity to transfer his/her homestead to a specified relative, before a lien is imposed. (See **RESOURCES TRANSFER OF ASSETS** for lists of who an A/R may transfer his/her homestead to without penalty.) Generally, the transfer is made within 90 days of the eligibility determination. A longer period may be allowed if necessitated by delays

OTHER ELIGIBILITY REQUIREMENTS RECOVERIES

LIENS

beyond the institutionalized individual's control.

NOTE: A lien may be imposed on a mobile home only if the mobile home is on land owned by the institutionalized individual, and the mobile home has been permanently affixed to the land (e.g., a basement, foundation, or other immovable structure ties the mobile home to the land).

- Against any asset(s) of the recipient including those that pass directly upon the recipient's death to individuals other than a surviving spouse or minor child, or blind or disabled child during the lifetime of the surviving spouse, or at any time when the recipient has a surviving child who is under age 21 or a child of any age who is certified blind or certified disabled.
- Against the income, resources and property belonging to an American Indian or Alaskan Native.
- Against government reparation payments paid to special populations.
- Against Workers' Compensation, volunteer firemen's benefits, Social Security, SSI or other such benefits.
- Against the recipient's personal injury action that was filed against a nursing home. This prohibition runs for the lifetime of the recipient.
- Against the personal account of a veteran who died in a Veteran's Administration (VA) nursing facility. If a veteran was transferred from a non-VA facility to a VA facility (e.g. a VA hospital) for treatment and died while in the VA facility no recovery from the personal account maintained by the non-VA facility is pursued. Similarly if the VA contracted for the care of a veteran in a private nursing facility at VA expense recovery is not sought from the personal account maintained by the private nursing facility.
- Against payments made through the Office of Mental Health Comprehensive Outpatient Program (COPs).

If the prohibited period ends (e.g., the spouse dies or a minor child reaches the age of 21) or in the case of a decedent's home, the sibling or adult child no longer resides in the home or the property is to be sold, a recovery can then be pursued.

OTHER ELIGIBILITY REQUIREMENTS RECOVERIES

LIENS

Liens and Qualified Partnership Policyholders

The extent to which liens may be imposed and recoveries pursued with respect to Medicaid recipients who are Qualified Partnership Policyholders (QPPs) depends on the type of plan chosen by the QPP.

Total Asset Protection Plans (TAP) - No liens may be imposed against the real property of a permanently institutionalized individual who is a TAP QPP nor may recoveries be made from the estate of a TAP QPP.

Dollar-for-Dollar Asset Protection (DDAP) Plans - Since homes of DDAP QPPs must be evaluated for their exempt/countable status, a lien shall be placed on the real property of the permanently institutionalized individual DDAP QPP in an amount equivalent to his/her unprotected resources, if any.

Real Property Post Death Lien

If not otherwise prohibited (as described above), a post death lien may be placed on real property that passes outside the probate estate to a joint owner, heir, dependent or survivor to secure their obligation to pay the Medicaid estate claim up to the value of the property received. Such liens should be imposed against real property as soon as practicable after the individual's death to put mortgage lenders and prospective purchasers of the property on notice of the Medicaid program's claim against the property.

Notices

- "Informational Notice to Institutionalized Individuals with Real Property" is provided to the individual at the time of application.
- LDSS 4466 "Notice of Intent to Impose a Lien on Real Property" is provided when the district has determined that a lien will be filed on specified real property.
- "Notice of Medical Assistance Lien" is a sample notice of lien that may be adapted for purposes of filing a SSL Section 369 lien against real property.

**OTHER ELIGIBILITY REQUIREMENTS
RECOVERIES****VOLUNTARY REPAYMENTS**

Disposition: A voluntary repayment is a payment made by a recipient, without coercion, to the local district for Medicaid correctly or incorrectly paid.

Policy: A client may elect to reimburse a local social services district for Medicaid correctly or incorrectly paid. Reimbursement for Medicaid correctly paid is always voluntary. The record clearly documents that the decision to reimburse the district was totally voluntary and that the client fully understood that s/he had no obligation to provide reimbursement. An SSI-related recipient who receives a lump sum payment, placing him/her over the resource limit, may choose to reimburse the district for previously paid medical bills and continue his/her eligibility uninterrupted.

See **OTHER ELIGIBILITY REQUIREMENTS RECOVERIES** for recovery and voluntary reimbursement or repayment of assistance incorrectly paid.

References: Dept. Reg. 360-7.11

ADM 02 ADM-03

Documentation: A statement from the A/R or his/her representative that the repayment was voluntary. The statement should include the amount of the repayment and when appropriate, the services or time period covered by the repayment.

When the repayment is for assistance correctly paid, the statement clearly indicates that the decision to reimburse was totally voluntary and that the A/R understands s/he is under no obligation to reimburse the district.

OTHER ELIGIBILITY REQUIREMENTS

STATE AND FEDERAL CHARGES

Description:

Generally the cost of any care provided through federally reimbursable (FP) Medicaid is shared by the federal, State and local government at a rate of 50/25/25. Under certain circumstances, the federal and/or State government assumes responsibility for a greater share or the full cost of care provided by the Medicaid program. For example: the federal government is responsible for approximately 50%, the State for about 40% and the local government around 10% of the cost of care provided to recipients of certain long term care services.

Federal charge refers to care fully reimbursed by the federal government; there is no local or State share. State charge refers to care reimbursed by both the federal and State governments or by the State alone. There is no local share in the cost of care provided to a recipient entitled to State or federal charge status.

NOTE: New York State is currently providing Medicaid with federal participation to most recipients, regardless of category. This time limited waiver was granted pursuant to Section 1115 of the Social Security Act.

Policy:

The cost of Medicaid may be borne completely by the State government, or it may be shared with the federal and local governments. The cost of care for a specified time period for refugees and Cuban-Haitian entrants is totally reimbursable by the federal government. The cost of care is fully reimbursed by the State and/or federal government for: Native Americans and their families residing on reservations; and individuals who have been patients in an Office of Mental Health (OMH) or Office for People with Developmental Disabilities (OPWDD) facility for five or more continuous years under Chapter 621 of the Law of 1974.

NOTE: The New York State Veteran's Home at Oxford is a State-operated facility for New York State veterans and their dependents. The State and federal government are financially responsible for veterans and their dependents who are patients at the Oxford Home. Local districts are administratively responsible for determining MA eligibility and processing the eligibility for these A/Rs.

New York State also operates other nursing facilities for veterans. These facilities include the New York City Veteran's Home at St. Albans, the New York State Veteran's Home at Batavia and

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STATE AND FEDERAL CHARGES

the Long Island Veteran’s Home. Local districts share in the administrative and fiscal responsibility for residents of these facilities.

NOTE: To assure proper claiming special coding is available through WMS.

References:	SSL Sect.	2.19 62.4(c) 153 365
	ADMs	97 ADM-2 OMM/ADM 97-1 96 ADM-7 82 ADM-24 81 ADM-47
	INFs	89 INF-43 88 INF-67
	LCM	95 LCM-92

Interpretation: This section discusses: A/Rs for whom local districts retain only the administrative responsibility of providing Medicaid, but no fiscal responsibility; and A/Rs for whom local districts have no responsibility (eligibility is determined by the State). It is organized as follows:

Native Americans and their families living on a reservation;

Refugees and Cuban-Haitian entrants;

Human Services Overburden;

OMH/OMR Chapter 621 eligibles.

Office of Mental Health (OMH);

Office for People with Developmental Disabilities (OPWDD).

**OTHER ELIGIBILITY REQUIREMENTS
STATE AND FEDERAL CHARGES**

NATIVE AMERICANS AND THEIR FAMILIES LIVING ON A RESERVATION

Policy: There is no local participation in the cost of Medicaid provided to Native Americans and their families living on reservations in New York State. When such a person is eligible (See **OTHER ELIGIBILITY REQUIREMENTS NATIVE AMERICANS**), the cost of his/her care is shared by the State and federal government.

NYS will receive 100% Federal Financial Participation (FFP) when Medicaid services are provide through an Indian Health Services facility, whether operated by the Indian Health Service or by an Indian tribe or tribal organization, to Native Americans living on a reservation.

References:

SSL Sect.	2.19(b) 368-a(1)(c)
SSA	1095 (b)

Interpretation: Although there is no local share in the cost of Medicaid provided to Native Americans and their families living on reservations, local districts remain administratively responsible for processing the cases of such persons. For Native Americans not living on reservations and receiving Medicaid, the local share of the cost of care is the usual percentage. (See **OTHER ELIGIBILITY REQUIREMENTS STATE AND FEDERAL CHARGES**)

Disposition: Local districts determine Medicaid eligibility for Native Americans and their families living on reservations using the appropriate category. The cost of care for such persons is fully reimbursed by the State or by the State and federal government.

**OTHER ELIGIBILITY REQUIREMENTS
STATE AND FEDERAL CHARGES****HUMAN SERVICES OVERBURDEN**

Policy: The State will reimburse 100% of the local share for Medicaid expenses paid on behalf of an overburden-qualifying mentally disabled person.

References: INFs 89 INF-43

Interpretation: The local share of Medicaid expenditures for qualifying mentally disabled recipients is 100% reimbursable by the State. For Human Services Overburden funding, a person defined as mentally disabled meets one of the following criteria:

- (1) resides in a Residential Treatment Facility certified by the New York State Office of Mental Health or in an Intermediate Care Facility for the Developmentally Disabled certified by the New York State Office for People with Developmental Disabilities;
- (2) was discharged from a New York State Office of Mental Health Psychiatric Center or New York State Office for People with Developmental Disabilities Developmental Center from April 1, 1971 to December 31, 1982 and has 90 or more cumulative days of inpatient treatment;
- (3) resides in a community-based facility as certified by the New York State Office of Mental Health or the New York State Office for People with Developmental Disabilities. This includes A/Rs who:
 - have received services in certified Community Residences (CR) or Individual Residential Alternatives (IRA);
 - are residents of schools certified by the New York State Office for People with Developmental Disabilities;
 - are inpatients in Terrance Cardinal Cook (Flower Hospital); or
- (4) receives a minimum of 45 visits in any calendar quarter of day or continuing day treatment programs (including Subchapter A day treatment).

**OTHER ELIGIBILITY REQUIREMENTS
STATE AND FEDERAL CHARGES**

OMH/OPWDD CHAPTER 621 ELIGIBLES

Description: Full State and federal reimbursement is available for the cost of care provided to A/Rs who meet the requirements for State charge funding under the provisions of Chapter 621 of the Laws of 1974. These A/Rs are frequently referred to as 621 eligibles.

621 eligibles are A/Rs who: are discharged from a psychiatric center operated by the Office of Mental Health (OMH) or a developmental center being operated by the Office for People with Developmental Disabilities (OPWDD) (including stays in Family Care); and have spent five or more continuous years in these facilities.

Policy: Local districts are responsible for determining Medicaid eligibility for 621 eligibles residing within the geographic boundaries of the district regardless of other residency rules (See **OTHER ELIGIBILITY REQUIREMENTS DISTRICT OF FISCAL RESPONSIBILITY**). There is no local district financial participation in the cost of care for 621 eligibles.

NOTE: 621 eligibility is determined solely by OMH or OPWDD and is transmitted to the Department in an automated file that is loaded onto eMedNY which is then used in paying claims.

References:

SSL Sect.	62 131 365
ADMs	97 ADM-1 82 ADM-72 75 ADM-28 74 ADM-134
INFs	11 OHIP/INF-1 89 INF-43
LCMs	95 LCM-92

Interpretation: 621 eligible persons have their eligibility for Medicaid determined by the local social services district in which they are found. The local district determines eligibility and processes the A/R's case, regardless of other residency issues. Full reimbursement for the cost of medical care for 621 eligibles is available from the State and federal government.

OTHER ELIGIBILITY REQUIREMENTS**OMH/OPWDD CHAPTER 621 ELIGIBLES**

- Verification:** 621 status is verified by the “OMR/OMH 621 Eligibles Discharge Date” field on eMedNY.
- When to Verify:** When an A/R or his/her representative indicates that s/he was a resident in an OMH or OPWDD facility;
- when an A/R or his/her representative states that s/he is 621 eligible; or
 - when an A/R is living in an OMH or OPWDD community facility.
- Disposition:** Local social services districts are responsible to determine Medicaid eligibility for 621 eligible persons living within their district. The cost of care for these persons is fully reimbursed by the State and federal government.

**OTHER ELIGIBILITY REQUIREMENTS
STATE AND FEDERAL CHARGES**

OFFICE OF MENTAL HEALTH (OMH)

Policy: The Office of Mental Health (OMH) is responsible for providing care to persons with mental illness, as defined in Mental Hygiene Law.

References:

ADM	97 ADM-1
INF	89 INF-43
LCMs	93 LCM-40 92 LCM-119

Interpretation: The following are living arrangements, operated or certified by OMH, with which local districts have the greatest contact:

- (1) Psychiatric Centers (PC) (Adult, Children, and Forensic) - The State Department of Health (SDOH) in conjunction with OMH is responsible for determining Medicaid eligibility for A/Rs in PCs. Medicaid funding is shared jointly (50/50) by New York State and the federal government;
- (2) Family Care (FC) - The SDOH in conjunction with OMH is responsible for determining Medicaid eligibility for A/Rs in State Operated Family Care (SOFC) facilities. Local districts are responsible for determining Medicaid eligibility for A/Rs in Voluntary Operated Family Care (VOFC) facilities. Medicaid funding is shared jointly (50/50) by New York State and the federal government;
- (3) Residential Treatment Facilities for Children and Youth (RTF) - The SDOH in conjunction with OMH is responsible for determining Medicaid eligibility for A/Rs in RTFs. Medicaid funding is shared jointly (50/50) by New York State and the federal government;
- (4) Community Residence (CR) - Generally, the SDOH in conjunction with OMH is responsible for determining Medicaid eligibility for A/Rs in State Operated Community Residences (SOCR). (See 89 INF-43 for exceptions.) Local districts are responsible for determining Medicaid eligibility for A/Rs in a Voluntary Operated Community Residence (VOCR). Generally for SOCRs, Medicaid funding is shared jointly (50/50) by New York State and the federal government. For A/Rs in VOCRs, Medicaid funding is shared (50/25/25) by the

OTHER ELIGIBILITY REQUIREMENTS STATE AND FEDERAL CHARGES

OFFICE OF MENTAL HEALTH (OMH)

federal government, New York State and local districts. For all categories, except S/CC, local districts receive reimbursement of the local share through overburden (See **OTHER ELIGIBILITY REQUIREMENTS STATE AND FEDERAL CHARGES HUMAN SERVICES OVERBURDEN**);

NOTE: New York State is currently providing Medicaid with federal participation to most recipients, regardless of category. This time-limited waiver was granted pursuant to Section 1115 of the Social Security Act.

- (5) Residential Care Centers for Adults (RCCA) - The SDOH in conjunction with OMH is responsible for determining Medicaid eligibility for A/Rs in State Operated Residential Care Centers for Adults (SORCCA). Local districts are responsible for determining Medicaid eligibility for A/Rs in Voluntary Operated Residential Care Centers for Adults (VORCCA). For A/Rs in SORCCAs, funding is shared jointly (50/50) by the federal government and New York State. For A/Rs in VORCCAs, funding is shared (50/25/25) by the federal government, New York State and local districts. Local districts receive reimbursement of the local share through overburden (See **OTHER ELIGIBILITY REQUIREMENTS STATE AND FEDERAL CHARGES HUMAN SERVICES OVERBURDEN** and NOTE above);
- (6) Family Based Treatment (FBT) - The SDOH in conjunction with OMH is responsible for determining Medicaid eligibility for A/Rs in FBT. Medicaid funding is shared jointly (50/50) by the federal government and New York State.
- (7) Teaching Family Homes (TFH) - The SDOH in conjunction with OMH is responsible for determining Medicaid eligibility for A/Rs in TFH. Medicaid funding is shared jointly (50/50) by the federal government and New York State.

**OTHER ELIGIBILITY REQUIREMENTS
STATE AND FEDERAL CHARGES**

OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

Policy: The Office for People with Developmental Disabilities (OPWDD) is charged with the responsibility of caring for persons who are developmentally disabled as defined in Mental Hygiene Law.

References:

ADM	97 ADM-1
INFs	92 INF-33 89 INF-43
LCMs	94 LCM-24 93 LCM-62 92 LCM-170

Interpretation: The following are living arrangements operated or certified by OPWDD, with which local districts have the greatest contact:

- (1) Developmental Centers (DC) - The State Department of Health (SDOH) in conjunction with OPWDD is responsible for determining Medicaid eligibility for A/Rs in DCs. Medicaid funding is shared jointly (50/50) by New York State and the federal government;
- (2) Small Residential Units (SRU) - The SDOH in conjunction with OPWDD is responsible for determining Medicaid eligibility for A/Rs in SRUs. Medicaid funding is shared jointly (50/50) by New York State and the federal government;
- (2) Family Care (FC) - The SDOH in conjunction with OPWDD is responsible for determining Medicaid eligibility for A/Rs in State or Voluntary Operated Family Care homes. For A/Rs in State and Voluntary Operated FCs, Medicaid funding is shared jointly (50/50) by the federal government and New York State.
- (3) Community Residence (CR) and Individual Residential Alternative (IRA) - The SDOH in conjunction with OPWDD is responsible for determining Medicaid eligibility for 621 eligible individuals in State Operated Community Residences (SOCRs) and State Operated Individual Residential Alternatives (SOIRAs). Local districts are responsible for determining Medicaid eligibility for all other A/Rs in VOICRs or VOIRAs and non-621 individuals in SOICRs. For State

**OTHER ELIGIBILITY REQUIREMENTS
STATE AND FEDERAL CHARGES**

OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

administered cases and 621 eligible local district cases, Medicaid funding is shared jointly (50/50) by the federal government and New York State. For all categories except S/CC, non-621 eligible A/R's Medicaid funding is shared (50/25/25) with the local share reimbursable through overburden funding. (See **OTHER ELIGIBILITY REQUIREMENTS STATE AND FEDERAL CHARGES HUMAN SERVICES OVERBURDEN**)

NOTE: New York State is currently providing Medicaid with federal participation to most recipients, regardless of category. This time-limited waiver was granted pursuant to Section 1115 of the Social Security Act.

- (5) Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) - The SDOH in conjunction with OPWDD is responsible for determining Medicaid eligibility for 621 eligible A/Rs in State or Voluntary Operated ICF/DDs. Local districts are responsible for determining Medicaid eligibility for non-621 eligible A/Rs in State or Voluntary Operated ICF/DDs. For 621 individuals, Medicaid funding is shared jointly (50/50) by the Federal government and New York State.

For non-621 individuals, Medicaid funding is shared 50/25/25 with the local share being reimbursed through Overburden funding for all categories, except S/CC.

OTHER ELIGIBILITY REQUIREMENTS

SOCIAL SECURITY ENUMERATION

Policy:

With certain exceptions, all applicants must tell the local social services district what their Social Security Number (SSN) is or apply for an initial or replacement Social Security card.

NOTE: There are three exceptions to this policy:

- An undocumented alien, applying for Medicaid coverage of care and services necessary for the treatment of an emergency medical condition, is not required to apply for or provide an SSN.
- A pregnant woman is not required to apply for or provide an SSN. Districts cannot require a pregnant woman to provide an SSN until the end of the month in which the sixtieth (60th) day following the end of her pregnancy occurs. (See **CATEGORICAL FACTORS MEDICAID EXTENSIONS/CONTINUATIONS**) However, some pregnant women may want to provide a SSN and may do so.
- An SSN is not required for a child, born to a woman eligible for and receiving Medicaid, at the time of the child's birth for up to one year. **NOTE:** Deemed newborns are required to provide an SSN upon reaching one year of age. (See **CATEGORICAL FACTORS MEDICAID EXTENSIONS/CONTINUATIONS**)

References:

Taxpayer Relief Act of 1997

SSL Sect. 131-c

Dept. Regs. 369.2(b)(1)
370.2(c)(3)

ADMs 10 OHIP/ADM-8
OMM/ADM 97-2
97 ADM-23
93 ADM-4
90 ADM-9
89 ADM-12
88 ADM-47
88 ADM-4
87 ADM-25
83 ADM-29

OTHER ELIGIBILITY REQUIREMENTS**SOCIAL SECURITY ENUMERATION**

	80 ADM-75
	80 ADM-42
INFs	08 OHIP/INF-1 90 INF-14
GISs	00 TA/DC-008 03 MA/008 98 TA/DC-014 07 MA/010

Interpretation: With some exceptions, all Medicaid applicants regardless of age, who fail, or in the case of a child under 21 whose parent or caretaker relative fails, to tell the local social services district what their SSN is, or apply for an initial SSN, are ineligible for Medicaid. A Medicaid application for benefits must not be denied or delayed pending issuance of a social security number. Local district staff must follow up with the recipient if the SSN has not been provided within four months after the SSN application is filed.

See **NOTE** above for the three exceptions.

- The Taxpayer Relief Act of 1997 requires the SSN of each parent to be on the application for an original SSN for a child under 18.
- Effective June 30, 2000, all applications for original SSNs and replacement cards must be made directly to the applicant's local SSA Office. The local SSA office will issue a SSA-5028 (Receipt for Application for a Social Security Number) if the applicant requests verification that s/he has applied for an SSN.
- Except for S/CC, a non-applying legally responsible relative (spouse or parent) of an A/R is not required to furnish a Social Security number. The local district may request the non-applying spouse or parent to provide an SSN, but the individual is informed that the disclosure is voluntary and how the number will be used.

OTHER ELIGIBILITY REQUIREMENTS

SOCIAL SECURITY ENUMERATION

Aliens with work authorization are required to apply for a Social Security Number and card.

NOTE: If the alien with work authorization has an individual Taxpayer Identification Number (ITIN) from the Internal Revenue Service, the ITIN is considered a tax processing number and is not an equivalent to an SSN. In such situations, the alien with work authorization must provide or apply for an SSN.

Aliens without work authorization who appear to meet all eligibility requirements for federal or State funded Medicaid/Family Health Plus, except for the SSN requirement, must be provided with a letter addressed to the Social Security Administration. This letter must be provided by the district to each immigrant who lacks work authorization and is otherwise eligible for benefits. The applicant is directed to submit the letter to the Social Security Administration along with the social security number application (SS5). The district must assist the immigrant with the social security number application if necessary. The required letter formats are found in 08 OHIP/INF-2.

Verification:

Districts must continue to confirm that the SSN provided is correct. The Welfare Management System (WMS) uses two processes; verification and validation that help districts confirm the SSN.

Verification: Verification is the process in which an individual's SSN and demographics are matched to information contained in WMS. Verification is done when a case is in application status. Districts are alerted of any problems through the Resource File Integration (RFI) process.

Validation: Validation is the process in which WMS sends a SSN and certain other individual data to the Social Security Administration (SSA) for comparison. If the SSN and demographic data associated with an individual on WMS match the information on file with the SSA, that individual's SSN is

OTHER ELIGIBILITY REQUIREMENTS**SOCIAL SECURITY ENUMERATION**

validated as correct on WMS. Validation occurs after the case is opened or whenever a change in demographics occurs.

Medicaid A/Rs no longer have to provide documentation of their SSN, except in those cases where either the verification or the validation process fails to confirm the SSN. A copy of the A/R's Social Security card is always acceptable. The district may accept a printed pay stub indicating the SSN, or W-2 Form as documentation.

If the SSN does not validate through this process, the A/R must be notified to provide documentation of the SSN within 10 days (14 days NYC) from the date of notification. If the A/R does not provide documentation of the SSN, Medicaid benefits must be discontinued or denied.

Form SSA-2853 (message from Social Security), verification that an application was made through the Enumeration at Birth (EAB) process, or a copy of the birth certificate indicating enumeration at birth are the primary evidence that a newborn has applied for an SSN. An SSN is not required for a child born to a woman eligible for, and receiving Medicaid, at the time of the child's birth for up to one year.

OTHER ELIGIBILITY REQUIREMENTS**PRESUMPTIVE ELIGIBILITY**

Policy: Presumptive eligibility is Medicaid coverage provided to certain applicants who reasonably appear to meet all of the criteria, financial and non-financial, pending the completion of the full eligibility determination.

References:

SSL Sect.	364-i 4. (a)(e) 364-1 368-a
Dept. Reg.	360-3.7 Part 531
ADMs	08 OHIP/ADM-2 97 ADM-10 90 ADM-9

Interpretation: A/Rs can apply for Medicaid through the presumptive eligibility process if they meet one of the following certain conditions:

- a pregnant women who applies for Medicaid at an Article 28 Pre-natal Care Provider or other entity designated by the State Department of Health, who has been trained to perform presumptive eligibility and perform application assistance ;
- a child under the age of 19 who applies for Medicaid with a Qualified Entity (QE) that has a signed Memorandum of Understanding (MOU) with the State Department of Health, or
- a patient in an acute care hospital awaiting discharge but needing the type of medical care provided by a Certified Home Health Agency, Long Term Home Health Care Program, nursing facility or hospice.

The sections that follow discuss these forms of presumptive eligibility:

- Nursing facility, hospice or home health care services,
- Children up to age 19
- Pregnant women.

**OTHER ELIGIBILITY REQUIREMENTS
PRESUMPTIVE ELIGIBILITY**

**NURSING FACILITY, HOSPICE OR
HOME HEALTH CARE SERVICES**

Policy:

Presumptive eligibility is Medicaid coverage provided to certain applicants who reasonably appear to meet all of the criteria, financial and non-financial, pending the completion of the full eligibility determination.

Presumptive eligibility for nursing facility, hospice or home health care services is available to persons meeting the following criteria:

- (1) the applicant is receiving care in an acute hospital at the time of application;
- (2) a physician certifies that the applicant no longer requires acute hospital care, but requires the type of medical care provided by a Certified Home Health Agency (CHHA), a Long Term Home Health Care Program (LTHHCP), nursing facility or hospice;
- (3) the applicant or his/her representative states that there is insufficient insurance coverage for this type of care and that the applicant would not otherwise be able to pay for that required care;
- (4) it appears that 65% of the cost of care provided by the nursing facility or hospice, would be less than the cost of continued hospital care computed at the Medicaid rate (alternate care rate); and
- (5) the applicant appears to meet all the criteria, financial and non-financial, for Medicaid. A screening checklist is used to eliminate those cases from the presumptive eligibility process which require in-depth reviews to determine eligibility.

Persons applying for presumptive eligibility for home health care services are budgeted as community cases. They are not considered to be in chronic care.

A period of presumptive eligibility begins on the date of discharge from the hospital and continues for sixty (60) days or until the standard eligibility determination is completed, whichever is earlier.

**OTHER ELIGIBILITY REQUIREMENTS
PRESUMPTIVE ELIGIBILITY**

NURSING FACILITY, HOSPICE OR HOME HEALTH CARE SERVICES

During a period of presumptive eligibility, all Medicaid services are covered except:

- (a) hospital-based clinic services;
- (b) hospital emergency room services;
- (c) acute hospital inpatient services (except when provided as part of hospice care); and
- (d) bed hold for an individual determined presumptively eligible for Medicaid coverage of nursing facility services.

References:

SSL Sect.	364-i
Dept. Reg.	360-3.7 531.1
ADM	97 ADM-10

Interpretation: When an application is being made for presumptive eligibility, the local district:

- (1) determines that the applicant meets the above criteria;
- (2) makes an eligibility determination by reviewing the application package;
- (3) notifies the applicant of his/her presumptive eligibility determination within five working days of the receipt of the presumptive eligibility application package or by the discharge date if that date is later. The local social services district sends the "Notice of Decision on Your Presumptive Medicaid Eligibility Application for Home Health or Community Hospice Care Services" or "Notice of Decision on Your Presumptive Medicaid Eligibility Application for Coverage of Nursing Facility Services or Inpatient Hospice Care", whichever is appropriate. The local social services district sends the notice of the client's eligibility to the applicant (in care of the hospital

**OTHER ELIGIBILITY REQUIREMENTS
PRESUMPTIVE ELIGIBILITY**

NURSING FACILITY, HOSPICE OR HOME HEALTH CARE SERVICES

if there is no authorized representative), the hospital, and the proposed provider, if presumptively eligible. In addition, the provider is advised of the client's liability toward the cost of care, if applicable.

NOTE: See 97 ADM-10 for copies of the Notices.

- (4) authorizes the applicant for up to sixty days of presumptive eligibility from the date of discharge from the hospital if the stated conditions are met; and
- (5) processes a routine, complete and fully documented eligibility determination.

Documentation: The DOH-4220, completed by the applicant or authorized representative, is submitted to the local social services district, with the physician's statement that the patient no longer requires care in an acute care hospital, but does require nursing facility, CHHA, LTHHCP, or hospice services. Included with the application package is the completed Screening Checklist (Attachment I to 97 ADM-10), the medical documentation from the hospital of the type of care and, in the case of CHHA services, the amount of care required.

Upon receipt of the application for presumptive Medicaid eligibility, the local social services district must review the application package, including the Screening Checklist, to determine if the applicant meets the basic qualifying conditions to participate in the presumptive Medicaid eligibility program.

The local social services district may ask questions to resolve conflicting information, particularly for items on the Screening Checklist. However, documentation cannot be required to determine presumptive Medicaid eligibility. Attestation of facts is sufficient to determine if an individual is presumptively eligible for assistance.

The local social services district or its agent must agree that the CHHA or LTHHCP services recommended are appropriate. The local social services district agent providing the evaluation of medical need might be a Community Alternative Systems Agency (CASA) or staff in the Medicaid or Long Term Care Unit. The local

**OTHER ELIGIBILITY REQUIREMENTS
PRESUMPTIVE ELIGIBILITY**

NURSING FACILITY, HOSPICE OR HOME HEALTH CARE SERVICES

social services district is neither expected to or required to visit or converse with the applicant or hospital staff at this time to evaluate medical need. The evaluation is performed from the written material provided by the hospital to explain the care required.

The hospital submits medical documentation of the type of care required. The hospital may use the suggested Medical Documentation Transmittal Form (Attachment II to 97 ADM-10) to transmit this information to the local social services district. Documentation of the type of care required should be sufficiently detailed to enable a local social services district to evaluate the appropriateness of LTHHCP or CHHA services. In addition, documentation needs to be sufficiently detailed to enable the local social services district to determine cost effectiveness of CHHA services.

1. Home Care

If the applicant will be receiving the services of a CHHA, the local social services district multiplies the hourly or visit rate for each home health service by the number of hours or visits the patient requires per month. This monthly amount is then divided by 30 days to determine the average daily cost. Sixty five percent of the average daily cost is then compared to the hospital's Medicaid alternate level of care rate to determine cost effectiveness.

No cost comparison is required for persons who will receive their care through a LTHHCP, since in order to participate in the LTHHCP the cost of care in that program must be less than the cost of care in a skilled nursing facility.

2. Nursing Facility and Hospice Services

If the applicant will be receiving nursing facility services, the local social services district compares 65 percent of the average regional Medicaid nursing facility rate with the appropriate (Upstate or New York City/Metro Region) Medicaid alternate level of care rate to determine cost effectiveness.

**OTHER ELIGIBILITY REQUIREMENTS
PRESUMPTIVE ELIGIBILITY**

NURSING FACILITY, HOSPICE OR HOME HEALTH CARE SERVICES

To determine cost effectiveness of hospice services (whether provided to an individual residing in the community or to an institutionalized individual), the local social services district compares 65 percent of the average regional Medicaid nursing facility rate with the appropriate alternate level of care rate.

NOTE: Presumptive eligibility is not available for S/CC.

**OTHER ELIGIBILITY REQUIREMENTS
PRESUMPTIVE ELIGIBILITY**

PREGNANT WOMEN

Policy: Presumptive eligibility is a means of immediately providing Medicaid services for prenatal care pending a full Medicaid determination. All Article 28 Pre-Natal Care providers and others as designated by the SDOH who have been trained must perform a preliminary assessment of a pregnant woman's income and provide application assistance if requested. Then, based upon guidelines established by the Department, s/he determines whether or not the woman is presumptively eligible for a limited array of medical services, based on income.

References:

PHL	2529
Dept. Reg.	360-3.7(d)
ADM	90 ADM-9
INF	90 INF-45
LCM	95 LCM-106
GISs	00 MA/024 97 MA/028 95 MA/034 94 MA/016 91 MA/007

Interpretation: A pregnant woman is presumed eligible for limited Medicaid coverage when it is determined that the woman's income does not exceed 200% of the federal poverty level. The information used in the presumptive eligibility determination does not have to be verified. Pregnant women have the benefit of a larger "family size" by counting other family members (parents, stepparents, siblings, stepsiblings and half-siblings), whether or not they are applying. The income of such family members residing in the household is counted when determining the eligibility of pregnant women and children under the federal poverty levels, with two exceptions:

1. Public Assistance and SSI cash recipients and their income are invisible; and
2. The income/resources of parents are not considered in determining the income/resources available to a pregnant minor.

OTHER ELIGIBILITY REQUIREMENTS PRESUMPTIVE ELIGIBILITY

PREGNANT WOMEN

The following deductions from income are allowed: \$90 from earned income; child care from employment income; \$100 from child support received; and health insurance premiums, if not already deducted from the wages. (See INCOME LIF BUDGETING METHODOLOGY \$90 WORK EXPENSE DISREGARDS and INCOME ADC-RELATED BUDGETING METHODOLOGY CHILD/INCAPCITATED ADULT CARE COST and INCOME ADC-RELATED DISREGARDS and INCOME HEALTH INSURANCE PREMIUMS) All resources are disregarded.

When the pregnant woman's family income is equal to or less than 100% of the federal poverty level, she is presumptively eligible for all care, services and supplies available under the Medicaid program.

When the pregnant woman's family income exceeds 100% of the poverty level, but does not exceed 200%, she is presumptively eligible for Medicaid covered ambulatory prenatal services only.

The Article 28 Pre-Natal Care provider or others designated by SDOH:

- completes the screening checklist at the first visit to determine the applicant's presumptive eligibility;
- assists the pregnant woman in completing the standard application for assistance and assist her with choosing a health plan;
- advises a presumptively eligible woman of her responsibility to complete the Medicaid application process;
- forwards screening checklist and Medicaid application to the appropriate local social services district within five working days; and
- provides the pregnant woman with a copy of the checklist and notice of presumptive eligibility determination.

Outreach sites that are not Article 28 Pre-Natal Care providers or other providers designated by the SDOH are not able to authorize presumptive eligibility.

**OTHER ELIGIBILITY REQUIREMENTS
PRESUMPTIVE ELIGIBILITY**

PREGNANT WOMEN

The local social services district will authorize Medicaid for the presumptively eligible woman. If the woman does not submit the required documentation by the date specified on the documentation checklist, without good cause, her presumptive case may be closed after appropriate notification.

Eligibility for pregnant women is determined as follows:

- (a) If the net household income is equal to or less than 100% of the federal poverty level, the Medicaid level or Medicaid Standard (whichever is most beneficial), the woman and any infant under age one are fully eligible for all Medicaid services.
- (b) If the net household income is above 100% of the federal poverty level and does not exceed 200% of the federal poverty level, the woman is eligible for ambulatory Medicaid prenatal care services and any infant under age one is fully eligible for all Medicaid services. If the net household income exceeds 200% of the federal poverty level, the pregnant woman is referred to the local social services district to determine eligibility for Medicaid under the "spenddown" provisions.

Disposition:

A pregnant woman may be determined presumptively eligible for Medicaid. The provider completes a preliminary assessment of the woman's income and establishes her eligibility based on Department guidelines. If the woman's income is less than 100% of the federal poverty level, she is eligible for all ambulatory Medicaid services. When the income is above 100% but less than or equal to 200% of the poverty level, the pregnant woman is eligible for ambulatory prenatal care Medicaid services only. For the pregnant woman to continue her coverage past the period of presumptive eligibility, she submits the required documentation to the local social services district. Only one period of presumptive eligibility is allowed per pregnancy.

Presumptive Medicaid eligibility begins on the date the provider determines presumptive eligibility. This is usually the date of the pregnant woman's first visit or the date services were first rendered to her. This is also the date of application for on-going Medicaid. Presumptive eligibility continues until a finding of eligibility is made or if the woman does not file a Medicaid application, until the last day of the month following the month after the woman was first found to be presumptively eligible.

**OTHER ELIGIBILITY REQUIREMENTS
PRESUMPTIVE ELIGIBILITY****CHILDREN UNDER THE AGE OF 19**

Policy: Presumptive eligibility is a means of immediately providing Medicaid covered care and services to children under the age of 19. A Qualified Entity (QE) performs a preliminary assessment of the child's eligibility based upon guidelines established by the Department. If the child is found to be presumptively eligible for Medicaid s/he is provided full Medicaid care and services for a limited period of time during which a full determination of eligibility is performed.

References: SSL Sect. 364-i4. (a)-(e)
ADM 08 OHIP/ADM-2

Interpretation: A child under the age of 19 is presumed eligible for full Medicaid coverage when a Qualified Entity determines that the child's household income does not exceed the appropriate federal poverty level (133% for children ages 1-5; 100% for children ages 6-18; and 200% for children under the age of 1).

The information used in the presumptive eligibility determination may be attested to and does not have to be verified in order to authorize presumptive coverage.

The household size is determined by counting the child and the mother of the applying child, and, if she is pregnant, count as 2 (mother plus the unborn child). Count the legal spouse and/or father of the child, if they live in the household. Count as 1 the Caretaker Relative (if no parents live in the household) and if the Caretaker Relative will also be applying for Medicaid. Count all of the children under age 21 in the household whether or not they are applying. Do not count persons who receive Temporary Cash Assistance or SSI cash assistance.

The following deductions from monthly gross income of the household (including the income of the caretaker relative, if they are part of the household count and are applying for Medicaid) are allowed: \$90 from earned income (See INCOME ADC, LIF, AND S/CC-RELATED BUDGETING METHODOLOGY \$90 WORK EXPENSE DISREGARD); child care from employment income (See INCOME ADC, LIF, AND S/CC-RELATED BUDGETING METHODOLOGY CHILD/INCAPACITATED ADULT CARE COST);

**OTHER ELIGIBILITY REQUIREMENTS
PRESUMPTIVE ELIGIBILITY**

CHILDREN UNDER THE AGE OF 19

\$100 from child support received (See **INCOME ADC, LIF, AND S/CC-RELATED DISREGARDS**); and health insurance premiums (See **INCOME ADC, LIF, S/CC AND SSI-RELATED BUDGETING METHODOLOGY HEALTH INSURANCE PREMIUM**), if not already deducted from the wages. Do not count grants, loans, or student wages or grants of Temporary Assistance (TA) and Supplemental Social Security Income (SSI). All resources are disregarded.

When the child under age 19's family income is equal to or less than the appropriate federal poverty level, s/he is presumptively eligible for all Medicaid covered care and services.

The qualified entity who has a signed MOU with SDOH:

- completes a personal screening interview with the A/R using the DOH-4441, "Medicaid Presumptive Eligibility for Children Screening Form";
- contacts the designated toll-free number to determine whether the screened eligible child is entitled to PE (**NOTE:** a child is entitled to only ONE period of PE in a 12 month period);
- provides the applying household a determination letter on the approved form, "Presumptive Eligibility for Children Screening Determination Letter", OHIP-0012 indicating their findings, and advises the applying household of the next steps in the process, which includes mandatory completion of a full application for Medicaid (DOH 4220, ACCESS NY Application) if eligible for PE, and/or referrals to the LDSS, or to a Facilitated Enroller if ineligible for PE.
- informs the applicant/representative of his/her rights and responsibilities as well as issuing required informational materials and brochures;
- assists the PE eligible applicant/representative with the "Access NY Health Care Application", DOH-4220 which must be completed, signed and properly documented in order for the LDSS to determine ongoing Medicaid eligibility. Responsibilities including requesting and compiling necessary documentation are delegated to the QE;

NOTE: QE's may enter into formal agreements with Facilitated Enrollers (FEs) to assist them in the Medicaid application,

OTHER ELIGIBILITY REQUIREMENTS PRESUMPTIVE ELIGIBILITY

CHILDREN UNDER THE AGE OF 19

documentation requirement and collection process. However, the QE continues to be responsible for the PE screening process and issuance of the PE screening determination form.

- forwards the completed application package (the PE for Children Screening form; PE for Children Determination letter; DOH 4220 application form; and, all documentation needed to determine eligibility) within 21 days from the date of initial screening (or within a reasonable extended timeframe if the applicant is making a good-faith effort to secure necessary documentation).
- QEs are not to forward completed PE screening forms to the LDSS for children who do not screen as PE eligible. The QE should provide the ineligible household with the DOH-4220 application form to complete and submit to a Facilitated Enroller or to the LDSS. Children are to be referred to FEs and/or Child Health Plus health plans.

The local social services district:

- designates one or more staff as a liaison to the designated QEs;
- accepts completed PE/MA application packets from the QE and processes them in a timely manner, but in no event later than 30 days from the date of the QE screening/assessment for pregnant women and children, and within 45 days for all other applications not requiring a disability determination;
- allows for a reasonable extension of time and extends PE coverage so that the applying household and/or the QE/FE can obtain required documentation;
- determines eligibility for the 3-month retroactive period as appropriate **NOTE:** Retroactive eligibility cannot be provided to children who are eligible for presumptive coverage only ;
- provides notice of the results of the final Medicaid eligibility determination simultaneously to the applicant and the QE including the CIN for billing purposes;
- documents in the case record delays in the receipt of completed applications from the QE that result in untimely determinations of eligibility;

**OTHER ELIGIBILITY REQUIREMENTS
PRESUMPTIVE ELIGIBILITY**

CHILDREN UNDER THE AGE OF 19

- open and maintain Medicaid case (s) including all undercare and renewals for individuals found eligible for ongoing coverage for a period of no less than 12 months from the date of screening/application. If the PE-only eligible child turns age 19 during the PE authorization period, authorizes the PE-only case to the last day of the month in which the child turns age 19;

Disposition:

Parents/guardians of children up to age 19 may attest to basic information including citizenship, identity, residency, household size and composition and income during a brief interview with a Qualified Entity. The QE may provide services under Medicaid presumptive eligibility when the screened child's estimated family income (after applying simple disregards), does not exceed the applicable income standards. The PE eligible child may receive all care, services and supplies covered by the Medicaid program, from any Medicaid enrolled provider, prior to a full Medicaid determination by the LDSS. A CBIC card will not be issued for the PE period. Cards will be issued only for fully eligible MA children.

Children screened eligible for PE may receive ONE presumptive coverage authorization period in a 12-month period. Children found fully eligible will be authorized for no less than 12 months of Medicaid coverage OR through the last day of the month in which their 19th birthday occurs, whichever is earlier.

A completed MA application, DOH 4220, must be submitted by the QE along with the PE screening form and supporting documentation.

OTHER ELIGIBILITY REQUIREMENTS**IMMEDIATE MEDICAL NEED**

Policy: An A/R with an immediate medical need is referred to a hospital and/or advised to seek medical care.

References: ADM 86 ADM-7

Interpretation: Applicants who indicate that they have a medical need are advised to seek medical care. When a local district believes that an A/R requires immediate medical care, i.e., a life-threatening situation, the A/R is referred to a hospital. Under 10 NYCRR Part 405, hospitals are obligated to provide care to the individual regardless of the source of payment. An applicant may advise his/her medical provider that s/he has applied for Medicaid and that if s/he is eligible, reimbursement may be available for care and services provided up to three months prior to the month of application.

The application is processed as quickly as possible. When primary sources of documentation are not available, secondary sources are used as appropriate.

OTHER ELIGIBILITY REQUIREMENTS

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

Policy: COBRA allows certain persons who lose their health insurance coverage, provided through an employer, to continue coverage by paying the entire premium himself or herself. The premium is paid at the group rate paid by the employer. Generally, COBRA continuation election must be made within 60 days of the date coverage ends or the date of notice of the coverage option from the plan administrator, whichever is later. The plan must allow no less than 45 days from the date of the initial election to pay for the premium for the period beginning the day coverage would otherwise have ended. Coverage can continue for 18 to 36 months depending on the circumstances.

References:

SSL	104 367-a (1) (d)
Dept Reg	360-3.2 360-4.6(a) 360-4.7(b) 360-7.5(h)
ADMs	91 ADM-53 91 ADM-27 87 ADM-40
GISs	09 MA/024 97MA/001

Intrepretation: To be a COBRA Continuation Beneficiary (CCB), the individual must meet the following conditions:

1. Be an employee, spouse, or dependent child (ren) of the employee, or a retiree and/or his/her dependents or surviving spouse.
2. Have lost group health insurance coverage because of one of the following:
 - Death of the covered employee
 - Termination of covered employee's employment (except due to gross misconduct) or reduction in hours
 - Divorce or legal separation of covered employee from the employee's spouse

OTHER ELIGIBILITY REQUIREMENTS

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

- Covered employee's entitlement to Medicare
- Dependent child loses dependent status under the requirements of the group health plan
- For a covered retiree, the filing of Chapter 11 bankruptcy by the employer under certain circumstances.

A CCB may be eligible for Medicaid to pay the COBRA premium when they meet the following criteria:

- Coverage is available through an employer with 75 or more employees
- The insurance is cost effective
- The A/R's income, using SSI budgeting (See **INCOME SSI-RELATED DISREGARDS**) does not exceed 100% of the Federal Poverty Level
- The A/R's resources, using SSI budgeting (See **RESOURCES SSI-RELATED DISREGARDS**) do not exceed twice the SSI resource level
- The A/R meets all other non-financial requirements for Medicaid eligibility.

When a member of the household, other than the former employee, is eligible for the COBRA Continuation Program Coverage, Medicaid may pay for family coverage. For example: A mother and her 3 children apply for coverage. The mother is receiving Unemployment benefits and her oldest child is receiving child support. The income of the mother and the second child is below 100% of the FPL. The oldest child has income above 100% of the FPL and is not eligible for Medicaid payment of COBRA COVERAGE. However, because the youngest child is eligible for COBRA Continuation Program coverage, Medicaid will pay the premium for family coverage. If it is determined cost effective, the mother and both children will receive health insurance coverage.

Medicaid pays the health insurance premium only. The recipient incurs any co-payments.

OTHER ELIGIBILITY REQUIREMENTS**CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)**

Medicaid payments for premiums may be made to the insurance company, employer, or recipient. Payments are only made to the recipient to reimburse for self-payment or when the employer/insurance company refuses to accept Medicaid payments.

The decision to continue coverage is to be made within 60 days after coverage ends or date of notice of coverage option from plan administrator. Premium payment is to be made within 45 days after election is made to continue coverage. If payment is not made in a timely manner, coverage will end.

Verification:

The following information is verified:

- Group health insurance plan coverage, including COBRA coverage effective date, exclusions to enrollment, services covered and premium amounts;
- That the A/R is CCB eligible;
- The dates of the 60 day enrollment period; and
- All other appropriate eligibility criteria are met.

OTHER ELIGIBILITY REQUIREMENTS**COMPUTER MATCHING**

Policy: All eligibility factors must be documented to substantiate an A/R's eligibility for assistance. When a computer match is used to document factors of eligibility without further verification, the information must be "verified upon receipt". "Verified upon receipt" means that the information from the computer match is coming from a primary source, is timely, and is not questionable.

References: GIS 06 OMM/INF-4

Interpretation: The Department of Labor (Unemployment Insurance Benefits (UIB)), Social Security Administration (RSDI or SSI), etc., are primary sources; there is no need for the district to independently verify the information provided through the match as long as the data is current (within 60 days of the date of case action) and there is no reason to believe that the information from the match is not valid. No further verification is required.

When a computer match involves a secondary source (for example, a contractor that provides information), the case record should be reviewed to determine if the information is already documented. When the information is not documented in the case record, the district needs to verify the accuracy of the information with the client or primary source before initiating any case action.

OTHER ELIGIBILITY REQUIREMENTS

WAIVERS

CARE AT HOME WAIVERS

Description: Section 366.6 & .7 of Social Services Law authorizes the Care At Home (CAH) program. The CAH Medicaid waiver programs were established and began enrolling children December 1, 1985. Currently there are 5 CAH waivers administered by the SDOH; CAH I & II are overseen on a daily basis by the LDSS and CAH III, IV & VI are overseen on a daily basis by the Office for People with Developmental Disabilities (OPWDD) and the Developmental Disabilities Services Office (DDSO) in twelve regional offices.

The CAH programs are 1915(c) Home and Community Based Medicaid waivers that enable children to access Medicaid for medically necessary State Plan services as well as waiver services such as case management and respite. In order to be enrolled in the CAH waiver, the child must meet several criteria. For example, to enroll in CAH I & II the child(ren) must be: under the age of 18, physically disabled based on SSI program criteria, require the level of care provided by a skilled nursing facility or hospital, and be capable of being cared for safely in the community. For CAH III, IV & VI the children must be disabled based on SSI program criteria and in addition have a developmental disability. The disability certification for any of the waivers can be done by the State or LDSS Disability Review Team. The Social Security Administration determines disability for CAH I and II children who are also in receipt of SSI.

NOTE: Applicants no longer require a 30 day inpatient stay.

Each LDSS has a designated CAH coordinator who can be contacted for information regarding the CAH program. It is important for all staff in the LDSS to be aware of the CAH program as applicants may be referred to them from the LDSS CAH coordinator as well as from various other outside sources, such as DDSOs, hospitals, physicians, case management agencies and parents.

Policy: The Medicaid eligibility determination for participants in the CAH waiver is different for CAH I & II and CAH III, IV and VI. Effective 12/01/2008 for CAH I/II, children who are Medicaid eligible based on their parent's income and, if applicable, resources, as well as children who are ineligible for Medicaid based on their parent's income and/or resources, may apply for enrollment in the waiver if they meet the qualifications stated above. For OPWDD CAH waivers (III, IV and VI) only children who are ineligible for Medicaid based on their parent's income and/or resources, may apply for enrollment.

OTHER ELIGIBILITY REQUIREMENTS WAIVERS

CARE AT HOME WAIVERS

For CAH III, IV & VI, and the CAH I/II children who are not otherwise Medicaid eligible based on their parent's income and/or resources, the eligibility determination is made for the child counting only their own income and resources and excluding the income and resources of the parent/legal guardian. The child is considered a household of one and the child's income and resources are compared to the medically needy level for one. If the child is receiving services paid for by a public program (i.e. Early Intervention, School Supportive Health), these services can be used to spend down the child's excess income/resources. (See **INCOME EXCESS** and **RESOURCES EXCESS RESOURCES**)

Enrollment in the CAH waivers ends on the child's 18th birthday. Prior to turning 18 the child may file an application for SSI.

References:	SSL Sect.	366.6 & .7
	ADMs	86 ADM-4 91 ADM-11
	GIS	11 OLTC/001 09 OLTC/04

Interpretation: **CAH III, IV and VI:** When making an eligibility determination for a CAH III, IV and VI applicant, the child must be found ineligible for Medicaid when parental income and resources are budgeted and found eligible when deeming is not applied.

CAH I/II: When making an eligibility determination for a CAH I/II applicant, the child may be:

- found ineligible for Medicaid when parental income and resources are budgeted, but found eligible when deeming is not applied, OR
- be Medicaid eligible when parental income and resources are budgeted.

OTHER ELIGIBILITY REQUIREMENTS WAIVERS

NURSING HOME TRANSITION AND DIVERSION WAIVER (NHTD)

Description: Section 366 (6-a) of the Social Services Law authorizes the Nursing Home Transition and Diversion Waiver (NHTD). The NHTD waiver is overseen on a daily basis by 9 Regional Resource Development Centers (RRDCs) under contract with the New York State Department of Health.

The NHTD is a 1915 (c) Medicaid Home and Community Based Services Waiver (HCBS) authorized by the federal government. This waiver provides a community based alternative for providing care to seniors and persons with physical disabilities who are at least 18 years of age and require nursing home level of care. The waiver allows individuals to access Medicaid for medically necessary State Plan services as well as NHTD waiver services.

Policy: An individual participating in the NHTD waiver must be:

- Assessed to be eligible for nursing home level of care, using the Patient Review Instrument (PRI) (DOH-694) and SCREEN (DOH-695), which must be performed by a certified assessor who can conduct a PRI/SCREEN;
- In receipt of Medicaid coverage for Community Based Long Term Care services OR Outpatient Coverage for Community-Based Long Term Care;
- Capable of living in the community with the assistance of available informal supports, Medicaid State Plan services and one or more waiver service;
- At least eighteen years of age with a physical disability or aged 65 and older; and
- Part of an aggregate group that can be cared for at less cost in the community than in a nursing home.

An individual cannot be enrolled in the NHTD waiver and any of the other HCBS waivers at the same time (i.e. the Long Term Home Health Care Program waiver, the Traumatic Brain Injury waiver, and the Office for People with Developmental Disabilities HCBS waiver). Nor can an individual be enrolled in NHTD and Program of All Inclusive Care of the Elderly (PACE). If an individual is determined to be eligible for more than one waiver, a choice between the NHTD waiver and other HCBS waivers must be made by the applicant and/or legal guardian.

OTHER ELIGIBILITY REQUIREMENTS WAIVERS

NURSING HOME TRANSITION AND DIVERSION WAIVER

Due to the many roles the LDSS has in the NHTD waiver, it is important for all staff in the LDSS to be aware of the NHTD program. The Regional Resource Development Specialist (RRDS) and Service Coordinator must collaborate with LDSS staff to have an understanding of the applicant's history, if any, of participation in Medicaid State Plan community-based services or adult protective services. This collaboration furthers the RRDS and Service Coordinator's understanding of the strengths and needs of the applicant, as well as the availability of informal and formal supports. This knowledge and understanding will enhance the development of the waiver Service Plan and support the applicant's health and welfare if s/he is approved for the NHTD waiver.

The LDSS and/or State DOH retain responsibility for all prior authorizations/approvals of Medicaid State Plan services such as the Personal Care Services Program (PCSP), the Consumer Directed Personal Assistance Program (CDPAP), Personal Emergency Response Services (PERS) or private duty nursing (PDN). It is anticipated the RRDS/Service Coordinator will be in contact with LDSS home care staff when applicants require referrals for assessment and authorization of these services. LDSS home care staff may be asked to participate in team meetings, convened by waiver Service Coordinators, related to development or reassessment of the participant's waiver Service Plan.

In addition, the LDSS is responsible for determining financial eligibility for NHTD A/Rs.

References:	SSL Sect. 366 (6-a)
	ADMs 11 ADM-06 08 OLTC-1
	GISs 11 LTC007 11 LTC004 08 OLTC-03

Interpretation: Individuals interested in participating in the NHTD waiver will be applying for Medicaid coverage for Community-Based Long-Term Care. The RRDS will send a Letter of Introduction to the LDSS for such individuals and will also give a copy of the letter to the individual to bring with him/her when he/she meets with the LDSS to file the application. The LDSS will determine financial eligibility and return the letter, along with the appropriate form(s) and notices, to the applicant and RRDS.

**OTHER ELIGIBILITY REQUIREMENTS
WAIVERS**

NURSING HOME TRANSITION AND DIVERSION WAIVER

Individuals who request Medicaid coverage of NHTD waiver services must provide proof of current income and resources and be otherwise eligible for Medicaid. See **INCOME PERSONS IN MEDICAL FACILITIES BUDGETING FOR INSTITUTIONALIZED SPOUSES IN SPECIFIED HOME AND COMMUNITY BASED WAIVERS (HCBS)** and **INCOME SSI-RELATED BUDGETING METHODOLOGY and RESOURCES PERSONS IN MEDICAL FACILITIES BUDGETING FOR INSTITUTIONALIZED SPOUSES IN HOME AND COMMUNITY BASED WAIVERS (HCBS)**.

OTHER ELIGIBILITY REQUIREMENTS WAIVERS

BRIDGES TO HEALTH (B2H)

Description: Effective January 1, 2008, the federal government authorized the Bridges to Health (B2H) Waiver. The B2H is a federal Home and Community Based (HCBS) Medicaid waiver for children in foster care up to 21 years of age.

B2H provides community based services to children who are in the care and custody of a local department of social services (LDSS) or the Office of Children and Family Services (OCFS) and who have significant mental health care needs, developmental disabilities or medical fragility and who require an institutional level of care.

B2H is administered as three separate targeted 1915(c) Medicaid waivers providing Medicaid State Plan services, and the following waiver services: Health Care Integration, Skill building, Family care giver supports and services, Day habilitation, Prevocational services, Supported employment, Planned respite, Special needs community advocacy and support, Crisis avoidance, management and training, Immediate crisis response services, Intensive in-home supports crisis respite, Accessibility modifications and Adaptive and Assistive equipment.

Policy: Children must be in foster care and categorically eligible for Medicaid to be considered for enrollment in the B2H waivers. B2H participants who are discharged from foster care may remain in the B2H waiver if they meet the waiver and Medicaid eligibility criteria.

References: ADMs 08 OLTC/001

Interpretation: Health Care Integration Agencies (HCIA's) are voluntary child care agencies responsible for the operational and administrative functions of the B2H waivers. The Waiver Service Provider (WSP) networks operate throughout the State to ensure the delivery of comparable B2H services regardless of the location of a child's residence. The existing OCFS regions form the basis for the B2H regional designations. The B2H and OCFS regional designations are identical, with one exception: OCFS Region V is divided into the Lower Hudson Valley and Long Island B2H regions. Please refer to OCFS's website, www.ocfs.state.ny.us/main/b2h/ for specific information regarding the OCFS and B2H regions.

A B2H participant who has been discharged from foster care will have her/his Medicaid eligibility determined based on a household of one, and her/his own income and resources will be compared to the

**OTHER ELIGIBILITY REQUIREMENTS
WAIVERS**

BRIDGES TO HEALTH (B2H)

Medically Needy level. If a child's income and/or resources exceed the Medically Needy level, s/he may spenddown. Either ADC-related budgeting or SSI-related budgeting may be used, whichever is most beneficial to the child. However, if SSI-related budgeting is used, a disability review must be completed. Medicaid and waiver eligibility must be renewed annually. The LDSS will approve children for a B2H waiver based on their qualifying diagnosis; significant mental health care needs, developmental disabilities or medical fragility.

**OTHER ELIGIBILITY REQUIREMENTS
WAIVERS**

TRAUMATIC BRAIN INJURY (TBI) WAIVER

Description: On March 23, 1994, the Medicaid Home and Community-Based Services Waiver for Persons with Traumatic Brain Injuries (HCBS/TBI Waiver) was approved by the Federal Government. This waiver is one component of a comprehensive strategy developed by New York State to repatriate and de-institutionalize individuals with TBIs who reside in nursing facilities (NF) either in or out-of-state and to offer an alternative to NF placement for others currently living in the community who are at significant risk of NF placement. The HCBS/TBI Waiver is designed to provide the necessary services and supports to achieve these objectives.

The TBI Waiver is overseen on a daily basis by 9 Regional Resource Development Center (RRDCs) under contract with the New York State Department of Health. The RRDCs employ Regional Resource Development Specialists (RRDSs) who are responsible for the administration of the daily activities of the TBI Waiver.

Policy: An individual participating or seeking application in the HCBS/TBI Waiver must be:

- Between the ages of 18 and 65 with a primary diagnosis of Traumatic Brain Injury or other related acquired brain injury upon application to the waiver;
- Assessed to be eligible for nursing home level of care as a direct result of the brain injury. Nursing home eligibility is determined by using the Patient Review Instrument (PRI) (DOH-694) and SCREEN (DOH-695), which must be performed by a certified assessor who can conduct a PRI/SCREEN;
- In receipt of Medicaid coverage for Community Based Long Term Care services or Outpatient Coverage for Community Based Long term Care; and
- Capable of living in the community with the assistance of available informal supports, Medicaid State Plan services and one or more waiver services; and
- Part of an aggregate group that can be cared for at less cost in the community than in a nursing home.

An individual cannot be enrolled in the TBI waiver and any of the other HCBS waivers at the same time (i.e. the Long Term Home Health Care Program waiver, the Nursing Home Transition and Diversion

OTHER ELIGIBILITY REQUIREMENTS WAIVERS

TRAUMATIC BRAIN INJURY (TBI) WAIVER

Waiver, and the Office for People with Developmental Disabilities HCBS waiver). If an individual is determined to be eligible for more than one waiver, a choice between the TBI waiver and other HCBS waivers must be made by the applicant and/or legal guardian.

Under the waiver, waiver participants may receive existing MA services and waiver services including: service coordination, independent living skills training and development, structured day programs, substance abuse programs, positive behavioral interventions and support services, community integration counseling, home and community support services, environmental modifications, respite care, special medical equipment and supplies, community transitional services and transportation.

Local departments of social services (LDSS) are responsible for determining the financial eligibility of the TBI Waiver A/Rs.

References: LCMs 96 LCM 37
95 LCM 70

Interpretation: Individuals apply through the RRDC for participation in the TBI waiver. The RRDS will provide the potential waiver participant with a list of available Service Coordination agencies. The applicant will choose a service coordinator who will assist in the development and compilation of all documentation needed to establish the individual's financial and non financial eligibility for the waiver. The individual and the service coordinator develop a comprehensive service plan which will include informal supports, necessary State Plan Medicaid services, any other federal or state programs and specific waiver services necessary to support the individual's health and welfare in the community.

If the individual has not been determined to be MA eligible and/or certified disabled, the RRDS will send a Letter of Introduction which is presented to the LDSS. The LDSS will determine financial eligibility and return the letter, along with the appropriate form (s) and notices, to the applicant and RRDS.

To determine eligibility of TBI A/Rs see **INCOME PERSONS IN MEDICAL FACILITIES BUDGETING FOR INSTITUTIONALIZED SPOUSES IN SPECIFIED HOME AND COMMUNITY BASED WAIVERS (HCBS)** and **INCOME SSI-RELATED BUDGETING METHODOLOGY** and **RESOURCES PERSONS IN MEDICAL FACILITIES BUDGETING FOR INSTITUTIONALIZED SPOUSES IN HOME AND COMMUNITY BASED WAIVERS (HCBS)**.

OTHER ELIGIBILITY REQUIREMENTS WAIVERS

LONG TERM HOME HEALTH CARE PROGRAM (LTHHCP)

Description: The Long Term Home Health Care Program (LTHHCP) also known as the “Nursing Home Without Walls” or “Lombardi Program” is a federal 1915 c Home and Community Based Services waiver (HCBS). It is administered by local departments of social services and overseen by the State Department of Health (SDOH).

This Medicaid waiver was first authorized by the federal government in 1979 and became operational in 1983. It is designed to serve seniors and individuals with physical disabilities who: are medically eligible for nursing facility (NF) level of care; chose to remain at home; have assessed service needs that can be met safely in the home and community; and, have a service plan with Medicaid costs for services which fall within the participant’s county of residence expenditure cap for nursing facility level of care. LTHHCP is available in all counties of New York State with the exception of: Chenango, Essex, Hamilton, Lewis, Livingston, Schoharie and Schuylar.

Pursuant to a written authorization from the State Health Commissioner, LTHHCP services may be provided by a certified home health agency (public or voluntary non-profit organization) or a residential health care facility or a hospital currently certified under Article 28 of the Public Health Law.

The AIDS Home Care Program (AHCP) instituted in 1992 to meet the challenge of the high incidence of AIDS in New York State is a subset of the LTHCCP. Certain LTHHCP agencies are approved by the federal government and New York Department of Health to provide the AHC.

LTHHCP services include: nursing, home health aide services, medical supplies and equipment, therapies (e.g. physical therapy, occupational therapy, speech therapy,), and personal care services including homemaker and housekeeper. In addition there are waiver services including: medical social services, respiratory therapy, nutritional counseling, home maintenance tasks, environmental modifications (home improvement services) and vehicular modifications, respite care both at home or in an institution, social day care, transportation to social day care, home delivered or congregate meals, assistive technology that includes Personal Emergency Response System (PERS), home and community support services, community transitional services, moving assistance, home and community support services, community transitional services and assistive technology.

**OTHER ELIGIBILITY REQUIREMENTS
WAIVERS**

LONG TERM HOME HEALTH CARE PROGRAM (LTHHCP)

Policy:

An individual participating in the LTHHCP waiver (including AHCP participants) must fulfill requirements in three categories:

1. Be medically eligible for placement in a residential health care facility or hospital for an extended period of time;
2. Have total expenditures for health and medical services described in a comprehensive plan of care that do not exceed, on an annual basis, 75% of the monthly cost of care in a RHCF or 100% of the monthly cost when determined as special needs or 50% of the monthly cost when residing in an Adult Care Facility; and
3. Be determined eligible for Medicaid.

An important feature of the LTHHCP is the use of a comprehensive and coordinated assessment process to formulate a summary of the required services and a plan of care. Two distinct assessment processes are required for each individual prior to the development of a summary of services requirements for the individual; these are a medical assessment and a home assessment.

Individuals participating in the LTHHCP are assessed prior to enrollment in the program and must be reassessed for continued participation in the program every 180 days through the use of a joint assessment process between the local department of social services and a certified LTHHCP provider.

References:

- | | |
|------|---|
| ADMs | 11 OLTC/ADM-1
09 OLTC/ADM-01
02 ADM-04
85 ADM-27
83 ADM-74
78 ADM-70 |
| GISs | 11 LTC005
11 LTC008
11 LTC009
10 LTC001
09 OLTC003
09 OLTC002
08 OLTC-008
06 MA-011
05 MA-37
01 MA-035 |

**OTHER ELIGIBILITY REQUIREMENTS
WAIVERS**

LONG TERM HOME HEALTH CARE PROGRAM (LTHHCP)

LCM 07 OHIP/LCM-1

Interpretation: Persons who request participation in the LTHHCP must be determined eligible for Medicaid, if Medicaid is to cover such services. Such persons must comply with the eligibility requirements of the appropriate category of assistance. See: **INCOME, PERSONS IN MEDICAL FACILITIES, CHRONIC CARE BUDGETING METHODOLOGY FOR INSTITUTIONALIZED SPOUSES** and **INCOME SSI-RELATED BUDGETING METHODOLOGY;** and **RESOURCES PERSONS IN MEDICAL FACILITIES.**

**OTHER ELIGIBILITY REQUIREMENTS
WAIVERS****OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES (OPWDD)
HOME AND COMMUNITY BASED SERVICES WAIVER (HCBS)**

Description: The Office for People with Developmental Disabilities (OPWDD) Home and Community Based Services waiver (HCBS) is administered by OPWDD in conjunction with the State Department of Health (SDOH). The waiver is operated on a daily basis by OPWDD Developmental Disabilities Services Offices (DDSOs).

This Medicaid waiver was authorized by the federal government in September 1991 and provides a community based alternative for providing care to adults and children with developmental disabilities who live at home, in Family Care (FC), Community Residences (CRs), or in Individualized Residential Alternatives (IRAs). The HCBS waiver allows individuals to access Medicaid for medically necessary State Plan services as well as waiver services such as: Residential Habilitation, Day Habilitation, Respite, Prevocational Services, Supported Employment, Adaptive Technologies and Environmental Modifications.

Policy: An individual participating in the OPWDD HCBS waiver must:

- Have a developmental disability as defined by MHL 1.03.(22);
- Require an Intermediate Care Facility for the Mentally Retarded (ICF/MR) level of care;
- Reside in a qualifying living arrangement: (FC, CR or IRA, or their own home);
- Submit a waiver application to the DDSO and be approved by the DDSO for waiver services; and,
- Be Medicaid eligible.

Local districts are responsible for determining Medicaid eligibility for individuals seeking enrollment in the waiver who are not already in receipt of Medicaid. Districts are also responsible for the maintenance of new and existing Medicaid cases.

References: LCMs 94 LCM-137
93 LCM-62
92 LCM-170

**OTHER ELIGIBILITY REQUIREMENTS
WAIVERS**

**OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES (OPWDD)
HOME AND COMMUNITY BASED SERVICES WAIVER (HCBS)**

Interpretation: For individuals who are not Medicaid eligible at the time the Waiver application is filed with the DDSO, a referral letter will be given to the Waiver applicant/enrollee to present to the LDSS.

Local districts must utilize the most advantageous eligibility option available to the family including a determination of disability, if necessary, as well as a determination of eligibility for the three month retroactive period, if appropriate, with the following exceptions:

- Children who are certified blind or certified disabled, under the age of 18, who live at home, may have Medicaid eligibility determined by disregarding parental income (and resources) and applying the child's income and resources to the Medically Needy level for a household of one.
- Certified blind or certified disabled children under the age of 18 who are expected to live outside the parental household (in a Waiver qualifying living arrangement) may have eligibility determined by disregarding parental income (and resources) and applying only the child's income and resources to the Medically Needy (or appropriate congregate care) level for a household of one.

NOTE: If the family of a certified blind or certified disabled Waiver child chooses not to apply for Medicaid for other household members, eligibility is to be determined for the Waiver child alone.

Children under the age of 18, who live at home, will be identified to the local district through a referral letter, completed by the local OPWDD Revenue Support Field Office, so the local district will be aware of the authority to waive parental deeming.

When Medicaid eligibility is determined by waiving parental deeming, a child support referral is not pursued.

HCBS Waiver applicants are required to document current resources, so that Community Coverage with Community-Based Long Term Care (coverage code 19) (or Outpatient Coverage with Community-Based Long Term Care, coverage code 21) can be authorized.

**OTHER ELIGIBILITY REQUIREMENTS
WAIVERS**

**OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES (OPWDD)
HOME AND COMMUNITY BASED SERVICES WAIVER (HCBS)**

Under Community Transition Services (CTS), an OPWDD HCBS Waiver participant may receive a payment to enable the individual to establish a basic household when transitioning from an institutional or provider-operated living arrangement to private residence living. These payments may include items such as security deposits, essential household furnishings and set-up fees or deposits for utility or service access. CTS payments are not considered income when determining Medicaid eligibility.

(See **INCOME PERSONS IN MEDICAL FACILITIES BUDGETING FOR INSTITUTIONALIZED SPOUSE IN SPECIFIED HOME AND COMMUNITY-BASED WAIVERS (HCBS)** and **INCOME SSI-RELATED BUDGETING METHODOLOGY** and **RESOURCES PERSONS IN MEDICAL FACILITIES BUDGETING FOR INSTITUTIONALIZED SPOUSES IN HOME AND COMMUNITY-BASED WAIVERS (HCBS)**)

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**REFERENCE/DESK AIDS
CATEGORICAL FACTORS****MEDICAID EXTENSIONS/CONTINUATIONS
SECTION 249E OF THE PUBLIC LAW 92-603**

The complete description of the Section 249E eligibility determination process can be found in CATEGORICAL FACTORS MEDICAID EXTENSIONS/CONTINUATIONS, SECTION 249E OF THE PUBLIC LAW 92-603.

Effective January 1 each year, the factors used to establish 249e eligibility may increase and are identified below:

	RSDI Benefit Increases	RSDI factor
2008	.188	.893
2009	.174	.965
2010	.174	.965
2011	.174	.965
2012	.168	.966

**REFERENCE/DESK AIDS
CATEGORICAL FACTORS**

FAMILY HEALTH PLUS AND FAMILY HEALTH PLUS PREMIUM ASSISTANCE PROGRAM

A full explanation of the use of Family Health Plus premium rates for adults, Medicaid Managed Care rates for children and Medicaid wrap-around service rates can be found in **CATEGORICAL FACTORS FAMILY HEALTH PLUS** and **FAMILY HEALTH PLUS PREMIUM ASSISTANCE PROGRAM**. The following rates are shown for effective April 1, 2008 through March 2009 and beginning January 1, 2010 for nine regions of the State:

WESTERN		FHP Adults		Expanded Children	
		4/08-3/09	1/01/10	4/08-3/09	1/01/10
Counties	Monthly Managed Care Premiums	\$317.31	\$417.10	\$181.14	\$201.40
	Cost of Wrap				
Erie	Vision	\$ 2.08	\$2.15	\$1.03	\$1.25
Genesee	DME	\$2.61	\$2.79	\$0.47	\$0.53
Monroe	ER Transportation	\$2.18	\$2.44	\$1.30	\$1.37
Niagara	Non-ER Transportation	\$0.00	\$0.00	\$1.20	\$1.76
Orleans	(\$0 for adults)				
Wyoming	Dental	\$16.16	\$18.34	\$14.47	\$16.19
	Pharmacy	\$66.78	\$155.00	\$41.00	\$46.47

NORTHEAST		FHP Adults		Expanded Children	
		4/08-3/09	1/01/10	4/08-3/09	1/01/10
Counties	Monthly Managed Care Premiums	\$330.08	\$413.67	\$181.97	\$202.09
	Cost of Wrap				
Albany	Vision	\$2.25	\$2.27	\$1.50	\$1.59
Fulton	DME	\$2.92	\$2.79	\$1.07	\$1.06
Montgomery	ER Transportation	\$1.23	\$1.66	\$1.44	\$1.47
Rensselaer	Non-ER Transportation	\$0.00	\$0.00	\$3.35	\$3.33
Saratoga	(\$0 for adults)				
Schenectady	Dental	\$17.55	\$19.33	\$13.09	\$15.12
Warren	Pharmacy	\$81.30	\$155.00	\$41.00	\$46.47
Washington					

**REFERENCE/DESK AIDS
CATEGORICAL FACTORS**

**FAMILY HEALTH PLUS AND FAMILY HEALTH PLUS PREMIUM ASSISTANCE
PROGRAM**

MID-HUDSON		FHP Adults		Expanded Children	
		4/08-3/09	1/01/10	4/08-3/09	1/01/10
Counties	Monthly Managed Care Premiums	\$377.88	\$458.66	\$212.96	\$230.08
	Cost of Wrap				
Dutchess Orange Sullivan Ulster	Vision	\$1.35	\$1.55	\$1.08	\$1.25
	DME	\$1.31	\$1.62	\$0.63	\$0.61
	ER Transportation	\$1.68	\$1.95	\$1.11	\$1.24
	Non-ER Transportation (\$0 for adults)	\$0.00	\$0.00	\$4.01	\$3.81
	Dental	\$17.30	\$19.15	\$14.21	\$15.93
	Pharmacy	\$92.41	\$155.00	\$41.00	\$46.47

UTICA-ADIRONDACK		FHP Adults		Expanded Children	
		4/08-3/09	1/01/10	4/08-3/09	1/10/10
Counties	Monthly Managed Care Premiums	\$367.85	\$456.77	\$183.49	\$203.33
	Cost of Wrap				
Clinton Essex Franklin Hamilton Herkimer Jefferson Lewis Oneida Oswego St. Lawrence	Vision	\$1.92	\$2.11	\$1.15	\$1.32
	DME	\$1.67	\$1.82	\$0.59	\$0.61
	ER Transportation	\$1.42	\$1.58	\$1.14	\$1.26
	Non-ER Transportation (\$0 for adults)	\$0.00	\$0.00	\$0.58	\$1.31
	Dental	\$21.55	\$22.15	\$14.45	\$16.11
	Pharmacy	\$79.18	\$155.00	\$41.00	\$46.47

**REFERENCE/DESK AIDS
CATEGORICAL FACTORS**

**FAMILY HEALTH PLUS AND FAMILY HEALTH PLUS PREMIUM ASSISTANCE
PROGRAM**

NORTHERN METRO		FHP Adults		Expanded Children	
		4/08-3/09	1/01/10	4/08-3/09	1/01/10
Counties	Monthly Managed Care Premiums	\$337.23	\$436.46	\$194.22	\$211.57
	Cost of Wrap				
Putnam Rockland Westchester	Vision	\$1.46	\$1.61	\$1.37	\$1.52
	DME	\$1.04	\$1.10	\$0.67	\$0.70
	ER Transportation	\$0.82	\$0.88	\$0.68	\$0.92
	Non-ER Transportation (\$0 for adults)	\$0.00	\$0.00	\$2.54	\$2.74
	Dental	\$17.92	\$19.59	\$17.28	\$18.17
	Pharmacy	\$69.88	\$155.00	\$41.00	\$46.47

NYC		FHP Adults		Expanded Children	
		4/08-3/09	1/01/10	4/08-3/09	1/01/10
Counties	Monthly Managed Care Premiums	\$255.10	\$371.65	\$177.35	\$197.01
	Cost of Wrap				
	Vision	\$1.14	\$1.28	\$0.80	\$0.92
	DME	\$0.59	\$0.68	\$0.51	\$0.58
	ER Transportation	\$0.34	\$0.43	\$0.47	\$0.61
	Non-ER Transportation (\$0 for adults)	\$0.00	\$0.00	\$0.28	\$0.33
	Dental	\$14.97	\$15.82	\$10.90	\$11.73
		Pharmacy	\$52.73	\$155.00	\$41.00

LONG ISLAND		FHP Adults		Expanded Children	
		4/08-3/09	1/01/10	4/08-3/09	1/01/10
Counties	Monthly Managed Care Premiums	\$295.36	\$412.48	\$189.14	\$208.76
	Cost of Wrap				
Nassau Suffolk	Vision	\$1.17	\$1.26	\$0.82	\$0.88
	DME	\$0.91	\$0.94	\$0.66	\$0.68
	ER Transportation	\$0.29	\$0.31	\$0.55	\$0.82
	Non-ER Transportation (\$0 for adults)	\$0.00	\$0.00	\$1.79	\$2.20
	Dental	\$17.25	\$19.11	\$15.07	\$16.56
		Pharmacy	\$50.06	\$155.00	\$41.00

**REFERENCE/DESK AIDS
CATEGORICAL FACTORS**

**FAMILY HEALTH PLUS AND FAMILY HEALTH PLUS PREMIUM ASSISTANCE
PROGRAM**

CENTRAL		FHP Adults		Expanded Children	
		4/08-3/09	1/01/10	4/08-3/09	1/01/10
Counties	Monthly Managed Care Premiums	\$339.85	\$436.75	\$169.43	\$188.15
	Cost of Wrap				
Cayuga	Vision	\$2.02	\$2.20	\$1.15	\$1.23
Chenango	DME	\$1.71	\$1.79	\$0.49	\$0.53
Columbia	ER Transportation	\$1.94	\$2.14	\$1.47	\$1.49
Cortland	Non-ER Transportation	\$0.00	\$0.00	\$2.36	\$2.61
Delaware	(\$0 for adults)				
Greene	Dental	\$17.14	\$19.03	\$12.56	\$14.64
Madison	Pharmacy	\$76.32	\$155.00	\$41.00	\$46.47
Onondaga					
Otsego					
Schoharie					
Tomplins					

FINGER LAKES		FHP Adults		Expanded Children	
		4/08-3/09	1/01/10	4/08-3/09	1/01/10
Counties	Monthly Managed Care Premiums	\$362.70	\$457.02	\$186.76	\$217.47
	Cost of Wrap				
Allegany	Vision	\$2.12	\$2.44	\$1.17	\$1.41
Broome	DME	\$2.17	\$2.51	\$0.74	\$0.79
Cattaraugus	ER Transportation	\$1.54	\$1.68	\$0.91	\$1.09
Chautauqua	Non-ER Transportation	\$0.00	\$0.00	\$0.58	\$1.31
Chemung	(\$0 for adults)				
Livingston	Dental	\$19.58	\$20.76	\$0.00	\$8.37
Ontario	Pharmacy	\$79.52	\$155.00	\$41.00	\$46.47
Schuyler					
Seneca					
Steuben					
Tioga					
Wayne					
Yates					

**REFERENCE/DESK AIDS
CATEGORICAL FACTORS**

**REDUCTION FACTORS FOR CALCULATING MEDICAID ELIGIBILITY
UNDER PICKLE AMENDMENT**

<i>If SSI was terminated during this period:</i>	Multiply Social Security income by:		<i>If SSI was terminated during this period:</i>	Multiply Social Security income by:
May – June 1977	.267		Jan. 1995 – Dec. 1995	.680
July 1977 – June 1978	.282		Jan. 1996 – Dec. 1996	.698
July 1978 – June 1979	.301		Jan. 1997 – Dec. 1997	.718
July 1979 – June 1980	.330		Jan. 1998 – Dec. 1998	.733
July 1980 – June 1981	.378		Jan. 1999 – Dec. 1999	.742
July 1981 – June 1982	.420		Jan. 2000 – Dec. 2000	.761
July 1982 – Dec. 1983	.451		Jan. 2001 – Dec. 2001	.788
Jan. 1984 – Dec. 1984	.467		Jan. 2002 – Dec. 2002	.808
Jan. 1985 – Dec. 1985	.483		Jan. 2003 – Dec. 2003	.819
Jan. 1986 – Dec. 1986	.498		Jan. 2004 – Dec. 2004	.837
Jan. 1987 – Dec. 1987	.505		Jan. 2005 – Dec. 2005	.859
Jan. 1988 – Dec. 1988	.526		Jan. 2006 – Dec. 2006	.894
Jan. 1989 – Dec. 1989	.547		Jan. 2007 – Dec. 2007	.924
Jan. 1990 – Dec. 1990	.573		Jan. 2008 – Dec. 2008	.944
Jan. 1991 – Dec. 1991	.604		Jan. 2009 – Dec. 2009	1.00
Jan. 1992 – Dec. 1992	.626		Jan. 2010 – Dec. 2010	1.00
Jan. 1993 – Dec. 1993	.645		Jan. 2011 – Dec. 2011	1.00
Jan. 1994 – Dec. 1994	.661		Jan. 2012 – Dec. 2012	1.00

To determine the countable SSA income to be used in determining eligibility under the Pickle Amendment:

- Locate the month in which the person last received SSI and the corresponding Reduction factor.
- Multiply the individual's (and/or spouse's)
- current Social Security benefit by the applicable Reduction factor.
- The result is the countable SSA income to be used. This figure should be added to any other countable income.
- If the resulting total (minus \$20.00 SSI-related income disregard) is less than the current SSI income standard and resources are less than the current SSI resource level, the individual is financially eligible for Medicaid under the Pickle amendment.

**REFERENCE/DESK AIDS
CATEGORICAL FACTORS**

MEDICAID ELIGIBILITY UNDER THE PICKLE AMENDMENT

Screening for Medicaid eligibility under the Pickle Amendment is as follows:

Step 1: Ask the person, "Are you now receiving a Social Security check?" If the answer is no, the person cannot be Pickle eligible. If the answer is yes, go on to the next step.

Step 2: Ask the person, "After April 1977, did you ever get an SSI check at the same time that you got Social Security, or did you get SSI in the month just before your Social Security started?" If the answer is no, the person cannot be Pickle eligible. If the answer is yes, go on to step 3.

Step 3: Ask the person, "What is the last month in which you received SSI?"

Step 4: Look up that month in which the person last received SSI. (See **REFERENCE REDUCTION FACTORS FOR CALCULATING MEDICAID ELIGIBILITY UNDER THE PICKLE AMENDMENT**) Find the percentage that applies to that year and month. Multiply the present amount of the person's (and/or spouse's) Social Security benefits by the applicable percentage.

Step 5: You have just calculated the person's countable Social Security income under the Pickle Amendment. Add the figure that you have just calculated to any other countable income the person may have. If the resulting total is less than the current SSI income criteria, the person is Pickle eligible, from the standpoint of income, for Medicaid benefits. (The person must still satisfy separate Medicaid resource and non-financial requirements.)

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**REFERENCE/DESK AIDS
CATEGORICAL FACTORS****SUBSTANTIAL GAINFUL ACTIVITY (SGA)**

A full explanation of SGA is found in the **CATEGORICAL FACTORS SUBSTANTIAL GAINFUL ACTIVITY (SGA)**.

Federal regulations provide for annual automatic cost of living adjustments to the SGA threshold amount each January 1. An individual is considered to be able to engage in Substantial Gainful Activity (SGA) if that individual's average gross earnings from work activities exceed the amounts identified below:

Year	Non-Blind Per Month	Blind Per Month
2008	\$940	\$1,570
2009	\$980	\$1,640
2010	\$1,000	\$1,640
2011	\$1,000	\$1,640
2012	\$1,010	\$1,690

**REFERENCE/DESK AIDS
CATEGORICAL FACTORS****TRIAL WORK PERIOD**

A full explanation of trial work period is found in the **CATEGORICAL FACTORS TRIAL WORK PERIOD**.

Federal regulations provide for annual cost of living adjustments to the trial work threshold amount each January 1. A trial work period month is any calendar month in which the certified disabled recipient earns an amount equal to or greater than that identified below:

Year	Monthly Amount
2008	\$670 per month
2009	\$700 per month
2010	\$720 per month
2011	\$720 per month
2012	\$720 per month

REFERENCE/DESK AIDS
INCOME SECTION

**REFERENCE/DESK AIDS
INCOME**

INCOME DISREGARDS

The following types of income are disregarded in whole or in part in the determination of gross monthly income for Medicaid. An “X” indicates a disregard for the category of assistance. For details refer to **INCOME DISREGARDS** for appropriate category.

NOTE: In determining eligibility for persons applying for Family Planning Benefit Program (FPBP), apply the disregards of the category for which the individual is most closely related (LIF, ADC-related or S/CC. The SSI category is NOT used.)

In determining eligibility for persons applying for Medicare Savings Programs (MSP), apply the disregards for the SSI category; however, the MSP premium is not allowed as a deduction from income.

TYPE OF DISREGARD	ADC-related	FPBP See note above	FHP/ FHP- PAP	LIF	S/CC	MSP See note above	SSI-Related including MBI-WPD
Americorps	X		X	X	X		X
Assistance based on need	X		X	X	X		X
Blood Plasma settlements	X		X*	X			X
Bona Fide loans	X		X	X	X		X
Burial Fund/Burial Arrangements (excluded)							X
Cash Assistance income	X		X	X	X		X
Certified Blind or Certified Disabled Child Support Payments							X
Certified Blind Reasonable Work-related Expenses							X
Child and Adult Care Food Program (CACFP)	X		X	X	X		
Childcare/incapacitated adult care costs subject to dollar limitations	X			X			

X* For FHP, applied to parents living with their children under age of 21, and persons aged 19 and 20.

**REFERENCE/DESK AIDS
INCOME**

INCOME DISREGARDS

TYPE OF DISREGARD	ADC-related	FPBP See note above	FHP/ FHP- PAP	LIF	S/CC	MSP See note above	SSI-Related, including MBI-WPD
Childcare services payments made by agencies	X			X	X		X
Childcare income	X**			X**	X**		
Child support including arrearage payments	X		X	X	X		X
Crime Victims' Fund Payments							X
Disaster Relief and Emergency Assistance	X		X*	X			X
Dividend/Interest Income							X
Donated Foods	X		X	X	X		X
Earned Income, percentage of	X			X			X
Earned Income Tax Credit Payments	X		X	X	X		X
Emergency Safety Net Payments					X		
Expenses Obtaining Income							X
Federal Economic Opportunity Act, Title III	X		X	X	X		
Federal Energy Assistance Payment	X		X	X	X		X
Federal Older Americans Act of 1965-Green thumb, non-salary only	X			X			X
Federal Relocation Assistance	X		X	X	X		X
Food Stamps	X		X	X	X		X

X* For FHP, applied to parents living with their children under age of 21, and persons aged 19 and 20.

X** Disregard may be a partial amount or a partial time period.

**REFERENCE/DESK AIDS
INCOME**

INCOME DISREGARDS

TYPE OF DISREGARD	ADC-related	FPBP See note above	FHP/ FHP-PAP	LIF	S/CC	MSP See note above	SSI-Related, including MBI-WPD
Foster Parent Payments	X		X	X	X		X
Free Meals	X		X	X	X		X
Garden Produce or Livestock for personal use	X		X	X	X		X
G.I. Bill Deduction	X		X	X	X		X
Health Insurance Premiums	X						X
Hostile Fire Pay							X
Housing and Urban Development (HUD) Community Development Block Grant Funds	X		X	X	X		X
Impairment –Related Work Expense							X
Income Tax Refunds	X		X	X	X		X
Individual Development Accounts				X			
Infrequent or Irregular Income							X**
In-kind Income or maintenance from non-LRR, no services rendered	X		X	X	X		X
Insurance Payments	X		X*	X			
Interest/Dividend Payment							X
Job Corps	X		X	X	X		
Native American Payments	X**		X**	X**	X**		X**
NYS Department of Labor youth program payments	X		X	X	X		

X* For FHP, applied to parents living with their children under age of 21, and persons aged 19 and 20.

X** Disregard may be a partial amount or a partial time period.

**REFERENCE/DESK AIDS
INCOME**

INCOME DISREGARDS

TYPE OF DISREGARD	ADC-related	FPBP See note above	FHP/ FHP-PAP	LIF	S/CC	MSP See note above	SSI-Related, including MBI-WPD
Other Income as required by federal law							X
Overpayments	X			X	X		X
Persecution Payments	X		X	X	X		X
Plan to Achieve Self-Support (PASS)							X
Preventative Housing Service	X		X	X	X		X
Radiation Exposure Compensation Trust Fund Payments	X		X*	X			X
Reduced (Limited) \$90 Veteran's Administration Pension							X
Refunds							X
Replacement of Assistance Already Paid							X
Retroactive Benefits Under the SSI Program							X
Room and/or Board payments received	X			X	X		X
SSI Payments	X		X	X	X		X
State or Local Relocation Assistance Payments							X
Students							
--Earned Income	X		X	X	X		X
--Educational related income							X
--Graduate Education Grants or Scholarship	X		X	X	X		

X* For FHP, applied to parents living with their children under age of 21, and persons aged 19 and 20.

X** Disregard may be a partial amount or a partial time period.

**REFERENCE/DESK AIDS
INCOME**

INCOME DISREGARDS

TYPE OF DISREGARD	ADC-related	FPBP See note above	FHP/ FHP- PAP	LIF	S/CC	MSP See note above	SSI- Related, including MBI-WPD
--School Meals	X		X	X	X		X
--Student Loans	X		X	X	X		X
--Undergraduate Educational Grants, Scholarships or Work Study	X		X	X	X		
Support Payments	X**			X**	X**		
Third Party Insurance Payments							X
Trade Readjustment Allowance (TRA)	X			X	X		
Unearned Income							X
U.S. Census	X			X	X		X
Veterans A and A/UME							X
Vietnam Veterans Agent Orange/Spina Bifida	X		X	X	X		X
VISTA	X		X	X	X		X
Vocational Rehabilitation Act							X
Volunteer Program Payments	X		X	X	X		X
Women's, Infants, Children (WIC)	X		X	X			X
Work Expense	X**			X**	X**		
Workforce Investment Act (WIA) (formerly Job Training Partnership Act (JTPA))	X		X	X	X		

X* For FHP, applied to parents living with their children under age of 21, and persons aged 19 and 20.

X** Disregard may be a partial amount or a partial time period.

**REFERENCE/DESK AIDS
INCOME
LIF BUDGETING METHODOLOGY**

EARNED INCOME DISREGARD

A full explanation of the Earned Income Disregard is found in the **INCOME LIF BUDGETING METHODOLOGY**.

The earned income disregard is adjusted annually to reflect changes in the poverty level:

Year	Percentage
Effective June 1, 2004	53%
Effective June 1, 2005	54%
Effective June 1, 2006	55%
Effective June 1, 2007	57%
Effective June 1, 2008	28% *
Effective June 1, 2009	28%
Effective June 1, 2010	28%

* The 2008 level was adjusted downward to reflect the substantial increase in the Medicaid Standard.

**REFERENCE/DESK AIDS
INCOME****STUDENT INCOME**

A full explanation of the SSI-related disregards and students' income as an earned income can be found in the **INCOME** SSI-RELATED DISREGARDS.

Effective January 1 each year, the standard for a student's income as an SSI-disregard is:

Year	Monthly income	Annual income
2008	\$1,550	\$6,240
2009	\$1,640	\$6,600
2010	\$1,640	\$6,600
2011	\$1,640	\$6,600
2012	\$1,700	\$6,840

**REFERENCE/DESK AIDS
INCOME**

INCOME ALLOCATION

The full explanation of the use of Income Allocations in the SSI-related budgeting process can be found in the **INCOME** SSI-RELATED BUDGETING METHODOLOGY.

Numbers are effective January 1 of each year:

Allocation to	Allocation Amount		How Determined
Non-SSI Child	2008	\$342	Difference between Medicaid income level for one and two
	2009	\$350	
	2010	\$350	
	2011	\$350	
	2012	\$367	
Single parent (regardless of category)	2008	\$637	Federal SSI Benefit Rate (FBR) for one
	2009	\$674	
	2010	\$674	
	2011	\$674	
	2012	\$698	
Two parents (regardless of category)	2008	\$956	Federal SSI Benefit Rate (FBR) for two
	2009	\$1,011	
	2010	\$1,011	
	2011	\$1,011	
	2012	\$1,048	
An SSI-related parent and a non-SSI-related parent residing with an SSI-related child and a non-SSI-related child	2007	\$957	The Federal SSI Benefit Rate (FBR) for two, living alone, plus the SSI State supplement for one, living with others
	2008	\$989	
	2009	\$1,034	
	2010	\$1,034	
	2011	\$1,034	
	2012	\$1,071	

**REFERENCE/DESK AIDS
INCOME**

MEDICALLY NEEDY INCOME LEVELS AND FEDERAL POVERTY LEVELS
(annual and monthly amounts)

HOUSEHOLD SIZE	ONE	TWO	THREE	FOUR	FIVE	SIX	SEVEN	EIGHT	EACH ADD'L PERSON
MA Standard S/CC-LIF 4/1-12/31/08	8,067 673	10,070 840	11,981 999	13,911 1,160	15,907 1,326	17,366 1,448	18,903 1,576	20,876 1,740	1,131 95
2009	8,462 706	10,563 881	12,568 1,048	14,593 1,217	16,686 1,391	18,217 1,519	19,829 1,653	21,899 1,825	99
2010	8,479 707	10,584 883	12,593 1,050	14,622 1,219	16,719 1,394	18,253 1,522	19,869 1,656	21,943 1,829	99
2011	8,487 708	10,595 883	12,606 1,051	14,637 1,220	16,736 1,395	18,271 1,523	19,889 1,658	21,965 1,831	99
2012	8,818 735	11,008 918	13,098 1,092	15,208 1,268	17,389 1,450	18,984 1,582	20,665 1,723	22,822 1,902	1,236 104
MA INCOME 2008 1/1-3/31	8,700 725	12,800 1,067	13,200 1,100	13,300 1,109	13,400 1,117	13,600 1,134	15,300 1,275	17,000 1,417	1,700 142
2008 4/1-12/31/08	8,700 725	12,800 1,067	14,800 1,234	16,700 1,392	18,600 1,550	20,500 1,709	22,400 1,867	24,400 2,034	1,900 159
2009	9,200 767	13,400 1,117	15,410 1,285	17,420 1,452	19,430 1,620	21,440 1,787	23,450 1,955	25,460 2,122	2,010 168
2010	9,200 767	13,400 1,117	15,410 1,285	17,420 1,452	19,430 1,620	21,440 1,787	23,450 1,955	25,460 2,122	2,010 168
2011	9,200 767	13,400 1,117	15,410 1,285	17,420 1,452	19,430 1,620	21,440 1,787	23,450 1,955	25,460 2,122	2,010 168
2012	9,500 792	13,900 1,159	15,985 1,333	18,070 1,506	20,155 1,680	22,240 1,854	24,325 2,028	26,410 2,201	2,085 174
100% FPL 2008 1/1-3/31	10,400 867	14,000 1,167	17,600 1,467	21,200 1,767	24,800 2,067	28,400 2,367	32,000 2,667	35,600 2,967	3,600 300
2008 4/1-12/31/08	10,400 867	14,000 1,167	17,600 1,467	21,200 1,767	24,800 2,067	28,400 2,367	32,000 2,667	35,600 2,967	3,600 300
2009	10,830 903	14,570 1,215	18,310 1,526	22,050 1,838	25,790 2,150	29,530 2,461	33,270 2,773	37,010 3,085	3,740 312
2010	10,830 903	14,570 1,215	18,310 1,526	22,050 1,838	25,790 2,150	29,530 2,461	33,270 2,773	37,010 3,085	3,740 312
2011	10,890 908	14,710 1,226	18,530 1,545	22,350 1,863	26,170 2,181	29,990 2,500	33,810 2,818	37,630 3,136	3,820 319

**REFERENCE/DESK AIDS
INCOME**

MEDICALLY NEEDY INCOME LEVELS AND FEDERAL POVERTY LEVELS
(annual and monthly amounts)

HOUSEHOLD SIZE	ONE	TWO	THREE	FOUR	FIVE	SIX	SEVEN	EIGHT	EACH ADDITIONAL PERSON
120% FPL	12,132	16,308							
2007	1,011	1,359	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2008	12,480	16,800							
1/1-3/31	1,040	1,400	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2008	12,480	16,800							
4/1-12/31/08	1,040	1,400	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2009	12,996	17,484							
	1,083	1,457	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2010	12,996	17,484							
	1,083	1,457	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2011	13,068	17,652							
	1,089	1,471	N/A	N/A	N/A	N/A	N/A	N/A	N/A
133% FPL									
2007	13,580	18,208	22,837	27,465	32,093	36,722	41,350	45,979	4,629
	1,132	1,518	1,904	2,289	2,675	3,061	3,446	3,832	386
2008	13,832	18,620	23,408	28,196	32,984	37,772	42,560	47,348	4,788
1/1-3/31	1,153	1,552	1,951	2,350	2,749	3,148	3,547	3,946	399
2008	13,832	18,620	23,408	28,196	32,984	37,772	42,560,	47,348	4,788
4/1-12/31/08	1,153	1,552	1,951	2,350	2,749	3,148	3, 547	3,946	399
2009	14,404	19,379	24,353	29,327	34,301	39,275	44,250	49,224	4,975
	1,201	1,615	2,030	2,444	2,859	3,273	3,688	4,102	415
2010	14,404	19,379	24,353	29,327	34,301	39,275	44,250	49,224	4,975
	1,201	1,615	2,030	2,444	2,859	3,273	3,688	4,102	415
2011	14,484	19,565	24,645	29,726	34,807	39,887	44,968	50,048	5,081
	1,207	1,631	2,054	2,478	2,901	3,324	3,748	4,171	424
135% FPL									
2007	13,649	18,347							
	1,138	1,529	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2008	14,040	18,900							
1/1-3/31	1,170	1,575	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2008	14,040	18,900							
4/1-12/31/08	1,170	1,575	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2009	14,621	19,670							
	1,219	1,640	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2010	14,621	19,670							
	1,219	1,640	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2011	14,702	19,859							
	1,226	1,655	N/A	N/A	N/A	N/A	N/A	N/A	N/A

**REFERENCE/DESK AIDS
INCOME**

MEDICALLY NEEDY INCOME LEVELS AND FEDERAL POVERTY LEVELS
(annual and monthly amounts)

HOUSEHOLD SIZE	ONE	TWO	THREE	FOUR	FIVE	SIX	SEVEN	EIGHT	EACH ADDITIONAL PERSON
150% FPL	15,165	20,385	25,605	30,825	36,045	41,265	46,485	51,705	5,220
2007	1,264	1,699	2,134	2,569	3,004	3,439	3,874	4,309	435
2008	15,600	21,000	26,400	31,800	37,200	42,600	48,000	53,400	5,400
1/1-3/31	1,300	1,750	2,200	2,650	3,100	3,550	4,000	4,450	450
2008	15,600	21,000	26,400	31,800	37,200	42,600	48,000	53,400	5,400
4/1-12/31/08	1,300	1,750	2,200	2,650	3,100	3,550	4,000	4,450	450
2009	16,245	21,855	27,465	33,075	38,685	44,295	49,905	55,515	5,610
	1,354	1,822	2,289	2,757	3,224	3,692	4,159	4,627	468
2010	16,245	21,855	27,465	33,075	38,685	44,295	49,905	55,515	5,610
	1,354	1,822	2,289	2,757	3,224	3,692	4,159	4,627	468
2011	16,335	22,065	27,795	33,525	39,255	44,985	50,715	56,445	5,730
	1,362	1,839	2,317	2,794	3,272	3,749	4,227	4,704	478
160% FPL	17,424	28,536	29,648	35,760	41,872	47,984	54,096	62,208	6,112
2011	1,452	1,962	2,471	2,980	3,490	3,999	4,508	5,018	510
185% FPL	18,704	25,142	31,580	38,018	44,456	50,894	57,332	63,770	6,436
2007	1,559	2,096	2,632	3,169	3,705	4,242	4,778	5,315	537
2008	19,240	25,900	32,500	39,220	45,880	52,540	59,200	65,860	6,600
1/1-3/31	1,604	2,159	2,714	3,269	3,824	4,379	4,934	5,489	555
2008	19,240	25,900	32,560	39,220	45,880	52,540	59,200	65,860	6,660
4/1-12/31/08	1,604	2,159	2,714	3,269	3,824	4,379	4,934	5,489	555
2009	20,036	26,955	33,874	40,793	47,712	54,631	61,550	68,469	6,919
	1,670	2,247	2,823	3,400	3,976	4,553	5,130	5,706	577
2010	20,036	26,955	33,874	40,793	47,712	54,631	61,550	68,469	6,919
	1,670	2,247	2,823	3,400	3,976	4,553	5,130	5,706	577
2011	21,047	27,214	34,281	41,348	48,415	55,482	62,549	69,616	7,067
	1,679	2,268	2,857	3,446	4,035	4,624	5,213	5,802	589

**REFERENCE/DESK AIDS
INCOME**

MEDICALLY NEEDY INCOME LEVELS AND FEDERAL POVERTY LEVELS
(annual and monthly amounts)

HOUSEHOLD SIZE	ONE	TWO	THREE	FOUR	FIVE	SIX	SEVEN	EIGHT	EACH ADDITIONAL PERSON
200% FPL	20,200	27,180	34,140	41,100	48,060	55,020	61,980	68,940	6,960
2007	1,685	2,265	2,845	3,425	4,005	4,585	5,165	5,745	580
2008	20,800	28,000	35,200	42,400	49,600	56,800	64,000	71,200	7,200
1/1-3/31	1,734	2,334	2,934	3,534	4,134	4,734	5,334	5,934	600
2008	20,800	28,000	35,200	42,400	49,600	56,800	64,000	71,200	7,200
4/1-12/31/08	1,734	2,334	2,934	3,534	4,134	4,734	5,334	5,934	600
2009	21,660	29,140	36,620	44,100	51,580	59,060	66,540	74,020	7,480
	1,805	2,429	3,052	3,675	4,299	4,922	5,545	6,169	624
2010	21,660	29,140	36,620	44,100	51,580	59,060	66,540	74,020	7,480
	1,805	2,429	3,052	3,675	4,299	4,922	5,545	6,169	624
2011	21,780	29,420	37,060	44,700	52,340	59,980	67,620	75,260	7,640
	1,815	2,452	3,089	3,725	4,362	4,999	5,635	6,272	637
250% FPL	25,275	33,975							
2007	2,107	2,832	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2008	26,000	35,000							
1/1-3/31	2,167	2,917	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2008	26,000	35,000							
4/1-12/31/08	2,167	2,917	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2009	27,075	36,425							
	2,257	3,036	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2010	27,075	36,425							
	2,257	3,036	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2011	27,225	36,775							
	2,2269	3,065	N/A	N/A	N/A	N/A	N/A	N/A	N/A

INCOME/RESOURCE TEST

Category	Year	Income Compared	Household Size		Resource Level		Special Notes
			1	2	1	2	
Presumptive Eligibility for Pregnant Women	2007	100% FPL 200% FPL	N/A N/A	\$1,141 \$2,282	No Resource Test		Qualified provider makes the presumptive eligibility determination. Cannot spend down to become presumptive eligible.
	2008	100% FPL 200% FPL	N/A N/A	\$1,167 \$2,334	No Resource Test		Same as 2007
	2009	100% FPL 200% FPL	N/A N/A	\$1,215 \$2,429	No Resource Test		Same as 2007
	2010	100% FPL 200% FPL	N/A N/A	\$1,215 \$2,429	No Resource Test		An Article 28 Pre-Natal Care provider or other entity designated by SDOH who has completed required training makes the PE determination. Cannot spend down to become eligible for presumptive eligibility.
	2011	100% FPL 200% FPL	N/A N/A	\$1,226 \$2,452	No Resource Test		Same as 2010
Pregnant Women	2007	100% FPL 200% FPL	N/A N/A	\$1,141 \$2,282	No Resource Test		If the woman is determined eligible in any month of her pregnancy, she is guaranteed eligibility for the entire pregnancy (prospectively). If the A/R applies prior to the birth of the child she is entitled to a 60 day post-partum extension also. The baby is guaranteed eligibility for one year. If the income is above 200% FPL the A/R must spend down to the Medicaid income level.
	2008	100% FPL 200% FPL	N/A N/A	\$1,167 \$2,334	No Resource Test		Same as 2007
	2009	100% FPL 200% FPL	N/A N/A	\$1,215 \$2,429	No Resource Test		Same as 2007
	2010	100% FPL 200% FPL	N/A N/A	\$1,215 \$2,429	No Resource Test		Same as 2007
	2011	100% FPL 200% FPL	N/A N/A	\$1,226 \$2,452	No Resource Test		A woman determined eligible for Medicaid for any time during her pregnancy remains eligible for Medicaid coverage until the last day of the month in which the 60th day from the date the pregnancy ends occurs, regardless of any change in income or household composition. If the income is above 200% FPL the A/R must spend down to the Medicaid income level. The baby will have guaranteed eligibility for one year.
Children Under One	2007	200% FPL	\$1,702	\$2,282	No Resource Test		If the income is above 200% FPL the A/R must spend down to the Medicaid income level. One year guaranteed eligibility if mother is in receipt of Medicaid at delivery. Eligibility can be determined in the 3 months retro to obtain the 1 year extension
	2008	200% FPL	\$1,734	\$2,334	No Resource Test		Same as 2007
	2009	200% FPL	\$1,805	\$2,429	No Resource Test		Same as 2007
	2010	200% FPL	\$1,805	\$2,429	No Resource Test		Same as 2007
	2011	200% FPL	\$1,815	\$2,452	No Resource Test		Same as 2007
Children Age 1 through 5	2007	133% FPL	\$1,132	\$1,518	No Resource Test		If the income is above 133% FPL the A/R must spend down to the Medicaid income level, resources will also be evaluated
	2008	133% FPL	\$1,153	\$1,552	No Resource Test		Same as 2007
	2009	133% FPL	\$1,201	\$1,615	No Resource Test		Same as 2007
	2010	133% FPL	\$1,201	\$1,615	No Resource Test		If the income is above 133% FPL the A/R must spend down to MA income level
	2011	133% FPL	\$1,207	\$1,631	No resource Test		Same as 2010

INCOME/RESOURCE TEST

Category	Year	Income Compared	Household Size		Resource Level		Special Notes
			1	2	1	2	
Under 21, ADC-related and FNP	2008	MA Level	\$775	\$1,067	\$4,250	\$6,400	FNP parents cannot spend down
Effective 4/1	2008	MA Level	\$725	\$1,067	\$13,050	\$19,200	Same as 2008
	2009	MA Level	\$767	\$1,117	\$13,800	\$20,100	Same as 2008
	2010	MA Level	\$767	\$1,117	No Resource Test		Same as 2008
	2011	MA Level	\$767	\$1,117	No Resource Test		Same as 2008
	2012	MA Level	\$792	\$1,159	No Resource Test		Same as 2008
Singles/Childless Couples	2008	PA Standard of Need	Varies by County	Varies by County	\$2,000	\$2,000	The A/R cannot spend down income or resources. Over age 60, resources are \$3000.
Effective 4/1	2008	MA Standard	\$673	\$840	\$13,050	\$19,200	The A/R cannot spend down income or resources
	2009	MA Standard	\$706	\$881	\$13,800	\$20,100	Same as 2008
	2010	MA Standard	\$707	\$883	No Resource Test		The A/R cannot spend down income
	2011	MA Standard	\$708	\$883	No Resource Test		The A/R cannot spend down income
	2012	MA Standard	\$735	\$918	No Resource Test		Same as 2011
Low Income Families	2008	PA Standard of Need	Varies by County	Varies by county	\$3000	\$3000	The A/R cannot spend down income or resources
Effective 4/1	2008	MA Standard	\$673	\$840	\$13,050	\$19,200	The A/R cannot spend down income or resources.
	2009	MA Standard	\$706	\$881	\$13,800	\$20,100	The A/R cannot spend down income
	2010	MA Standard	\$707	\$883	No Resource Test		
	2011	MA Standard	\$708	\$883	No Resource Test		
	2012	MA Standard	\$735	\$918	No Resource Test		
SSI-Related	2008	MA Level	\$725	\$1,067	\$4,350	\$6,400	Household size is always one or two
Effective 4/1	2008	MA Level	\$725	\$1,067	\$13,050	\$19,200	Same as 2008
	2009	MA Level	\$767	\$1,117	\$13,800	\$20,100	Same as 2008
	2010	MA Level	\$767	\$1,117	\$13,800	\$20,100	Same as 2008
	2011	MA Level	\$767	\$1,117	\$13,800	\$20,100	Same as 2008
	2012	MA Level	\$792	\$1,159	\$14,250	\$20,850	Same 2008
Children Age 6 through 18	2007	100% FPL	\$851	\$1,141	No Resource Test		If the income is above 100% FPL the A/R must spend down to the Medicaid income level, resources will also be evaluated
	2008	100% FPL	\$867	\$1,167	No Resource Test		Same as 2007
	2009	100% FPL	\$903	\$1,215	No Resource Test		Same as 2007
	2010	100% FPL	\$903	\$1,215	No Resource Test		If the income is above 100% FPL the A/R must spend down to MA income level.
	2011	100% FPL	\$908	\$1,226	No Resource Test		Same as 2010
Children Age 1 through 18	11/1 2011	133% FPL	\$1207	\$1631	No Resource Test		

INCOME/RESOURCE TEST

Category	Year	Income Compared	Household Size		Resource Level		Special Notes
			1	2	1	2	
Buy-In (QMB)	2007	100% FPL	\$851	\$1,141	\$4,000	\$6,000	Medicare Part A & B, coinsurance, deductible and premium will be paid if eligible
	2008	100%FPL	\$867	\$1,167	\$4,000	\$6,000	Same as 2007
Effective 4/1	2008	100% FPL	\$867	\$1,167	No Resource Test		Same as 2007
	2009	100% FPL	\$903	\$1,215	No Resource Test		Same as 2007
	2010	100% FPL	\$903	\$1,215	No Resource Test		Same as 2007
	2011	100% FPL	\$908	\$1,226	No Resource Test		Same as 2007
	2007	100%FPL	\$851	\$1,141	\$4,000	\$6,000	
COBRA Continuation Coverage	2008	100%FPL	\$867	\$1,167	\$4,000	\$6,000	
	2008	100% FPL	\$867	\$1,167	\$4,000	\$6,000	
	2009	100% FPL	\$903	\$1,215	\$4,000	\$6,000	
	2010	100% FPL	\$903	\$1,215	\$4,000	\$6,000	
	2011	100% FPL	\$908	\$1,226	\$4,000	\$6,000	
AIDS Health Insurance Program (AHIP)	2007	185% FPL	\$1,575	\$2,111	No Resource Test		A/R must be ineligible for Medicaid, including COBRA continuation. Premium payments are FNP
	2008	185% FPL	\$1,604	\$2,159	No Resource Test		Same as 2006
	2009	185% FPL	\$1,670	\$2,247	No Resource Test		A/R must be ineligible for Medicaid, including COBRA continuation
	2010	185% FPL	\$1,670	\$2,247	No Resource Test		Same as 2009
	2011	185% FPL	\$1,679	\$2,268	No Resource Test		Same as 2009
Qualified Disabled & Working Individual	2007	200% FPL	\$1,702	\$2,282	\$4,000	\$6,000	Medicaid will pay Medicare Part A premium
	2008	200% FPL	\$1,734	\$2,334	\$4,000	\$6,000	Same as 2007
	2009	200%FPL	\$1,805	\$2,429	\$4,000	\$6,000	Same as 2007
	2010	200% FPL	\$1,805	\$2,429	\$4,000	\$6,000	Same as 2007
	2011	200% FPL	\$1,815	\$2,452	\$4,000	\$6,000	Same as 2007

INCOME/RESOURCE TEST

Category	Year	Income Compared	Household Size		Resource Level		Special Notes
			1	2	1	2	
			\$980	\$1,320			
Specified Low Income Medicare Beneficiaries (SLIMBs)	2007	Greater than 100% but less than 120%	\$851	\$1,141	\$4,000	\$6,000	If the A/R is determined eligible, Medicaid will pay Medicare Part B premium
			\$1,021	\$1,369			
	2008	Greater than 100% but less than 120%	\$867	\$1,167	\$4,000	\$6,000	Same as 2007
			\$1,040	\$1,400			
Effective 4/1	2008	Greater than 100% but less than 120%	\$867	\$1,167	No Resource Test		Same as 2007
				\$1,040			
	2009	Greater than 100% but less than 120%	\$903	\$1,215	No Resource Test		Same as 2007
			\$1,083	\$1,457			
	2010	Greater than 100% but less than 120%	\$903	\$1,215	No Resource Test		Same as 2007
			\$1,083	\$1,457			
	2011	Greater than 100% but less than 120%	\$908	\$1,226	No Resource Test		Same as 2007
			\$1,089	\$1,471			
Qualified Individuals (QI)	2007	Equal to or greater than 120% but less than 135%	\$1,021	\$1,369	No Resource Test		If the A/R is determined eligible, Medicaid will pay Medicare Part B premium
				\$1,149			
	2008	Equal to or greater than 120% but less than 135%	\$1,040	\$1,400	No Resource Test		Same as 2007
			\$1,170	\$1,575			
	2009	Equal to or greater than 120% but less than 135%	\$1,083	\$1,457	No Resource Test		Same as 2007
			\$1,219	\$1,640			
	2010	Equal to or greater than 120% but less than 135%	\$1,083	\$1,457	No Resource Test		Same as 2007
			\$1,129	\$1,640			
	2011	Equal to or greater than 120% but less than 135%	\$1,089	\$1,471	No Resource Test		Same as 2007
			\$1,226	\$1,655			
Family Health Plus Parents Living with Children Singles/Childless Couples	2007	150% FPL	\$1,277	\$1,712	\$12,600	\$16,200	The A/R must be ineligible for Medicaid. The A/R cannot spend down to become eligible for Family Health Plus
		100% FPL	\$851	\$1,141			
	2008	150% FPL	\$1,300	\$1,750	\$13,050	\$19,200	Same as 2007
		100% FPL	\$867	\$1,167			
	2009	150% FPL	\$1,354	\$1,822	\$13,800	\$20,100	Same as 2007
		100% FPL	\$903	\$1,215			
	2010	150% FPL	\$1,354	\$1,822	No Resource Test		Same as 2007
		100% FPL	\$903	\$1,215			
	2011	150% FPL	\$1,362	\$1,839	No Resource Test		Same as 2007
		100% FPL	\$908	\$1,226			

INCOME/RESOURCE TEST

Category	Year	Income Compared	Household Size		Resource Level		Special Notes
			1	2	1	2	
Family Planning Benefit Program (FPBP)	2007	200% FPL	\$1,702	\$2,282	No Resource Test		The A/R must be ineligible for Medicaid or Family Health Plus. The A/R cannot spend down to become eligible for Family Planning Benefit Program.
	2008	200% FPL	\$1,734	\$2,334	No Resource Test		Same as 2007
	2009	200% FPL	\$1,805	\$2,429	No Resource Test		Provides Medicaid coverage for family planning services to persons of childbearing age with incomes at or below 200% FPL. Potentially eligible individuals will be screened for Medicaid and FHPlus, unless they specifically request to be screened only for FPBP eligibility.
	2010	200% FPL	\$1,805	\$2,429	No Resource Test		Same as 2009
	2011	200% FPL	\$1,815	\$2,452	No Resource Test		Same as 2009
Medicaid Buy-in Program for People with Disabilities (MBI-WPD)	2007	250% FPL	\$2,128	\$2,853	\$10,000		A/R's with a net income that is at least 150% but at or below 250% will pay a premium. Currently there is a moratorium on premium payment collection.
	2008	250% FPL	\$2,167	\$2,917	\$10,000		Same as 2007
Effective 4/1	2008	250% FPL	\$2,167	\$2,917	\$13,050	\$19,200	Same as 2007
	2009	250% FPL	\$2,257	\$3,036	\$13,800	\$20,100	Same as 2007
	2010	250% FPL	\$2,257	\$3,036	\$13,800	\$20,100	Same as 2007
	2011	250% FPL	\$2,269	\$3,065	\$13,800	\$20,100	Same as 2007
	2011	250% FPL	\$2,269	\$3,065	\$20,000	\$30,000	Same as 2007
Breast and Cervical Cancer	2005	250% FPL	\$1,994	\$2,673	No Resource Test		
	2006	250% FPL	\$2,042	\$2,750	No Resource Test		
	2007	250% FPL	\$2,128	\$2,853	No Resource Test		See Medicaid Cancer Treatment Programs after 2007
Medicaid Cancer Treatment Programs	2008	250% FPL	\$2,167	\$2,917	No Resource Test		Includes both Breast and Cervical Cancer and Colorectal and Prostate Cancer Treatment Programs
	2009	250% FPL	\$2,257	\$3,036	No Resource Test		Same as 2008
	2010	250% FPL	\$2,257	\$3,036	No Resource Test		Same as 2008
	2011	250% FPL	\$2,269	\$3,065	No Resource Test		Same as 2008

**REFERENCE/DESK AIDS
INCOME**

MEDICARE PART A AND PART B PREMIUMS

Discussion of Medicare Part A and Part B Premiums is found in the **INCOME MEDICARE SAVINGS PROGRAM**.

Monthly Medicare Part A premium, effective January 1 each year

Year	Monthly Amount
2008	\$423 per month
2009	\$244 per month-- for persons having 30-39 quarters * \$443 per month-- not otherwise eligible for premium-free hospital insurance and have less than 30 quarters
2010	\$244 per month-- for persons having 30-39 quarters * \$443 per month-- not otherwise eligible for premium-free hospital insurance and have less than 30 quarters
2011	\$248 per month-- for persons having 30-39 quarters * \$450 per month-- not otherwise eligible for premium-free hospital insurance and have less than 30 quarters
2012	Same as 2011

Monthly Medicare Part B standard premium, effective January 1 each year

Year	Monthly Amount
2008	\$96.40 per month*
2009	\$96.40 per month*
2010	\$96.40 per month-- \$110.50 per month—if newly applying for Medicare or not protected by “hold harmless” provisions [See below]
2011	\$96.40 per month -- if previously enrolled in Medicare \$115.40 per month- if newly applying for Medicare or not protected by “hold harmless” provisions [See below]
2012	\$99.90 per month with no “hold harmless” provisions

NOTE: Under a “hold-harmless” provision of federal law, basic Medicare Part B premiums in any year cannot rise higher than that year’s COLA.

The Hold Harmless provision does not apply to the following individuals who must pay a higher premium:

Individuals whose income is above \$85,000 or by a married individual when the couple’s combined income is over \$170,000.

Individuals who do not have the Part B premium deducted from their Social Security benefit. This includes individuals who are on the Medicare Buy-In program and have their premiums paid for them. The increased premium will be paid by the State.

**REFERENCE/DESK AIDS
INCOME****NEW YORK STATE MINIMUM WAGE**

The Empire State Wage Act establishes minimum hourly wages, effective January each year. Discussion of minimum wage can be found in **INCOME LIF DISREGARDS**, **ADC-RELATED DISREGARDS** and **S/CC DISREGARDS**. The amounts are as follows:

Year	Amount
2005	\$6.00
2006	\$6.75
2007	\$7.15
2008	\$7.15
2009 *	\$7.25
2010	\$7.25

*Effective 7/24/2009

The federal minimum hourly wage is: \$7.25

**REFERENCE/DESK AIDS
INCOME****PERSONAL NEEDS ALLOWANCE -- PACE-PNA**

An explanation of the use of the PNA amount for certain waiver recipients and non-institutionalized participant of the Program of All-Inclusive Care for the Elderly (PACE) recipients, whose eligibility is determined under the spousal impoverishment provisions, can be found in **INCOME CHRONIC CARE BUDGETING METHODOLOGY FOR INSTITUTIONALIZED SPOUSES**. The PNA is the difference between the monthly Medicaid income level for a household of two and a household of one.

The amount of the PNA, effective each January 1, is found below:

Year	Amount
2008	\$342
2009	\$350
2010	\$350
2011	\$350
2012	\$367

**REFERENCE/DESK AIDS
INCOME**

MBL LIVING ARRANGEMENT CHART

MBL Shelter Type Table – Medicaid Standard beginning April 1, 2008

Code	Shelter Type	PreAdd	Shelter	MA Standard for appropriate year Household of 1	Standard Applied
01	Rent				New Standard + water
02	Rent Public				New Standard + water
03	Own Home				New Standard + water
04	Room & Board				New Standard
05	Hotel Permanent				New Standard
06	Hotel Temporary		unlimited		New Std + unlimited shelter
07	Migrant Camp				New Standard + water
09	Medical Facility	40.00	unlimited		No change
11	Room				New Standard
12	Non Level II Alcohol Treatment Facility	45.00	unlimited		No change
14	Public Home	17.00	unlimited		No change
15	Congregate Care Level I (NYC, Nassau, Suffolk, Westchester)	PNA			No change
16	Congregate Care Level II (NYC, Nassau, Suffolk, Westchester)	PNA			No change
18	Foster Care		unlimited		No change
20	Emergency Rental Supplement Program				New Standard + water
22	Shelter for Victims of Domestic Violence	45.00	unlimited		No change
23	Undomiciled				New Standard
28	Congregate Care Level I (Rest of State)	PNA Level I			No change
29	Congregate Care Level II (Rest of State)	PNA Level II			No change
33	Homeless Shelter Tier II - Less than 3 Meals/Day		unlimited		New Std + unlimited shelter
34	Homeless Shelter Tier II - 3 Meals/Day				New Standard
35	Homeless Shelter Non Tier I or Tier II	45.00	unlimited		No change
36	Shelter for Homeless less than 3 Meals/Day		unlimited		New Std + unlimited shelter
37	Residential Program for Victim of Domestic Violence		unlimited		New Std + unlimited shelter
42/51	Congregate Care Level III	PNA			No change
44	Supportive Specialized Housing	45.00	unlimited		No change

**REFERENCE/DESK AIDS
INCOME**

PUBLIC ASSISTANCE STANDARD OF NEED

NOTE: EFFECTIVE FOR DETERMINATION DONE PRIOR TO APRIL 1, 2008 only

Information regarding the Public Assistance (PA) Standard of Need can be found in the **GLOSSARY** under PUBLIC ASSISTANCE STANDARD OF NEED.

No. in Applying Household	1	2	3	4	5	6	7	
Pre-Add	\$112	\$179	\$238	\$307	\$379	\$438	\$498	Each Additional Person - \$60
Home Energy Allowance	\$14.14	\$22.50	\$30	\$38.70	\$47.70	\$55.20	\$62.70	Each Additional Person - \$7.50
Supplemental Home Energy Allowance	\$11	\$17	\$23	\$30	\$37	\$42	\$47	Each Additional Person - \$5
Monthly Shelter Allowance with Heat*								
Monthly Shelter Allowance w/out Heat:*								
Monthly Heating Allowance: Oil, Kerosene, Propane*								
Monthly Heating Allowance: Natural Gas, Coal, Wood, Municipal Electric, Other*								
Monthly Heating Allowance: PSC Electric, Greenport Electric*								
Add Pre-Add, Home Energy Allowance, Supplemental Home Energy Allowance, Shelter (with or without heat) and appropriate monthly heating allowance to arrive at the TOTAL STANDARD of NEED								
Total Standard of Need:*								

*District Specific Information. Complete as described.

**REFERENCE/DESK AIDS
INCOME**

SSI BENEFIT LEVELS

A full description of the SSI Benefit Levels used in determination of eligibility can be found in the **INCOME DETERMINATION OF ELIGIBILITY**.

These benefit levels generally change January 1 each year.

Living Arrangement	Year	Federal Benefit Rate		State Supplement		Total Benefit	
		Ind.	Couple	Ind.	Couple	Ind.	Couple
Living Alone	2008	\$637	\$956	\$87	\$104	\$724	\$1060
	2009	\$674	\$1011	\$87	\$104	\$761	\$1115
	2010	\$674	\$1011	\$87	\$104	\$761	\$1115
	2011	\$674	\$1011	\$87	\$104	\$761	\$1115
	2012	\$698	\$1048	\$87	\$104	\$785	\$1152
Living with Others	2007	\$623	\$934	\$23	\$46	\$646	\$980
	2008	\$637	\$956	\$23	\$46	\$660	\$1002
	2009	\$674	\$1011	\$23	\$46	\$697	\$1057
	2010	\$674	\$1011	\$23	\$46	\$697	\$1057
	2011	\$674	\$1011	\$23	\$46	\$697	\$1057
Living in Household of Another	2007	\$415.34	\$622.67	\$23	\$46	\$438.34	\$668.67
	2008	\$424.67	\$637.34	\$23	\$46	\$447.67	\$683.34
	2009	\$449.34	\$674	\$23	\$46	\$472.34	\$720
	2010	\$449.34	\$674	\$23	\$46	\$472.34	\$720
	2011	\$449.34	\$674	\$23	\$46	\$472.34	\$720

Title XIX (Medicaid Certified) Institutions

Living Arrangement	Year	Federal Benefit Rate		State Supplement		Total Benefit	
		Ind.	Couple	Ind.	Couple	Ind.	Couple
Statewide	2007	\$30	\$60	\$0	\$0	\$30	\$60
	2008	\$30	\$60	\$0	\$0	\$30	\$60
	2009	\$30	\$60	\$0	\$0	\$30	\$60
	2010	\$30	\$60	\$0	\$0	\$30	\$60
	2011	\$30	\$60	\$0	\$0	\$30	\$60

Minimum Personal Needs Allowances

	2007	2008	2009	2010	2011
Congregate Care Level 1	\$120	\$123	\$130	\$130	\$130
Congregate Care Level 2	\$139	\$142	\$150	\$150	\$150
Congregate Care Level 3	\$164	\$168	\$178	\$178	\$178

**REFERENCE/DESK AIDS
INCOME**

SSI BENEFIT LEVELS (continued)

Level I - Family Care (OCFS certified Family Type Home, OMH or OPWDD certified Family Care Homes)

Living Arrangement	Year	Federal Benefit Rate		State Supplement		Total Benefit	
		Ind.	Couple	Ind.	Couple	Ind.	Couple
NYC, Nassau, Suffolk, Westchester, and Rockland	2007	\$623	\$934	\$266.48	\$844.96	\$889.48	\$1,778.96
	2008	\$637	\$956	\$266.48	\$850.96	\$903.48	\$1,806.96
	2009	\$674	\$1,011	\$266.48	\$869.96	\$940.48	\$1,880.96
	2010	\$674	\$1,011	\$266.48	\$869.96	\$940.48	\$1,880.96
	2011	\$674	\$1,011	\$266.48	\$869.96	\$940.48	\$1,880.96
Rest of State	2007	\$623	\$934	\$228.48	\$768.96	\$851.48	\$1,702.96
	2008	\$637	\$956	\$228.48	\$774.96	\$865.48	\$1,730.96
	2009	\$674	\$1,011	\$228.48	\$793.96	\$902.48	\$1,804.96
	2010	\$674	\$1,011	\$228.48	\$793.96	\$902.48	\$1,804.96
	2011	\$674	\$1,011	\$228.48	\$793.96	\$902.48	\$1,804.96

Level II - Residential Care (DOH certified Residences for Adults, OMH or OPWDD certified Community Residences, Individualized Residential Alternatives and OASAS certified Chemical Dependence Residential Services)

Living Arrangement	Year	Federal Benefit Rate		State Supplement		Total Benefit	
		Ind.	Couple	Ind.	Couple	Ind.	Couple
NYC, Nassau, Suffolk, Rockland and Westchester	2007	\$623	\$934	\$435	\$1,182	\$1,058	\$2,116
	2008	\$637	\$956	\$435	\$1,188	\$1,072	\$2,144
	2009	\$674	\$1,011	\$435	\$1,207	\$1,109	\$2,218
	2010	\$674	\$1,011	\$435	\$1,207	\$1,109	\$2,218
	2011	\$674	\$1,011	\$435	\$1,207	\$1,109	\$2,218
Rest of State	2007	\$623	\$934	\$405	\$1,122	\$1,028	\$2,056
	2008	\$637	\$956	\$405	\$1,128	\$1,042	\$2,084
	2009	\$674	\$1,011	\$405	\$1,147	\$1,079	\$2,158
	2010	\$674	\$1,011	\$405	\$1,147	\$1,079	\$2,158
	2011	\$674	\$1,011	\$405	\$1,147	\$1,079	\$2,158

**REFERENCE/DESK AIDS
INCOME**

SSI BENEFIT LEVELS (continued)

Level III- 2006- Enhanced Residential Care (DOH certified Adult Homes and Enriched Housing, OPWDD certified Schools for the Mentally Retarded)

Living Arrangement	Year	Federal Benefit Rate		State Supplement		Total Benefit	
		Ind.	Couple	Ind.	Couple	Ind.	Couple
NYC, Nassau, Suffolk, Rockland and Westchester	2006	\$603	\$904	\$525	\$1,339	\$1,128	\$2,243
Rest of the State	2006	\$603	\$904	\$510	\$1,309	\$1,113	\$2,213

Level III- 2007, 2008, 2009 and 2010- Enhanced Residential Care (DOH certified Adult Homes and Enriched Housing, OPWDD certified Schools for the Mentally Retarded)

Living Arrangement	Year	Federal Benefit Rate		State Supplement		Total Benefit	
		Ind.	Couple	Ind.	Couple	Ind.	Couple
Statewide	2007	\$623	\$934	\$641	\$1,594	\$1,264	\$2,528
	2008	\$637	\$956	\$656	\$1,630	\$1,293	\$2,586
	2009	\$674	\$1,011	\$694	\$1,725	\$1,368	\$2,736
	2010	\$674	\$1,011	\$694	\$1,725	\$1,368	\$2,736
	2011	\$674	\$1,011	\$694	\$1,725	\$1,368	\$2,736

**REFERENCE/DESK AIDS
INCOME****FAMILY MEMBER ALLOWANCE (FMA)**

A full explanation of the Family Member Allowance (FMA) policy can be found in the **INCOME PERSONS IN MEDICAL FACILITIES, COMMUNITY SPOUSE AND FAMILY MEMBER ALLOWANCES.**

Effective January 1 each year the maximum Family Member Allowance is as follows:

Year	FMA Amount
2007	\$571
2008	\$584
2009	\$608
2010	\$608
2011	\$613

**REFERENCE/DESK AIDS
INCOME**

**SPOUSAL IMPOVERISHMENT
INCOME ALLOWANCES**

Discussion of income allowances under spousal impoverishment can be found in the **INCOME CHRONIC CARE BUDGETING METHODOLOGY FOR INSTITUTIONALIZED SPOUSES**.

Spousal Impoverishment	Year	Income
Community Spouse	2008	\$2,610
	2009	\$2,739
	2010	\$2,739
	2011	\$2,739
	2012	\$2,841
Institutionalized Spouse	2008	\$50
	2009	\$50
	2010	\$50
	2011	\$50
	2012	\$50

**REFERENCE/DESK AIDS
INCOME****MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE (MMMNA)**

A full explanation of the Minimum Monthly Maintenance Needs Allowance (MMMNA) policy can be found in the **INCOME PERSONS IN MEDICAL FACILITIES, COMMUNITY SPOUSE AND FAMILY MEMBER ALLOWANCES.**

Effective January 1 each year the Minimum Monthly Maintenance Needs Allowance is as follows:

:

Year	MMMNA Amount
2008	\$2,610
2009	\$2,739
2010	\$2,739
2011	\$2,739
2012	\$2,841

**REFERENCE/DESK AIDS
INCOME****SPOUSAL IMPOVERISHMENT: PERSONAL NEEDS ALLOWANCE (PNA)**

A discussion of the personal needs allowance for Institutionalized Spouses who reside in the Community is found in the **INCOME CHRONIC CARE BUDGETING METHODOLOGY FOR INSTITUTIONALIZED SPOUSES**.

The personal needs allowance for institutionalized spouses who reside in the community are:

Year	Amount
2008	\$342
2009	\$350
2010	\$350
2011	\$350
2012	\$367

**REFERENCE/DESK AIDS
INCOME**

CHILD HEALTH PLUS INCOME LEVELS

Effective 2/1/2009

Child Health Plus Premium Levels Chart							
Premium Categories	1	2	3	4	5	6	Each Add'l Person
Free Insurance	\$1,443	\$1,942	\$2,441	\$2,939	\$3,438	\$3,937	\$499
\$9/Child/Month (Max. \$27/Family)	\$2,004	\$2,696	\$3,388	\$4,080	\$4,772	\$5,464	\$692
\$15/Child/Month (Max \$45/Family)	\$2,257	\$3,036	\$3,815	\$4,594	\$5,373	\$6,153	\$780
\$30/Child/Month (Max \$90/Family)	\$2,708	\$3,643	\$4,578	\$5,513	\$6,448	\$7,383	\$935
\$45/Child/Month (Max \$135/Family)	\$3,159	\$4,250	\$5,341	\$6,432	\$7,523	\$8,613	\$1,091
\$60/Child/Month (Max \$180/Family)	\$3,610	\$4,857	\$6,104	\$7,350	\$8,597	\$9,844	\$1,247
Full Premium*/ Child/Month	Over \$3,610	Over \$4,857	Over \$6,104	Over \$7,350	Over \$8,597	Over \$9,844	

*The full premium varies, depending on the health plan chosen by the family.

REFERENCE

PAID/INCURRED EXPENSES UNDER THE EXCESS INCOME PROGRAM

		DEDUCTED FROM EXCESS INCOME IN (Accounting period)		
		Retroactive	First Prospective	Current
UNPAID EXPENSES INCURRED IN:				
Pre-retroactive		YES	YES	YES *
Retroactive		YES	YES	YES *
First Prospective		N/A	YES	YES *
Current		N/A	N/A	YES
EXPENSES PAID IN:				
Pre-retroactive		NO	NO	NO
Retroactive		YES	YES**	NO
First Prospective		N/A	YES	NO
Current		N/A	N/A	YES

* If the individual met his/her excess income liability in the previous period without deducting all of the unpaid expense, the portion not already used to establish eligibility is carried forward as long as the expense remains viable and there is no break in eligibility, (i.e., no intervening month or months in which the excess income is not met or in which there is no excess income liability).

** If the individual met his/her income liability in the retroactive period without deducting all of the paid expense, that portion not already used to establish eligibility may be deducted from income in the first prospective period.

DEFINITIONS: As used in this chart:

Expenses means expenses incurred for health insurance premiums, deductibles or other coinsurance charges, and necessary medical and remedial services that are recognized under State law, which have not previously been used to establish eligibility.

Accounting period means a period of time, extending from one to six months, over which income is determined and compared to the Medical Assistance income standard to determine eligibility.

Pre-retroactive period means the period prior to the first day of the third month of application for Medicaid.

Retroactive period means any portion of the three month period immediately prior to the month of application for Medicaid.

First prospective period means the first accounting period that includes the month of application.

Current period means an accounting period occurring after the first prospective period.

REFERENCE/DESK AIDS

RESOURCES SECTION

**REFERENCE/DESK AIDS
RESOURCE**

MINIMUM/MAXIMUM COMMUNITY SPOUSE ALLOWANCE

Full explanation of the Assessment/Determination for Persons in Medical Facilities including the State minimum and Federal maximum community spouse resource allowances, can be found in the **RESOURCE: RETIREMENT FUNDS, PERSONAL NEEDS ALLOWANCE ACCOUNTS, PERSON IN MEDICAL FACILITIES ASSESSMENT/DETERMINATION** and **TRANSFER OF ASSETS**.

Federal **Maximum** Community Spouse Resource Allowance:

Year	Amount
2008	\$104,400
2009	\$109,560
2010	\$109,560
2011	\$109,560
2012	\$113,640

The State **Minimum** Community Spouse Resource Allowance is \$74,820.

NOTE: In determining the community resource allowance on and after January 1, 2008, the community spouse is permitted to retain resources in an amount equal to the greater of the following: \$74,820 or the amount of the spousal share up to the maximum amount. The spousal share is the amount equal to one-half of the total value of the countable resources of the couple as of the beginning of the most continuous period of institutionalization of the institutionalized spouse on or after September 30, 1989.

**REFERENCE/DESK AIDS
RESOURCE**

SSI-RELATED ONLY MEDICAID RESOURCE LEVELS

Discussion of the use of the medically needy resource levels in the determination of eligibility is found in the **RESOURCE MEDICAID RESOURCE LEVEL**. The SSI-RELATED ONLY resource levels, according to family size, are:

HOUSEHOLD SIZE	ONE	TWO	THREE	FOUR	FIVE	SIX	SEVEN	EIGHT	EACH ADD'L PERSON
RESOURCES (ASSETS)									
1/1-3/31/2008	\$4,350	\$6,400	\$6,600	\$6,650	\$6,700	\$6,800	\$7,650	\$8,500	\$850
4/1/2008	\$13,050	\$19,200	\$22,200	\$25,050	\$27,900	\$30,750	\$33,600	\$36,600	\$2,850
2009	\$13,800	\$20,100	\$23,115	\$26,130	\$29,145	\$32,160	\$35,175	\$38,190	\$3,015
2010	\$13,800	\$20,100	\$23,115	\$26,130	\$29,145	\$32,160	\$35,175	\$38,190	\$3,015
2011	\$13,800	\$20,100	\$23,115	\$26,130	\$29,145	\$32,160	\$35,175	\$38,190	\$3,015
2012	\$14,250	\$20,850	\$23,978	\$27,105	\$30,233	\$33,360	\$36,488	\$39,615	\$3,128
FHP RESOURCES									
1/1-3/31/2008	\$13,050	\$19,200	\$19,800	\$19,950	\$20,010	\$20,400	\$22,950	\$25,500	\$2,500
4/1/2008	\$13,050	\$19,200	\$22,200	\$25,050	\$27,900	\$30,750	\$33,600	\$36,600	\$2,850
2009	\$13,800	\$20,100	\$23,115	\$26,130	\$29,145	\$32,160	\$33,175	\$38,190	\$3,015
2010	NO RESOURCE TEST								
2011	NO RESOURCE TEST								
2012	NO RESOURCE TEST								

MBI-WPD									
10/1/2011	\$20,000	\$30,000							

**REFERENCE/DESK AIDS
RESOURCES****SSI RESOURCE LEVELS**

The SSI Resource Levels for individuals and couples:

SSI RESOURCE LEVEL	Individuals	Couples
2008	\$2000	\$3000
2009	\$2000	\$3000
2010	\$2000	\$3000
2011	\$2000	\$3000
2012	\$2000	\$3000

**REFERENCE/DESK AIDS
RESOURCES****SUBSTANTIAL HOME EQUITY LIMIT**

A full explanation of Substantial Home Equity of SSI-related A/Rs can be found in RESOURCES SUBSTANTIAL HOME EQUITY.

The amount is effective January 1 each year.

Year	Amount
2010	\$750,000
2011	\$758,000
2012	\$786,000

**REFERENCE/DESK AIDS
RESOURCE**

TRANSFER OF ASSETS REGIONAL RATES

A full explanation of the regional rates for use in determining the effect of a transfer of assets for less than the fair market value is discussed in **RESOURCE TRANSFER OF ASSETS**.

Regional rates are used to determine the period of restricted Medicaid coverage when a prohibited transfer is made. The rates listed below for each of the seven regions in the state are used for persons who apply for Medicaid as an institutionalized person on or after January 1, 2011.

<u>NORTHEASTERN</u> \$8,323			<u>WESTERN</u> \$7,863	
Albany	Fulton	Saratoga	Allegany	Orleans
Clinton	Greene	Schenectady	Cattaraugus	Wyoming
Columbia	Hamilton	Schoharie	Chautauqua	
Delaware	Montgomery	Warren	Erie	
Essex	Otsego	Washington	Genesee	
Franklin	Rensselaer		Niagara	

<u>ROCHESTER</u> \$8,942		<u>NORTHERN METROPOLITAN</u> \$10,105		
Chemung	Steuben	Dutchess		Westchester
Livingston	Wayne	Orange		
Monroe	Yates	Putnam		
Ontario		Rockland		
Schuyler		Sullivan		
Seneca		Ulster		

<u>CENTRAL</u> \$7,688			<u>NEW YORK CITY</u> \$10,579	
Broome	Lewis	Tioga	Bronx	
Cayuga	Madison`	Tompkins	Kings (Brooklyn)	
Chenango	Oneida		NY (Manhattan)	
Cortland	Onondaga		Queens	
Herkimer	Oswego		Richmond (Staten Island)	
Jefferson	St. Lawrence			

<u>LONG ISLAND</u> \$11,445	
Nassau	Suffolk

**REFERENCE/DESK AIDS
RESOURCE**

TRANSFER OF ASSETS REGIONAL RATES (continued)

Regional Rates are effective January 1 each year.

	2010	2009	2008	2007	2006
Central	\$7,264	\$6,938	\$6,696	\$6,506	\$6,232
Long Island	\$11,227	\$10,852	\$10,555	\$10,123	\$9,842
New York City	\$10,285	\$9,838	\$9,636	\$9,636	\$9,132
Northeastern	\$7,927	\$7,766	\$7,431	\$7,189	\$6,872
Northern Metropolitan	\$10,163	\$9,439	\$9,361	\$9,074	\$8,724
Rochester	\$9,058	\$8,720	\$8,089	\$8,002	\$7,375
Western	\$7,694	\$7,418	\$7,066	\$6,820	\$6,540

**REFERENCE/DESK AIDS
RESOURCES**

LOOK-BACK PERIOD

For applications of Medicaid coverage for nursing facility services and for SSI-related recipients who request an increase in coverage for nursing facility services, the look-back period increases from 36 months to 60 months (60 months for trusts) for transfers made on or after February 8, 2006.

The look-back period increases each month by 1-month increments beginning March 1, 2009 (37 months) until February 2011. Effective February 1, 2011, the full 60 month look-back period will be in place for ALL transfers of assets.

Application Date	Number of Months	Look-Back Period
February 2009	36	Feb-2006-Jan 2009
March 2009	37	Feb 2006-Feb 2009
Apr 2009	38	Feb 2006-Mar 2009
Apr 2010	50	Feb 2006-Mar 2010
Sept 2010	55	Feb 2006-Aug 2010
Feb 2011	60	Feb 2006-Jan 2011
Mar 2011	60	Mar 2006-Feb 2011

REFERENCE

TRUST FUNDS

Situation	Supplemental Needs Trusts	OBRA 1993 Exception Trusts	
		Individual Trusts	Pooled Trusts
Legal Reference		Social Security Act Section 1917(d)(4)A)	Social Security Act Section 1917(d)(4)(C)
Beneficiary's Age	Any age	Under Age 65*	Any age*
Disability	Severe and chronic or persistent impairment	In receipt of SSI Disability, SSA Disability, or certified disabled either when the trust was established or retroactively as of the date the trust was established.	Same as for an individual trust
Whose assets are used to establish the trust?	Assets of anybody	Must be the assets of the individual.	May be the assets of the individual.
Who establishes the trust?	By anyone other than the A/R.	Parent, grandparent, legal guardian of individual, or a court.	The individual, grandparent, legal guardian of the individual, or a court open account.
Medicaid repayment requirement.	If Exceptions Trust, Department recovers all amounts up to the MA paid amount.	The Department recovers all amounts up to the MA paid amount.	The Department recovers all amounts not retained by the not-for-profit organization up to the MA paid amount.
Miscellaneous unique requirements			Established and managed by a nonprofit association.

* Transfer penalties apply for transfers of assets to trusts once the person is 65 years of age or older for both individual and pooled trusts.

REFERENCE

LIFE EXPECTANCY TABLE FOR ANNUITIES

Age	Life Expectancy		Age	Life Expectancy		Age	Life Expectancy	
	Male	Female		Male	Female		Male	Female
0	74.14	79.45	40	36.64	40.97	80	7.31	8.95
1	73.70	78.94	41	35.73	40.03	81	6.85	8.40
2	72.74	77.97	42	34.83	39.09	82	6.42	7.87
3	71.77	77.00	43	33.94	38.16	83	6.00	7.36
4	70.79	76.01	44	33.05	37.23	84	5.61	6.88
5	69.81	75.03	45	32.16	36.31	85	5.24	6.42
6	68.82	74.04	46	31.29	35.39	86	4.89	5.98
7	67.83	73.05	47	30.42	34.47	87	4.56	5.56
8	66.84	72.06	48	29.56	33.56	88	4.25	5.17
9	65.85	71.07	49	28.70	32.65	89	3.97	4.81
10	64.86	70.08	50	27.85	31.75	90	3.70	4.47
11	63.87	69.09	51	27.00	30.85	91	3.45	4.15
12	62.88	68.09	52	26.16	29.95	92	3.22	3.86
13	61.89	67.10	53	25.32	29.07	93	3.01	3.59
14	60.91	66.11	54	24.50	28.18	94	2.82	3.35
15	59.93	65.13	55	23.68	27.31	95	2.64	3.13
16	58.97	64.15	56	22.86	26.44	96	2.49	2.93
17	58.02	63.17	57	22.06	25.58	97	2.35	2.75
18	57.07	62.20	58	21.27	24.73	98	2.22	2.58
19	56.14	61.22	59	20.49	23.89	99	2.11	2.43
20	55.20	60.25	60	19.72	23.06	100	2.00	2.29
21	54.27	59.28	61	18.96	22.24	101	1.89	2.15
22	53.35	58.30	62	18.21	21.43	102	1.79	2.02
23	52.42	57.33	63	17.48	20.63	103	1.69	1.89
24	51.50	56.36	64	16.76	19.84	104	1.59	1.77
25	50.57	55.39	65	16.05	19.06	105	1.50	1.66
26	49.64	54.41	66	15.36	18.30	106	1.41	1.55
27	48.71	53.44	67	14.68	17.54	107	1.33	1.44
28	47.77	52.47	68	14.02	16.80	108	1.25	1.34
29	46.84	51.50	69	13.38	16.07	109	1.17	1.25
30	45.90	50.53	70	12.75	15.35	110	1.10	1.16
31	44.96	49.56	71	12.13	14.65	111	1.03	1.07
32	44.03	48.60	72	11.53	13.96	112	0.96	0.99
33	43.09	47.63	73	10.95	13.28	113	0.89	0.91
34	42.16	46.67	74	10.38	12.62	114	0.83	0.84
35	41.23	45.71	75	9.83	11.97	115	0.77	0.77
36	40.30	44.76	76	9.29	11.33	116	0.71	0.71
37	39.38	43.80	77	8.77	10.71	117	0.66	0.66
38	38.46	42.86	78	8.27	10.11	118	0.61	0.61
39	37.55	41.91	79	7.78	9.52	119	0.56	0.56

Effective 9/26/2011, see **OTHER ELIGIBILITY REQUIREMENTS RECOVERIES ESTATE RECOVERIES.**

REFERENCE/DESK AIDS
OTHER ELIGIBILITY REQUIREMENTS SECTION

**REFERENCE/DESK AIDS
OTHER ELIGIBILITY REQUIREMENTS**

CO-PAYMENT AMOUNTS

Discussion of co-payment amounts for fee-for-service, managed care and Family Health Plus recipients is found in **OTHER ELIGIBILITY REQUIREMENTS CO-PAY**.

<u>SERVICE</u>	<u>AMOUNT (\$) for FFS</u>	<u>AMOUNT for MC</u>	<u>FHPlus</u>	<u>FPBP</u>
Inpatient Hospital	\$25.00 per stay upon discharge	No co-payment	\$25.00 per stay upon discharge	No co-payment
Outpatient Hospital and Clinic	\$3.00 per visit	No co-payment	\$5.00 per visit	No co-payment
Non-emergency/Non-urgent ER	\$3.00 per visit	No co-payment	\$3.00 per visit	No co-payment
Prescription drugs*				No co-payment
Brand name	\$3.00	\$3.00	\$6.00	
Generic	\$1.00	\$1.00	\$3.00	
Over-the-Counter Drugs (OTC) **(per medication)	\$.50	No co-payment	\$.50	No co-payment
Enteral/Parental Formulae/Supplies	\$1.00 per order/prescription	No co-payment	No co-payment	N/A
Covered Medical/Surgical Supplies ***	\$.50 per order	No co-payment	\$1.00 per supply	No co-payment
Laboratory	\$.50 per procedure code	No co-payment	\$.50 per procedure code	No co-payment
X-ray ****	\$1.00 per procedure	No co-payment	\$1.00 per procedure	No co-payment
Dental services	No co-payment	No co-payment	\$5.00 per visit up to total of \$25 per year	N/A
Physician Services	No co-payment	No co-payment	\$5.00 per visit	No co-payment
Family Planning Service/Supplies	No co-payment	No co-payment	No co-payment	
* One co-payment for each new prescription and each new refill				
** Covered OTC e.g. smoking cessation products, insulin				
*** Covered medical supplies e.g. diabetic supplies such as syringes, lancets, test strips, enteral formula				
**** Radiology services e.g. diagnostic x-rays, ultrasound, nuclear medicine & oncology services				

**REFERENCE/DESK AIDS
OTHER ELIGIBILITY REQUIREMENTS**

MEDICAID COVERED SERVICES

Federally Mandated Services:

- Inpatient Hospital Services
- Outpatient Hospital Services
- Physician Services
- Medical and Surgical Dental Services
- Nursing facility services for individuals aged 21 or older
- Home Health Care (Nursing, Home Health Aide, Medical Supplies & Equipment)
- Family Planning Services and Supplies
- Rural Health Clinic Services
- Laboratory and X-Ray Services
- Nurse Practitioner Services
- Federally Qualified Health Center Services
- Midwife Services
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services for individuals under 21 (Child/Teen Health Plan in NYS)
- Medicare Coinsurance and Deductibles for qualified Medicare beneficiaries for: Chiropractors, Podiatrists, Portable X-Ray and Clinical Social Work Services

Non-Mandated Services (covered by New York State Medicaid):

- Free-standing Clinic Services
- Nursing Facility Services for under age 21
- Intermediate Care Facility Services for the Developmentally Disabled
- Optometrist Services and Eyeglasses
- Physical, Speech and Occupational Therapy
- Prosthetic Devices and Orthotic Appliances
- Dental Services
- Audiology and Hearing Aids
- Clinical Psychologist Services
- Private Duty Nursing
- Diagnosis, Screening, Preventive and Rehabilitative Services
- Personal Care Services
- Transportation to Covered Services
- Hospice
- Case Management
- Inpatient Psychiatric Facility Services for Individuals under age 21 and over 65
- Drugs—prescription and non-prescription

**REFERENCE/DESK AIDS
OTHER ELIGIBILITY REQUIREMENTS**

COVERED SERVICES FOR PREGNANT WOMEN

	Presumptive Eligibility		Ongoing Medicaid Eligibility		
	Perinatal A Under 100% FPL	Perinatal B Under 200% FPL	Perinatal Family	MA-Fully Eligible	Fully Eligible under 100%FPL
Coverage Code	13	14	15	01	01
SERVICES					
Physician Care	Yes	Yes	Yes	Yes	Yes
Midwife Care	Yes	Yes	Yes	Yes	Yes
Outpatient Clinic	Yes	Yes	Yes	Yes	Yes
Pharmacy	Yes	Yes	Yes	Yes	Yes
Dental	Yes	Yes	Yes	Yes	Yes
Laboratory	Yes	Yes	Yes	Yes	Yes
Eye Care	Yes	Excluded	Excluded	Yes	Yes
Transportation	Yes	Yes	Yes	Yes	Yes
Home Health Care	Yes	Yes	Yes	Yes	Yes
Personal Care	Yes	Yes	Yes	Yes	Yes
Nursing Services	Yes	Yes	Yes	Yes	Yes
Podiatry	Yes	Excluded	Excluded	Yes	Yes
Physical Therapy	Yes	Excluded	Excluded	Yes	Yes
Occupational Therapy	Yes	Excluded	Excluded	Yes	Yes
Speech Therapy	Yes	Excluded	Excluded	Yes	Yes
Durable Medical Equipment	Yes	Excluded	Excluded	Yes	Yes
Abortion	Yes	Excluded	Excluded	Yes	Yes
Clinical Psychology	Yes	Yes	Yes	Yes	Yes
Outpatient/ Mental Health	Yes	Yes	Yes	Yes	Yes
Outpatient/ Alcoholism	Yes	Yes	Yes	Yes	Yes
Health Education	Yes	Yes	Yes	Yes	Yes
Nutritional Counseling	Yes	Yes	Yes	Yes	Yes
Family Planning	Yes	Yes	Yes	Yes	Yes
Hospice	Excluded	Excluded	Excluded	Yes	Yes
Inpatient Care	Excluded	Excluded	Yes	Yes	Yes
Alternate Level of Care	Excluded	Excluded	Excluded	Yes	Yes
Institutional LTC	Excluded	Excluded	Excluded	Yes	Yes
LT Home Health Care	Excluded	Excluded	Excluded		

COMMUNITY-BASED LONG-TERM CARE AND NURSING FACILITY SERVICES

Coverage	Community Coverage <u>without</u> Long Term Care	Community Coverage <u>with</u> Community Based Long-Term Care	All Medicaid Covered Care and Services (Applicants must be in receipt of Nursing Facility Services)
Documentation	Application: Attest to value of current resources Renewal: Attest to value of current resources	Application: Document Current Resources Renewal: Attest to value of current resources	Application: Document resources for the past 60 months or back to 2/8/2006 whichever is shorter (60 months for trusts) Renewal: Document current resources
Benefit Package	-All non-LTC Outpatient Services -Inpatient Acute Care -Inpatient Psychiatric Care -Inpatient Alcohol Rehabilitation -Short-term rehabilitation up to 29 consecutive days in a 12 month period of: -Nursing Home Care -Certified Home Health Agency (CHHA)	-All services in Community Coverage without Community Based Long Term Care PLUS: -Adult Day Health Care -Assisted Living Program (ALP) -Certified Home Health Agency-CHHA, unlimited -Hospice in the Community -Hospice Residence Program -Residential Treatment Facility -Managed LTC in the Community -Personal Care Services -Private Duty Nursing -Home and Community-Based Waiver Programs – Waiver and Non-Waiver Services -Limited Licensed Home Care Services -Personal Emergency Response Services -Consumer Directed Personal Assistant Program	-All services in Community Coverage <u>with</u> and <u>without</u> Community Based LTC, PLUS: -Nursing Facility Services which include: -Nursing Home care provided in a nursing home or hospital -Hospice in a Nursing Home -Intermediate Care Facility -Managed LTC in a Nursing Home
Coverage Code(s)	20 or 24 (NYC only–legal alien during 5 year ban)	19	01 or 11 (Legal/Alien – Full Coverage) or 10* (Provided up to 60 months look-back info and is in penalty period – no spenddown or 6 mos. spenddown met)
Outpatient only Coverage code (Spend down)	22	21	02 (Outpatient Coverage with nursing facility services) or 23* (Outpatient coverage with no nursing facility services)
RVI Code	RVI Code 3	RVI Code 2	RVI Code 1 (documentation), 4 (transfer)

* Those individuals in a transfer penalty period are not eligible for any Nursing Facility Services including short-term rehabilitation in a nursing home.

**REFERENCE/DESK AIDS
OTHER ELIGIBILITY REQUIREMENTS**

REFUGEE MEDICAL ASSISTANCE PROGRAM (RMA)

**ELIGIBILITY PERIODS, STATE/FEDERAL (S/F) CHARGE CODE AND ALIEN
CITIZENSHIP INDICATOR CODES (ACI)**

State and Federal Charge Code 30 is only assigned when a Single Individual or Childless Couple (S/CC), age 21-64, is not otherwise eligible for “regular” Medicaid (S/CC/FHPlus – 02 budget) and eligibility for the Refugee Medical Assistance program has been determined (ADC-related – 01 budget).

Immigration Status	ACI RMA Eligible	S/F Charge Code	Eligibility Period Based on either the Date Entered Country (DEC) or the Date Status is granted or achieved (DOS)
Refugee	R	30	Eight months from the date entered country (DEC) as indicated on the Arrival Departure Record (I-94) or other immigration documentation
Amerasian Immigrants	R	30	Eight months from the date entered country (DEC) as indicated on the Arrival Departure Record (I-94) or other immigration documentation
Cuban/Haitian Entrants	H	30	Eight months from the date entered country (DEC) as indicated on the Arrival Departure Record (I-94) or other immigration documentation
Asylee	A	30	Eight months from the date asylum status is granted (DOS)
Federally Certified Victims of a Severe Form of Human Trafficking	D	30	Eight months from the date of the Certification letter for adults (DOS); date of eligibility letter for children
Family Member of victims of a severe form of human trafficking issued a Derivative T-Visa (T2, T3, T4, or T5) while in the United States	D	30	Eight months from the notice date found in the I-797 (Notice of Action) (DOS)
Family Member of victims of a severe form of human trafficking issued a Derivative T-Visa (T2, T3, T4, or T5) when entering the United States	D	30	Eight months from the date entered country (DEC) as indicated on the I-94 or other immigration documentation
Iraqi/Afghan Special Immigrant (SI)	R	30	Eight months from the date they entered the U.S. (DEC) or, if already in the U.S., eight months from the date they acquired their Special Immigrant status (DOS)

**REFERENCE/DESK AIDS
OTHER ELIGIBILITY REQUIREMENTS**

DISTRICT OF FISCAL RESPONSIBILITY

The where found district is responsible for eligible persons found in the district (SSL62.1) except when:

Rules	Action	Until
Medical SSL 62.5(d)	The DFR is the district of legal residence when an individual is admitted into a medical facility outside the district of legal residence. The individual has the freedom of choice as relates to the facility.	There is at least a 30-day break in need (one full calendar month)
Placement SSL 62.5(b)	The DFR is the district of legal residence when the SS district was directly or indirectly involved in placing the eligible individual into a formal residential care setting outside the district of legal residence.	There is a least a 30-day break in need (one full calendar month)
Transition 08 OHIP/LCM-1	The DFR is the “ from ” district when a recipient of public assistance and/or care moves to another district and continues to be eligible.	If the LDSS was notified of the new address in writing after the move; the end of the month following the month the move was reported. If the LDSS was not notified of new address in writing or notified of new address in writing <u>prior</u> to move the end of the month following the month of the move.
Temporary Absence SSL 365.1(a)	The DFR is the district of legal residence when an eligible individual leaves the district of legal residence for a specific purpose and intends to return to the home district upon completion of the activity.	The individual ceases to be engaged in the activity for which the individual left the permanent home. At that point, the transition rule applies.
Domestic Violence SSL 62.5(f)	The DFR is the district of legal residence at the time of the domestic violence incident when an individual goes into a residential program for victims of domestic violence in another county.	The individual leaves the approved shelter and chooses not to return to the “ from ” district. At that point, the transition rule applies.
Emergency Temporary Housing SSL 365.1(a)	The DFR is the placing district when a homeless person is placed by one district into temporary housing in another district.	The individual leaves temporary housing. At that point, the transition rule applies.

**REFERENCE/DESK AIDS
OTHER ELIGIBILITY REQUIREMENTS
DISTRICT OF FISCAL RESPONSIBILITY**

Rules	Action	Until
Parole SSL 366 (1-a)	The DFR for an inmate released on parole is the district of legal residence prior to incarceration.	Conditions of parole are completed.
Infants Residing with Incarcerated Mother 95 ADM-4	The DFR for an infant residing with the incarcerated mother is the mother's district of legal residence at the time of her sentencing.	The infant leaves the facility.
Assisted Living Program & Adult Care Facilities 18 NYCRR 505.35(l)	The DFR is the district of legal residence at the time of admission.	Break in need.
Minor Children < 21 yrs old GIS 00 MA/018	The DFR for a child capable of indicating intent is the district "where found", unless exception applies.	The child moves to another district. At that point the transition rule applies.
	The DFR for a child incapable of indicating intent is the district of legal residence of the parents/legal guardians.	The parent/legal guardian moves to another district. At that point the transition rule applies.

**REFERENCE/DESK AIDS
DETERMINING THE MEDICAID/CHPLUS HOUSEHOLD/FAMILY SIZE**

You <u>MUST</u> Count	You <u>MAY</u> Count (it is the family's choice)	Do <u>NOT</u> Count
<p>Applicant , and the applicant's:</p> <ul style="list-style-type: none"> • Legally Responsible Relatives: (LRRs) <ul style="list-style-type: none"> ○ Parents and Stepparents of children under 21 ○ Spouses ○ Adoptive parents • Applying siblings under 21 (can Mehler child(ren)out if income makes other applying individuals in household ineligible) • Pregnant women count as a HH of 2 (self plus unborn - if expecting a multiple birth, still count as 2) <p>When an individual of any age is counted, you must also count their income</p> <p><u>It is the family's choice</u> to select the most advantageous budgeting method for those household members who are applying</p> <p>Children/minors are defined as individuals who are under age 21</p>	<ul style="list-style-type: none"> • Non-applying siblings under 21 • Applying or Non-Applying related children (e.g. niece, cousin) under 21 • Non-applying Children under 21 of applying adults • One Caretaker Relative, (e.g. grandparent, aunt, uncle - only if no parent is in HH) <u>If child is applying for Medicaid</u>, the Caretaker Relative may only be counted if (s)he is also applying <u>If child is applying for Child Health Plus</u>, the Caretaker Relative may be counted even if (s)he is not applying for Medicaid • Unwed Father of Unborn: may count if family chooses to (if he resides and budgets his income with the pregnant woman) (do not count for CHPlus) • Unwed parents of common children (who reside and budget their money together) may or may not be counted in each other's HH size • <u>For Child Health Plus determinations only:</u> you <u>may</u> count Recipients of SSI Cash, Temporary Cash Assistance and Foster Children <u>only</u> if it results in another child's full premium being reduced to subsidized coverage (a lower or zero amount) 	<ul style="list-style-type: none"> • Parents of applying pregnant minors • Recipients of SSI Cash or Temporary Cash Assistance • Unrelated Foster Children • Children and siblings over 21 • Other unrelated, non- legally responsible persons (e. g. the unmarried boyfriend of a woman who has no child or unborn in common with him or the unrelated friend of an adult or child who resides in the HH) • Parents of a minor child who is applying only for the Family Planning Benefit Program (only if (s)he claims Good Cause and/or has a need for confidentiality or is unable to access parental income information)
<p align="center">Count only those people who live with the applicant(s)</p>		

**REFERENCE/DESK AIDS
OTHER ELIGIBILITY REQUIREMENTS**

**BIRTH VERIFICATION INDICATOR (BVI)
CONVERSION FROM SSA**

The BVI (Birth Verification Indicator) will be populated based on the following conversion chart:

SSA Response Code	Description	BVI Code	Edits/Handling
A	SSN is verified, there is no indication of death, and the allegation of citizenship is consistent with SSA data	1	<ul style="list-style-type: none"> ➤ System generated based on response from SSA ➤ Not data enterable by worker ➤ Worker cannot update or delete
B	SSN is verified, there is no indication of death, and the allegation of citizenship is NOT consistent with SSA data	B	<ul style="list-style-type: none"> ➤ System generated based on response from SSA ➤ Not data enterable by worker ➤ Worker cannot delete ➤ Worker can update with 3 ➤ Batch processing will not delete but will update
C*	SSN is verified, there is indication of death, and the allegation of citizenship is consistent with SSA data	C*	<ul style="list-style-type: none"> ➤ System generated based on response from SSA ➤ Not data enterable by worker ➤ Worker cannot delete ➤ Batch processing will not delete but will update
D*	SSI is verified, there is indication of death, and the allegation of citizenship is NOT consistent with SSA data	D*	<ul style="list-style-type: none"> ➤ System generated based on response from SSA ➤ Not data enterable by worker ➤ Worker cannot delete ➤ Worker can update with 3 ➤ Batch processing will not delete but will update

* BVI values "C" and "D" will not appear on the citizenship report. "C" and "D" must be reconciled from the death match report.

REFERENCE

APPLICATION REQUIREMENTS

CATEGORY	FACE-TO-FACE	DOCUMENTATION		
		RESOURCES	INTEREST INCOME	TPHI, INCOME & RESIDENCE*
SSI-RELATED				
Community coverage without LTC	NO	Attest to resources, Document Trusts & burial funds	Document	Document
Community coverage with LTC	NO	Document current resources	Document	Document
All care and services including nursing home	NO	Document current resources and look-back period	Document	Document
MBI-WPD	NO	Attest to resources, Document Trusts & burial funds	Document	Document
ADC-RELATED	NO	No resource test	Attest	Document
LIF				
S/CC				
PARENTS WITH CHILDREN UNDER 21				
CHILDREN UNDER 21				
PREGNANT WOMEN				
CHILDREN UNDER 1				
FPBP				
MEDICAID CANCER TREATMENT				
MEDICARE SAVINGS				
QI, QMB, SLMB				
AHIP				
PARTNERSHIP FOR LTC				

REFERENCE

RENEWAL/RECERTIFICATION DOCUMENTATION REQUIREMENTS

CATEGORY	RESOURCES	INCOME	CHANGE RESIDENCY	TPHI	INTEREST INCOME
SSI-RELATED					
Community coverage without LTC	Itemize and Attest	Attest	Attest	Document	Attest
Community coverage with LTC	Itemize and Attest	Attest	Attest	Document	Attest
All care and services including nursing home	Document	Document	Document	Document	Document
MBI-WPD	Attest	Attest	Attest	Document	Attest
ADC-RELATED	No resource test	Attest	Attest	Document	Attest
LIF					
S/CC					
PARENTS WITH CHILDREN UNDER 21					
CHILDREN UNDER 21					
PREGNANT WOMEN					
CHILDREN UNDER 1					
FPBP					
MEDICAID CANCER TREATMENT					
MEDICARE SAVINGS					
QI, QMB, SLMB					
AHIP					
PARTNERSHIP FOR LTC					

**REFERENCE/DESK AIDS
INCOME
LIF BUDGETING METHODOLOGY**

EARNED INCOME DISREGARD

A full explanation of the Earned Income Disregard is found in the **INCOME LIF BUDGETING METHODOLOGY**.

The earned income disregard is adjusted annually to reflect changes in the poverty level:

Year	Percentage
Effective June 1, 2004	53%
Effective June 1, 2005	54%
Effective June 1, 2006	55%
Effective June 1, 2007	57%
Effective June 1, 2008	28% *
Effective June 1, 2009	28%
Effective June 1, 2010	28%

* The 2008 level was adjusted downward to reflect the substantial increase in the Medicaid Standard.

**REFERENCE/DESK AIDS
INCOME****STUDENT INCOME**

A full explanation of the SSI-related disregards and students' income as an earned income can be found in the **INCOME** SSI-RELATED DISREGARDS.

Effective January 1 each year, the standard for a student's income as an SSI-disregard is:

Year	Monthly income	Annual income
2008	\$1,550	\$6,240
2009	\$1,640	\$6,600
2010	\$1,640	\$6,600
2011	\$1,640	\$6,600
2012	\$1,700	\$6,840

**REFERENCE/DESK AIDS
INCOME**

INCOME ALLOCATION

The full explanation of the use of Income Allocations in the SSI-related budgeting process can be found in the **INCOME** SSI-RELATED BUDGETING METHODOLOGY.

Numbers are effective January 1 of each year:

Allocation to	Allocation Amount		How Determined
Non-SSI Child	2008	\$342	Difference between Medicaid income level for one and two
	2009	\$350	
	2010	\$350	
	2011	\$350	
	2012	\$367	
Single parent (regardless of category)	2008	\$637	Federal SSI Benefit Rate (FBR) for one
	2009	\$674	
	2010	\$674	
	2011	\$674	
Two parents (regardless of category)	2008	\$956	Federal SSI Benefit Rate (FBR) for two
	2009	\$1,011	
	2010	\$1,011	
	2011	\$1,011	
	2012	\$1,048	
An SSI-related parent and a non-SSI-related parent residing with an SSI-related child and a non-SSI-related child	2007	\$957	The Federal SSI Benefit Rate (FBR) for two, living alone, plus the SSI State supplement for one, living with others
	2008	\$989	
	2009	\$1,034	
	2010	\$1,034	
	2011	\$1,034	
	2012	\$1,071	

**REFERENCE/DESK AIDS
INCOME**

MEDICALLY NEEDY INCOME LEVELS AND FEDERAL POVERTY LEVELS
(annual and monthly amounts)

HOUSEHOLD SIZE	ONE	TWO	THREE	FOUR	FIVE	SIX	SEVEN	EIGHT	EACH ADD'L PERSON
MA Standard S/CC-LIF 4/1-12/31/08	8,067 673	10,070 840	11,981 999	13,911 1,160	15,907 1,326	17,366 1,448	18,903 1,576	20,876 1,740	1,131 95
2009	8,462 706	10,563 881	12,568 1,048	14,593 1,217	16,686 1,391	18,217 1,519	19,829 1,653	21,899 1,825	99
2010	8,479 707	10,584 883	12,593 1,050	14,622 1,219	16,719 1,394	18,253 1,522	19,869 1,656	21,943 1,829	99
2011	8,487 708	10,595 883	12,606 1,051	14,637 1,220	16,736 1,395	18,271 1,523	19,889 1,658	21,965 1,831	99
2012	8,818 735	11,008 918	13,098 1,092	15,208 1,268	17,389 1,450	18,984 1,582	20,665 1,723	22,822 1,902	1,236 104
MA INCOME 2008 1/1-3/31	8,700 725	12,800 1,067	13,200 1,100	13,300 1,109	13,400 1,117	13,600 1,134	15,300 1,275	17,000 1,417	1,700 142
2008 4/1-12/31/08	8,700 725	12,800 1,067	14,800 1,234	16,700 1,392	18,600 1,550	20,500 1,709	22,400 1,867	24,400 2,034	1,900 159
2009	9,200 767	13,400 1,117	15,410 1,285	17,420 1,452	19,430 1,620	21,440 1,787	23,450 1,955	25,460 2,122	2,010 168
2010	9,200 767	13,400 1,117	15,410 1,285	17,420 1,452	19,430 1,620	21,440 1,787	23,450 1,955	25,460 2,122	2,010 168
2011	9,200 767	13,400 1,117	15,410 1,285	17,420 1,452	19,430 1,620	21,440 1,787	23,450 1,955	25,460 2,122	2,010 168
2012	9,500 792	13,900 1,159	15,985 1,333	18,070 1,506	20,155 1,680	22,240 1,854	24,325 2,028	26,410 2,201	2,085 174
100% FPL 2008 1/1-3/31	10,400 867	14,000 1,167	17,600 1,467	21,200 1,767	24,800 2,067	28,400 2,367	32,000 2,667	35,600 2,967	3,600 300
2008 4/1-12/31/08	10,400 867	14,000 1,167	17,600 1,467	21,200 1,767	24,800 2,067	28,400 2,367	32,000 2,667	35,600 2,967	3,600 300
2009	10,830 903	14,570 1,215	18,310 1,526	22,050 1,838	25,790 2,150	29,530 2,461	33,270 2,773	37,010 3,085	3,740 312
2010	10,830 903	14,570 1,215	18,310 1,526	22,050 1,838	25,790 2,150	29,530 2,461	33,270 2,773	37,010 3,085	3,740 312
2011	10,890 908	14,710 1,226	18,530 1,545	22,350 1,863	26,170 2,181	29,990 2,500	33,810 2,818	37,630 3,136	3,820 319

**REFERENCE/DESK AIDS
INCOME**

MEDICALLY NEEDY INCOME LEVELS AND FEDERAL POVERTY LEVELS
(annual and monthly amounts)

HOUSEHOLD SIZE	ONE	TWO	THREE	FOUR	FIVE	SIX	SEVEN	EIGHT	EACH ADDITIONAL PERSON
120% FPL	12,132	16,308							
2007	1,011	1,359	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2008	12,480	16,800							
1/1-3/31	1,040	1,400	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2008	12,480	16,800							
4/1-12/31/08	1,040	1,400	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2009	12,996	17,484							
	1,083	1,457	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2010	12,996	17,484							
	1,083	1,457	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2011	13,068	17,652							
	1,089	1,471	N/A	N/A	N/A	N/A	N/A	N/A	N/A
133% FPL									
2007	13,580	18,208	22,837	27,465	32,093	36,722	41,350	45,979	4,629
	1,132	1,518	1,904	2,289	2,675	3,061	3,446	3,832	386
2008	13,832	18,620	23,408	28,196	32,984	37,772	42,560	47,348	4,788
1/1-3/31	1,153	1,552	1,951	2,350	2,749	3,148	3,547	3,946	399
2008	13,832	18,620	23,408	28,196	32,984	37,772	42,560,	47,348	4,788
4/1-12/31/08	1,153	1,552	1,951	2,350	2,749	3,148	3, 547	3,946	399
2009	14,404	19,379	24,353	29,327	34,301	39,275	44,250	49,224	4,975
	1,201	1,615	2,030	2,444	2,859	3,273	3,688	4,102	415
2010	14,404	19,379	24,353	29,327	34,301	39,275	44,250	49,224	4,975
	1,201	1,615	2,030	2,444	2,859	3,273	3,688	4,102	415
2011	14,484	19,565	24,645	29,726	34,807	39,887	44,968	50,048	5,081
	1,207	1,631	2,054	2,478	2,901	3,324	3,748	4,171	424
135% FPL									
2007	13,649	18,347							
	1,138	1,529	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2008	14,040	18,900							
1/1-3/31	1,170	1,575	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2008	14,040	18,900							
4/1-12/31/08	1,170	1,575	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2009	14,621	19,670							
	1,219	1,640	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2010	14,621	19,670							
	1,219	1,640	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2011	14,702	19,859							
	1,226	1,655	N/A	N/A	N/A	N/A	N/A	N/A	N/A

**REFERENCE/DESK AIDS
INCOME**

MEDICALLY NEEDY INCOME LEVELS AND FEDERAL POVERTY LEVELS
(annual and monthly amounts)

HOUSEHOLD SIZE	ONE	TWO	THREE	FOUR	FIVE	SIX	SEVEN	EIGHT	EACH ADDITIONAL PERSON
150% FPL	15,165	20,385	25,605	30,825	36,045	41,265	46,485	51,705	5,220
2007	1,264	1,699	2,134	2,569	3,004	3,439	3,874	4,309	435
2008	15,600	21,000	26,400	31,800	37,200	42,600	48,000	53,400	5,400
1/1-3/31	1,300	1,750	2,200	2,650	3,100	3,550	4,000	4,450	450
2008	15,600	21,000	26,400	31,800	37,200	42,600	48,000	53,400	5,400
4/1-12/31/08	1,300	1,750	2,200	2,650	3,100	3,550	4,000	4,450	450
2009	16,245	21,855	27,465	33,075	38,685	44,295	49,905	55,515	5,610
	1,354	1,822	2,289	2,757	3,224	3,692	4,159	4,627	468
2010	16,245	21,855	27,465	33,075	38,685	44,295	49,905	55,515	5,610
	1,354	1,822	2,289	2,757	3,224	3,692	4,159	4,627	468
2011	16,335	22,065	27,795	33,525	39,255	44,985	50,715	56,445	5,730
	1,362	1,839	2,317	2,794	3,272	3,749	4,227	4,704	478
160% FPL	17,424	28,536	29,648	35,760	41,872	47,984	54,096	62,208	6,112
2011	1,452	1,962	2,471	2,980	3,490	3,999	4,508	5,018	510
185% FPL	18,704	25,142	31,580	38,018	44,456	50,894	57,332	63,770	6,436
2007	1,559	2,096	2,632	3,169	3,705	4,242	4,778	5,315	537
2008	19,240	25,900	32,500	39,220	45,880	52,540	59,200	65,860	6,600
1/1-3/31	1,604	2,159	2,714	3,269	3,824	4,379	4,934	5,489	555
2008	19,240	25,900	32,560	39,220	45,880	52,540	59,200	65,860	6,660
4/1-12/31/08	1,604	2,159	2,714	3,269	3,824	4,379	4,934	5,489	555
2009	20,036	26,955	33,874	40,793	47,712	54,631	61,550	68,469	6,919
	1,670	2,247	2,823	3,400	3,976	4,553	5,130	5,706	577
2010	20,036	26,955	33,874	40,793	47,712	54,631	61,550	68,469	6,919
	1,670	2,247	2,823	3,400	3,976	4,553	5,130	5,706	577
2011	21,047	27,214	34,281	41,348	48,415	55,482	62,549	69,616	7,067
	1,679	2,268	2,857	3,446	4,035	4,624	5,213	5,802	589

**REFERENCE/DESK AIDS
INCOME**

MEDICALLY NEEDY INCOME LEVELS AND FEDERAL POVERTY LEVELS
(annual and monthly amounts)

HOUSEHOLD SIZE	ONE	TWO	THREE	FOUR	FIVE	SIX	SEVEN	EIGHT	EACH ADDITIONAL PERSON
200% FPL	20,200	27,180	34,140	41,100	48,060	55,020	61,980	68,940	6,960
2007	1,685	2,265	2,845	3,425	4,005	4,585	5,165	5,745	580
2008	20,800	28,000	35,200	42,400	49,600	56,800	64,000	71,200	7,200
1/1-3/31	1,734	2,334	2,934	3,534	4,134	4,734	5,334	5,934	600
2008	20,800	28,000	35,200	42,400	49,600	56,800	64,000	71,200	7,200
4/1-12/31/08	1,734	2,334	2,934	3,534	4,134	4,734	5,334	5,934	600
2009	21,660	29,140	36,620	44,100	51,580	59,060	66,540	74,020	7,480
	1,805	2,429	3,052	3,675	4,299	4,922	5,545	6,169	624
2010	21,660	29,140	36,620	44,100	51,580	59,060	66,540	74,020	7,480
	1,805	2,429	3,052	3,675	4,299	4,922	5,545	6,169	624
2011	21,780	29,420	37,060	44,700	52,340	59,980	67,620	75,260	7,640
	1,815	2,452	3,089	3,725	4,362	4,999	5,635	6,272	637
250% FPL	25,275	33,975							
2007	2,107	2,832	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2008	26,000	35,000							
1/1-3/31	2,167	2,917	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2008	26,000	35,000							
4/1-12/31/08	2,167	2,917	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2009	27,075	36,425							
	2,257	3,036	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2010	27,075	36,425							
	2,257	3,036	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2011	27,225	36,775							
	2,2269	3,065	N/A	N/A	N/A	N/A	N/A	N/A	N/A

INCOME/RESOURCE TEST

Category	Year	Income Compared	Household Size		Resource Level		Special Notes
			1	2	1	2	
Presumptive Eligibility for Pregnant Women	2007	100% FPL 200% FPL	N/A N/A	\$1,141 \$2,282	No Resource Test		Qualified provider makes the presumptive eligibility determination. Cannot spend down to become presumptive eligible.
	2008	100% FPL 200% FPL	N/A N/A	\$1,167 \$2,334	No Resource Test		Same as 2007
	2009	100% FPL 200% FPL	N/A N/A	\$1,215 \$2,429	No Resource Test		Same as 2007
	2010	100% FPL 200% FPL	N/A N/A	\$1,215 \$2,429	No Resource Test		An Article 28 Pre-Natal Care provider or other entity designated by SDOH who has completed required training makes the PE determination. Cannot spend down to become eligible for presumptive eligibility.
	2011	100% FPL 200% FPL	N/A N/A	\$1,226 \$2,452	No Resource Test		Same as 2010
Pregnant Women	2007	100% FPL 200% FPL	N/A N/A	\$1,141 \$2,282	No Resource Test		If the woman is determined eligible in any month of her pregnancy, she is guaranteed eligibility for the entire pregnancy (prospectively). If the A/R applies prior to the birth of the child she is entitled to a 60 day post-partum extension also. The baby is guaranteed eligibility for one year. If the income is above 200% FPL the A/R must spend down to the Medicaid income level.
	2008	100% FPL 200% FPL	N/A N/A	\$1,167 \$2,334	No Resource Test		Same as 2007
	2009	100% FPL 200% FPL	N/A N/A	\$1,215 \$2,429	No Resource Test		Same as 2007
	2010	100% FPL 200% FPL	N/A N/A	\$1,215 \$2,429	No Resource Test		Same as 2007
	2011	100% FPL 200% FPL	N/A N/A	\$1,226 \$2,452	No Resource Test		A woman determined eligible for Medicaid for any time during her pregnancy remains eligible for Medicaid coverage until the last day of the month in which the 60th day from the date the pregnancy ends occurs, regardless of any change in income or household composition. If the income is above 200% FPL the A/R must spend down to the Medicaid income level. The baby will have guaranteed eligibility for one year.
Children Under One	2007	200% FPL	\$1,702	\$2,282	No Resource Test		If the income is above 200% FPL the A/R must spend down to the Medicaid income level. One year guaranteed eligibility if mother is in receipt of Medicaid at delivery. Eligibility can be determined in the 3 months retro to obtain the 1 year extension
	2008	200% FPL	\$1,734	\$2,334	No Resource Test		Same as 2007
	2009	200% FPL	\$1,805	\$2,429	No Resource Test		Same as 2007
	2010	200% FPL	\$1,805	\$2,429	No Resource Test		Same as 2007
	2011	200% FPL	\$1,815	\$2,452	No Resource Test		Same as 2007
Children Age 1 through 5	2007	133% FPL	\$1,132	\$1,518	No Resource Test		If the income is above 133% FPL the A/R must spend down to the Medicaid income level, resources will also be evaluated
	2008	133% FPL	\$1,153	\$1,552	No Resource Test		Same as 2007
	2009	133% FPL	\$1,201	\$1,615	No Resource Test		Same as 2007
	2010	133% FPL	\$1,201	\$1,615	No Resource Test		If the income is above 133% FPL the A/R must spend down to MA income level
	2011	133% FPL	\$1,207	\$1,631	No resource Test		Same as 2010

INCOME/RESOURCE TEST

Category	Year	Income Compared	Household Size		Resource Level		Special Notes
			1	2	1	2	
Under 21, ADC-related and FNP	2008	MA Level	\$775	\$1,067	\$4,250	\$6,400	FNP parents cannot spend down
Effective 4/1	2008	MA Level	\$725	\$1,067	\$13,050	\$19,200	Same as 2008
	2009	MA Level	\$767	\$1,117	\$13,800	\$20,100	Same as 2008
	2010	MA Level	\$767	\$1,117	No Resource Test		Same as 2008
	2011	MA Level	\$767	\$1,117	No Resource Test		Same as 2008
	2012	MA Level	\$792	\$1,159	No Resource Test		Same as 2008
Singles/Childless Couples	2008	PA Standard of Need	Varies by County	Varies by County	\$2,000	\$2,000	The A/R cannot spend down income or resources. Over age 60, resources are \$3000.
Effective 4/1	2008	MA Standard	\$673	\$840	\$13,050	\$19,200	The A/R cannot spend down income or resources
	2009	MA Standard	\$706	\$881	\$13,800	\$20,100	Same as 2008
	2010	MA Standard	\$707	\$883	No Resource Test		The A/R cannot spend down income
	2011	MA Standard	\$708	\$883	No Resource Test		The A/R cannot spend down income
	2012	MA Standard	\$735	\$918	No Resource Test		Same as 2011
Low Income Families	2008	PA Standard of Need	Varies by County	Varies by county	\$3000	\$3000	The A/R cannot spend down income or resources
Effective 4/1	2008	MA Standard	\$673	\$840	\$13,050	\$19,200	The A/R cannot spend down income or resources.
	2009	MA Standard	\$706	\$881	\$13,800	\$20,100	The A/R cannot spend down income
	2010	MA Standard	\$707	\$883	No Resource Test		
	2011	MA Standard	\$708	\$883	No Resource Test		
	2012	MA Standard	\$735	\$918	No Resource Test		
SSI-Related	2008	MA Level	\$725	\$1,067	\$4,350	\$6,400	Household size is always one or two
Effective 4/1	2008	MA Level	\$725	\$1,067	\$13,050	\$19,200	Same as 2008
	2009	MA Level	\$767	\$1,117	\$13,800	\$20,100	Same as 2008
	2010	MA Level	\$767	\$1,117	\$13,800	\$20,100	Same as 2008
	2011	MA Level	\$767	\$1,117	\$13,800	\$20,100	Same as 2008
	2012	MA Level	\$792	\$1,159	\$14,250	\$20,850	Same 2008
Children Age 6 through 18	2007	100% FPL	\$851	\$1,141	No Resource Test		If the income is above 100% FPL the A/R must spend down to the Medicaid income level, resources will also be evaluated
	2008	100% FPL	\$867	\$1,167	No Resource Test		Same as 2007
	2009	100% FPL	\$903	\$1,215	No Resource Test		Same as 2007
	2010	100% FPL	\$903	\$1,215	No Resource Test		If the income is above 100% FPL the A/R must spend down to MA income level.
	2011	100% FPL	\$908	\$1,226	No Resource Test		Same as 2010
Children Age 1 through 18	11/1 2011	133% FPL	\$1207	\$1631	No Resource Test		

INCOME/RESOURCE TEST

Category	Year	Income Compared	Household Size		Resource Level		Special Notes
			1	2	1	2	
Buy-In (QMB)	2007	100% FPL	\$851	\$1,141	\$4,000	\$6,000	Medicare Part A & B, coinsurance, deductible and premium will be paid if eligible
	2008	100%FPL	\$867	\$1,167	\$4,000	\$6,000	Same as 2007
Effective 4/1	2008	100% FPL	\$867	\$1,167	No Resource Test		Same as 2007
	2009	100% FPL	\$903	\$1,215	No Resource Test		Same as 2007
	2010	100% FPL	\$903	\$1,215	No Resource Test		Same as 2007
	2011	100% FPL	\$908	\$1,226	No Resource Test		Same as 2007
	2007	100%FPL	\$851	\$1,141	\$4,000	\$6,000	
COBRA Continuation Coverage	2008	100%FPL	\$867	\$1,167	\$4,000	\$6,000	
	2008	100% FPL	\$867	\$1,167	\$4,000	\$6,000	
	2009	100% FPL	\$903	\$1,215	\$4,000	\$6,000	
	2010	100% FPL	\$903	\$1,215	\$4,000	\$6,000	
	2011	100% FPL	\$908	\$1,226	\$4,000	\$6,000	
AIDS Health Insurance Program (AHIP)	2007	185% FPL	\$1,575	\$2,111	No Resource Test		A/R must be ineligible for Medicaid, including COBRA continuation. Premium payments are FNP
	2008	185% FPL	\$1,604	\$2,159	No Resource Test		Same as 2006
	2009	185% FPL	\$1,670	\$2,247	No Resource Test		A/R must be ineligible for Medicaid, including COBRA continuation
	2010	185% FPL	\$1,670	\$2,247	No Resource Test		Same as 2009
	2011	185% FPL	\$1,679	\$2,268	No Resource Test		Same as 2009
Qualified Disabled & Working Individual	2007	200% FPL	\$1,702	\$2,282	\$4,000	\$6,000	Medicaid will pay Medicare Part A premium
	2008	200% FPL	\$1,734	\$2,334	\$4,000	\$6,000	Same as 2007
	2009	200%FPL	\$1,805	\$2,429	\$4,000	\$6,000	Same as 2007
	2010	200% FPL	\$1,805	\$2,429	\$4,000	\$6,000	Same as 2007
	2011	200% FPL	\$1,815	\$2,452	\$4,000	\$6,000	Same as 2007

INCOME/RESOURCE TEST

Category	Year	Income Compared	Household Size		Resource Level		Special Notes
			1	2	1	2	
			\$980	\$1,320			
Specified Low Income Medicare Beneficiaries (SLIMBs)	2007	Greater than 100% but less than 120%	\$851	\$1,141	\$4,000	\$6,000	If the A/R is determined eligible, Medicaid will pay Medicare Part B premium
			\$1,021	\$1,369			
	2008	Greater than 100% but less than 120%	\$867	\$1,167	\$4,000	\$6,000	Same as 2007
			\$1,040	\$1,400			
Effective 4/1	2008	Greater than 100% but less than 120%	\$867	\$1,167	No Resource Test		Same as 2007
				\$1,040			
	2009	Greater than 100% but less than 120%	\$903	\$1,215	No Resource Test		Same as 2007
			\$1,083	\$1,457			
	2010	Greater than 100% but less than 120%	\$903	\$1,215	No Resource Test		Same as 2007
			\$1,083	\$1,457			
	2011	Greater than 100% but less than 120%	\$908	\$1,226	No Resource Test		Same as 2007
			\$1,089	\$1,471			
Qualified Individuals (QI)	2007	Equal to or greater than 120% but less than 135%	\$1,021	\$1,369	No Resource Test		If the A/R is determined eligible, Medicaid will pay Medicare Part B premium
				\$1,149			
	2008	Equal to or greater than 120% but less than 135%	\$1,040	\$1,400	No Resource Test		Same as 2007
			\$1,170	\$1,575			
	2009	Equal to or greater than 120% but less than 135%	\$1,083	\$1,457	No Resource Test		Same as 2007
			\$1,219	\$1,640			
	2010	Equal to or greater than 120% but less than 135%	\$1,083	\$1,457	No Resource Test		Same as 2007
			\$1,129	\$1,640			
	2011	Equal to or greater than 120% but less than 135%	\$1,089	\$1,471	No Resource Test		Same as 2007
			\$1,226	\$1,655			
Family Health Plus Parents Living with Children Singles/Childless Couples	2007	150% FPL	\$1,277	\$1,712	\$12,600	\$16,200	The A/R must be ineligible for Medicaid. The A/R cannot spend down to become eligible for Family Health Plus
		100% FPL	\$851	\$1,141			
	2008	150% FPL	\$1,300	\$1,750	\$13,050	\$19,200	Same as 2007
		100% FPL	\$867	\$1,167			
	2009	150% FPL	\$1,354	\$1,822	\$13,800	\$20,100	Same as 2007
		100% FPL	\$903	\$1,215			
	2010	150% FPL	\$1,354	\$1,822	No Resource Test		Same as 2007
		100% FPL	\$903	\$1,215			
	2011	150% FPL	\$1,362	\$1,839	No Resource Test		Same as 2007
		100% FPL	\$908	\$1,226			

INCOME/RESOURCE TEST

Category	Year	Income Compared	Household Size		Resource Level		Special Notes
			1	2	1	2	
Family Planning Benefit Program (FPBP)	2007	200% FPL	\$1,702	\$2,282	No Resource Test		The A/R must be ineligible for Medicaid or Family Health Plus. The A/R cannot spend down to become eligible for Family Planning Benefit Program.
	2008	200% FPL	\$1,734	\$2,334	No Resource Test		Same as 2007
	2009	200% FPL	\$1,805	\$2,429	No Resource Test		Provides Medicaid coverage for family planning services to persons of childbearing age with incomes at or below 200% FPL. Potentially eligible individuals will be screened for Medicaid and FHPlus, unless they specifically request to be screened only for FPBP eligibility.
	2010	200% FPL	\$1,805	\$2,429	No Resource Test		Same as 2009
	2011	200% FPL	\$1,815	\$2,452	No Resource Test		Same as 2009
Medicaid Buy-in Program for People with Disabilities (MBI-WPD)	2007	250% FPL	\$2,128	\$2,853	\$10,000		A/R's with a net income that is at least 150% but at or below 250% will pay a premium. Currently there is a moratorium on premium payment collection.
	2008	250% FPL	\$2,167	\$2,917	\$10,000		Same as 2007
Effective 4/1	2008	250% FPL	\$2,167	\$2,917	\$13,050	\$19,200	Same as 2007
	2009	250% FPL	\$2,257	\$3,036	\$13,800	\$20,100	Same as 2007
	2010	250% FPL	\$2,257	\$3,036	\$13,800	\$20,100	Same as 2007
	2011	250% FPL	\$2,269	\$3,065	\$13,800	\$20,100	Same as 2007
	2011	250% FPL	\$2,269	\$3,065	\$20,000	\$30,000	Same as 2007
Breast and Cervical Cancer	2005	250% FPL	\$1,994	\$2,673	No Resource Test		
	2006	250% FPL	\$2,042	\$2,750	No Resource Test		
	2007	250% FPL	\$2,128	\$2,853	No Resource Test		See Medicaid Cancer Treatment Programs after 2007
Medicaid Cancer Treatment Programs	2008	250% FPL	\$2,167	\$2,917	No Resource Test		Includes both Breast and Cervical Cancer and Colorectal and Prostate Cancer Treatment Programs
	2009	250% FPL	\$2,257	\$3,036	No Resource Test		Same as 2008
	2010	250% FPL	\$2,257	\$3,036	No Resource Test		Same as 2008
	2011	250% FPL	\$2,269	\$3,065	No Resource Test		Same as 2008

**REFERENCE/DESK AIDS
INCOME**

MEDICARE PART A AND PART B PREMIUMS

Discussion of Medicare Part A and Part B Premiums is found in the **INCOME MEDICARE SAVINGS PROGRAM**.

Monthly Medicare Part A premium, effective January 1 each year

Year	Monthly Amount
2008	\$423 per month
2009	\$244 per month-- for persons having 30-39 quarters * \$443 per month-- not otherwise eligible for premium-free hospital insurance and have less than 30 quarters
2010	\$244 per month-- for persons having 30-39 quarters * \$443 per month-- not otherwise eligible for premium-free hospital insurance and have less than 30 quarters
2011	\$248 per month-- for persons having 30-39 quarters * \$450 per month-- not otherwise eligible for premium-free hospital insurance and have less than 30 quarters
2012	Same as 2011

Monthly Medicare Part B standard premium, effective January 1 each year

Year	Monthly Amount
2008	\$96.40 per month*
2009	\$96.40 per month*
2010	\$96.40 per month-- \$110.50 per month—if newly applying for Medicare or not protected by “hold harmless” provisions [See below]
2011	\$96.40 per month -- if previously enrolled in Medicare \$115.40 per month- if newly applying for Medicare or not protected by “hold harmless” provisions [See below]
2012	\$99.90 per month with no “hold harmless” provisions

NOTE: Under a “hold-harmless” provision of federal law, basic Medicare Part B premiums in any year cannot rise higher than that year’s COLA.

The Hold Harmless provision does not apply to the following individuals who must pay a higher premium:

Individuals whose income is above \$85,000 or by a married individual when the couple’s combined income is over \$170,000.

Individuals who do not have the Part B premium deducted from their Social Security benefit. This includes individuals who are on the Medicare Buy-In program and have their premiums paid for them. The increased premium will be paid by the State.

**REFERENCE/DESK AIDS
INCOME****NEW YORK STATE MINIMUM WAGE**

The Empire State Wage Act establishes minimum hourly wages, effective January each year. Discussion of minimum wage can be found in **INCOME LIF DISREGARDS**, **ADC-RELATED DISREGARDS** and **S/CC DISREGARDS**. The amounts are as follows:

Year	Amount
2005	\$6.00
2006	\$6.75
2007	\$7.15
2008	\$7.15
2009 *	\$7.25
2010	\$7.25

*Effective 7/24/2009

The federal minimum hourly wage is: \$7.25

**REFERENCE/DESK AIDS
INCOME****PERSONAL NEEDS ALLOWANCE -- PACE-PNA**

An explanation of the use of the PNA amount for certain waiver recipients and non-institutionalized participant of the Program of All-Inclusive Care for the Elderly (PACE) recipients, whose eligibility is determined under the spousal impoverishment provisions, can be found in **INCOME CHRONIC CARE BUDGETING METHODOLOGY FOR INSTITUTIONALIZED SPOUSES**. The PNA is the difference between the monthly Medicaid income level for a household of two and a household of one.

The amount of the PNA, effective each January 1, is found below:

Year	Amount
2008	\$342
2009	\$350
2010	\$350
2011	\$350
2012	\$367

**REFERENCE/DESK AIDS
INCOME**

MBL LIVING ARRANGEMENT CHART

MBL Shelter Type Table – Medicaid Standard beginning April 1, 2008

Code	Shelter Type	PreAdd	Shelter	MA Standard for appropriate year Household of 1	Standard Applied
01	Rent				New Standard + water
02	Rent Public				New Standard + water
03	Own Home				New Standard + water
04	Room & Board				New Standard
05	Hotel Permanent				New Standard
06	Hotel Temporary		unlimited		New Std + unlimited shelter
07	Migrant Camp				New Standard + water
09	Medical Facility	40.00	unlimited		No change
11	Room				New Standard
12	Non Level II Alcohol Treatment Facility	45.00	unlimited		No change
14	Public Home	17.00	unlimited		No change
15	Congregate Care Level I (NYC, Nassau, Suffolk, Westchester)	PNA			No change
16	Congregate Care Level II (NYC, Nassau, Suffolk, Westchester)	PNA			No change
18	Foster Care		unlimited		No change
20	Emergency Rental Supplement Program				New Standard + water
22	Shelter for Victims of Domestic Violence	45.00	unlimited		No change
23	Undomiciled				New Standard
28	Congregate Care Level I (Rest of State)	PNA Level I			No change
29	Congregate Care Level II (Rest of State)	PNA Level II			No change
33	Homeless Shelter Tier II - Less than 3 Meals/Day		unlimited		New Std + unlimited shelter
34	Homeless Shelter Tier II - 3 Meals/Day				New Standard
35	Homeless Shelter Non Tier I or Tier II	45.00	unlimited		No change
36	Shelter for Homeless less than 3 Meals/Day		unlimited		New Std + unlimited shelter
37	Residential Program for Victim of Domestic Violence		unlimited		New Std + unlimited shelter
42/51	Congregate Care Level III	PNA			No change
44	Supportive Specialized Housing	45.00	unlimited		No change

**REFERENCE/DESK AIDS
INCOME**

PUBLIC ASSISTANCE STANDARD OF NEED

NOTE: EFFECTIVE FOR DETERMINATION DONE PRIOR TO APRIL 1, 2008 only

Information regarding the Public Assistance (PA) Standard of Need can be found in the **GLOSSARY** under PUBLIC ASSISTANCE STANDARD OF NEED.

No. in Applying Household	1	2	3	4	5	6	7	
Pre-Add	\$112	\$179	\$238	\$307	\$379	\$438	\$498	Each Additional Person - \$60
Home Energy Allowance	\$14.14	\$22.50	\$30	\$38.70	\$47.70	\$55.20	\$62.70	Each Additional Person - \$7.50
Supplemental Home Energy Allowance	\$11	\$17	\$23	\$30	\$37	\$42	\$47	Each Additional Person - \$5
Monthly Shelter Allowance with Heat*								
Monthly Shelter Allowance w/out Heat:*								
Monthly Heating Allowance: Oil, Kerosene, Propane*								
Monthly Heating Allowance: Natural Gas, Coal, Wood, Municipal Electric, Other*								
Monthly Heating Allowance: PSC Electric, Greenport Electric*								
Add Pre-Add, Home Energy Allowance, Supplemental Home Energy Allowance, Shelter (with or without heat) and appropriate monthly heating allowance to arrive at the TOTAL STANDARD of NEED								
Total Standard of Need:*								

*District Specific Information. Complete as described.

**REFERENCE/DESK AIDS
INCOME**

SSI BENEFIT LEVELS

A full description of the SSI Benefit Levels used in determination of eligibility can be found in the **INCOME DETERMINATION OF ELIGIBILITY**.

These benefit levels generally change January 1 each year.

Living Arrangement	Year	Federal Benefit Rate		State Supplement		Total Benefit	
		Ind.	Couple	Ind.	Couple	Ind.	Couple
Living Alone	2008	\$637	\$956	\$87	\$104	\$724	\$1060
	2009	\$674	\$1011	\$87	\$104	\$761	\$1115
	2010	\$674	\$1011	\$87	\$104	\$761	\$1115
	2011	\$674	\$1011	\$87	\$104	\$761	\$1115
	2012	\$698	\$1048	\$87	\$104	\$785	\$1152
Living with Others	2007	\$623	\$934	\$23	\$46	\$646	\$980
	2008	\$637	\$956	\$23	\$46	\$660	\$1002
	2009	\$674	\$1011	\$23	\$46	\$697	\$1057
	2010	\$674	\$1011	\$23	\$46	\$697	\$1057
	2011	\$674	\$1011	\$23	\$46	\$697	\$1057
Living in Household of Another	2007	\$415.34	\$622.67	\$23	\$46	\$438.34	\$668.67
	2008	\$424.67	\$637.34	\$23	\$46	\$447.67	\$683.34
	2009	\$449.34	\$674	\$23	\$46	\$472.34	\$720
	2010	\$449.34	\$674	\$23	\$46	\$472.34	\$720
	2011	\$449.34	\$674	\$23	\$46	\$472.34	\$720

Title XIX (Medicaid Certified) Institutions

Living Arrangement	Year	Federal Benefit Rate		State Supplement		Total Benefit	
		Ind.	Couple	Ind.	Couple	Ind.	Couple
Statewide	2007	\$30	\$60	\$0	\$0	\$30	\$60
	2008	\$30	\$60	\$0	\$0	\$30	\$60
	2009	\$30	\$60	\$0	\$0	\$30	\$60
	2010	\$30	\$60	\$0	\$0	\$30	\$60
	2011	\$30	\$60	\$0	\$0	\$30	\$60

Minimum Personal Needs Allowances

	2007	2008	2009	2010	2011
Congregate Care Level 1	\$120	\$123	\$130	\$130	\$130
Congregate Care Level 2	\$139	\$142	\$150	\$150	\$150
Congregate Care Level 3	\$164	\$168	\$178	\$178	\$178

**REFERENCE/DESK AIDS
INCOME**

SSI BENEFIT LEVELS (continued)

Level I - Family Care (OCFS certified Family Type Home, OMH or OPWDD certified Family Care Homes)

Living Arrangement	Year	Federal Benefit Rate		State Supplement		Total Benefit	
		Ind.	Couple	Ind.	Couple	Ind.	Couple
NYC, Nassau, Suffolk, Westchester, and Rockland	2007	\$623	\$934	\$266.48	\$844.96	\$889.48	\$1,778.96
	2008	\$637	\$956	\$266.48	\$850.96	\$903.48	\$1,806.96
	2009	\$674	\$1,011	\$266.48	\$869.96	\$940.48	\$1,880.96
	2010	\$674	\$1,011	\$266.48	\$869.96	\$940.48	\$1,880.96
	2011	\$674	\$1,011	\$266.48	\$869.96	\$940.48	\$1,880.96
Rest of State	2007	\$623	\$934	\$228.48	\$768.96	\$851.48	\$1,702.96
	2008	\$637	\$956	\$228.48	\$774.96	\$865.48	\$1,730.96
	2009	\$674	\$1,011	\$228.48	\$793.96	\$902.48	\$1,804.96
	2010	\$674	\$1,011	\$228.48	\$793.96	\$902.48	\$1,804.96
	2011	\$674	\$1,011	\$228.48	\$793.96	\$902.48	\$1,804.96

Level II - Residential Care (DOH certified Residences for Adults, OMH or OPWDD certified Community Residences, Individualized Residential Alternatives and OASAS certified Chemical Dependence Residential Services)

Living Arrangement	Year	Federal Benefit Rate		State Supplement		Total Benefit	
		Ind.	Couple	Ind.	Couple	Ind.	Couple
NYC, Nassau, Suffolk, Rockland and Westchester	2007	\$623	\$934	\$435	\$1,182	\$1,058	\$2,116
	2008	\$637	\$956	\$435	\$1,188	\$1,072	\$2,144
	2009	\$674	\$1,011	\$435	\$1,207	\$1,109	\$2,218
	2010	\$674	\$1,011	\$435	\$1,207	\$1,109	\$2,218
	2011	\$674	\$1,011	\$435	\$1,207	\$1,109	\$2,218
Rest of State	2007	\$623	\$934	\$405	\$1,122	\$1,028	\$2,056
	2008	\$637	\$956	\$405	\$1,128	\$1,042	\$2,084
	2009	\$674	\$1,011	\$405	\$1,147	\$1,079	\$2,158
	2010	\$674	\$1,011	\$405	\$1,147	\$1,079	\$2,158
	2011	\$674	\$1,011	\$405	\$1,147	\$1,079	\$2,158

**REFERENCE/DESK AIDS
INCOME**

SSI BENEFIT LEVELS (continued)

Level III- 2006- Enhanced Residential Care (DOH certified Adult Homes and Enriched Housing, OPWDD certified Schools for the Mentally Retarded)

Living Arrangement	Year	Federal Benefit Rate		State Supplement		Total Benefit	
		Ind.	Couple	Ind.	Couple	Ind.	Couple
NYC, Nassau, Suffolk, Rockland and Westchester	2006	\$603	\$904	\$525	\$1,339	\$1,128	\$2,243
Rest of the State	2006	\$603	\$904	\$510	\$1,309	\$1,113	\$2,213

Level III- 2007, 2008, 2009 and 2010- Enhanced Residential Care (DOH certified Adult Homes and Enriched Housing, OPWDD certified Schools for the Mentally Retarded)

Living Arrangement	Year	Federal Benefit Rate		State Supplement		Total Benefit	
		Ind.	Couple	Ind.	Couple	Ind.	Couple
Statewide	2007	\$623	\$934	\$641	\$1,594	\$1,264	\$2,528
	2008	\$637	\$956	\$656	\$1,630	\$1,293	\$2,586
	2009	\$674	\$1,011	\$694	\$1,725	\$1,368	\$2,736
	2010	\$674	\$1,011	\$694	\$1,725	\$1,368	\$2,736
	2011	\$674	\$1,011	\$694	\$1,725	\$1,368	\$2,736

**REFERENCE/DESK AIDS
INCOME****FAMILY MEMBER ALLOWANCE (FMA)**

A full explanation of the Family Member Allowance (FMA) policy can be found in the **INCOME PERSONS IN MEDICAL FACILITIES, COMMUNITY SPOUSE AND FAMILY MEMBER ALLOWANCES.**

Effective January 1 each year the maximum Family Member Allowance is as follows:

Year	FMA Amount
2007	\$571
2008	\$584
2009	\$608
2010	\$608
2011	\$613

**REFERENCE/DESK AIDS
INCOME**

**SPOUSAL IMPOVERISHMENT
INCOME ALLOWANCES**

Discussion of income allowances under spousal impoverishment can be found in the **INCOME CHRONIC CARE BUDGETING METHODOLOGY FOR INSTITUTIONALIZED SPOUSES**.

Spousal Impoverishment	Year	Income
Community Spouse	2008	\$2,610
	2009	\$2,739
	2010	\$2,739
	2011	\$2,739
	2012	\$2,841
Institutionalized Spouse	2008	\$50
	2009	\$50
	2010	\$50
	2011	\$50
	2012	\$50

**REFERENCE/DESK AIDS
INCOME****MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE (MMMNA)**

A full explanation of the Minimum Monthly Maintenance Needs Allowance (MMMNA) policy can be found in the **INCOME PERSONS IN MEDICAL FACILITIES, COMMUNITY SPOUSE AND FAMILY MEMBER ALLOWANCES**.

Effective January 1 each year the Minimum Monthly Maintenance Needs Allowance is as follows:

:

Year	MMMNA Amount
2008	\$2,610
2009	\$2,739
2010	\$2,739
2011	\$2,739
2012	\$2,841

**REFERENCE/DESK AIDS
INCOME****SPOUSAL IMPOVERISHMENT: PERSONAL NEEDS ALLOWANCE (PNA)**

A discussion of the personal needs allowance for Institutionalized Spouses who reside in the Community is found in the **INCOME CHRONIC CARE BUDGETING METHODOLOGY FOR INSTITUTIONALIZED SPOUSES**.

The personal needs allowance for institutionalized spouses who reside in the community are:

Year	Amount
2008	\$342
2009	\$350
2010	\$350
2011	\$350
2012	\$367

**REFERENCE/DESK AIDS
INCOME**

CHILD HEALTH PLUS INCOME LEVELS

Effective 2/1/2009

Child Health Plus Premium Levels Chart							
Premium Categories	1	2	3	4	5	6	Each Add'l Person
Free Insurance	\$1,443	\$1,942	\$2,441	\$2,939	\$3,438	\$3,937	\$499
\$9/Child/Month (Max. \$27/Family)	\$2,004	\$2,696	\$3,388	\$4,080	\$4,772	\$5,464	\$692
\$15/Child/Month (Max \$45/Family)	\$2,257	\$3,036	\$3,815	\$4,594	\$5,373	\$6,153	\$780
\$30/Child/Month (Max \$90/Family)	\$2,708	\$3,643	\$4,578	\$5,513	\$6,448	\$7,383	\$935
\$45/Child/Month (Max \$135/Family)	\$3,159	\$4,250	\$5,341	\$6,432	\$7,523	\$8,613	\$1,091
\$60/Child/Month (Max \$180/Family)	\$3,610	\$4,857	\$6,104	\$7,350	\$8,597	\$9,844	\$1,247
Full Premium*/ Child/Month	Over \$3,610	Over \$4,857	Over \$6,104	Over \$7,350	Over \$8,597	Over \$9,844	

*The full premium varies, depending on the health plan chosen by the family.

REFERENCE

PAID/INCURRED EXPENSES UNDER THE EXCESS INCOME PROGRAM

		DEDUCTED FROM EXCESS INCOME IN (Accounting period)		
		Retroactive	First Prospective	Current
UNPAID EXPENSES INCURRED IN:				
Pre-retroactive		YES	YES	YES *
Retroactive		YES	YES	YES *
First Prospective		N/A	YES	YES *
Current		N/A	N/A	YES
EXPENSES PAID IN:				
Pre-retroactive		NO	NO	NO
Retroactive		YES	YES**	NO
First Prospective		N/A	YES	NO
Current		N/A	N/A	YES

* If the individual met his/her excess income liability in the previous period without deducting all of the unpaid expense, the portion not already used to establish eligibility is carried forward as long as the expense remains viable and there is no break in eligibility, (i.e., no intervening month or months in which the excess income is not met or in which there is no excess income liability).

** If the individual met his/her income liability in the retroactive period without deducting all of the paid expense, that portion not already used to establish eligibility may be deducted from income in the first prospective period.

DEFINITIONS: As used in this chart:

Expenses means expenses incurred for health insurance premiums, deductibles or other coinsurance charges, and necessary medical and remedial services that are recognized under State law, which have not previously been used to establish eligibility.

Accounting period means a period of time, extending from one to six months, over which income is determined and compared to the Medical Assistance income standard to determine eligibility.

Pre-retroactive period means the period prior to the first day of the third month of application for Medicaid.

Retroactive period means any portion of the three month period immediately prior to the month of application for Medicaid.

First prospective period means the first accounting period that includes the month of application.

Current period means an accounting period occurring after the first prospective period.

REFERENCE/DESK AIDS

RESOURCES SECTION

**REFERENCE/DESK AIDS
RESOURCE****MINIMUM/MAXIMUM COMMUNITY SPOUSE ALLOWANCE**

Full explanation of the Assessment/Determination for Persons in Medical Facilities including the State minimum and Federal maximum community spouse resource allowances, can be found in the **RESOURCE: RETIREMENT FUNDS, PERSONAL NEEDS ALLOWANCE ACCOUNTS, PERSON IN MEDICAL FACILITIES ASSESSMENT/DETERMINATION and TRANSFER OF ASSETS.**

Federal **Maximum** Community Spouse Resource Allowance:

Year	Amount
2008	\$104,400
2009	\$109,560
2010	\$109,560
2011	\$109,560
2012	\$133,640

The State **Minimum** Community Spouse Resource Allowance is \$74,820.

NOTE: In determining the community resource allowance on and after January 1, 2008, the community spouse is permitted to retain resources in an amount equal to the greater of the following: \$74,820 or the amount of the spousal share up to the maximum amount. The spousal share is the amount equal to one-half of the total value of the countable resources of the couple as of the beginning of the most continuous period of institutionalization of the institutionalized spouse on or after September 30, 1989.

**REFERENCE/DESK AIDS
RESOURCE**

SSI-RELATED ONLY MEDICAID RESOURCE LEVELS

Discussion of the use of the medically needy resource levels in the determination of eligibility is found in the **RESOURCE MEDICAID RESOURCE LEVEL**. The SSI-RELATED ONLY resource levels, according to family size, are:

HOUSEHOLD SIZE	ONE	TWO	THREE	FOUR	FIVE	SIX	SEVEN	EIGHT	EACH ADD'L PERSON
RESOURCES (ASSETS)									
1/1-3/31/2008	\$4,350	\$6,400	\$6,600	\$6,650	\$6,700	\$6,800	\$7,650	\$8,500	\$850
4/1/2008	\$13,050	\$19,200	\$22,200	\$25,050	\$27,900	\$30,750	\$33,600	\$36,600	\$2,850
2009	\$13,800	\$20,100	\$23,115	\$26,130	\$29,145	\$32,160	\$35,175	\$38,190	\$3,015
2010	\$13,800	\$20,100	\$23,115	\$26,130	\$29,145	\$32,160	\$35,175	\$38,190	\$3,015
2011	\$13,800	\$20,100	\$23,115	\$26,130	\$29,145	\$32,160	\$35,175	\$38,190	\$3,015
2012	\$14,250	\$20,850	\$23,978	\$27,105	\$30,233	\$33,360	\$36,488	\$39,615	\$3,128
FHP RESOURCES									
1/1-3/31/2008	\$13,050	\$19,200	\$19,800	\$19,950	\$20,010	\$20,400	\$22,950	\$25,500	\$2,500
4/1/2008	\$13,050	\$19,200	\$22,200	\$25,050	\$27,900	\$30,750	\$33,600	\$36,600	\$2,850
2009	\$13,800	\$20,100	\$23,115	\$26,130	\$29,145	\$32,160	\$33,175	\$38,190	\$3,015
2010	NO RESOURCE TEST								
2011	NO RESOURCE TEST								
2012	NO RESOURCE TEST								

MBI-WPD									
10/1/2011	\$20,000	\$30,000							

**REFERENCE/DESK AIDS
RESOURCES****SSI RESOURCE LEVELS**

The SSI Resource Levels for individuals and couples:

SSI RESOURCE LEVEL	Individuals	Couples
2008	\$2000	\$3000
2009	\$2000	\$3000
2010	\$2000	\$3000
2011	\$2000	\$3000
2012	\$2000	\$3000

**REFERENCE/DESK AIDS
RESOURCES****SUBSTANTIAL HOME EQUITY LIMIT**

A full explanation of Substantial Home Equity of SSI-related A/Rs can be found in RESOURCES SUBSTANTIAL HOME EQUITY.

The amount is effective January 1 each year.

Year	Amount
2010	\$750,000
2011	\$758,000
2012	\$786,000

**REFERENCE/DESK AIDS
RESOURCE**

TRANSFER OF ASSETS REGIONAL RATES

A full explanation of the regional rates for use in determining the effect of a transfer of assets for less than the fair market value is discussed in **RESOURCE TRANSFER OF ASSETS**.

Regional rates are used to determine the period of restricted Medicaid coverage when a prohibited transfer is made. The rates listed below for each of the seven regions in the state are used for persons who apply for Medicaid as an institutionalized person on or after January 1, 2011.

<u>NORTHEASTERN</u> \$8,323			<u>WESTERN</u> \$7,863	
Albany	Fulton	Saratoga	Allegany	Orleans
Clinton	Greene	Schenectady	Cattaraugus	Wyoming
Columbia	Hamilton	Schoharie	Chautauqua	
Delaware	Montgomery	Warren	Erie	
Essex	Otsego	Washington	Genesee	
Franklin	Rensselaer		Niagara	

<u>ROCHESTER</u> \$8,942		<u>NORTHERN METROPOLITAN</u> \$10,105	
Chemung	Steuben	Dutchess	Westchester
Livingston	Wayne	Orange	
Monroe	Yates	Putnam	
Ontario		Rockland	
Schuyler		Sullivan	
Seneca		Ulster	

<u>CENTRAL</u> \$7,688			<u>NEW YORK CITY</u> \$10,579
Broome	Lewis	Tioga	Bronx
Cayuga	Madison`	Tompkins	Kings (Brooklyn)
Chenango	Oneida		NY (Manhattan)
Cortland	Onondaga		Queens
Herkimer	Oswego		Richmond (Staten Island)
Jefferson	St. Lawrence		

<u>LONG ISLAND</u> \$11,445	
Nassau	Suffolk

**REFERENCE/DESK AIDS
RESOURCE**

TRANSFER OF ASSETS REGIONAL RATES (continued)

Regional Rates are effective January 1 each year.

	2010	2009	2008	2007	2006
Central	\$7,264	\$6,938	\$6,696	\$6,506	\$6,232
Long Island	\$11,227	\$10,852	\$10,555	\$10,123	\$9,842
New York City	\$10,285	\$9,838	\$9,636	\$9,636	\$9,132
Northeastern	\$7,927	\$7,766	\$7,431	\$7,189	\$6,872
Northern Metropolitan	\$10,163	\$9,439	\$9,361	\$9,074	\$8,724
Rochester	\$9,058	\$8,720	\$8,089	\$8,002	\$7,375
Western	\$7,694	\$7,418	\$7,066	\$6,820	\$6,540

**REFERENCE/DESK AIDS
RESOURCES**

LOOK-BACK PERIOD

For applications of Medicaid coverage for nursing facility services and for SSI-related recipients who request an increase in coverage for nursing facility services, the look-back period increases from 36 months to 60 months (60 months for trusts) for transfers made on or after February 8, 2006.

The look-back period increases each month by 1-month increments beginning March 1, 2009 (37 months) until February 2011. Effective February 1, 2011, the full 60 month look-back period will be in place for ALL transfers of assets.

Application Date	Number of Months	Look-Back Period
February 2009	36	Feb-2006-Jan 2009
March 2009	37	Feb 2006-Feb 2009
Apr 2009	38	Feb 2006-Mar 2009
Apr 2010	50	Feb 2006-Mar 2010
Sept 2010	55	Feb 2006-Aug 2010
Feb 2011	60	Feb 2006-Jan 2011
Mar 2011	60	Mar 2006-Feb 2011

REFERENCE

TRUST FUNDS

Situation	Supplemental Needs Trusts	OBRA 1993 Exception Trusts	
		Individual Trusts	Pooled Trusts
Legal Reference		Social Security Act Section 1917(d)(4)A)	Social Security Act Section 1917(d)(4)(C)
Beneficiary's Age	Any age	Under Age 65*	Any age*
Disability	Severe and chronic or persistent impairment	In receipt of SSI Disability, SSA Disability, or certified disabled either when the trust was established or retroactively as of the date the trust was established.	Same as for an individual trust
Whose assets are used to establish the trust?	Assets of anybody	Must be the assets of the individual.	May be the assets of the individual.
Who establishes the trust?	By anyone other than the A/R.	Parent, grandparent, legal guardian of individual, or a court.	The individual, grandparent, legal guardian of the individual, or a court open account.
Medicaid repayment requirement.	If Exceptions Trust, Department recovers all amounts up to the MA paid amount.	The Department recovers all amounts up to the MA paid amount.	The Department recovers all amounts not retained by the not-for-profit organization up to the MA paid amount.
Miscellaneous unique requirements			Established and managed by a nonprofit association.

* Transfer penalties apply for transfers of assets to trusts once the person is 65 years of age or older for both individual and pooled trusts.

REFERENCE

LIFE EXPECTANCY TABLE FOR ANNUITIES

Age	Life Expectancy			Age	Life Expectancy			Age	Life Expectancy	
	Male	Female			Male	Female			Male	Female
0	74.14	79.45		40	36.64	40.97		80	7.31	8.95
1	73.70	78.94		41	35.73	40.03		81	6.85	8.40
2	72.74	77.97		42	34.83	39.09		82	6.42	7.87
3	71.77	77.00		43	33.94	38.16		83	6.00	7.36
4	70.79	76.01		44	33.05	37.23		84	5.61	6.88
5	69.81	75.03		45	32.16	36.31		85	5.24	6.42
6	68.82	74.04		46	31.29	35.39		86	4.89	5.98
7	67.83	73.05		47	30.42	34.47		87	4.56	5.56
8	66.84	72.06		48	29.56	33.56		88	4.25	5.17
9	65.85	71.07		49	28.70	32.65		89	3.97	4.81
10	64.86	70.08		50	27.85	31.75		90	3.70	4.47
11	63.87	69.09		51	27.00	30.85		91	3.45	4.15
12	62.88	68.09		52	26.16	29.95		92	3.22	3.86
13	61.89	67.10		53	25.32	29.07		93	3.01	3.59
14	60.91	66.11		54	24.50	28.18		94	2.82	3.35
15	59.93	65.13		55	23.68	27.31		95	2.64	3.13
16	58.97	64.15		56	22.86	26.44		96	2.49	2.93
17	58.02	63.17		57	22.06	25.58		97	2.35	2.75
18	57.07	62.20		58	21.27	24.73		98	2.22	2.58
19	56.14	61.22		59	20.49	23.89		99	2.11	2.43
20	55.20	60.25		60	19.72	23.06		100	2.00	2.29
21	54.27	59.28		61	18.96	22.24		101	1.89	2.15
22	53.35	58.30		62	18.21	21.43		102	1.79	2.02
23	52.42	57.33		63	17.48	20.63		103	1.69	1.89
24	51.50	56.36		64	16.76	19.84		104	1.59	1.77
25	50.57	55.39		65	16.05	19.06		105	1.50	1.66
26	49.64	54.41		66	15.36	18.30		106	1.41	1.55
27	48.71	53.44		67	14.68	17.54		107	1.33	1.44
28	47.77	52.47		68	14.02	16.80		108	1.25	1.34
29	46.84	51.50		69	13.38	16.07		109	1.17	1.25
30	45.90	50.53		70	12.75	15.35		110	1.10	1.16
31	44.96	49.56		71	12.13	14.65		111	1.03	1.07
32	44.03	48.60		72	11.53	13.96		112	0.96	0.99
33	43.09	47.63		73	10.95	13.28		113	0.89	0.91
34	42.16	46.67		74	10.38	12.62		114	0.83	0.84
35	41.23	45.71		75	9.83	11.97		115	0.77	0.77
36	40.30	44.76		76	9.29	11.33		116	0.71	0.71
37	39.38	43.80		77	8.77	10.71		117	0.66	0.66
38	38.46	42.86		78	8.27	10.11		118	0.61	0.61
39	37.55	41.91		79	7.78	9.52		119	0.56	0.56

Effective 9/26/2011, see **OTHER ELIGIBILITY REQUIREMENTS RECOVERIES ESTATE RECOVERIES.**

REFERENCE/DESK AIDS
OTHER ELIGIBILITY REQUIREMENTS SECTION

**REFERENCE/DESK AIDS
OTHER ELIGIBILITY REQUIREMENTS**

CO-PAYMENT AMOUNTS

Discussion of co-payment amounts for fee-for-service, managed care and Family Health Plus recipients is found in **OTHER ELIGIBILITY REQUIREMENTS CO-PAY**.

<u>SERVICE</u>	<u>AMOUNT (\$)</u> for FFS	<u>AMOUNT</u> for MC	<u>FHPlus</u>	<u>FPBP</u>
Inpatient Hospital	\$25.00 per stay upon discharge	No co-payment	\$25.00 per stay upon discharge	No co-payment
Outpatient Hospital and Clinic	\$3.00 per visit	No co-payment	\$5.00 per visit	No co-payment
Non-emergency/Non-urgent ER	\$3.00 per visit	No co-payment	\$3.00 per visit	No co-payment
Prescription drugs*				No co-payment
Brand name	\$3.00	\$3.00	\$6.00	
Generic	\$1.00	\$1.00	\$3.00	
Over-the-Counter Drugs (OTC) **(per medication)	\$.50	No co-payment	\$.50	No co-payment
Enteral/Parental Formulae/Supplies	\$1.00 per order/prescription	No co-payment	No co-payment	N/A
Covered Medical/Surgical Supplies ***	\$.50 per order	No co-payment	\$1.00 per supply	No co-payment
Laboratory	\$.50 per procedure code	No co-payment	\$.50 per procedure code	No co-payment
X-ray ****	\$1.00 per procedure	No co-payment	\$1.00 per procedure	No co-payment
Dental services	No co-payment	No co-payment	\$5.00 per visit up to total of \$25 per year	N/A
Physician Services	No co-payment	No co-payment	\$5.00 per visit	No co-payment
Family Planning Service/Supplies	No co-payment	No co-payment	No co-payment	
* One co-payment for each new prescription and each new refill				
** Covered OTC e.g. smoking cessation products, insulin				
*** Covered medical supplies e.g. diabetic supplies such as syringes, lancets, test strips, enteral formula				
**** Radiology services e.g. diagnostic x-rays, ultrasound, nuclear medicine & oncology services				

**REFERENCE/DESK AIDS
OTHER ELIGIBILITY REQUIREMENTS**

MEDICAID COVERED SERVICES

Federally Mandated Services:

- Inpatient Hospital Services
- Outpatient Hospital Services
- Physician Services
- Medical and Surgical Dental Services
- Nursing facility services for individuals aged 21 or older
- Home Health Care (Nursing, Home Health Aide, Medical Supplies & Equipment)
- Family Planning Services and Supplies
- Rural Health Clinic Services
- Laboratory and X-Ray Services
- Nurse Practitioner Services
- Federally Qualified Health Center Services
- Midwife Services
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services for individuals under 21 (Child/Teen Health Plan in NYS)
- Medicare Coinsurance and Deductibles for qualified Medicare beneficiaries for: Chiropractors, Podiatrists, Portable X-Ray and Clinical Social Work Services

Non-Mandated Services (covered by New York State Medicaid):

- Free-standing Clinic Services
- Nursing Facility Services for under age 21
- Intermediate Care Facility Services for the Developmentally Disabled
- Optometrist Services and Eyeglasses
- Physical, Speech and Occupational Therapy
- Prosthetic Devices and Orthotic Appliances
- Dental Services
- Audiology and Hearing Aids
- Clinical Psychologist Services
- Private Duty Nursing
- Diagnosis, Screening, Preventive and Rehabilitative Services
- Personal Care Services
- Transportation to Covered Services
- Hospice
- Case Management
- Inpatient Psychiatric Facility Services for Individuals under age 21 and over 65
- Drugs—prescription and non-prescription

**REFERENCE/DESK AIDS
OTHER ELIGIBILITY REQUIREMENTS**

COVERED SERVICES FOR PREGNANT WOMEN

	Presumptive Eligibility		Ongoing Medicaid Eligibility		
	Perinatal A Under 100% FPL	Perinatal B Under 200% FPL	Perinatal Family	MA-Fully Eligible	Fully Eligible under 100%FPL
Coverage Code	13	14	15	01	01
SERVICES					
Physician Care	Yes	Yes	Yes	Yes	Yes
Midwife Care	Yes	Yes	Yes	Yes	Yes
Outpatient Clinic	Yes	Yes	Yes	Yes	Yes
Pharmacy	Yes	Yes	Yes	Yes	Yes
Dental	Yes	Yes	Yes	Yes	Yes
Laboratory	Yes	Yes	Yes	Yes	Yes
Eye Care	Yes	Excluded	Excluded	Yes	Yes
Transportation	Yes	Yes	Yes	Yes	Yes
Home Health Care	Yes	Yes	Yes	Yes	Yes
Personal Care	Yes	Yes	Yes	Yes	Yes
Nursing Services	Yes	Yes	Yes	Yes	Yes
Podiatry	Yes	Excluded	Excluded	Yes	Yes
Physical Therapy	Yes	Excluded	Excluded	Yes	Yes
Occupational Therapy	Yes	Excluded	Excluded	Yes	Yes
Speech Therapy	Yes	Excluded	Excluded	Yes	Yes
Durable Medical Equipment	Yes	Excluded	Excluded	Yes	Yes
Abortion	Yes	Excluded	Excluded	Yes	Yes
Clinical Psychology	Yes	Yes	Yes	Yes	Yes
Outpatient/ Mental Health	Yes	Yes	Yes	Yes	Yes
Outpatient/ Alcoholism	Yes	Yes	Yes	Yes	Yes
Health Education	Yes	Yes	Yes	Yes	Yes
Nutritional Counseling	Yes	Yes	Yes	Yes	Yes
Family Planning	Yes	Yes	Yes	Yes	Yes
Hospice	Excluded	Excluded	Excluded	Yes	Yes
Inpatient Care	Excluded	Excluded	Yes	Yes	Yes
Alternate Level of Care	Excluded	Excluded	Excluded	Yes	Yes
Institutional LTC	Excluded	Excluded	Excluded	Yes	Yes
LT Home Health Care	Excluded	Excluded	Excluded		

COMMUNITY-BASED LONG-TERM CARE AND NURSING FACILITY SERVICES

Coverage	Community Coverage <u>without</u> Long Term Care	Community Coverage <u>with</u> Community Based Long-Term Care	All Medicaid Covered Care and Services (Applicants must be in receipt of Nursing Facility Services)
Documentation	Application: Attest to value of current resources Renewal: Attest to value of current resources	Application: Document Current Resources Renewal: Attest to value of current resources	Application: Document resources for the past 60 months or back to 2/8/2006 whichever is shorter (60 months for trusts) Renewal: Document current resources
Benefit Package	-All non-LTC Outpatient Services -Inpatient Acute Care -Inpatient Psychiatric Care -Inpatient Alcohol Rehabilitation -Short-term rehabilitation up to 29 consecutive days in a 12 month period of: -Nursing Home Care -Certified Home Health Agency (CHHA)	-All services in Community Coverage without Community Based Long Term Care PLUS: -Adult Day Health Care -Assisted Living Program (ALP) -Certified Home Health Agency-CHHA, unlimited -Hospice in the Community -Hospice Residence Program -Residential Treatment Facility -Managed LTC in the Community -Personal Care Services -Private Duty Nursing -Home and Community-Based Waiver Programs – Waiver and Non-Waiver Services -Limited Licensed Home Care Services -Personal Emergency Response Services -Consumer Directed Personal Assistant Program	-All services in Community Coverage <u>with</u> and <u>without</u> Community Based LTC, PLUS: -Nursing Facility Services which include: -Nursing Home care provided in a nursing home or hospital -Hospice in a Nursing Home -Intermediate Care Facility -Managed LTC in a Nursing Home
Coverage Code(s)	20 or 24 (NYC only–legal alien during 5 year ban)	19	01 or 11 (Legal/Alien – Full Coverage) or 10* (Provided up to 60 months look-back info and is in penalty period – no spenddown or 6 mos. spenddown met)
Outpatient only Coverage code (Spend down)	22	21	02 (Outpatient Coverage with nursing facility services) or 23* (Outpatient coverage with no nursing facility services)
RVI Code	RVI Code 3	RVI Code 2	RVI Code 1 (documentation), 4 (transfer)

* Those individuals in a transfer penalty period are not eligible for any Nursing Facility Services including short-term rehabilitation in a nursing home.

**REFERENCE/DESK AIDS
OTHER ELIGIBILITY REQUIREMENTS**

REFUGEE MEDICAL ASSISTANCE PROGRAM (RMA)

**ELIGIBILITY PERIODS, STATE/FEDERAL (S/F) CHARGE CODE AND ALIEN
CITIZENSHIP INDICATOR CODES (ACI)**

State and Federal Charge Code 30 is only assigned when a Single Individual or Childless Couple (S/CC), age 21-64, is not otherwise eligible for “regular” Medicaid (S/CC/FHPlus – 02 budget) and eligibility for the Refugee Medical Assistance program has been determined (ADC-related – 01 budget).

Immigration Status	ACI RMA Eligible	S/F Charge Code	Eligibility Period Based on either the Date Entered Country (DEC) or the Date Status is granted or achieved (DOS)
Refugee	R	30	Eight months from the date entered country (DEC) as indicated on the Arrival Departure Record (I-94) or other immigration documentation
Amerasian Immigrants	R	30	Eight months from the date entered country (DEC) as indicated on the Arrival Departure Record (I-94) or other immigration documentation
Cuban/Haitian Entrants	H	30	Eight months from the date entered country (DEC) as indicated on the Arrival Departure Record (I-94) or other immigration documentation
Asylee	A	30	Eight months from the date asylum status is granted (DOS)
Federally Certified Victims of a Severe Form of Human Trafficking	D	30	Eight months from the date of the Certification letter for adults (DOS); date of eligibility letter for children
Family Member of victims of a severe form of human trafficking issued a Derivative T-Visa (T2, T3, T4, or T5) while in the United States	D	30	Eight months from the notice date found in the I-797 (Notice of Action) (DOS)
Family Member of victims of a severe form of human trafficking issued a Derivative T-Visa (T2, T3, T4, or T5) when entering the United States	D	30	Eight months from the date entered country (DEC) as indicated on the I-94 or other immigration documentation
Iraqi/Afghan Special Immigrant (SI)	R	30	Eight months from the date they entered the U.S. (DEC) or, if already in the U.S., eight months from the date they acquired their Special Immigrant status (DOS)

**REFERENCE/DESK AIDS
OTHER ELIGIBILITY REQUIREMENTS**

DISTRICT OF FISCAL RESPONSIBILITY

The where found district is responsible for eligible persons found in the district (SSL62.1) except when:

Rules	Action	Until
Medical SSL 62.5(d)	The DFR is the district of legal residence when an individual is admitted into a medical facility outside the district of legal residence. The individual has the freedom of choice as relates to the facility.	There is at least a 30-day break in need (one full calendar month)
Placement SSL 62.5(b)	The DFR is the district of legal residence when the SS district was directly or indirectly involved in placing the eligible individual into a formal residential care setting outside the district of legal residence.	There is a least a 30-day break in need (one full calendar month)
Transition 08 OHIP/LCM-1	The DFR is the “ from ” district when a recipient of public assistance and/or care moves to another district and continues to be eligible.	If the LDSS was notified of the new address in writing after the move; the end of the month following the month the move was reported. If the LDSS was not notified of new address in writing or notified of new address in writing <u>prior</u> to move the end of the month following the month of the move.
Temporary Absence SSL 365.1(a)	The DFR is the district of legal residence when an eligible individual leaves the district of legal residence for a specific purpose and intends to return to the home district upon completion of the activity.	The individual ceases to be engaged in the activity for which the individual left the permanent home. At that point, the transition rule applies.
Domestic Violence SSL 62.5(f)	The DFR is the district of legal residence at the time of the domestic violence incident when an individual goes into a residential program for victims of domestic violence in another county.	The individual leaves the approved shelter and chooses not to return to the “ from ” district. At that point, the transition rule applies.
Emergency Temporary Housing SSL 365.1(a)	The DFR is the placing district when a homeless person is placed by one district into temporary housing in another district.	The individual leaves temporary housing. At that point, the transition rule applies.

**REFERENCE/DESK AIDS
OTHER ELIGIBILITY REQUIREMENTS
DISTRICT OF FISCAL RESPONSIBILITY**

Rules	Action	Until
Parole SSL 366 (1-a)	The DFR for an inmate released on parole is the district of legal residence prior to incarceration.	Conditions of parole are completed.
Infants Residing with Incarcerated Mother 95 ADM-4	The DFR for an infant residing with the incarcerated mother is the mother's district of legal residence at the time of her sentencing.	The infant leaves the facility.
Assisted Living Program & Adult Care Facilities 18 NYCRR 505.35(l)	The DFR is the district of legal residence at the time of admission.	Break in need.
Minor Children < 21 yrs old GIS 00 MA/018	The DFR for a child capable of indicating intent is the district "where found", unless exception applies.	The child moves to another district. At that point the transition rule applies.
	The DFR for a child incapable of indicating intent is the district of legal residence of the parents/legal guardians.	The parent/legal guardian moves to another district. At that point the transition rule applies.

**REFERENCE/DESK AIDS
DETERMINING THE MEDICAID/CHPLUS HOUSEHOLD/FAMILY SIZE**

You <u>MUST</u> Count	You <u>MAY</u> Count (it is the family's choice)	Do <u>NOT</u> Count
<p>Applicant , and the applicant's:</p> <ul style="list-style-type: none"> • Legally Responsible Relatives: (LRRs) <ul style="list-style-type: none"> ○ Parents and Stepparents of children under 21 ○ Spouses ○ Adoptive parents • Applying siblings under 21 (can Mehler child(ren)out if income makes other applying individuals in household ineligible) • Pregnant women count as a HH of 2 (self plus unborn - if expecting a multiple birth, still count as 2) <p>When an individual of any age is counted, you must also count their income</p> <p><u>It is the family's choice</u> to select the most advantageous budgeting method for those household members who are applying</p> <p>Children/minors are defined as individuals who are under age 21</p>	<ul style="list-style-type: none"> • Non-applying siblings under 21 • Applying or Non-Applying related children (e.g. niece, cousin) under 21 • Non-applying Children under 21 of applying adults • One Caretaker Relative, (e.g. grandparent, aunt, uncle - only if no parent is in HH) <u>If child is applying for Medicaid</u>, the Caretaker Relative may only be counted if (s)he is also applying <u>If child is applying for Child Health Plus</u>, the Caretaker Relative may be counted even if (s)he is not applying for Medicaid • Unwed Father of Unborn: may count if family chooses to (if he resides and budgets his income with the pregnant woman) (do not count for CHPlus) • Unwed parents of common children (who reside and budget their money together) may or may not be counted in each other's HH size • <u>For Child Health Plus determinations only:</u> you <u>may</u> count Recipients of SSI Cash, Temporary Cash Assistance and Foster Children <u>only</u> if it results in another child's full premium being reduced to subsidized coverage (a lower or zero amount) 	<ul style="list-style-type: none"> • Parents of applying pregnant minors • Recipients of SSI Cash or Temporary Cash Assistance • Unrelated Foster Children • Children and siblings over 21 • Other unrelated, non- legally responsible persons (e. g. the unmarried boyfriend of a woman who has no child or unborn in common with him or the unrelated friend of an adult or child who resides in the HH) • Parents of a minor child who is applying only for the Family Planning Benefit Program (only if (s)he claims Good Cause and/or has a need for confidentiality or is unable to access parental income information)
Count only those people who live with the applicant(s)		

**REFERENCE/DESK AIDS
OTHER ELIGIBILITY REQUIREMENTS**

**BIRTH VERIFICATION INDICATOR (BVI)
CONVERSION FROM SSA**

The BVI (Birth Verification Indicator) will be populated based on the following conversion chart:

SSA Response Code	Description	BVI Code	Edits/Handling
A	SSN is verified, there is no indication of death, and the allegation of citizenship is consistent with SSA data	1	<ul style="list-style-type: none"> ➤ System generated based on response from SSA ➤ Not data enterable by worker ➤ Worker cannot update or delete
B	SSN is verified, there is no indication of death, and the allegation of citizenship is NOT consistent with SSA data	B	<ul style="list-style-type: none"> ➤ System generated based on response from SSA ➤ Not data enterable by worker ➤ Worker cannot delete ➤ Worker can update with 3 ➤ Batch processing will not delete but will update
C*	SSN is verified, there is indication of death, and the allegation of citizenship is consistent with SSA data	C*	<ul style="list-style-type: none"> ➤ System generated based on response from SSA ➤ Not data enterable by worker ➤ Worker cannot delete ➤ Batch processing will not delete but will update
D*	SSI is verified, there is indication of death, and the allegation of citizenship is NOT consistent with SSA data	D*	<ul style="list-style-type: none"> ➤ System generated based on response from SSA ➤ Not data enterable by worker ➤ Worker cannot delete ➤ Worker can update with 3 ➤ Batch processing will not delete but will update

* BVI values "C" and "D" will not appear on the citizenship report. "C" and "D" must be reconciled from the death match report.

REFERENCE

APPLICATION REQUIREMENTS

CATEGORY	FACE-TO-FACE	DOCUMENTATION		
		RESOURCES	INTEREST INCOME	TPHI, INCOME & RESIDENCE*
SSI-RELATED				
Community coverage without LTC	NO	Attest to resources, Document Trusts & burial funds	Document	Document
Community coverage with LTC	NO	Document current resources	Document	Document
All care and services including nursing home	NO	Document current resources and look-back period	Document	Document
MBI-WPD	NO	Attest to resources, Document Trusts & burial funds	Document	Document
ADC-RELATED	NO	No resource test	Attest	Document
LIF				
S/CC				
PARENTS WITH CHILDREN UNDER 21				
CHILDREN UNDER 21				
PREGNANT WOMEN				
CHILDREN UNDER 1				
FPBP				
MEDICAID CANCER TREATMENT				
MEDICARE SAVINGS				
QI, QMB, SLMB				
AHIP				
PARTNERSHIP FOR LTC				

REFERENCE

RENEWAL/RECERTIFICATION DOCUMENTATION REQUIREMENTS

CATEGORY	RESOURCES	INCOME	CHANGE RESIDENCY	TPHI	INTEREST INCOME
SSI-RELATED					
Community coverage without LTC	Itemize and Attest	Attest	Attest	Document	Attest
Community coverage with LTC	Itemize and Attest	Attest	Attest	Document	Attest
All care and services including nursing home	Document	Document	Document	Document	Document
MBI-WPD	Attest	Attest	Attest	Document	Attest
ADC-RELATED	No resource test	Attest	Attest	Document	Attest
LIF					
S/CC					
PARENTS WITH CHILDREN UNDER 21					
CHILDREN UNDER 21					
PREGNANT WOMEN					
CHILDREN UNDER 1					
FPBP					
MEDICAID CANCER TREATMENT					
MEDICARE SAVINGS					
QI, QMB, SLMB					
AHIP					
PARTNERSHIP FOR LTC					

GLOSSARY

request of the individual or the individual's spouse; or by a court or administrative body with legal authority to act in place of or on behalf of the individual or the individual's spouse or at the direction or upon the request of the individual or the individual's spouse.

ASSET PROTECTION – The total asset protection or dollar-for-dollar protection from Medicaid resource spenddown requirements available under the Medicaid Extended Coverage feature of Partnership plans. NOTE: When the term “asset” is used by the Partnership (e.g., in promotional materials, e-learning, etc.) it only includes a resource. It does not include income.

ASSISTED LIVING PROGRAM (ALP) - Program that serves individuals who are medically eligible for nursing home placement, yet who are not in need of the highly structured, medicalized environment of a nursing facility and whose needs could be met in a less restrictive and lower cost residential setting.

BATTERED - The term “battered” applies to an individual based on the fact that s/he was battered, abused or subjected to extreme cruelty, in the U.S., by a U.S. citizen or lawful permanent resident spouse or parent and who has an approved or pending petition/application (I-130, I-360) with USCIS that has been granted, or has been found prima facie eligible for relief under the Violence Against Women Act of 1994 (P.L. 103-322) and/or has credible proof of abuse/battery.

BLIND – “Blind” has the same definition given to such term in Section 1614 (a) (2) of the Social Security Act.

BLINDNESS - The total lack of vision or residual vision being no better than 20/200 or less in the better eye with a corrective lens or restriction of the visual fields or other factors which affect the usefulness of vision.

BREAST AND CERVICAL CANCER – The Breast and/or Cervical Cancer Treatment Program (BCCTP), now a part of the Medicaid Cancer Treatment Program (MCTP), provides full Medicaid coverage to individuals who meet the established criteria to qualify for the Centers for Disease Control and Prevention (CDC) screening under the National Breast and Cervical Cancer Early Detection Program (NBCCEDP).

BUDGETING - The process which is used to determine the value of a client's income and as appropriate, resources and whether or not they are below the allowable exemption levels.

BURIAL TRUSTS - Irrevocable pre-need funeral agreements with a funeral director or other entity to meet the expenses associated with burial for Medicaid applicants/recipients and certain family members of the A/R. The agreement can include burial spaces as well as the services of the funeral director. Burial spaces are conventional gravesites, crypts, vaults, mausoleums, caskets, urns or other repositories which are customarily and traditionally used for the remains of the deceased persons, plus the cost of opening and closing a grave.

GLOSSARY

CASH VALUE OF LIFE INSURANCE - Amount which the insurer will pay upon cancellation of the policy before death or maturity. This value usually increases with the age of the policy.

CERTIFIED HOME HEALTH AGENCY (CHHA) – Provides nursing services, home health aide services, medical supplies, equipment and appliances and at least one of the following services: physical therapy, speech/language pathology, occupational therapy, social work services and nutritional services.

CHILD - For Medicaid purposes, a person under the age of 21 unless otherwise specified.

CHILD ASSISTANCE PROGRAM (CAP) – The CAP program, originally a demonstration program, is now available in any social services district that requests to participate in the program and receives Office of Temporary and Disability Assistance (OTDA) approval. The CAP program provides a cash benefit and supportive services program designed to foster the federal and State welfare reform goals of work and self-sufficiency. Some of the key program features are an intensive case management component, and enhanced earnings disregard and potential Transitional Medicaid eligibility, and an eligibility threshold designed to reduce recidivism.

CHILD HEALTH PLUS - The federal Balanced Budget Act (BBA) of 1997 (Public Law 105-33) created the State Children's Health Insurance Program as Title XXI of the Social Security Act (known as Child Health Plus in New York State). Child Health Plus is not a Medicaid (Title XIX) Program.

CHILD SUPPORT – The legal obligation of a non-custodial parent to contribute to the economic maintenance of his/her child; the payments under that obligation.

CHILD SUPPORT ENFORCEMENT - Obtaining payment of a child support or medical support obligation through administrative or judicial means.

CHRONIC CARE BUDGETING - A budgeting procedure used for individuals who are in permanent absence status. Chronic care budgeting begins on the first day of the calendar month following the month in which the A/R is determined to be in permanent absence status.

CITIZEN - A person who was born in the United States or who has been naturalized.

COLORECTAL AND PROSTATE CANCER TREATMENT PROGRAM - A part of the Medicaid Cancer Treatment Program. The Medicaid Cancer Treatment Program for Colorectal and/or Prostate Cancer provides full Medicaid coverage for individuals who are screened and/or diagnosed by the Cancer Services Program Partnerships (CSPP) or a CSPP provider and meet established criteria.

GLOSSARY

COMMUNITY-BASED LONG-TERM CARE SERVICES – Community-based long-term care services include: adult day health care (medical model); limited licensed home care; certified home health agency service, hospice in the community; hospice residence program; personal care services; personal emergency response services; private duty nursing; Consumer Directed Personal Assistance Program; Assisted Living Program, managed long-term care in the community; residential treatment facility; and non-waiver services in a home and community-based waiver program.

COMMUNITY SPOUSE - A person who is the spouse of an institutionalized person, and who is residing in the community and not expected to receive home and community-based services provided pursuant to a waiver under Section 1915(c) of the Social Security Act for at least 30 consecutive days.

COMMUNITY SPOUSE MONTHLY INCOME ALLOWANCE - The amount by which the minimum monthly maintenance needs allowance for the community spouse exceeds the otherwise available monthly income of the community spouse, unless a greater amount is established pursuant to a fair hearing or a court order for support of the community spouse.

COMPREHENSIVE MEDICAID CASE MANAGEMENT - A process which assists selected Medicaid eligible individuals to access necessary medical, social, psychosocial, educational, financial and other services in accordance with goals contained in a written case management plan mutually agreed upon by the case manager and the client. State initiatives are: AIDS Institute Case Management; Office of Mental Health Supportive Case Management and Intensive Case Management; Office for People with Developmental Disabilities Case Management; Early Intervention Case Management; and School Supportive Health Services Program Case Management. Local Initiatives: Teen Age Services Act (TASA) Case Management; CONNECT; Onondaga County Case Management; and Neighborhood Based Alliance Case Management.

CONSUMER DIRECTED PERSONAL ASSISTANCE (CDPAP) - A program that enables Medicaid recipients, who are eligible for home care services, and who accept responsibility, to have greater flexibility and freedom of choice in obtaining needed services.

CONTIGUOUS PROPERTY - Land adjoining the homestead, which is not an integral part of the homestead and can be separately, liquidated.

CONTINUOUS PERIOD OF INSTITUTIONALIZATION - At least 30 consecutive days of care in a medical institution and/or nursing facility, or at least 30 consecutive days of receipt of home and community-based waiver services or a combination of institutional and home and community-based waiver services for at least 30 consecutive days. A continuous period is presumed to cease upon discharge from the medical institution/facility or discontinuance of home and community-based waiver services unless the individual returns to care within 30 days or there is adequate medical documentation that s/he will return to care within 30 days.

GLOSSARY

COUNTABLE RESOURCES - Available resources which are not disregarded.

CUSTODIAL PARENT - Person with primary physical custody as granted by valid agreement between the parties or by court order or decree and with whom the child lives; may be parent, other relative, or someone else.

CUSTODY ORDER - Legal determination that establishes with whom a child shall live.

DEFAULT JUDGMENT - Decision made by the court when the defendant fails to respond.

DEFAULT ORDER - A child support order issued when the non-custodial parent fails to appear in court after having received a summons.

DELINQUENT SUPPORT- Also referred to as ARREARS - Support not paid on time or in full.

DEPARTMENT OF HOMELAND SECURITY (DHS) - The [Homeland Security Act of 2002](#) transferred INS functions to the new Department of Homeland Security (DHS). Immigration enforcement functions were placed within the Directorate of Border and Transportation Security (BTS), either directly, or under Customs and Border Protection (CBP) (which includes the Border Patrol and INS Inspections) or Immigration and Customs Enforcement (ICE) (which includes the enforcement and investigation components of INS such as Investigations, Intelligence, Detention and Removals).

DISABLED – “Disabled” has the same meaning given to such term in Section 1614 (a) (3) of the Social Security Act, which states that an individual shall be considered to be disabled if 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 12 months.

DISABILITY - The inability 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 has lasted or can be expected to last for a continuous period of not less than 12 months.

DISABILITY REVIEW TEAM – Responsible to review the medical and vocational information to determine whether an individual meets the SSI definition of disabled and can be categorized as SSI-related. The State or local disability review team consists of a physician or psychological consultant, and another person who is qualified to interpret and evaluate medical reports to determine the individual's capacity to perform work activities.

DISREGARDS OF INCOME - Income that is not considered in determining eligibility for Medicaid.

GLOSSARY

DOLLAR-FOR-DOLLAR ASSET PROTECTION (DDAP) – The amount of assets that is disregarded, up to the amount paid in benefits after using the Dollar-for-Dollar 50 or Dollar-for-Dollar 100 Asset plan, in determining a qualified Partnership policyholder’s eligibility for Medicaid Extended Coverage.

DRUG AND ALCOHOL SCREENING - All adults and heads of household applying for temporary assistance are screened for drug and alcohol abuse. A positive screening results in an assessment of the individual by a certified drug/alcohol counselor. If a treatment program is indicated as a result of the assessment, the individual is referred to the appropriate credentialed substance abuse treatment program. The Drug and Alcohol requirements do not apply to the Medicaid program.

EARNED INCOME DISREGARDS (EID) - Earned income disregards are the allowable deductions and exclusions subtracted from the gross earnings. The resulting amount, or net income, is applied against the household’s need. EIDs vary in amount and type, depending on the category of the applicant and the program applied for.

EARNED INCOME TAX CREDIT (EITC) – The EITC is a special refundable tax benefit offered by the federal government. The credit is for working families and individuals who earn low or moderate incomes. The credit has several important purposes: to reduce the tax burden on these workers, to supplement wages, and to make work more attractive than welfare.

EMERGENCY ASSISTANCE FOR ADULTS (EAA) – EAA is a Temporary Assistance program that provides financial assistance to meet emergency needs of adults who are eligible for SSI.

EMERGENCY ASSISTANCE TO FAMILIES (EAF) – EAF provides assistance for families with children to deal with crisis situations threatening the family and meet emergent needs resulting from a sudden occurrence or set of circumstances demanding immediate attention.

EMERGENCY MEDICAL CONDITION - The term “emergency medical condition” means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- placing the person’s health in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Care and services related to an organ transplant procedure are not included in this definition.

EMERGENCY SAFETY NET ASSISTANCE (ESNA) – ESNA is a Temporary Assistance program that provides financial assistance to meet emergency needs of adults without minor children.

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EMERGENCY SHELTER GRANTS PROGRAM (ESGP) – The purpose of the ESGP is to help improve the quality and quantity of emergency shelters for the homeless, help meet the cost of operating such shelters, provide essential social services to the homeless and avoid an initial occurrence of homelessness through the provision of preventive services.

ENFORCEMENT – Obtaining payment of a child support or medical support obligation through administrative or judicial means.

ESTATE - (1) all of a decedent's real and personal property and other assets passing under the terms of a valid will or by intestacy; and (2) any other real and personal property and other assets in which the decedent had any legal title or interest at the time of death, including such assets conveyed to a survivor, heir, or assign of the decedent through joint tenancy, tenancy in common, survivorship, life estate, living trust or other arrangement, to the extent of the decedent's interest in the property immediately prior to death.

EXCESS (SURPLUS) RESOURCES - Available resources that are in excess of the resource exemption level.

EXPECTED TO REMAIN - Available medical evidence/documentation indicates a reasonable expectation that a person will remain in an institution/facility, receive home and community-based waiver services or a combination of institutional and community-based waiver services for at least 30 consecutive days, even though the person may not actually receive such services for at least 30 days.

FAIR HEARING – Fair Hearing means a formal procedure provided by the Office of Administrative Hearings, upon a request made by an applicant or recipient, to determine whether an action taken or failure to act by a local district was correct.

FAIR MARKET VALUE – “Fair market value” (FMV) means the estimate of the value of an asset if sold at the prevailing price at the time it was actually transferred. Fair market value of real property or other assets may be established by means of an appraisal by a real estate broker or other qualified dealer or appraiser.

FAMILY HEALTH PLUS (FHPlus or FHP) – FHPlus provides a comprehensive health insurance to low-income adults who have income or assets above the current Medicaid levels, and who do not have other health insurance coverage.

FAMILY HEALTH PLUS PREMIUM ASSISTANCE PROGRAM (FHP-PAP) - This program is available to A/Rs who have access to cost-effective employer sponsored health insurance and who are otherwise eligible for Family Health Plus. Such individuals have health services available to them including: payment of the recipient's share of the premium, co-insurance, any deductible amount and the cost-sharing obligations for the A/R's employer-sponsored health insurance that exceed the amount of the person's FHPlus co-payment obligations.

GLOSSARY

FAMILY ASSISTANCE (FA) – FA provides cash assistance to eligible needy families that include a minor child living with a parent(s) or caretaker relative. It is operated under the federal TANF rules. Under FA, eligible adults are limited to receiving benefits for a total of 60 months in their lifetime, including months of TANF-funded assistance granted in other states. Once this limit is reached, the adult and all members of his or her household are ineligible to receive any more FA benefits. FA recipients receive Medicaid under the categorical group Low Income Families (LIF). FA and LIF financial eligibility is generally equivalent. There is no time limit for Medicaid.

FAMILY MEMBER ALLOWANCE (FMA) FOR EACH FAMILY MEMBER - An amount equal to one-third of the amount by which the applicable percent of one-twelfth of the annual federal poverty line for a family of two exceeds the amount of the family member's otherwise available income. (See **REFERENCE SPOUSAL IMPOVERISHMENT FAMILY MEMBER ALLOWANCE** for the current maximum family allowance per family member.) A family member is a minor child, dependent child, dependent parent or dependent sibling of the institutionalized spouse or community spouse. The family member must be residing with the community spouse and have over 50% of his/her maintenance needs met by the community spouse and/or the institutionalized spouse.

FAMILY PLANNING BENEFIT PROGRAM (FPBP) - The FPBP provides Medicaid reimbursement for family planning services on a fee-for-service basis. Federal financial participation for such services is 90 percent in accordance with Section 1903(a)(5) of the Social Security Act. There is no local cost for services provided under the FPBP.

FAMILY TYPE HOME FOR ADULTS - An adult care facility established and operated for the purpose of providing long-term residential care and personal care, and/or supervision to four or fewer adult persons unrelated to the operator.

FEDERAL PARENT LOCATOR SERVICE (FPLS) – A service operated by the federal Office of Child Support Enforcement to help the States locate parents in order to obtain child support payments; also used in cases of parental kidnapping related to custody and visitation determinations; FPLS obtains address and employer information from federal agencies.

FEDERALLY-ASSISTED FOSTER CARE – A program, funded in part by the federal government, under which a child is raised in a household by someone other than his or her own parent.

FINDING – A formal determination by a court, or administrative process that has legal standing.

FOOD ASSISTANCE PROGRAM (FAP) – A state program that provides food assistance to some individuals who are ineligible for federal food stamps due to their alien status.

GLOSSARY

FOOD STAMPS (FS) – A federally mandated program with the purpose of reducing hunger and malnutrition by supplementing the food purchasing power of eligible low income individuals.

FULL FAITH AND CREDIT – Doctrine under which a State must honor an order or judgment entered in another State.

GARNISHMENT - A notice, issued through legal action, ordering attachment of personal property or income to guarantee payment of a debt.

GOOD CAUSE – An acceptable reason given by a client for refusing to cooperate in establishing paternity or establishing and enforcing child support.

GRANT DIVERSION – The use of funds that would otherwise be used to provide a welfare grant to a household to pay an employer for hiring the public assistance recipient. Grant Diversion is one method of funding a subsidized employment position (See definition of Subsidized Employment).

GUARDIAN – An individual vested with the legal authority, and charged with the duty, of taking care of the person and/or managing the property and financial affairs and rights of another person who is considered incapable of administering his or her own affairs.

HEARING – A court proceeding during which the facts of a case are heard and a decision regarding the case can be made.

HEARING EXAMINER – An attorney employed by the local Family Court who can hear and make decisions in child support cases.

HOME AND COMMUNITY-BASED WAIVER SERVICES - Services provided pursuant to a waiver under Section 1915(c) of the Social Security Act. New York State has obtained several such waivers:

- Long Term Home Health Care Program;
- Home and Community Based Services (HCBS) Waiver;
- Nursing Home Transition and Diversion (NHTD) Waiver;
- Office of Mental Health (OMH) Home and Community Based Services Waiver (HCBS) For Children and Adolescents With Serious Emotional Disturbance (SED); and
- Traumatic Brain Injury (TBI) Waiver.

Under these waivers, specialized services may be provided, in addition to the regular State Plan services. The general intent is to avoid institutionalization.

HOME ENERGY ASSISTANCE PROGRAM (HEAP) – A DTA federally funded program that provides emergency and non-emergency energy assistance.

GLOSSARY

HOME RELIEF (HR) – Home Relief is the pre-welfare reform state and locally funded cash assistance program. It provided benefits to eligible needy single and childless couples. This program was replaced by the Safety Net Assistance program.

HOMELESS - Any individual or family that is undomiciled, has no permanent address, has no regular nighttime residence, resides in a place not designed for or ordinarily used as a regular sleeping accommodation for human beings, resides in a homeless shelter, resides in a residential program for victims of domestic violence, or resides in a hotel/motel on a temporary basis.

HOMELESS HOUSING AND ASSISTANCE PROGRAM (HHAP) - The HHAP provides capital grants and loans to not-for-profit corporations, charitable and religious organizations, municipalities and public corporations to acquire, construct or rehabilitate housing for persons who are not domiciled and are unable to secure adequate housing without special assistance.

HOMELESSNESS INTERVENTION PROGRAM (HIP) - The intent of the Homeless Intervention Program is to allow more flexibility in the provision of services previously provided through the Homeless Rehousing Assistance Program (HRAP) and the Homelessness Prevention Program (HPP). HIP issues grants to eligible local social services districts and/or not-for-profit corporations that provide services to single individuals and/or families who are homeless or at risk of being homeless.

HOSPICE – A coordinated and supportive program for terminally ill persons and their families. care focuses on easing symptoms rather than treating disease. The patient and his or her family receive physical, psychological, social and spiritual support and care. Hospice may be provided in the community, in a nursing home, in a hospital or in a Hospice Residence Program.

HOUSING OPPORTUNITIES FOR PERSONS WITH AIDS (HOPWA) - The purpose of the HOPWA program is to provide strategies for meeting the housing and support services needs of low-income persons with AIDS and HIV-related diseases.

IMMEDIATE WAGE WITHHOLDING - Automatic deductions from income which start as soon as the agreement or order for support is established (see wage withholding).

IMMIGRANT - The term “immigrant” means any person who is not a citizen or national of the United States.

INCOME – “Income” has the same meaning given to such term in Section 1612 of the Social Security Act, and includes both earned and unearned income, with certain exceptions, as defined in such section.

INDIVIDUAL TAXPAYER IDENTIFICATION NUMBER (ITIN) – The Individual Taxpayer Identification Number (ITIN) is a tax processing number received from the Internal Revenue Service and is not considered an equivalent to an SSN.

GLOSSARY

INSTITUTIONALIZED SPOUSE - is a person who is:

- (a) in a medical institution or nursing facility and is expected to remain in such a medical institution or nursing facility for at least 30 consecutive days; or
- (b) in receipt of home and community-based waiver services, and expected to receive such services for at least 30 consecutive days; or
- (c) receiving institutional or non-institutional services under a Program of All-Inclusive Care for the Elderly (PACE); or
- (d) in a medical institution/nursing facility or in receipt of home and community-based waiver services, and expected to receive a combination of institutional services and home and community-based waiver services for at least 30 consecutive days;

AND

- (e) is married to a person who is not described in items (a) through (d).

INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED - "Intermediate care facility for the mentally retarded" means a facility certified under Article Sixteen of the Mental Hygiene Law and which has a valid agreement with the Department for providing intermediate care facility services and receiving payment under Title XIX of the Social Security Act.

JURISDICTION - Legal authority which a court has over particular persons, certain types of cases, and in a defined geographical area.

KINGAP - Kinship Guardian Assistance Program – The Kinship Guardian Assistance Program (KinGAP) is designed to provide a monthly payment and other benefits to qualified relative guardians of foster children who have been discharge from foster care. Medicaid coverage is provided to children in receipt of KinGAP payments as long as the child is a citizen or is in satisfactory immigration status. Children receiving KinGAP are eligible for Medicaid regardless of income or resources. The LDSS making the KinGAP payments is the district of fiscal responsibility.

LEGAL FATHER - A man who is recognized by law as the male parent.

LEGALLY RESPONSIBLE RELATIVE (LRR) - A relative who, by law, is responsible for the support and care of another person. In New York State, spouses are responsible for each other and parents are responsible for their children under 21.

LIEN - A claim upon property to prevent sale or transfer until a debt is satisfied.

LIFE ESTATE - A life estate is limited interest in real property

LIFE INSURANCE - A contract between the owner of a policy and an insurance company whereby the company agrees, in return for periodic premium payments, to pay a specified sum of money to the beneficiary upon the death of the insured.

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LIMITED LICENSED HOME CARE AGENCY - Provides hourly nursing care and homemaker, housekeeper, personal-care attendant and other health and social services.

LONG-TERM CARE INSURANCE – Insurance available through private companies as a means for individuals to pay for needed care and protect themselves against the high cost of long-term care.

LOOK-BACK PERIOD – For transfers made on or after February 8, 2006, the “look-back period” means the sixty-month period immediately preceding the date that an institutionalized individual is both institutionalized and has applied for Medicaid.

LOW INCOME FAMILIES (LIF) - A category consisting of families with children, children under 21 who are not living with a caretaker relative, applying caretaker relatives (includes adult cases only) and pregnant women. Most Family Assistance recipients will meet the LIF requirements.

LUMP SUM PAYMENTS - Deferred or delayed payments such as benefit awards, bonuses, year end profit sharing, retroactive pay increases and severance pay.

MANAGED LONG TERM CARE PROGRAM (MLTC) - provides health and long-term care services to adults with chronic illness or disabilities to better address their needs and to prevent or delay nursing home placement.

MANAGED LONG TERM CARE IN AN NURSING HOME – Case managed health and long term care to adults with chronic illness or disabilities to better address their needs while in a nursing home.

MEDICAID - A program to assist low-income persons in attaining and paying for medical care. Local Departments of Social Services administer the program, under the oversight of the Department of Health, Office of Health Insurance Programs (OHIP).

MEDICAID BUY-IN FOR WORKING PEOPLE WITH DISABILITIES - Sections 62-69 of Chapter 1 of the Laws of 2002 established a new Medicaid Buy-In Program to extend Medicaid coverage to working disabled applicants/recipients (A/Rs) who have net incomes at or below 250% of the Federal Poverty Level (FPL) and non-exempt resources. (See **REFERENCE INCOME/RESOURCE LEVEL**)

MEDICAID CANCER TREATMENT PROGRAM (MCTP) - The Medicaid Cancer Treatment Program for Breast and/or Cervical Cancer provides full Medicaid coverage to individuals who meet the established criteria to qualify for the Centers for Disease Control and Prevention (CDC) screening under the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). The Medicaid Cancer Treatment Program for Colorectal and/or Prostate Cancer provides full Medicaid coverage for individuals who are screened and/or diagnosed by the Cancer Services Program Partnerships (CSPP) or a CSPP provider and meet established criteria.

GLOSSARY

MEDICAID EXTENDED COVERAGE (MEC) – Medicaid that is available to a qualified Partnership participant who has met the minimum duration requirement under his/her policy. For Total Asset Protection plans, income is considered in determining Medicaid eligibility but resources are exempt. For Dollar-for-Dollar Asset Protection plans, income and unprotected resources are considered in determining Medicaid eligibility.

In the case of Total Asset Protection plans, no liens or recoveries will be pursued for correctly paid Medicaid payments made on behalf of qualified Partnership policyholders. In the case of a Dollar-for-Dollar Asset Protection plan participant, the amount of any lien or recovery against the participant's estate will be reduced by the amount of asset protection provided to the participant as a qualified Partnership policyholder.

MEDICAL INSTITUTIONS - Hospitals, nursing facilities, intermediate care facilities (ICFs), residential treatment facilities (RTFs), small residential units (SRUs), and room and board situations eligible for reimbursement under Title XIX of the Social Security Act.

MEDICAID INCOME STANDARDS - The Medicaid Income Standard is used to determine eligibility for Singles Childless Couples (SCC) and Low Income Family (LIF) categories.

MEDICAL SUPPORT - Any medical, dental, optical, prescription drug, health care services, or other health care benefits made available to a child through a legally responsible relative. Medical support can also be cash payments pursuant to a court order.

MEDICALLY NEEDY - An individual who is not eligible for or in receipt of SSI or LIF, but who has insufficient income and, as appropriate resources to meet the cost of his/her necessary medical and remedial care and services as determined by State standards. Such A/Rs must meet the categorical requirements for SSI or ADC.

MEDICATION GRANT PROGRAM - Section 15 of Kendra's Law authorizes the Commissioner of the Office of Mental Health (OMH) to provide grants to counties and New York City (NYC) for the Medication Grant Program (MGP). The MGP provides for medication and other services necessary to prescribe and administer medication to treat individuals with mental illness while a decision is being made on their application for Medicaid.

MEDICARE SAVINGS PROGRAM (MSP) - Certain A/Rs who receive Medicare may be eligible for Medicaid to pay the Medicare premium, coinsurance and deductible amounts. There are four groups that are eligible for payment or part-payment of Medicare premiums, coinsurance and deductibles: Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLIMBs), Qualified Disabled and Working Individuals (QDWIs), and Qualifying Individuals – (QI).

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MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE (MMMNA) - An amount equal to \$1,500 (effective October 1, 1989) as increased annually by the same percentage as the percentage increase in the federal Consumer Price Index. (See **REFERENCE** MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE for the current MMMNA dollar amount.)

MODIFICATION PETITION - A formal written application to a court requesting a change in an existing child support order.

MONEY JUDGMENT - A court order requiring a non-custodial parent to pay a sum of child support to the custodial parent or to the LDSS.

MORTGAGE - A pledge of a particular property for the payment of a debt or the performance of some other obligation within a prescribed time period.

NYS PARTNERSHIP PLAN - New York State has been granted a time-limited waiver pursuant to Section 1115 of the Social Security Act that provides federal matching funds for most eligibles, regardless of the category under which they receive Medicaid.

NATIVE AMERICAN BORN IN CANADA - A Native American born in Canada may freely enter and reside in the United States and is considered to be lawfully admitted for permanent residence if he or she is of at least one-half Native American Indian blood. As such, he or she is a qualified immigrant. This does not include a non-citizen spouse or child of such Native American or a non-citizen whose membership in a Native American Indian tribe or family is created by adoption, unless such person is at least 50 percent Native American Indian blood.

NEW YORK STATE PARTNERSHIP FOR LONG-TERM CARE (NYSPLTC) – Long-term care insurance policies which are approved under the Partnership program by the New York State Insurance Department. The NYSPLTC program combines private long-term care insurance and Medicaid Extended Coverage to assist New Yorkers in covering the cost of long-term care. The Partnership requires that participating insurers provide benefit coverage, operational activities, and oversight that may not be applicable to long-term care insurance products sold outside the Partnership. Qualified Partnership policyholders have their Medicaid Extended Coverage eligibility determined based on income while all or a portion of their resources are exempt, depending on the type of plan purchased. Consumers who own long-term care insurance policies that are not Partnership-approved policies do not have their resources exempted in a Medicaid eligibility determination. Partnership policies can be identified by the Partnership logo which appears on all materials related to the Partnership program.

NON-ASSIGNABLE – “Non-assignable” is a term that applies to a plan, annuity, or other arrangement (whether qualified or not qualified under Part I of Subchapter D of Chapter 1 of Subtitle A of the Internal Revenue Code) that qualifies for the marital deduction but for Section 2056 (d) (1) (A), and does not allow the policyholder to assign or transfer the policy to a third party.

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NON CITIZEN U.S. NATIONAL - A “national” is a person, who is not a U.S. citizen, but who owes permanent allegiance to the United States and may enter and work in the U.S. without restriction. A “national” who is otherwise qualified may be naturalized, if he becomes a resident of any state and completes the applicable requirements. Examples of nationals are: (1) persons born in American Samoa and Swain’s Island after December 24, 1952; and (2) residents of the Northern Mariana Islands who did not elect to become U.S. citizens.

NON-CUSTODIAL PARENT - The parent who does not live with or have physical custody of the child but is legally responsible for providing financial and medical support.

NON-IMMIGRANT - A “non-immigrant” is an individual who has been granted a status that allows him or her to remain in the U.S. temporarily for a specific purpose. Most non-immigrant categories require as a condition of the status that the individual have the intent of returning to a residence abroad.

NON-PROBATE – Non-probate assets include jointly owned financial institution accounts, jointly held real property, life estate interests, interest in certain trusts and annuities regardless of whether there is a named beneficiary or right of survivorship.

NURSING FACILITY - A facility that holds a current operating certificate issued by the State Health Department and meets the federal requirements for extended care facilities under Title XVIII of the Social Security Act and those for a nursing home under Title XIX of the Social Security Act.

NURSING FACILITY SERVICES – “Nursing facility services” means nursing care and health related services provided in a nursing facility; a level of care provided in a hospital which is equivalent to the care which is provided in a nursing facility; and care, services or supplies provided pursuant to a waiver under subsection (c) or (d) of Section 1915 of the Social Security Act.

NURSING HOME CARE – Care in a residential health care facility providing 24-hour skilled nursing supervision for patients requiring rehabilitative or custodial care. Nursing home level of care may be provided to a patient in a hospital when a nursing home bed is unavailable (must be eligible for all Medicaid covered services).

ORDER – Legal direction of a court.

ORDER OF FILIATION - A court order stating that a certain man is the father of a certain child.

OTHERWISE AVAILABLE INCOME - Income that is available to a community spouse or family member. In determining otherwise available income the following deductions, if applicable, are made: actual incapacitated adult/child care expenses, court-ordered support payments and health insurance premiums. In addition, German, Austrian and Netherlands reparation payments are disregarded in

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determining the otherwise available income of a community spouse or family member.

PACE - Program of All Inclusive Care for the Elderly - Institutional or non-institutional services provided under a PACE demonstration waiver program (as defined in Section 1934 of the Federal Social Security Act) or under a PACE program under section 1934 or 1894 of the Federal Social Security Act.

PARENT - A child's birth father or birth mother; adoptive father or adoptive mother; or putative father who has acknowledged paternity.

PARENT LOCATOR SERVICE - A computerized information service which the child support enforcement program uses to locate non-custodial parents through State and federal records for the purpose of establishing paternity and establishing and enforcing child support.

PARTICIPATING CONSUMER - An individual who has signed the Partnership Consumer Participation Agreement and has purchased long-term care coverage pursuant to a Partnership approved policy/certificate from a participating insurer.

PARTICIPATING INSURER - An insurance company offering policy/certificate coverage, approved under the New York State Insurance Department Regulation 144 (11 NYCRR 39) that signs the Insurer Participation Agreement. Insurers must submit products proposed for sale as Partnership for Long-Term Care policies for review and approval by the New York State Department of Insurance in order to be approved as a participating insurer.

PATERNITY - Legal determination of fatherhood.

PATERNITY HEARING - A proceeding to examine the facts regarding legal fatherhood for a child.

PATERNITY PETITION - A formal written application to a court requesting judicial action to determine legal fatherhood of a specific man for a specific child.

PERMANENT ABSENCE STATUS - When an individual is not expected to return home, or the individual is an institutionalized spouse. Permanent absence status will be presumed to exist for persons who are not institutionalized spouses if:

- (a) a person enters a nursing or intermediate care facility;
- (b) a person is initially admitted to acute care in a hospital and is then transferred to an alternate level of care, pending placement in a nursing facility; or
- (c) a person remains in acute care in a hospital for more than six calendar months.

Adequate medical evidence may overcome these presumptions.

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PERSONAL CARE SERVICES – Provide assistance with personal hygiene, dressing, feeding and incidental household services essential to the provision of home health services when prescribed by the attending physician.

PERSONAL EMERGENCY RESPONSE SERVICES (PERS) – An electronic device which enable high-risk patients to secure help in the event of an emergency.

PERSONAL NEEDS ALLOWANCE (PNA) - PNA is the amount that is set aside to meet the personal needs for persons who: are residing in a medical institution and are in permanent absence status; or have a community spouse and are in receipt of home and community-based waiver services.

PETITION - A formal written application to a court requesting judicial action on a particular matter.

PETITIONER - One who files a petition.

PRE-ADD ALLOWANCE - The monthly Public Assistance allowance that is intended to cover the costs of food, clothing, incidentals and utility bills.

PRESUMPTION OF PATERNITY - A rule of law under which evidence of a man's paternity (e.g., voluntary acknowledgment, genetic test results) creates a presumption that the husband is the father of his wife's child. A rebuttable presumption can be overcome by evidence that the man is not the father, but it shifts the burden of proof to the father to disprove paternity.

PRESUMPTIVE ELIGIBILITY - Presumptive eligibility is Medicaid coverage provided to certain applicants who reasonably appear to meet all of the criteria, financial and non-financial, pending the completion of the full eligibility determination.

PRIVATE DUTY NURSING – Nursing services at home from Registered Nurses (RNs) or Licensed Practical Nurses (LPNs), in accordance with physician orders which may be beyond the scope of care, or unavailable, from certified home care agencies.

PRIVATE PROPRIETARY HOME FOR ADULTS - An adult care facility which is operated for compensation and profit, established for the purpose of providing long term residential care, room, board, housekeeping, and supervision to five or more adults unrelated to the operator.

PROBABILITY OF PATERNITY - The probability that the alleged father is the biological father of the child as indicated by genetic test results.

PRUCOL (Permanently Residing Under Color Of Law) - Any immigrant who is permanently residing in the United States with the knowledge and permission or acquiescence of the United States Citizenship and Immigration Services (USCIS) (formerly the Immigration and Naturalization Services [INS]) and whose departure from the United States the USCIS does not contemplate enforcing.

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PUBLIC ASSISTANCE STANDARD OF NEED – Prior to April 2008 pursuant to a court order in *Atchison v. Berger* (76 ADM-17), Medicaid eligibility for Federally-related MA-Only individuals and families (persons under 21, over 65 and adults between 21 and 65 who are ADC or SSI related, and legally responsible relatives of MA-Only A/Rs who are determined able to contribute to the cost of care of their dependent relatives) was computed by comparing net available income to the Medically Needy Income Level or the PA Standard of Need, whichever was greater. The Public Assistance Standard of Need is an amount of money against which the income of an A/R is compared in order to determine eligibility for Public Assistance. The PA Standard is comprised of six separate items including the Pre-Add, the Home Energy Allowance, the Supplemental Home Energy Allowance, the Shelter Allowance, the Fuel for Heating Allowance and other Additional Allowances (including allowances for home delivered meals, a fifty dollar pregnancy allowance, a restaurant allowance, a special restaurant allowance, the cost of water, hotel or motel rates, and room and board where applicable) whose value must be added together to arrive at a needs level. At this time, the Public Assistance Standard of Need is not used when determining eligibility for Medicaid or Family Health Plus. In determining eligibility for LIF and ADC the net income of the A/R, after all appropriate disregards have been deducted, is compared to the Medically Needy Income Level or the Medicaid Standard (and MBL Living Arrangement chart as appropriate) whichever is most beneficial.

PUBLIC HOME - An adult care facility or a residential health care facility operated by a social services district.

PUBLIC INSTITUTION - An institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

PUTATIVE FATHER - Man alleged to be the biological father of a child.

QUALIFIED ALIEN - An alien who:

- has been lawfully admitted for permanent residence under the Immigration and Nationality Act (INA);
- has been granted asylum under Section 208 of the INA;
- has been admitted to the United States as a refugee under Section 207 of the INA (including Amerasian immigrants admitted under the provisions of Public Law 100-202);
- has been paroled into the United States under Section 212(d)(5) of the INA for a period of at least one year;
- has had deportation withheld under Section 243(h) or 241(b)(3) of the INA;
- is a Cuban and Haitian entrant (as defined in Section 501(e) of the Refugee Education Assistance Act of 1980);
- has been granted conditional entry pursuant to Section 203(a)(7) of the INA; or
- has been determined by the social services district to be in need of Medicaid as a result of being battered or subject to extreme cruelty in the United

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States by a spouse or a parent, or by a member of the spouse's or parent's family residing in the same household as the alien.

QUALIFIED - For the purposes of the MARG, the term "qualified" has the same meaning as the term "qualified alien", as used in the federal PRWORA (Welfare Reform). Qualifieds are individuals who usually live and work in the United States with the permission of the USCIS.

QUALIFIED ENTITY - Presumptive eligibility is a means of immediately providing Medicaid covered care and services to children under the age of 19. A Qualified Entity (QE), under a signed MOU with the State Department of Health, is used to perform a preliminary assessment of the child's eligibility based upon guidelines established by the Department.

QUALIFIED PARTNERSHIP POLICYHOLDER (QPP) - A participating consumer who has met the minimum benefit duration requirement of his or her New York State Partnership for Long-Term Care insurance policy and qualified to apply for Medicaid Extended Coverage under the Partnership.

REAL PROPERTY - Houses, condominiums, buildings and land including mineral, water and air rights.

RECIPIENT - An individual in receipt of Medicaid benefits.

REFUGEE CASH ASSISTANCE (RCA) - RCA is targeted to newly arriving refugees during their first eight months after entry into the United States and to those who are determined to be eligible for cash assistance but not eligible for Family Assistance.

REFUGEE MEDICAL ASSISTANCE (RMA) - RMA is targeted to newly arriving refugees during their first eight months after entry into the United States and to those who are determined to be ineligible for Medicaid, but meet certain requirements.

REFUGEE SOCIAL SERVICES PROGRAM (RSSP) - The RSSP assists documented refugees and their families in their transition to a new life in this Country. The Refugee Social Services Program provides job preparation training and job placement for refugees, asylees, Cuban and Haitian entrants and certain Amerasian immigrants.

RESIDENCE FOR ADULTS - An adult care facility established and operated for the purpose of providing long term residential care, room, board, housekeeping, case management activities and supervision to 5 or more adults, unrelated to the operator, who are unable or substantially unable to live independently.

RESIDENCES FOR SURVIVORS OF VIOLENCE PROGRAM (RSVP) - This transitional housing program is for victims of domestic violence. The initiative is exclusively targeted to New York City, as the demand for transitional housing for victims of domestic violence far exceeds the available supply there. The program is

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administered in accordance with Homeless Housing assistance Program (HHAP) procedures.

RESIDENTIAL HEALTH CARE FACILITY (RHCF) - A nursing home established and operated pursuant to Article 28 of the Public Health Law.

RESIDENTIAL TREATMENT FACILITY (RTF) - A medical facility certified by the State Office of Mental Health (OMH) which provides for long term psychiatric care for persons 21 years of age and younger.

RESOURCE - Property of all kinds including real and personal, tangible and intangible.

RESOURCE LEVEL - Allowable dollar amounts which an SSI-related A/R is permitted to have in reserve and still be eligible for Medicaid.

RESPONDENT - One who answers a petition.

SAFETY NET ASSISTANCE (SNA) - SNA is a State and locally funded program that provides cash assistance to eligible individuals, couples and families that are not eligible for family assistance. Generally, SNA can be provided for a maximum of two years in a lifetime. After that, if eligibility continues, SNA will be provided in non-cash form, such as two-party check or a voucher. In addition, non-cash SNA is provided for families of persons who are unable to work due to the abuse of drugs or alcohol or for refusing drug/alcohol screening, assessment or treatment.

The Medicaid eligibility category which most closely resembles SNA is Singles and Childless Couples (S/CC). It is for individuals ages 21 through 64 who are not certified blind or certified disabled or pregnant and do not have a minor dependent child living with them.

SATISFACTORY IMMIGRATION STATUS - The term "satisfactory immigration status" is defined as an immigration status that does not make the individual ineligible for benefits under the applicable program. All qualified immigrants and PRUCOL immigrants are individuals said to be in satisfactory immigration status, as are citizens, Native Americans and nationals. The only groups excluded are undocumented immigrants and temporary non-immigrants.

SIGNIFICANT FINANCIAL DISTRESS - Exceptional expenses that the community spouse cannot be expected to meet from the monthly maintenance needs allowance amounts or from amounts held in resources. Such expenses may be of a recurring nature or represent major one time costs. They may include, but are not limited to: recurring or extraordinary non-covered medical expenses of the community spouse or family members; amounts to preserve, maintain or make major repairs on the homestead; and amounts necessary to preserve an income-producing asset.

SINGLES/CHILDLESS COUPLES (S/CC) - Single individuals or members of childless married couples who are (1) at least age 21, but not yet 65; (2) not certified

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blind or certified disabled; (3) not pregnant; and (4) not caretaker relatives of children under age 21.

SPECIAL NON-IMMIGRANT - Some categories of “special” non-immigrant statuses allow the status (visa) holder to work in the United States and eventually adjust to lawful permanent residence status. These categories allow the individual to apply for adjustment to Lawful Permanent Resident (LPR) status after he or she has had the non-immigrant status for a period of time.

SPENDDOWN - The use of medical expenses to reduce available net income and as appropriate, resources in excess of the medically needy income/resource levels. Spenddown is only available to A/Rs whose eligibility is determined under the NYS medically needy income/resources levels. The A/R must submit paid or incurred bills equal to or greater than the amount of any excess. The A/R may also pay the amount of the excess income to the local district (Pay-In).

SPOUSE - A person married to an A/R (not a common law relationship). This includes married persons who are separated, but not divorced. This definition also applies to individuals of the same sex who are married.

SSI-RELATED - A medically needy Medicaid category for the aged, certified blind or certified disabled.

STATE INCOME STANDARDS - The State Income Standards are the standards used in determining the financial eligibility of families for childcare services. The State Income Standards are established each year using the federal poverty level for family size of four as a base, adjusted by family size scale.

STATE PARENT LOCATOR SERVICE (SPLS) - A service operated by the State Child Support Enforcement Agencies to locate non-custodial parents to establish paternity, and establish and enforce child support obligations.

STATUTE OF LIMITATIONS - The period during which someone can be held liable for an action or a debt - statutes of limitations for collecting child support vary from State to State.

STAY - An order by a court that suspends all or some of the proceedings in a case.

STEPPARENT - A person who is not a child’s birth or adoptive parent, but is married to the child’s birth or adoptive parent.

SUBSIDIZED EMPLOYMENT - Subsidized employment occurs when an employer receives a subsidy in exchange for hiring a public assistance recipient. The subsidy payment may offset the employer’s costs of providing wages, fringe benefits or training or for other purposes. Funds used to subsidize a position may include welfare funds, such as those made available through grant diversion, or other funding sources. Subsidized employment is a public assistance work activity. (See definition of Grant Diversion)

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SUMMONS - The notice used to inform all parties of a court proceeding.

SUPPLANT - To replace current spending with another funding source.

SUPPLEMENTAL SECURITY INCOME (SSI) - A federally supported and administered benefit program for eligible individuals or couples who are 65 or over, or who, regardless of age are certified blind or certified disabled.

SUPPORT COLLECTION UNIT – The part of the child support enforcement program responsible for administration, collection, monitoring, and disbursement of support payments.

SUPPORT ENFORCEMENT- The processes by which a court order to provide cash/medical support can be legally enforced using judicial and/or administrative means.

SUPPORT HEARING – A proceeding to examine the facts regarding financial support for a child.

SUPPORT OBLIGATION – The amount a non-custodial parent is ordered to pay for child support.

SUPPORT ORDER – A court order establishing a child support obligation may include cash and/or medical support.

SUPPORT PETITION – A formal written application to a court requesting judicial action on a matter of child support.

TAX-QUALIFIED LONG-TERM CARE INSURANCE CONTRACT- A long-term care insurance policy that provides favorable federal tax treatment for premiums and benefits paid by the policy. These policies must conform to the requirements of the federal Health Insurance Portability and Accountability Act of 1996 in order to have favorable tax status. Long-term care insurance policies that are approved as tax-qualified by the New York State Insurance Department also are provided favorable tax treatment by New York State.

TEMPORARY ABSENCE - A time when a person is absent from his/her permanent residence and is expected to return. Reasons for temporary absence may include employment, hospitalization, military service, vacation, education or visits. A period of temporary absence will be presumed to exist if:

- (a) the person is not an institutionalized spouse and returns to his/her permanent residence in the month in which s/he left or the following month;
- (b) a person without a community spouse is in an acute care hospital for six calendar months or less;

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- (c) a person with a community spouse is expected to be in an acute care hospital for less than 30 consecutive days; or
- (d) a person with a community spouse is expected to receive home and community-based services provided pursuant to a waiver under Section 1915(c) of the Social Security Act for less than 30 consecutive days.

The presumptions set forth in (a) and (b) may be overcome by adequate evidence. Adequate medical evidence is required to overcome the presumptions set forth in (c) and (d).

TEMPORARY ASSISTANCE (TA) – TA is the “cash” assistance component of welfare. In New York State, temporary assistance includes Family Assistance, Safety Net Assistance, Emergency Assistance for Families, Emergency Safety Net Assistance and Emergency Assistance for Adults. TA is often referred to as “public assistance”.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) – Commonly used in reference to the federal assistance program which a state operates. It is the Block Grant that was established under the Personal Responsibility and Work Opportunity Reconciliation Act under which states operate a federally funded program to assist families with children. TANF funds are used for supportive services and federal benefits.

TEMPORARY NON-IMMIGRANT - A temporary non-immigrant is an immigrant who has been allowed to enter the United States for a specific purpose and for a limited period of time. There are more than two dozen non-immigrant categories, each of which has specific requirements concerning the purpose of the individual’s stay in the U.S. Examples include tourists, students, and visitors on business or pleasure.

TEMPORARY PROTECTED STATUS (TPS) - “Temporary Protected Status” is granted to individuals who are physically present in the U.S. and who are from certain countries designated by the U.S. attorney general as unsafe to accept their return. Individuals granted TPS are authorized to remain in the U.S. for a specific, limited period.

TITLE IV-E - Title IV, Part E of the Social Security Act describes federal payments for foster care and adoption assistance. Title IV-E foster care reimbursement is provided for children who would have been categorically and financially eligible for the former ADC program in public assistance. Title IV-E Adoption Assistance reimbursement is provided for special needs children who would have been eligible under either the former ADC program of public assistance or who are eligible for SSI at the time the adoption petition is filed. Children who are Title IV-E eligible are automatically eligible for Medicaid. Children who are not IV-E eligible are categorically and are automatically eligible for Medicaid. Usually eligibility is based on a household of one. If the non-IV-E child is pregnant, the usual Medicaid rules apply.

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TITLE XIX - That portion of the federal Social Security Act which authorizes a joint federal/state Medicaid program.

TOTAL ASSET PROTECTION (TAP) – Disregard of all qualifying Partnership policyholder’s assets in determining his or her eligibility for Medicaid Extended Coverage, after the policyholder has used the required amount of benefits under a Total Asset 50 or Total Asset 100 insurance policy.

TRANSFER OF ASSETS - A voluntary assignment of property for less than the fair market value of the property.

TRUST FUNDS - Fund held by one party (the trustee) for the benefit of a person (beneficiary) or group of persons. These funds are not owned by the beneficiary but are usually under the control of a trustee who must carry out the stipulated conditions for payments specified in the trust.

UNCOMPENSATED VALUE – “Uncompensated value” means the difference between the fair market value at the time of transfer (less any outstanding loans, mortgages, or other encumbrances on the asset) and the amount received for the asset. If the client’s resources are below the appropriate Medicaid resource level, the amount by which the Medicaid resource level exceeds the client’s resources must be deducted from the uncompensated value of the transfer. Likewise, amounts specified in the Department regulations for burial funds, but not for burial space items, also must be deducted.

UNDERGRADUATE – A student who has not received a bachelor’s degree.

UNDOCUMENTED IMMIGRANT - Undocumented individuals are immigrants who do not have the permission or acquiescence of the United States Citizenship and Immigration Services (USCIS) to remain in the United States. They may have entered the United States legally but have violated the terms of their status, e.g., over-stayed a visa, or they may have entered without documents.

UNITED STATES CITIZEN: For the purposes of qualifying as a United States citizen, the United States includes the 50 states, the District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands and the Northern Mariana Islands. Nationals from American Samoa or Swain’s Island are also regarded as United States citizens for the purpose of Medicaid eligibility.

UNITED STATES CITIZENSHIP AND IMMIGRATION SERVICES (USCIS) - On March 1, 2003, service and benefit functions of the U.S. Immigration and Naturalization Service (INS) transitioned into the Department of Homeland Security (DHS) as the U.S. Citizenship and Immigration Services (USCIS). The USCIS is responsible for the administration of immigration and naturalization adjudication functions and establishing immigration services, policies and priorities. These functions include:

- adjudication of immigrant visa petitions;

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- adjudication of naturalization petitions;
- adjudication of asylum and refugee applications;
- adjudications performed at the service centers, and all other adjudications performed by the INS.

VETERAN - The term veteran means a person who served in the active military, naval or air service of the United States who fulfilled the minimum active duty service requirements and was honorably discharged or released, not on account of immigration status.

VICTIMS OF A SEVERE FORM OF TRAFFICKING: A “victim of a severe form of trafficking” is defined as anyone who:

1. has been subjected to a “severe form of trafficking in persons” which is defined as “sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; or the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud or coercion for the purpose of subsection (a)(1)(A), (a)(1)(B), (a)(1)(C), (a)(1)(D), (a)(1)(E), (a)(1)(F), (a)(1)(G), (a)(1)(H), (a)(1)(I), (a)(1)(J), (a)(1)(K), (a)(1)(L), (a)(1)(M), (a)(1)(N), (a)(1)(O), (a)(1)(P), (a)(1)(Q), (a)(1)(R), (a)(1)(S), (a)(1)(T), (a)(1)(U), (a)(1)(V), (a)(1)(W), (a)(1)(X), (a)(1)(Y), (a)(1)(Z), (a)(1)(AA), (a)(1)(AB), (a)(1)(AC), (a)(1)(AD), (a)(1)(AE), (a)(1)(AF), (a)(1)(AG), (a)(1)(AH), (a)(1)(AI), (a)(1)(AJ), (a)(1)(AK), (a)(1)(AL), (a)(1)(AM), (a)(1)(AN), (a)(1)(AO), (a)(1)(AP), (a)(1)(AQ), (a)(1)(AR), (a)(1)(AS), (a)(1)(AT), (a)(1)(AU), (a)(1)(AV), (a)(1)(AW), (a)(1)(AX), (a)(1)(AY), (a)(1)(AZ), (a)(1)(BA), (a)(1)(BB), (a)(1)(BC), (a)(1)(BD), (a)(1)(BE), (a)(1)(BF), (a)(1)(BG), (a)(1)(BH), (a)(1)(BI), (a)(1)(BJ), (a)(1)(BK), (a)(1)(BL), (a)(1)(BM), (a)(1)(BN), (a)(1)(BO), (a)(1)(BP), (a)(1)(BQ), (a)(1)(BR), (a)(1)(BS), (a)(1)(BT), (a)(1)(BU), (a)(1)(BV), (a)(1)(BW), (a)(1)(BX), (a)(1)(BY), (a)(1)(BZ), (a)(1)(CA), (a)(1)(CB), (a)(1)(CC), (a)(1)(CD), (a)(1)(CE), (a)(1)(CF), (a)(1)(CG), (a)(1)(CH), (a)(1)(CI), (a)(1)(CJ), (a)(1)(CK), (a)(1)(CL), (a)(1)(CM), (a)(1)(CN), (a)(1)(CO), (a)(1)(CP), (a)(1)(CQ), (a)(1)(CR), (a)(1)(CS), (a)(1)(CT), (a)(1)(CU), (a)(1)(CV), (a)(1)(CW), (a)(1)(CX), (a)(1)(CY), (a)(1)(CZ), (a)(1)(DA), (a)(1)(DB), (a)(1)(DC), (a)(1)(DD), (a)(1)(DE), (a)(1)(DF), (a)(1)(DG), (a)(1)(DH), (a)(1)(DI), (a)(1)(DJ), (a)(1)(DK), (a)(1)(DL), (a)(1)(DM), (a)(1)(DN), (a)(1)(DO), (a)(1)(DP), (a)(1)(DQ), (a)(1)(DR), (a)(1)(DS), (a)(1)(DT), (a)(1)(DU), (a)(1)(DV), (a)(1)(DW), (a)(1)(DX), (a)(1)(DY), (a)(1)(DZ), (a)(1)(EA), (a)(1)(EB), (a)(1)(EC), (a)(1)(ED), (a)(1)(EE), (a)(1)(EF), (a)(1)(EG), (a)(1)(EH), (a)(1)(EI), (a)(1)(EJ), (a)(1)(EK), (a)(1)(EL), (a)(1)(EM), (a)(1)(EN), (a)(1)(EO), (a)(1)(EP), (a)(1)(EQ), (a)(1)(ER), (a)(1)(ES), (a)(1)(ET), (a)(1)(EU), (a)(1)(EV), (a)(1)(EW), (a)(1)(EX), (a)(1)(EY), (a)(1)(EZ), (a)(1)(FA), (a)(1)(FB), (a)(1)(FC), (a)(1)(FD), (a)(1)(FE), (a)(1)(FF), (a)(1)(FG), (a)(1)(FH), (a)(1)(FI), (a)(1)(FJ), (a)(1)(FK), (a)(1)(FL), (a)(1)(FM), (a)(1)(FN), (a)(1)(FO), (a)(1)(FP), (a)(1)(FQ), (a)(1)(FR), (a)(1)(FS), (a)(1)(FT), (a)(1)(FU), (a)(1)(FV), (a)(1)(FW), (a)(1)(FX), (a)(1)(FY), (a)(1)(FZ), (a)(1)(GA), (a)(1)(GB), (a)(1)(GC), (a)(1)(GD), (a)(1)(GE), (a)(1)(GF), (a)(1)(GG), (a)(1)(GH), (a)(1)(GI), (a)(1)(GJ), (a)(1)(GK), (a)(1)(GL), (a)(1)(GM), (a)(1)(GN), (a)(1)(GO), (a)(1)(GP), (a)(1)(GQ), (a)(1)(GR), (a)(1)(GS), (a)(1)(GT), (a)(1)(GU), (a)(1)(GV), (a)(1)(GW), (a)(1)(GX), (a)(1)(GY), (a)(1)(GZ), (a)(1)(HA), (a)(1)(HB), (a)(1)(HC), (a)(1)(HD), (a)(1)(HE), (a)(1)(HF), (a)(1)(HG), (a)(1)(HH), (a)(1)(HI), (a)(1)(HJ), (a)(1)(HK), (a)(1)(HL), (a)(1)(HM), (a)(1)(HN), (a)(1)(HO), (a)(1)(HP), (a)(1)(HQ), (a)(1)(HR), (a)(1)(HS), (a)(1)(HT), (a)(1)(HU), (a)(1)(HV), (a)(1)(HW), (a)(1)(HX), (a)(1)(HY), (a)(1)(HZ), (a)(1)(IA), (a)(1)(IB), (a)(1)(IC), (a)(1)(ID), (a)(1)(IE), (a)(1)(IF), (a)(1)(IG), (a)(1)(IH), (a)(1)(II), (a)(1)(IJ), (a)(1)(IK), (a)(1)(IL), (a)(1)(IM), (a)(1)(IN), (a)(1)(IO), (a)(1)(IP), (a)(1)(IQ), (a)(1)(IR), (a)(1)(IS), (a)(1)(IT), (a)(1)(IU), (a)(1)(IV), (a)(1)(IW), (a)(1)(IX), (a)(1)(IY), (a)(1)(IZ), (a)(1)(JA), (a)(1)(JB), (a)(1)(JC), (a)(1)(JD), (a)(1)(JE), (a)(1)(JF), (a)(1)(JG), (a)(1)(JH), (a)(1)(JI), (a)(1)(JJ), (a)(1)(JK), (a)(1)(JL), (a)(1)(JM), (a)(1)(JN), (a)(1)(JO), (a)(1)(JP), (a)(1)(JQ), (a)(1)(JR), (a)(1)(JS), (a)(1)(JT), (a)(1)(JU), (a)(1)(JV), (a)(1)(JW), (a)(1)(JX), (a)(1)(JY), (a)(1)(JZ), (a)(1)(KA), (a)(1)(KB), (a)(1)(KC), (a)(1)(KD), (a)(1)(KE), (a)(1)(KF), (a)(1)(KG), (a)(1)(KH), (a)(1)(KI), (a)(1)(KJ), (a)(1)(KK), (a)(1)(KL), (a)(1)(KM), (a)(1)(KN), (a)(1)(KO), (a)(1)(KP), (a)(1)(KQ), (a)(1)(KR), (a)(1)(KS), (a)(1)(KT), (a)(1)(KU), (a)(1)(KV), (a)(1)(KW), (a)(1)(KX), (a)(1)(KY), (a)(1)(KZ), (a)(1)(LA), (a)(1)(LB), (a)(1)(LC), (a)(1)(LD), (a)(1)(LE), (a)(1)(LF), (a)(1)(LG), (a)(1)(LH), (a)(1)(LI), (a)(1)(LJ), (a)(1)(LK), (a)(1)(LL), (a)(1)(LM), (a)(1)(LN), (a)(1)(LO), (a)(1)(LP), (a)(1)(LQ), (a)(1)(LR), (a)(1)(LS), (a)(1)(LT), (a)(1)(LU), (a)(1)(LV), (a)(1)(LW), (a)(1)(LX), (a)(1)(LY), (a)(1)(LZ), (a)(1)(MA), (a)(1)(MB), (a)(1)(MC), (a)(1)(MD), (a)(1)(ME), (a)(1)(MF), (a)(1)(MG), (a)(1)(MH), (a)(1)(MI), (a)(1)(MJ), (a)(1)(MK), (a)(1)(ML), (a)(1)(MM), (a)(1)(MN), (a)(1)(MO), (a)(1)(MP), (a)(1)(MQ), (a)(1)(MR), (a)(1)(MS), (a)(1)(MT), (a)(1)(MU), (a)(1)(MV), (a)(1)(MW), (a)(1)(MX), (a)(1)(MY), (a)(1)(MZ), (a)(1)(NA), (a)(1)(NB), (a)(1)(NC), (a)(1)(ND), (a)(1)(NE), (a)(1)(NF), (a)(1)(NG), (a)(1)(NH), (a)(1)(NI), (a)(1)(NJ), (a)(1)(NK), (a)(1)(NL), (a)(1)(NM), (a)(1)(NN), (a)(1)(NO), (a)(1)(NP), (a)(1)(NQ), (a)(1)(NR), (a)(1)(NS), (a)(1)(NT), (a)(1)(NU), (a)(1)(NV), (a)(1)(NW), (a)(1)(NX), (a)(1)(NY), (a)(1)(NZ), (a)(1)(OA), (a)(1)(OB), (a)(1)(OC), (a)(1)(OD), (a)(1)(OE), (a)(1)(OF), (a)(1)(OG), (a)(1)(OH), (a)(1)(OI), (a)(1)(OJ), (a)(1)(OK), (a)(1)(OL), (a)(1)(OM), (a)(1)(ON), (a)(1)(OO), (a)(1)(OP), (a)(1)(OQ), (a)(1)(OR), (a)(1)(OS), (a)(1)(OT), (a)(1)(OU), (a)(1)(OV), (a)(1)(OW), (a)(1)(OX), (a)(1)(OY), (a)(1)(OZ), (a)(1)(PA), (a)(1)(PB), (a)(1)(PC), (a)(1)(PD), (a)(1)(PE), (a)(1)(PF), (a)(1)(PG), (a)(1)(PH), (a)(1)(PI), (a)(1)(PJ), (a)(1)(PK), (a)(1)(PL), (a)(1)(PM), (a)(1)(PN), (a)(1)(PO), (a)(1)(PP), (a)(1)(PQ), (a)(1)(PR), (a)(1)(PS), (a)(1)(PT), (a)(1)(PU), (a)(1)(PV), (a)(1)(PW), (a)(1)(PX), (a)(1)(PY), (a)(1)(PZ), (a)(1)(QA), (a)(1)(QB), (a)(1)(QC), (a)(1)(QD), (a)(1)(QE), (a)(1)(QF), (a)(1)(QG), (a)(1)(QH), (a)(1)(QI), (a)(1)(QJ), (a)(1)(QK), (a)(1)(QL), (a)(1)(QM), (a)(1)(QN), (a)(1)(QO), (a)(1)(QP), (a)(1)(QQ), (a)(1)(QR), (a)(1)(QS), (a)(1)(QT), (a)(1)(QU), (a)(1)(QV), (a)(1)(QW), (a)(1)(QX), (a)(1)(QY), (a)(1)(QZ), (a)(1)(RA), (a)(1)(RB), (a)(1)(RC), (a)(1)(RD), (a)(1)(RE), (a)(1)(RF), (a)(1)(RG), (a)(1)(RH), (a)(1)(RI), (a)(1)(RJ), (a)(1)(RK), (a)(1)(RL), (a)(1)(RM), (a)(1)(RN), (a)(1)(RO), (a)(1)(RP), (a)(1)(RQ), (a)(1)(RR), (a)(1)(RS), (a)(1)(RT), (a)(1)(RU), (a)(1)(RV), (a)(1)(RW), (a)(1)(RX), (a)(1)(RY), (a)(1)(RZ), (a)(1)(SA), (a)(1)(SB), (a)(1)(SC), (a)(1)(SD), (a)(1)(SE), (a)(1)(SF), (a)(1)(SG), (a)(1)(SH), (a)(1)(SI), (a)(1)(SJ), (a)(1)(SK), (a)(1)(SL), (a)(1)(SM), (a)(1)(SN), (a)(1)(SO), (a)(1)(SP), (a)(1)(SQ), (a)(1)(SR), (a)(1)(SS), (a)(1)(ST), (a)(1)(SU), (a)(1)(SV), (a)(1)(SW), (a)(1)(SX), (a)(1)(SY), (a)(1)(SZ), (a)(1)(TA), (a)(1)(TB), (a)(1)(TC), (a)(1)(TD), (a)(1)(TE), (a)(1)(TF), (a)(1)(TG), (a)(1)(TH), (a)(1)(TI), (a)(1)(TJ), (a)(1)(TK), (a)(1)(TL), (a)(1)(TM), (a)(1)(TN), (a)(1)(TO), (a)(1)(TP), (a)(1)(TQ), (a)(1)(TR), (a)(1)(TS), (a)(1)(TT), (a)(1)(TU), (a)(1)(TV), (a)(1)(TW), (a)(1)(TX), (a)(1)(TY), (a)(1)(TZ), (a)(1)(UA), (a)(1)(UB), (a)(1)(UC), (a)(1)(UD), (a)(1)(UE), (a)(1)(UF), (a)(1)(UG), (a)(1)(UH), (a)(1)(UI), (a)(1)(UJ), (a)(1)(UK), (a)(1)(UL), (a)(1)(UM), (a)(1)(UN), (a)(1)(UO), (a)(1)(UP), (a)(1)(UQ), (a)(1)(UR), (a)(1)(US), (a)(1)(UT), (a)(1)(UU), (a)(1)(UV), (a)(1)(UW), (a)(1)(UX), (a)(1)(UY), (a)(1)(UZ), (a)(1)(VA), (a)(1)(VB), (a)(1)(VC), (a)(1)(VD), (a)(1)(VE), (a)(1)(VF), (a)(1)(VG), (a)(1)(VH), (a)(1)(VI), (a)(1)(VJ), (a)(1)(VK), (a)(1)(VL), (a)(1)(VM), (a)(1)(VN), (a)(1)(VO), (a)(1)(VP), (a)(1)(VQ), (a)(1)(VR), (a)(1)(VS), (a)(1)(VT), (a)(1)(VU), (a)(1)(VV), (a)(1)(VW), (a)(1)(VX), (a)(1)(VY), (a)(1)(VZ), (a)(1)(WA), (a)(1)(WB), (a)(1)(WC), (a)(1)(WD), (a)(1)(WE), (a)(1)(WF), (a)(1)(WG), (a)(1)(WH), (a)(1)(WI), (a)(1)(WJ), (a)(1)(WK), (a)(1)(WL), (a)(1)(WM), (a)(1)(WN), (a)(1)(WO), (a)(1)(WP), (a)(1)(WQ), (a)(1)(WR), (a)(1)(WS), (a)(1)(WT), (a)(1)(WU), (a)(1)(WV), (a)(1)(WW), (a)(1)(WX), (a)(1)(WY), (a)(1)(WZ), (a)(1)(XA), (a)(1)(XB), (a)(1)(XC), (a)(1)(XD), (a)(1)(XE), (a)(1)(XF), (a)(1)(XG), (a)(1)(XH), (a)(1)(XI), (a)(1)(XJ), (a)(1)(XK), (a)(1)(XL), (a)(1)(XM), (a)(1)(XN), (a)(1)(XO), (a)(1)(XP), (a)(1)(XQ), (a)(1)(XR), (a)(1)(XS), (a)(1)(XT), (a)(1)(XU), (a)(1)(XV), (a)(1)(XW), (a)(1)(XX), (a)(1)(XY), (a)(1)(XZ), (a)(1)(YA), (a)(1)(YB), (a)(1)(YC), (a)(1)(YD), (a)(1)(YE), (a)(1)(YF), (a)(1)(YG), (a)(1)(YH), (a)(1)(YI), (a)(1)(YJ), (a)(1)(YK), (a)(1)(YL), (a)(1)(YM), (a)(1)(YN), (a)(1)(YO), (a)(1)(YP), (a)(1)(YQ), (a)(1)(YR), (a)(1)(YS), (a)(1)(YT), (a)(1)(YU), (a)(1)(YV), (a)(1)(YW), (a)(1)(YX), (a)(1)(YY), (a)(1)(YZ), (a)(1)(ZA), (a)(1)(ZB), (a)(1)(ZC), (a)(1)(ZD), (a)(1)(ZE), (a)(1)(ZF), (a)(1)(ZG), (a)(1)(ZH), (a)(1)(ZI), (a)(1)(ZJ), (a)(1)(ZK), (a)(1)(ZL), (a)(1)(ZM), (a)(1)(ZN), (a)(1)(ZO), (a)(1)(ZP), (a)(1)(ZQ), (a)(1)(ZR), (a)(1)(ZS), (a)(1)(ZT), (a)(1)(ZU), (a)(1)(ZV), (a)(1)(ZW), (a)(1)(ZX), (a)(1)(ZY), (a)(1)(ZZ).
2. has not attained the age of 18 years or who is the subject of a certification issued by the federal government pursuant to Section 107(b)(1)(E) of the Victims of Trafficking and Violence Protection Act of 2000 (P.L. 106-386).

VOLUNTARY ACKNOWLEDGEMENT OF PATERNITY – An acknowledgement by both parents, that the man is the father of a child, provided in writing on a form. This acknowledgement establishes paternity of the child without a court hearing.

WAGE SUBSIDY – A payment made to a public or private employer to subsidize an employee’s wage or fringe benefits. A wage subsidy may be offered as an incentive for an employer to hire a welfare recipient. Funds used to provide wage subsidies may be made available through diversion of the public assistance grant or other funds.

WAGE WITHHOLDING – Procedure by which automatic deductions are made from wage or income to pay some debt such as child support; may be voluntary or involuntary.

WINDFALLS - One-time payments such as inheritances, court ordered settlements, lottery winnings and gifts.