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100 MAABD OVERVIEW

The MAABD Program is medical assistance for persons who are aged, blind or disabled AND meet the requirements of one of the eligible categories.

101 APPLICATION PROCESS

Upon request, every person will be mailed or given an application and a pamphlet explaining the Medicaid program.

Applicants will be provided assistance in completing the application if such help is requested.

A. DEFINITIONS

1. DISTINCTION BETWEEN APPLICATION AND INQUIRY

An application not signed by the client or authorized representative is an inquiry only and must be returned for signature. Do not date stamp the unsigned application and do not register it in the computer system. An application must contain the applicant's name, address and appropriate signature. Encourage the applicant to submit all pages of the application, however, the first page of Form 2905-EG must be accepted to preserve the actual application date and begin the application process.

Applicants who cannot sign their name must have their mark witnessed by at least one other person. Applicants with no ability to understand what they are signing must have a competent adult family member sign for them. Example: [client name] by [family member name].

If there are no family members or the existing family members do not wish to assist the applicant, the hospital, nursing home or county agency social service staff may sign on behalf of the applicant. Example: [client name] by [the hospital, nursing home or county agency social service worker name]. In this case, a public guardian referral is required.

NOTE: When a request for institutional Medicaid assistance is received on a regular application versus the "institutional application," send Home Care Questionnaire (Form 2915-EG) with Insufficient Information (Form 2429-EE or EEB) to request the information which is not addressed on the regular application from the individual or agency submitting the application.

Applications for the Medicare Beneficiary program received through the Low Income Subsidy referral process do not require a signature. The applicant's signature is obtained by Social Security.

2. INITIAL APPLICATIONS

Initial requests for an application for assistance may be made verbally, in writing, in person, or through a representative. Every person has the right to apply for assistance. The date a signed application form is received in the district office is the DATE OF APPLICATION.

3. FAXED APPLICATIONS

A faxed application is acceptable and must be date-stamped the day it is received to protect the applicant's filing date. Enter the faxed application into the computer system the date received or no later than the close of business the next work day. An original signature is required before approval of benefits. Notify the client and their authorized representative their faxed application has been received and request the client's original application and signature allowing at least 20 days to respond. This request may be made with other information required to process the case on an Insufficient Information Form 2429-EE. If the applicant fails to provide the original signed application, deny the case for non-cooperation.

4. REAPPLICATIONS

Reapplications for assistance are made in the same manner as initial applications. Previous records and eligibility factors must be thoroughly reviewed/verified. All information used to verify eligibility factors which are subject to change, may be pulled forward from previous application if the information is less than thirty (30) days old.

Terminated cases must reapply for assistance.

5. REINSTATEMENTS

Reinstatements are made at the discretion of the social services manager (SSM) or supervisor.

6. TRANSFERS

When the client has previously applied for/received assistance in another Division of Welfare and Supportive Services (DWSS) office, request the case file from that office.

7. DUPLICATE ASSISTANCE

Assistance can only be provided from one Nevada program at a time.

Nevada Medicaid programs include:

TANF	Temporary Assistance for Needy Families
CHAP	Child Health Assurance Program
CWS	Child Welfare Services (*Division of Child & Family Services*)
MAABD	Medical Assistance to the Aged, Blind & Disabled
CHECK-UP	Nevada Check-Up Program

When an applicant indicates he/she received benefits from another state within 3 months prior to the month of application, verification of benefits (in writing or by telephone) of case status must be obtained from the other state. Any income or resources revealed by the other state which were not claimed on the current application must be evaluated. Use Form 2258 and 2531.

8. CLIENT REPRESENTATION

Clients may designate anyone they choose to act on their behalf by using an authorized representative Form 2525 OR they may sign a "Release of Information" allowing the Division to release case information to individuals or agencies/organizations. With each subsequent reapplication, a new Form 2525 and/or Release of Information is required. It is not necessary at RD, unless the client indicates a change of A/R.

There are two types of authorized representatives called primary and secondary representatives. Legal guardians are considered primary representatives.

Power of Attorney status varies with each client. Therefore, obtain a completed Form-2525 designating the Power of Attorney as either primary or secondary representation.

A primary representative receives all requests for information along with any attachments plus all notices. They hold the same responsibility as the client in securing information for determining eligibility, reporting responsibilities and they are the only one authorized to sign on behalf of the client. Primary representatives also have the same access to case information as a client. **There will be only one primary representative.**

Secondary representatives receive all requests for information and notices. They are not held responsible for securing or reporting information. However if they choose, they may secure and report information to the division. Secondary representatives also have the same access to case information as a client.

When applicants are unable to designate an authorized representative AND there are no family members or the existing family members do not wish to assist the applicant, the hospital, nursing home or county agency social service staff may designate themselves as an authorized representative.

The hospital, nursing home or county agency must make good faith efforts to contact family members of the applicant for information to help determine eligibility. The hospital, nursing home or county agency must provide the names and addresses of family members they contacted or tried to contact.

The case manager will send Form 2534 to the relatives advising of the application, the hospital, nursing home or county agency representative and request any eligibility information to assist in processing the case.

9. SPOUSAL AUTHORIZATION

A spouse whose income and resources are countable in determining a client’s financial eligibility, and is not applying for or receiving assistance, must sign an Interface Consent, Form 2179-EE, authorizing the DWSS to interface with other federal and state agencies for information and verifications.

Upon receipt of this form, the case manager must record the authorization on the client's MBR3 screen. This will instruct the system to include the spouse in our interface requests.

B. APPLICANTS MUST BE INFORMED OF THE FOLLOWING (not all inclusive)

An overall description of the Medicaid program as follows:

1. Medicaid is medical coverage only; there is no cash grant.

2. Rights and obligations to the agency.

3. The agency's responsibility for maintaining confidentiality.

4. Information necessary to establish eligibility.

5. The client's/representative's role in establishing eligibility.

Client/Representatives are responsible for securing all information needed to determine eligibility within specified deadlines. Clients/Representatives are responsible for reporting all changes to the Division.

6. The agency's role in establishing eligibility.

7. Right to Appeal.

An explanation of the right to appeal any action or failure to act by the Division must be given to each applicant/representative. See Administrative Manual Section.

8. Nondiscrimination.

According to federal rules and regulations, no person will be subjected to discrimination (such as, race, sex, color, national origin, handicap, age, etc.) for any reason under any program of the Division.

Explain the following procedures to clients who feel they have been discriminated against and want to file a complaint:

Encourage the client to complete Form 2174-EG. Once the complaint is received, submit it to the social welfare manager (SWM) for investigation. Clients may submit the complaint to any Division office, Central Office or directly to the address below.

U.S. Office of Civil Rights
Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, California 94103
(415) 437-8310
Toll Free (800) 368-1019
TDD (415) 437-8311

C. FORMS GIVEN TO THE CLIENT WITH APPLICATION

1. 2179-EE Interface Consent Form
2. 3200-SM MEDICAID - TITLE XIX (pamphlet)
3. 6160-AF Medicaid Estate Recovery Notification of Program Operation

D. REPORTING THE APPLICATION

The application date and information must be registered in the computer system within two (2) work days.

See NOMADS Task Guide.

E. DISPOSITION OF APPLICATION

Individually determine eligibility for each month using the policy in effect for each month. When processing applications, authorize assistance for each eligible month. Clients may be determined eligible for some months and ineligible for others.

1. APPROVAL

Assistance is approved when eligibility requirements are met.

MEDICAID, SLMB AND QUALIFIED INDIVIDUALS

Assistance begins with the first day of the month for which a person is determined eligible. There is no partial month eligibility.

Example: Client applies November 11 and is approved effective November and ongoing. Medicaid eligibility coverage begins November 1st and ongoing.

QMB ONLY

Coverage begins with the first of the month following the month an eligibility decision is made.

Example: Client applies November 11th. The eligibility decision is made in December. QMB coverage begins effective January 1st and ongoing.

2. WITHDRAWAL

Applications are withdrawn when:

a. The client/representative initiates a voluntary request,

OR

b. The agency either loses contact with the client before eligibility is determined or information verifies the client is no longer at the Nevada address given. Document the situation in the case file.

3. DENIAL

Assistance is denied when:

a. Ineligibility is established;

OR

b. The client submits written information which indicates ineligibility;

OR

c. The client/representative fails to provide information essential to determine eligibility.

102 MEDICAID ELIGIBILITY PRIOR TO APPLICATION

Prior medical coverage is available for up to 3 months prior to the month of Medicaid application. Prior medical requests may be added during the pending period and during the 12 month period after approval provided the case remains open.

A. Prior Medicaid coverage must be requested; AND

B. There must be evidence (paper document or documented telephone call) medical care or services were provided in the month(s) for which Medicaid is requested; AND

C. The client must meet one of the eligible categories including citizenship documentation for each of the months coverage is requested.

A request for prior medical coverage is considered a separate application because it is for months predating the initial application. Therefore, approval, denial or pending of a prior medical request must always be addressed in a notice of decision to the household.

Do not delay an ongoing eligibility decision while obtaining information to determine prior medical eligibility. In addition, if the household is only requesting prior coverage, provide an ongoing eligibility decision at the time of the application.

103 CASE RECORDS

Casefiles will contain the current application or R/D, the original application, and all prior applications dating back 37 months. The original application must be retained in the current casefile.

104 MEDICAID HOSPICE CARE PROGRAM

Hospice care is a service available to Medicaid recipients who elect hospice care and are certified by a qualified physician as terminally ill. A certification of terminal illness means a person has a condition with a usual life expectancy of six (6) months or less if the condition runs its normal course.

Hospice care is comfort care as contrasted with active treatment directed toward cure of an illness or prolongation of life often with radical measures.

Medicaid will reimburse qualified hospice programs to provide four levels of care for Medicaid clients in accordance with HCFA directions and Medicare guidelines.

Enrollment into hospice services is a Division of Health Care Financing and Policy (DHCFP) function.

200 FACTORS OF ELIGIBILITY

201 AGED INDIVIDUALS

A client must be 65 years or older.

A. VERIFICATION (not all inclusive)

Client's statement is accepted unless there is reason to question it, whereby verification would then be required. Possible sources of verification are:

1. A determination by the Social Security Administration.
2. Birth Certificate. A copy of the birth certificate, hospital certificate, or a written statement from a county official regarding the birth record.
3. Baptism or confirmation record. A copy of the original document.
4. School records.
5. Newspaper notices. A dated newspaper clipping is acceptable if it gives the name and age/date of birth of the client.
6. Certificate of Naturalization
7. Passport. Record the date issued, full name, and age of client.

202 BLIND/DISABLED INDIVIDUALS

Clients under 65 years old must be blind or disabled. The Division of Welfare and Supportive Services (DWSS) blindness/disability criteria are the same as the Social Security Administration's (SSA).

When SSA determines a client is not blind or disabled, deny Medicaid for all months requested, whether or not the SSA determination covers each month of the Medicaid requested period, unless it is apparent SSA's decision is based on a disability different from that of the Medicaid period.

When SSA determines a client is disabled, use the SSA disability onset/start date as proof of blindness/disability for any months covered by the onset date.

If the SSI disability onset date is greater than the SSA application date, deny all months prior to the onset date including months not covered by SSA determination.

If the SSI disability onset date is the same as the SSA application date and Medicaid is requested for months prior to the SSI application date request a disability determination by sending a Disability/Incapacity Determination Request Form (3004) to the Division of Health Care Financing and Policy district office.

Example: Medicaid application date 10/20/2009 with prior medical request for three months. Client applied for SSI on 10/30/2009. SSI is approved with an onset date of 11/10/2009. 10/2009 and all prior medical months would be denied for no disability and no 3004 would be requested.

Example: Medicaid application date 3/20/2010 with prior medical request. Client applied for SSI 04/10/2010 and is approved with an onset date of 4/01/2010. Approve 4/2010 ongoing and send a 3004 to DHCFP district office for 3/2010 and prior medical months requested.

A. NEVADA MEDICAID OFFICE (NMO) DETERMINATION

Submit a completed Form NMO-3004 to the local Division of Health Care Financing and Policy office requesting a disability decision for the months assistance is requested. Form NMO-3004 must include dates of service and provider information. EXAMINATIONS WILL ONLY BE REQUIRED WHEN DEEMED NECESSARY BY NMO.

Nevada Medicaid will notify the case manager of disability decision on Form NMO-3004.

203 RESERVED FOR FUTURE USE

204 FURNISHING SOCIAL SECURITY NUMBERS

Social Security numbers must be provided by every applicant and recipient, except ineligible non-citizens applying for emergency medical assistance. Applicants who do not know their SSN or applicants who are under the age of 18 and do not have a SSN, must complete a SS-5 form. Provide Form SS-5 and instruct the clients to mail the completed SS-5 to the Social Security Administration.

Individuals who are 18 or older who have never been issued a SSN must apply at the Social Security Office and provide proof of application. Failure to comply with the Social Security Number requirements will result in ineligibility for Medicaid.

Exception: A state may provide a pseudo Social Security Number (SSN) to an applicant who, because of well established religious objections, refuses to obtain a SSN.) The term "well established religious objections" means the applicant:

- is a member of a recognized religious sect or division of the sect; and
- adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number.

A. VERIFICATION

Verification of SSN is not required from the applicant/recipient as a condition of eligibility. Instead, the SSN is verified through the NUMIDENT system, which is Social Security's database of SSNs. However, if there is a discrepancy in the SSN-Match, follow-up action must be accomplished and a resend completed within 30 days. (See Task Guide, – Case Management 02). Check the application and other available information in the case file to make sure the client's SSN, last name, date of birth and sex were entered into the computer correctly. Check SOLQ to see if the discrepancy can be identified. If Social Security records need to be updated, refer the client to the Social Security Administration.

Types of verification:

1. An SDX
2. A copy of a Social Security check
3. A Completed Form 1610
4. A letter from the Social Security Administration
5. A copy of the SSA Benefit Letter

205 RESIDENCE REQUIREMENTS

A. NON-INSTITUTIONAL PERSONS (INCLUDES SSI RECIPIENTS NOT RECEIVING SSP)

Clients must be living in Nevada with the intention of making Nevada their home permanently or for an indefinite period (no expected end date) OR must be living in Nevada with a job commitment or seeking employment. Clients are not required to have a fixed place of residence to meet this requirement.

The ability to indicate intent to reside in Nevada is not to be taken lightly or stand by itself. A statement or indication of intent to reside in Nevada must be supported by additional verification or collateral material to substantiate the intent if residency is questionable. Manual section 205,F is not all-inclusive.

Nevada residency continues when a client is temporarily absent and he/she intends to return to Nevada when the purpose of the absence has been accomplished. Document in the case file the temporary absence situation and obtain the client/representative's statement concerning the intent of residency and the purpose of the absence.

State Law NRS 217 allows victims of domestic violence to protect their location by applying for a fictitious address through the Secretary of State Office's Confidential Address Program (CAP). Anyone requesting to apply for this protection is referred to their local community domestic violence advocacy group. Local advocacy group staff will explain CAP and complete a domestic violence assessment. When advocacy group staff determines CAP is appropriate for the victim, they assist the victim in completing the application process and forward the application and a referral to the Secretary of State's Office. When an advocacy group has submitted a CAP application to the Secretary of State's Office or a victim has been approved for CAP, the Division of Welfare and Supportive Services (DWSS) must not require the person to provide their actual physical address. Persons pending a determination for CAP may use an alternative address (i.e., friend, relative or shelter address). Victims of Domestic Violence approved for CAP can use the fictitious address assigned by the Secretary of State's Office.

The Secretary of State's Office verifies Nevada residency; therefore, the Division does not require residence verification for individuals who have applied or been approved for CAP. To conceal the client's location, the actual physical address will not be maintained anywhere in the case file. Verifications received showing the actual physical address, are viewed with a narration written. The narration must include details such as the amount of rent or utilities, household composition, dates, etc.

B. SSI RECIPIENTS RECEIVING A STATE SUPPLEMENTARY PAYMENT (SSP) FROM ANOTHER STATE

State Supplementary Payments are funds paid in addition to the Federal SSI payment. SSP amounts differ from state to state. When the client is receiving SSI/SSP through another state, the state paying the State Supplementary Payment is the state of residence UNLESS SSA acknowledges Nevada residency. In this instance ONLY, use SSA's effective date of residency.

C SSI RECIPIENTS NOT RECEIVING A STATE SUPPLEMENT FROM ANOTHER STATE

If a client is receiving SSI from another state but that state is <u>not</u> paying a supplementary payment (SSP) establish residency under "A or D."

D. INSTITUTIONALIZED PERSONS (INCLUDES SSI RECIPIENTS NOT RECEIVING SSP)

1. DEFINITIONS

a. Incapability of Indicating Intent to Reside

Persons are considered incapable of indicating their intent to reside when they:

1) Have an IQ of 49 or less or have a mental age of 7 or less; or
2) Are found incapable of indicating their intent to reside as verified through medical documentation by a physician or licensed psychologist; or
3) Are judged legally incompetent.

b. Emancipated

Persons are considered emancipated when they are:

1) 18 or over; or
2) Married; or
3) Enlisted in the armed services; or
4) Emancipated by court order.

c. Abandoned

Persons are considered abandoned when:

1) Location of parents is unknown; or
2) Parental rights have been terminated.

2. INDIVIDUALS PLACED IN AN INSTITUTION BY A STATE

Residence is the state making or arranging placement. Any agency of the state, including an entity recognized under state law as being under contract with the state for such purposes, that arranges for an individual to be placed in an institution (includes foster care homes) located in another state, is recognized as acting on behalf of the state making a placement.

EXCEPTION: Children who receive Title IV-E adoption assistance or foster care payments are considered residents of the state in which they are placed.

3. COMPETENCY AND RELATIONSHIP TO AGE 21

Residency requirements are based on client's competency, ability to indicate intent and age. When a client is incompetent or unable to indicate intent, the age at which (s)he became incompetent or unable to indicate intent must also be determined.

a. Persons Capable of Indicating Intent Age 21 or Over; or Persons under Age 21 and Emancipated

The state of residence is that in which the client is living with the intention of making his/her home permanently or for an indefinite period of time. An indefinite period has no expected end date.

The ability to indicate intent to reside in Nevada is not to be taken lightly or stand by itself. A statement or indication of intent to reside in Nevada must be supported by additional verification or collateral material to substantiate the intent if residency is questionable. Manual section 205,F is not all inclusive.

Nevada residency continues when a client is temporarily absent IF he/she intends to return to Nevada when the purpose of the absence has been accomplished. Document in the case file the temporary absence situation and obtain the client/representative's statement concerning the intent of residency and the purpose of the absence.

b. Persons Who Became Incapable of Indicating Intent Before Age 21

The state of residence is:

1) That of the parent applying for Medicaid on the individual's behalf IF the parents reside in separate states (if a legal guardian has been appointed and parental rights are terminated, the state of residence is that of the guardian instead of the parent's);

2) The parent's or legal guardian's state of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the state of residence is that of the guardian instead of the parent's); OR

The current state of residence of the parent or legal guardian who files the application if the individual is institutionalized in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence is that of the guardian instead of the parent's).

3) The state of residence of the individual or party who files an application if the individual has been abandoned by his/her parent(s), does not have a legal guardian and is institutionalized in that state.

c. Persons under Age 21 and Not Emancipated

The state of residence is:

1) The parent's or legal guardian's state of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the state of residence is that of the guardian instead of the parent's); OR

The current state of residence of the parent or legal guardian who files the application if the individual is institutionalized in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence is that of the guardian instead of the parent's).

2) The state of residence of the individual or party who files an application if the individual has been abandoned by his/her parent(s), does not have a legal guardian and is institutionalized in that state.

d. Persons Who Became Incapable of Indicating Intent at Age 21 or Later

The state of residence is the state in which the individual is physically present, except if placed pursuant to manual section 205,D,2.

E. DISPUTED RESIDENCY

When Nevada Medicaid determines a client is a resident of another state and that state disagrees, the following procedures apply:

a. Require the client to provide a copy of the disputing state's denial/termination letter.

b. Process the Nevada Medicaid application to determine eligibility.

c. Notify the Chief of E&P by memo. Include:

1) Case name and number.

2) Copy of denial/termination letter from the disputing state.

3) Copy of NOMADS NOD showing approval/denial.

F. VERIFICATION (not all inclusive)

a. Rent/Mortgage receipt

b. Landlord statement

c. Nevada driver's license

d. Nevada vehicle registration

e. Utility bills/receipts

f. Victims of Domestic Violence approved for fictitious address receive a letter from the Secretary of State's Office containing an individual authorization code and substitute mailing address. Request and keep a copy of this letter in the case file for verification. Request the client to provide a statement from the domestic violence advocacy group to verify a pending CAP application.

g. Award letter for Social Security

h. Employer's statement

i. Statement from a friend, relative or other person who is knowledgeable about the client's residency

j. State Data Exchange (SDX).

k. SSA State Online Query (SOLQ)

206 CITIZENSHIP AND IDENTIFICATION REQUIREMENTS

All persons applying for assistance must, as a condition of eligibility, sign the application form certifying they are United States citizens or non-citizens in lawful immigration status. If the person for whom the application is being submitted is unable to sign, the authorized representative may sign for him/her. Once signed, the declaration is valid for all subsequent applications, unless the claim of citizenship or non-citizen status is questionable.

Clients must be a U.S. citizen or a non-citizen who meets the eligibility criteria in the table below:

Program	"Qualified" Non-Citizens Who Entered the U.S. Before 8/22/96	"Qualified" Non-Citizens Who Entered the U.S. on or After 8/22/96	"Not Qualified" Non-Citizens
Medicaid	Eligible if: ● LPR ● residing under PRUCOL ● attains citizenship ● battered*** non-citizen	Eligible only if: ● were granted status as - refugee - asylee - withholding of deportation - Cuban/Haitian - Amerasian immigrant ● is a veteran, active duty military, - or a spouse, - or a surviving spouse who has not remarried - or a child ● have been in "qualified" non-citizen status for 5 years or more ● battered*** non-citizen who has served 5-year bar ● attains citizenship	Eligible only if: ● were receiving SSI on 8/22/96 ● American Indian born abroad ** ● victim of trafficking and their spouse and children
Emergency Medicaid (see MS 390)	Eligible if: ● not a qualified non-citizen	Eligible if: ● does not meet any of the criteria listed above	Eligible

Program	"Qualified" Non-Citizens Who Entered the U.S. Before 8/22/96	"Qualified" Non-Citizens Who Entered the U.S. on or After 8/22/96	"Not Qualified" Non-Citizens
Medicare "Premium Free" Part A (hospitalization) (eligibility based on work history)	Eligible	Eligible	**Eligible only if:** ● Lawfully present, and eligibility for assistance is based on authorized employment
Premium "Buy-in" Medicare	**Eligible only if:** ● Lawful permanent resident who has resided continuously in the U.S. for at least 5 years	**Eligible only if:** ● Lawful permanent resident who has resided continuously in the U.S. for at least 5 years.	**Not Eligible**

Key – * Status as refugee, asylee, withholding of deportation/removal, Cuban/Haitian Entrant or Amerasian.

** Eligible if a Native American born in Canada possessing at least 50% blood of an American Indian race or a member of an Indian tribe as listed in manual section C-760.

*** Battered non-citizens must meet the requirements listed in manual section 206,E to be eligible.

A. VERIFICATION OF CITIZENSHIP AND IDENTITY

All applicants/recipients must provide documentation that verifies both citizenship and identity. To meet this requirement, an individual can provide a document that verifies both, or one document to verify citizenship and one to verify identity.

The documentation of citizenship is a one-time occurrence. Once the verification of citizenship and identity is received, the recipient must not be required to provide it again. The verifications should be placed in the permanent section of the case file and never purged.

All documents must be either originals or copies certified by the issuing agency.

Certain individuals are not required to provide documentary evidence of identity or citizenship.

- Individuals who are Medicaid eligible and are entitled to enroll in Medicare benefits;
- Receiving Social Security benefits based on disability (SSDI) or receiving Supplemental Security Income SSI);
- Receiving child welfare benefits under Title IV-B, adoption or foster care assistance under Title IV-E.

If a household provides all requested verifications within the 20 day period, except for verification of citizenship for all required household members, approve the case and allow the household 90 days from the date of approval to provide satisfactory documentation of citizenship. If the required citizenship documentation is not provided by the end of the 90 day period, terminate assistance allowing adverse action. Only allow one 90 day period to provide citizenship documentation.

The 90-day period is not applicable to prior medical months.

Do not request citizenship documentation for individuals pending a SSI determination. If SSI is approved, the individual will be exempt from citizenship documentation requirements.

1. PRIMARY VERIFICATION

If the applicant/recipient is able to provide one of these documents, no further documentation is required.

The following forms of documentation are acceptable for citizenship and identity:

- United States Passport
- Certificate of Naturalization (Forms N-550 or N-570)
- Certificate of United States Citizenship (Forms N-560 or N-561)
- A document issued by a federally recognized Indian tribe evidencing membership or enrollment in, or affiliation with such tribe. (Ex: Tribal enrollment card, certificate of degree of Indian blood) See manual section C-760 for a list of federally recognized tribes.

NOTE: Although Certificates of Naturalization and Certificates of U.S. Citizenship are marked with a warning regarding photocopying the document, states are authorized to do so since it is a requirement under federal regulations.

2. SECONDARY VERIFICATION

If the applicant/recipient cannot present one of the documents listed as primary verification, the case manager must obtain suitable documentation of citizenship and identity from the categories listed below.

The following documents are acceptable for proof of citizenship. A separate document for proof of identity is required.

- A U.S. birth certificate from one of the following. A birth record document may be issued by the state, Commonwealth, territory or local jurisdiction. It must have been recorded before the person was 5 years of age.
  - 50 United States
  - District of Columbia
  - American Samoa
  - Swain's Island
  - Guam (on or after April 10, 1899)

The following will establish U.S. citizenship for collectively naturalized individuals:

Puerto Rico:

a. Evidence of birth in Puerto Rico on or after April 11, 1899 and the applicant's statement that he or she was residing in the U.S., possession, or Puerto Rico on January 13, 1941; or

b. Evidence that the applicant was a Puerto Rican citizen and the applicant'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:

a. Evidence of birth in the U.S. Virgin Islands, and the applicant's statement in the U.S., a U.S. possession, or the U.S. Virgin Islands on February 25, 1927; or

b. The applicant'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

c. Evidence of birth in the U.S. Virgin Islands and the applicant'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) (*formally part of the Trust of the pacific Islands* (TTPI)):

a. 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's statement that he or she did not owe allegiance to a foreign State on November 4, 1986 (NMI local time); or

b. Evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration before January 1, 1975 and the applicant's statement that he or she did not owe allegiance to a foreign State on November 4, 1986 (NMI local time); or

c. Evidence of continuous domicile in the NMI since before January 1, 1974 and the applicant's statement that he or she did not owe allegiance to a foreign State on November 4, 18=986 (NMI local time).

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.

- A Certification of Report of Birth issued by the Department of State (DS-1350)
- Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240)
- A Certification of Birth issued by the Department of State (FS-545 or DS-1350)
- A United States Citizen Identification Card (I-197 or I-179)
- An American Indian Card (I-872) issued by DHS with the classification code "KIC"

- Northern Mariana Identification Card (I-873)
- Final Adoption Decree showing name and U.S. place of birth
- Evidence of Civil Service employment by the U.S. government before June 1, 1976
- Official Military Record (i.e., DD-214) showing a U.S. place of birth.
- Department of Homeland Security's Systematic Alien Verification for Entitlement (SAVE).
- Child Citizenship Act
  - At least one parent of the child is a United States citizen by either birth or naturalization (as verified under the requirements of this Part);
  - The child is under the age of 18;
  - The child is residing in the United States in the legal and physical custody of the U.S. citizen parent;
  - The child was admitted to the United States for lawful permanent residence (as verified under the requirements of 8 U.S.C. 1641 pertaining to verification of qualified alien status); and
  - If adopted, the child satisfies the requirements of section 101(b)(1) of the Immigration and nationality Act (8 U.S.C. 1101 (b)(1) pertaining to international adoptions (admission for lawful permanent residence as IR-3 (child adopted outside the United States)), or as IR-4 (child coming to the United States to be adopted) with final adoption having subsequently occurred).

3. THIRD LEVEL VERIFICATION

The following documents are acceptable only if primary and secondary documentation is not available. A separate document for proof of identity is required.

- Extract of U.S. hospital record of birth established at the time of the person's birth, was created at least 5 years before the initial application date, and indicates a U.S. place of birth. . (*For children under 16, the document must have been created near the time of birth or 5 years before the date of application.*) **DO NOT** accept a souvenir "birth certificate" issued by the hospital.
- For children under 16, the document must have been created near the time of birth or 5 years before the date of application.
- Life, health or other insurance record showing a U.S. place of birth and was created at least 5 years before the initial application date.
- Religious records recorded in the U.S. within 3 months of birth, showing the birth occurred in the U.S. and showing either the date of the 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. **NOTE:** If questionable, the State must verify the religious record and/or document that the mother was in the U.S. at the time of birth.
- Early school records showing a U.S. place of birth. The school record must show the name of the child, the date of admission to school, date of birth, a U.S. place of birth and the name(s) and place(s) of birth of the applicant's parents.

4. FOURTH LEVEL VERIFICATION

The following documents are acceptable only if primary, secondary and third level documentation is not available. A separate document for proof of identity is required.

- Federal or State census record showing U.S. citizenship or a U.S. place of birth (generally for persons born from 1900 through 1950).
- One of the documents listed below created at least 5 years before the application for Medicaid and must show a U.S. place of birth.
  - 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.
  - A delayed U.S. public birth record that is recorded more than 5 years after the person's birth.
  - Statement signed by the physician or midwife who was in attendance at the time of birth.
  - Roll of Alaska Natives maintained by the Bureau of Indian Affairs
- Institutional admission papers from a nursing facility, skilled care facility or other institution and was created at least 5 years before the initial application date and indicates a U.S. place of birth.
- Medical (clinic, doctor or hospital) record created at least 5 years before the initial application date and indicates a U.S. place of birth. (*For children under 16, the document must have been created near the time of birth or 5 years before the date of application.)* **NOTE:** an immunization record is not considered a medical record for purposes of establishing U.S. citizenship.
- Written Affidavit

  Affidavits should **ONLY** be used in rare circumstances. An affidavit must be completed by at least two individuals of whom one is not related to the applicant/recipient and who have personal knowledge of the event(s) establishing the applicant's/recipient's claim of citizenship. The person(s) making the affidavit must be able to provide proof of his/her own citizenship and identity for the affidavit to be accepted. Obtain a separate affidavit from the applicant/recipient or other knowledgeable individual explaining why the evidence does not exist or cannot be obtained. All affidavits must be signed under penalty of perjury and DO NOT need to be notarized.

5. ACCEPTABLE VERIFICATION OF IDENTITY

The following documents can be accepted as proof of **identity** in combination with proof of citizenship. **DO NOT** accept a voter's registration card or Canadian driver's license to verify identity.

- Driver's license issued by the 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.
- Certificate of Degree of Indian Blood, or other American Indian/Alaska native tribal document with a photograph or other personal identifying information.

- Identification card issued by the federal, state or local government with the same information included on drivers' licenses.
- School identification card with a photograph of the individual.
- U.S. military card or draft record.
- Military dependent's identification card.
- U.S. Coast Guard Merchant Mariner card.
- Children who are under the age of 16 may have their identity documented using other means when the child does not have or cannot get any of the documents listed above. These include:
  - School record.
  - Clinic, doctor or hospital record.
  - Daycare or nursery school record .
  - Affidavit signed under penalty of perjury by a parent, guardian or caretaker relative attesting to the child's identity.

NOTE: To establish identity a document must show evidence that provides identifying information that relates to the person named on the document.

- Any combination of three or more corroborating documents to prove identity, such as marriage license, divorce decree, high school and college diploma, employer ID card and property deed and title. These cannot be used when applicant submitted a fourth level verification of citizenship.
- Disabled individuals living in institutional care facilities may have their identity documented using an affidavit signed by a director or administrator where the individual resides.

B. VERIFICATION OF NON-CITIZEN STATUS

Non-citizens must provide documentation that verifies qualified non-citizen status. Qualified non-citizen status is based upon the section of the Immigration and Naturalization Act (INA) under which they are residing in the United States.

1. VERIFYING NON-CITIZEN STATUS USING THE SYSTEMATIC ALIEN VERIFICATION TO ENTITLEMENTS (SAVE) SYSTEM

ALL non-citizens, except SSI recipients and victims of trafficking, who apply for assistance, must be verified through the Department of Homeland Security SAVE program. Staff can access the Department of Homeland Security's website at https://.vis-dhs.com/WebOne/vislogin.aspx?JS=YES. SAVE processing is required whether or not the alien's status is questionable.

The system shows the date of adjustment rather than the date the client entered the U.S. If the applicant claims an earlier date of entry into the U.S., they must provide proof. If the applicant claims to be a United States citizen, the system can verify that information as well. If you need additional information, please refer to the tutorial in the upper right hand corner of the VIS screen.

a. Primary Verification – The computer data base at the Department of Homeland Security SAVE website provides primary verification by the Verification Information System (VIS).

b. Additional Verification – Some circumstances require performing additional verification.

In the following circumstances, the worker will complete an electronic additional verification.

- The SAVE website advises the caseworker to complete "Additional Verification."
- The COA code indicates the LPR non-citizen may be sponsored.
- The LPR non-citizen indicates they have been sponsored.

The following circumstances require the case manager to request a manual "Additional Verification" directly from USCIS.

1) Any of the items presented as documentation appear counterfeit or altered.
2) An individual presents unfamiliar USCIS documentation, or a document that indicates immigration status, but does not contain an A-Number.
3) The document contains an A-Number in the A60 000 000 or A70 000 000 series. These ranges have not been issued.
4) The document contains an A-Number in the A80 000 000 series. This range is used for illegal border crossings.
5) The document presented as a Form I-689 or Form I-688 annotated with 210(a). These documents will always contain A-Numbers in the A90 000 000 series. This range is used for participants in the legalization (amnesty) or Special Agriculture Worker (SAW) programs. Because they are amnesty participants, policy requires the non-citizen's authorization, with original signature before secondary verification is performed.
6) The document presented as a letter, a fee receipt, or anything other than an established USCIS form.
7) The document presented is an I-181, or an I-94 in a foreign passport that bears the endorsement "Processed for I-551, Temporary Evidence of lawful Permanent Residence," AND the I-181 or I-94 is over one year old.

Complete a Form G-845S, SAVE Document Verification Request for each person requiring additional verification. Include the Alien registration Number or I-94 Number, name, nationality, date of birth, SSN, ASVI verification number, benefit type and case number. Attach readable photocopies (front and back) of immigration documents containing the registration number. If the individual's name has changed since the USCIA registration card was issued, also attach a document that verifies the name change.

Form 2768-EG SAVE Consent for Disclosure, may be used as a consent form for processing G-845 forms.

The name and address of the requesting office is provided in the block labeled "FROM". The G-845S can be accessed on the USCIS website at www.uscis.gov.

Mail to: U.S. Citizenship and Immigration Services
Attn: Immigration Status Verification Unit
300 N. Los Angeles Street, B120
Los Angeles, CA 90012

USCIS will research the non-citizen's records, complete the response portion of the form and return both the form and the attached photocopies to the requesting office within ten working days of receipt. The Immigration Status Verifier (ISV) checks all appropriate statements on the lower half and back of the form to indicate the applicant's immigration status and work eligibility. The ISV will initial and stamp the front of the form in the block labeled "stamp".

When using secondary verification, of the non-citizen is otherwise eligible, do not delay, deny, or reduce the household's benefits while waiting for a response from USCIS.

When the G-845 is returned and the response indicates the non-citizen's document is not valid, disqualify the individual (allowing adverse action) or deny the application as appropriate and refer to I&R as possible fraud.

When the G-845 is returned and the response indicates the non-citizen's documents are valid, file the form in the permanent section of the eligibility file.

2. NON-CITIZEN STATUS

Determine if the individual claiming non-citizen status is a "qualified" or a "not qualified" non-citizen.

"Qualified" non-citizens include the following:

- Lawful Permanent Residents (LPRs)
- Refugees
- Asylees
- Persons granted withholding of deportation or removal
- Conditional Entrants
- Persons granted parole for a period of at least one year
- Cuban/Haitian entrants
- Certain Abused non-citizens

"Not-Qualified" non-citizens include all non-citizens without status on the above categories.

- Non-citizen students
- Undocumented non-citizens
- Citizens of the Federated States of Micronesia, Marshall Island and Republic of Palau.

Use the non-citizen's USCIS document(s), USCIS letter, a court order or a passport and other resources listed in the following sections to determine the non-citizen's qualified status.

Determine when individuals currently in "Qualified" non-citizen status began residing ion the United States.

For individuals who entered the United States prior to **August 22, 1996:**

Determine the date the individual began residing in the United States using the earliest verified date the person entered and continually resided in the country, regardless of the individual's legal status at the time they entered the United States.

For individuals who entered the United States on or after **August 22, 1996:**

These individuals must meet one of the categories listed in the chart in MAABD 206. For those individuals who must serve the five-year bar, the five-year bar begins with the date the individuals attained "Qualified" non-citizen status as determined by USCIS.

C. REVERIFICATION OF IMMIGRATON STATUS DUE TO AN INS DOCUMENT'S EXPIRATION DATE

When an eligible non-citizen's INS document has an expiration date, schedule a review of eligibility the month the document expires (unless the regular review occurs first).

Reverify the individual's status using SAVE if they want to continue receiving or are reapplying for benefits. Allow the person twenty (20) days to update their status with INS if they cannot provide an updated document. Disqualify the individual who no longer has acceptable immigration status.

Cuban/Haitian entrants whose Form I-94 has an expiration date of 1/15/81 may have a different current resident status assigned to them. Reverify their status using SAVE.

If an individual has been in prison since they last applied, regardless of the expiration date on the document on file, request to review their current document or call SAVE. Their residence may have been revoked, or they may have been issued a different status affecting their eligibility.

D. DOCUMENTATION OF VETERAN STATUS

Non-citizens may be eligible for certain benefits if they are veterans, on active military duty, or are the spouse or dependent child of a veteran or person on active military duty. This category also applies to certain reserve members, as specified in this section.

1. Definition of a Veteran

Individuals who actively served with the United States Armed Services whether or not they were citizens who:

- meet the minimum active duty requirement of 24 months, served for the period of time they were called to active duty, or have an honorable discharge;
- were military personnel and died during active duty; or
- were Filipinos who served in the Philippine Commonwealth Army during World War II or as Philippine Scouts after the war.

2. Spouses, Surviving Spouses, and Dependent Children of a Veteran

Individuals may qualify for certain benefits if they are a spouse, surviving spouse, or dependent child of a veteran and meet the appropriate criteria. Individuals claiming this status must show the same documentation as the veteran or active duty member. If the documentation is not available, they should be referred to the local VA regional office for verification of veteran status. **Note**: The VA will not verify the relationship, so relationship must be established using regular verification procedures for this requirement.

a. Spouse

The individual must be currently married to the veteran.

b. Surviving Spouse

- Must not have remarried; and
- Was married to the veteran or active-duty personnel within fifteen years after the termination of the period of service in which the injury or disease causing the death of the veteran was incurred or aggravated; and
- Was married to the veteran or active-duty personnel for one year or more; or
- a child was born of the relationship between the surviving spouse and the veteran or active-duty personnel, either during or before the marriage.

c. Dependent Child

- Must be unmarried; and
- Must meet program criteria under which benefits are being applied for to be considered as a dependent child.

3. Verification of Veteran Status

a. Discharged Members

A discharge certificate, DD-214 or equivalent, which meets the following criteria, is acceptable verification without further inquiry, unless the certificate appears to be altered or is otherwise irregular:

- It must show active duty in either the United States Army, Navy, Air Force, Marine Corps or Coast Guard; and
- It must show "Honorable" discharge ("Under Honorable Conditions" is not acceptable); and
- The individual must meet a minimum active duty requirement of two years or more in one of the branches listed above, unless their certificate shows an enlistment date prior to September 7, 1980 (there is no minimum active duty requirement for these individuals).

Refer the individual to the local Veterans' Administration Office to have VA staff determine satisfaction of the minimum active duty service and provide the applicant with documentation of their military status in the following circumstances:

- The discharge certificate shows "Honorable," but shows a branch of service not listed above. (Examples include: National Guard, active duty for training, inactive duty, etc.);
- The individual claims veteran status but has no documentation; or
- The document shows active duty of less than two years with an original enlistment date on or after September 7, 1980.

b. Active Duty Members

Active duty as a member of the U.S. Armed Forces means the individual is on full-time duty in the United States Army, Navy, Air Force, Marine Corps or Coast Guard. It does not include full-time National Guard duty.

Service members on active duty may establish their status by presenting a current Military Identification Card (DD Form 2 - Active), that lists an expiration date of more than one year from the date of the eligibility determination.

If the Military Identification Card is due to expire within one year from the date of determination, the service member may verify active duty by showing a copy of their current military orders.

If the service member is unable to furnish a copy of their orders, active duty may be verified through the nearest RAPIDS (Real Time Automated Personnel Identification System) which is located at many military installations, or by notifying the following in writing (which can be faxed):

DEERS Support Office
ATTN: Research and Analysis
400 GIGLING ROAD
SEASIDE, CA 93955-6771
FAX: (408) 655-8317

c. Reserve Members (Not On Active Duty For Training)

Active duty for training is temporary full-time duty in the Armed Forces performed by members of the Reserves, Army, National Guard, or Air National Guard for training purposes. Active duty for training does not establish eligible status. However, a discharge from active duty for training may establish veteran status and the applicant should be referred to the VA for a determination.

A member of a Reserve Component must establish their status by showing a current DD Form 2 - Reserve (red) and military active duty orders showing they are on active duty, but not on active duty for training. No other method for verifying this status is currently available.

E. DEFINITION OF BATTERED NON-CITIZEN

A battered non-citizen is:

a. An **adult or their child(ren)**, lawfully residing in the United States on August 22, 1996, who has been battered or subjected to extreme cruelty in the United States by a U.S. citizen or LPR who is:

- a spouse or a parent, or
- a member of the spouse or parent's family residing in the same household as the non-citizen (and the spouse or parent consented to, or acquiesced in the battery or cruelty).

b. A non-citizen, lawfully residing in the United States on August 22, 1996, whose child has been battered or subjected to extreme cruelty in the United States by a U.S. citizen or LPR who is:

- a spouse or a parent of the non-citizen (without the active participation of the non-citizen in the battery or cruelty), or
- a member of the spouse or parent's family residing in the same household as the non-citizen (and the spouse or parent consented to, or acquiesced in the battery or cruelty and the non-citizen did not actively participate).

F. IRAQI AND AFGHANI SPECIAL IMMIGRANTS

Effective December 26, 2007, Public Law 110-161, the Consolidated Appropriations ct of 2008 granted Iraqi and Afghan non-citizens special immigrant status under section 101(a)(27) of the Immigration and Nationality Act (INA). Individuals and family members granted this special immigrant status are eligible for resettlement assistance, TANF and entitlement programs including Medicaid and SNAP and other benefits the same as other refugees admitted under section 207 of the INA, except the period of eligibility cannot exceed eight months for Afghani and Iraqi immigrants.

Verification of Special Immigrant Status

For Medicaid program purposes, Iraqi and Afghan non-citizens and family members who claim special immigrant status must provide verification they have been admitted under section 101(a)(27) of the INA.

Afghans and some Iraqi special immigrants will have an Immigrant Visa category of SL1–S19 and some Iraqis will have an Immigrant Visa category of SQ1–SQ9.

Date of Eligibility and Certification Period

The effective date of eligibility as a qualified non-citizen is from the date the special immigrant enters the United States. The special immigrant's period of eligibility for Medicaid cannot exceed eight months from the special immigrant's date of entry, regardless of when they apply for benefits.

The effective date of eligibility is the date of application for all programs. These immigrants must meet all eligibility requirements for any program applied for. Special immigrants applying under this status are not eligible for prior medical coverage.

G. PRUCOL

Public Law 105-306 (Agricultural Research Extension and Education Reform Act of 1998) restored Medicaid eligibility to certain non-citizens residing in the U.S. prior to January 1, 1972. Individuals who are permanent residents under color of law (PRUCOL) are eligible for Medicaid if they were receiving SSI benefits on August 22, 1996. The PRUCOL chart is used to verify Social Security Numbers issued prior to January 1, 1972. The chart in Appendix G established PRUCOL eligibility.

H. VICTIMS OF TRAFFICKING

Under the Trafficking Victims Protection Act, adult victims of trafficking who are certified by the Office of Refugee Resettlement (ORR) at the Department of Health and Human Services are eligible for benefits to the same extent as refugees. Children who have been subjected to trafficking are also eligible like refugees but do not need to be certified. As of November 6, 2001, certification letters issued for adults and eligibility letters for children will no longer contain an expiration date. Individuals who were certified before this date received letters from 8-month expiration dates. As these letters expire, ORR will issue recertification letters without expiration dates.

Victims of Trafficking are awarded a T-Visa for entry. Certain members of their family may also apply for and receive a Derivative T-Visa and meet eligibility under refugee criteria.

If the victim of trafficking is under 21 at the time the T-Visa application was filed, Derivative T-Visas are available to the following members of their immediate family: spouse, children, unmarried siblings (under 18 at the time the application was filed) and parents of the victim of trafficking.

In the case where an application is filed after the individual turns 21, only the victim's spouse and children are eligible to apply for the Derivative T-Visa.

When a victim of trafficking applies for benefits, all eligibility requirements must be met except the following:

1. Victims are not required to provide any documentation of their immigration status. Accept the original OR recertification letter or letter for children in place of INS documentation. The "entry date" will not change on the recertification letter.

2. Call the trafficking verification line at (202) 401-5510 to confirm the validity of the certification letter or letter for children and notify ORR at HHS of the benefits for which the individual is applying.
3. Note the "entry date" for refugee benefit purposes. The individual's "entry date" is the certification date listed in the letter.
4. Call the trafficking verification line at (202) 401-5510 for assistance when having difficulty confirming identity.
5. Assist the individual in applying for a non-work Social Security Number.
6. Issue benefits to the same extent as a refugee.
7. Record the expiration date of the certification letter or letter so a review of eligibility will be done at the appropriate time.

207 SSI APPLICATION AND DETERMINATION

A. REQUIRED

Medicaid applicants in the following categories must provide written verification of Supplemental Security Income (SSI) application or receipt of SSI as a Nevada Resident. Allow applicants at least 20 calendar days to provide this proof. Failure to provide proof of SSI application or receipt of SSI within the specified time will cause denial.

Failure to pursue an SSI claim or failure to provide information essential to establish the claim will result in denial or termination of assistance including all prior medical requests associated with the application.

1. PERSONS NOT IN AN INSTITUTION WITH TOTAL COUNTABLE INCOME LESS THAN SSI PAYMENT LEVELS

   Medicaid will NOT be approved until the client is approved for SSI by SSA. This includes individuals who have temporary residency status.

2. PERSONS IN AN INSTITUTION WITH TOTAL COUNTABLE INCOME LESS THAN $30

   A Medicaid eligibility decision will NOT be made until an SSI determination is received. This includes individuals who have temporary residency status. (See State Institutional Category for possible eligibility if SSI is denied.)

   Exception: Children receiving Medicaid under 1902(e)(3) (Katie Beckett) of the Social Security Act who enter an institution for long-term care. An SSI application must be made, however, there will be no break in Medicaid eligibility pending a decision from SSI.

B. NOT REQUIRED

SSI application and determination by SSA is not required for:

1. Deceased individuals who were institutionalized during the period Medicaid is requested.

2. Applications requesting only prior Medicaid eligibility as long as the client does not have an outstanding pending SSI determination for those months.

3. Institutionalized individuals with total net countable income of $30 or more.

208 INSURANCE COVERAGE

Medicaid is always payer of last resort whenever another resource may be responsible for payment, with the exception of Children with Special Needs, Indian Public Health Service (PHS), or Victims of Crime.

When insurance coverage is available at no cost to the client (e.g., through employment or Tricare, or as a veteran through the Veterans Administration), request the client to enroll. Assistance will be denied or terminated if the client refuses to apply for, pursue, or provide information necessary to establish insurance coverage/claims and/or fails to cooperate in the collection process from a third party.

NOTE: Ask the applicant to apply for Medicare if available. Do not deny if they fail to cooperate if the client is responsible for paying the premiums prior to state Buy-In accretion.

A Medicaid recipient must cooperate in pursuing Medicare Part B, if available, as a condition of continuing eligibility, since it would be available at no cost due to the state Buy-In. (See manual section 208.C.3 regarding Medicare Part A.)

If a client already has other health coverage, Nevada Medicaid is not liable for health care services if the client elects to seek treatment from a provider not authorized by their health care coverage.

A. NOTIFICATION OF THIRD PARTY LIABILITY (TPL) TO THE FISCAL INTERMEDIARY

TPL is any individual, entity, or program that is, or may be, liable to pay all or part of the medical cost for medical assistance furnished to a Medicaid recipient.

The purpose of TPL is to reduce erroneous expenditures by maximizing use of third party resources BECAUSE Medicaid is PAYER OF LAST RESORT.

Notify the fiscal intermediary of third party liability and changes to such by recording all known information on the NOMADS MINS or MEDI screens.

Subrogation is the right of the state to stand in place of the client in the collection of third party resources.

When the client has an accident or job related injury, was injured while in the custody of a law enforcement agency, or received insurance reimbursements for Medicaid-paid bills, the Medical Subrogation form 2511 must be completed providing details and any legal action involved. Once completed, the form is forwarded along with any supporting information to the fiscal agent at:

Emdeon
Attn: Subrogation Unit
3055 Lebanon Pike Suite 1000
Nashville, TN 37214

The fiscal intermediary will request completion of form 2511 whenever a trauma incident (accident) is reported to the fiscal intermediary through an outside source. However, the fiscal intermediary is not to request "additional investigations" through district office staff. If this should occur, notify the Chief of Eligibility and Payments in Central Office.

Clients are required to report and surrender all monies received for reimbursement of medical care and treatment being billed to or previously paid for by the Medicaid program. When monies are received by district offices, a Payment Receipt, Form 1070-MF, is completed and all available information and accompanying documentation (e.g., insurance explanation of benefits) should be obtained. All monies must be deposited into the State's account in accordance with deposit procedures. A copy of the receipt is sent to Accounting in Central Office. DO NOT APPLY THESE MONIES TO PATIENT LIABILITY. When monies are received by a medical provider other than the one who provided the medical services, all monies must be deposited into the State's account in accordance with deposit procedures. A copy of the receipt is sent to Accounting in Central Office. If the client refuses to surrender the money, the case must be referred to the Deputy Attorney General for action.

B. MANDATORY PREMIUM PAYMENTS FOR COST EFFECTIVE EMPLOYER GROUP HEALTH INSURANCE

Section 4402 of OBRA 1990 requires states pay for premiums, deductibles, co-insurance and other cost sharing obligations for Medicaid recipients entitled to employer group health insurance.

The health insurance coverage must be cost effective and the enrollee must be Medicaid eligible. An individual's enrollment in a group health plan is considered cost effective if Medicaid payments for services are likely to be greater than the cost of paying the insurance premiums and other cost sharing obligations for the same set of services.

Enrollment in the group health plan is a condition of eligibility except when the individual is unable to enroll on their own behalf. A child will not be penalized if their parent fails to cooperate with this requirement for the child's benefit.

The case manager must obtain a completed form NMO-5000 and a copy of their insurance policy or benefits letter, if available, in the intake or ongoing eligibility process when group health insurance is available to the client. Failure to comply will cause denial or termination of assistance.

Mail the completed forms to Emdeon Attn: Subrogation Unit, 3055 Lebanon Pike Suite 1000, Nashville, TN 37214. If the health insurance is determined to be cost effective, premiums will be paid to the employer or insurance carrier through Medicaid. Premiums which can only be paid through a payroll deduction will be reimbursed directly to the client. These reimbursements are exempt income to the client.

C. MEDICARE AND BUY-IN/BENDEX

1. MEDICARE

Medicare is Social Security's health insurance program. Medicare has two types of coverage Part A - Hospital Insurance: and Part B-Medical Insurance.

2. PERSONS ELIGIBLE FOR MEDICARE

a. All persons OVER AGE 65 who are either a U.S. citizen; or an alien lawfully admitted for permanent residency who has resided in the U.S. continuously 5 years immediately preceding the month the alien applies for Medicare.
b. Persons UNDER AGE 65 who have received monthly Social Security/Railroad Retirement disability benefits for 24 months.
c. Persons with chronic renal disease.

3. BUY-IN

Medicare is a prior resource to Medicaid. This helps cut Medicaid costs and it is to our advantage to ensure a recipient remain eligible for this coverage.

Welfare does not normally pay for Medicare Part A. In most instances, this premium is free to those who are entitled. Those who must pay for this premium have a suffix "M", "J" or "K" on their Medicare claim number.

EXCEPTION: The Medicare Catastrophic Coverage Act of 1988 mandates all ***recipients*** who qualify under the QMB category of assistance will have their Part A premium covered by Medicaid. QMBs will be accreted effective the date eligibility begins. (The month immediately following the month the decision is made.)

Due to cost savings realized, the Division has elected to pay the Part B Medicare premium for all Medicaid recipients enrolled in Medicare.

Buy-In regulations require different time periods for when a client can be initially accreted (added) to the Buy-In. The accretion time is based upon the type of assistance the person is eligible for under Medicaid. The following are the guidelines for when a person must be accreted:

a. CASH RECIPIENTS (RECEIVING TANF, SSI OR IV-E) NOT ELIGIBLE FOR QMB COVERAGE - These recipients are eligible to have only Part B paid by Medicaid and must be accreted to buy-in effective the date of Medicaid <u>eligibility</u>.

EXAMPLE: A client applies December 15th and requests prior medical coverage for September, October and November. The case is approved on February 2nd for September and ongoing. Buy-in accretion is effective September and the client WILL receive a reimbursement from Social Security for months they paid the Medicare premium. (This is why the premium is not a deduction when determining patient liability for these months.)

b. CASH RECIPIENTS (RECEIVING TANF, SSI OR IV-E) ELIGIBLE FOR QMB COVERAGE - These recipients are eligible to have both Part A and Part B paid by Medicaid. However, the dates when they can be accreted are as follows:

1) Part A for these recipients must be paid (bought in) effective the month QMB eligibility begins.

EXAMPLE: Client applies December 4th as an SSI case. On January 15th the case is approved as an SSI case effective December ongoing. This client is also eligible for QMB coverage, which begins the month after the month of decision, or February. Therefore, the Medicare Part A premium will be bought in effective February.

2) Part B for these recipients is picked up beginning with the month of Medicaid eligibility as usual. In the above example, the Part B premium would be bought in effective December.

c. MEDICAL ONLY RECIPIENTS (NOT RECEIVING TANF, SSI OR IV-E) NOT ELIGIBLE FOR QMB COVERAGE WITH INCOME ABOVE THE SLMB LIMIT - These recipients are eligible to have only the Medicare Part B premium bought in. The Part B premium must be bought in beginning with the second month after the month of Medicaid approval. Any months prior to this, the client may be financially responsible for the premiums and may not receive a reimbursement even if Medicaid is approved for those months.

EXAMPLE: A client applies December 15th and requests prior medical coverage for September, October and November. The case is approved February 2nd for September and ongoing. The first month the Division can begin to pay the Part B premium is April. The premiums for September through March are the client's responsibility; they WILL NOT receive a reimbursement for those months. (That is why they are allowed the expense when determining patient liability for these months.) If the person is accreted on the Buy-In after April, he will receive a reimbursement of the premium paid for April. (This is why we cannot allow the premium as a deduction beginning the second month after the month of Medicaid approval.)

d. MEDICAL-ONLY RECIPIENTS (NOT RECEIVING TANF, SSI, OR IV-E) ELIGIBLE FOR QMB COVERAGE B These recipients are eligible to have both Medicare Part A and Part B bought-in. Because of the QMB coverage, these individuals are eligible for Part B to be paid one month earlier than the other group of Medical-Only recipients. Therefore, these recipients must have both Part A and Part B bought in beginning with the month QMB coverage begins.

EXAMPLE: Client applies as a state institutional case December 15th. On January 20th the case is approved as a state institutional case eligible for QMB coverage. Medicaid assistance begins December, QMB coverage begins February. Therefore, the Medicare Part A and Part B must be bought-in effective February. In these cases, the Part B premium could no longer be allowed as a deduction when determining patient liability beginning February.

e. QUALIFIED MEDICARE BENEFICIARIES (QMB) ONLY B These recipients are eligible to have both Medicare Part A and Part B premiums bought-in. These individuals must be accreted to the buy-in for both premiums effective the date of QMB eligibility.

EXAMPLE: Client applies December 15th. Case is approved January 3rd as a QMB only case. Eligibility for QMB begins February. Therefore, the client must be bought in for both Part A and Part B effective February.

f. SPECIAL LOW-INCOME MEDICARE BENEFICIARY (SLMB) are Medicare recipients with income between 100% - 120% of the federal poverty level. Medicaid pays their Medicare Part B medical insurance premiums. The Part B premium must be bought in effective the first of eligibility. Prior medical is available.

g. MEDICAL ONLY RECIPIENTS (NOT RECEIVING TANF, SSI OR IV-E) NOT ELIGIBLE FOR QMB COVERAGE WITH INCOME IN THE SLMB RANGE - These recipients are eligible to have only the Medicare Part B premium bought in. The Part B premium must be bought in effective the first month of eligibility. Prior medical is available.

EXAMPLE: A client applies December 15th and requests prior medical coverage for September, October and November. The case is approved February 2nd for September and ongoing. The first month the Division can begin to pay the Part B premium is September.

h. QUALIFYING INDIVIDUAL I (QI1) are Medicare recipients with income of at least 120%, but less than 135% of federal poverty level and not eligible for any other category of Medicaid. Medicaid pays their Medicare Part B medical insurance premiums. The Part B premium must be bought in effective the first month of eligibility. Prior medical is available.

i. QUALIFIED DISABLED WORKING INDIVIDUAL (QDWI) have their Medicare Part A hospital insurance premium paid by Medicaid. Eligibility begins with the application month, with three months of prior medical coverage available.

4. HOW THE BUY-IN PROCESS WORKS

When a Medicaid case is approved, the computer will automatically send a code to the Centers for Medicare and Medicaid (CMS) to accrete (enroll and begin paying the premium) this person to the Buy-In for the appropriate months.

When a case is terminated, the system will automatically request the person be terminated from Buy-In effective the date of Medicaid termination.

If the person is reinstated, the system will automatically send a request to reaccrete the person to the Buy-In.

The automatic accretions and deletions are completed with the information contained on the MEDI screen. The computer file includes names, birth date, Social Security number and Medicare claim number. If the information in NOMADS is incorrect, it can compromise the automated accretion/deletion process, thereby requiring manual intervention.

In some instances, a person cannot be automatically accreted to or deleted from the Buy-In. If this happens, manual input must be done in Central Office to get the person accreted/deleted.

Both the automatic and manual accretion/deletions can be attempted only once a month (we are not permitted to try more often). The entire process works as follows:

a. Around the 22nd of each month, a tape is produced by Data Processing containing all the automatic and manual accretion/ deletions for the month. This tape is sent to the CMS in Baltimore. The tape must be received by CMS no later than the 25th of each month. The tape is also run against the BENDEX tapes received from Social Security each month to check Medicare eligibility.

b. CMS sends a tape back (around the 22nd of each month) giving the responses on each of the automatic and manual accretion/deletions sent the previous month.

c. The tape received from CMS is used to update the INFC Buy-In System including the Buy-In Inquiry Screen which indicates whether or not a person was accreted/deleted.

Because only one attempt per month is allowed to accrete a person, it can take several months to accrete a person when there are problems. In rare instances when none of the attempts will work, Central Office must send the problem to CMS in Baltimore. If this happens, it could take a year or more from the time Baltimore is notified of the problem to get the person accreted.

5. CASE MANAGER RESPONSIBILITIES IN THE BUY-IN PROCESS

The case manager must ensure the client name, birth date, Social Security number and Medicare claim number are correctly input in NOMADS. If information is input incorrectly, it could delay accreting the individual to the Buy-In.

When a person is eligible for Buy-In for Part A and/or B, the case manager must future action the case to check the Buy-In Inquiry Screen to ensure the client was accreted. If there is no response on the inquiry screen for the client, or a response is received indicating a problem with accreting the person, the case manager must correct any discrepancies in NOMADS, and request a manual accretion from Eligibility and Payments in Central Office. The following are general rules for requesting a manual accretion:

CASH ASSISTANCE ONLY

- If the case was approved before the 20th of a month, the inquiry should show a code sent through the Buy-In accreting the person after the 25th of the same month. After the 25th of the following month, a code should be received showing the person has been accreted or one telling why the person cannot be accreted. If there is a code indicating the person cannot be accreted or there is no response, request assistance verifying the Medicare Part A/B coverage and claim number.

  If the case was approved on the 21st or later, the inquiry will not show a code indicating an accretion was sent until after the 25th of the following month. The reply code would be received another month after that and the above procedures requesting assistance should be followed as appropriate.

CASH AND QMB ELIGIBLE

- The same procedure for Cash Assistance cases above applies to this category, except two separate effective dates will be received for Part A and Part B. If a code is received showing one or both coverages cannot be bought in, or there is no response, follow the procedures for requesting assistance above.

MEDICAL-ONLY CASES	-	The same procedures above apply, except the reply code showing accretion will not appear on the inquiry screen until the second month following the month of Medicaid approval.
MEDICAL-ONLY CASES ELIGIBLE FOR QMB COVERAGE	-	The same procedures for Cash Assistance cases apply, except the accretion date will be the month QMB coverage begins for both Part A and Part B.
QMB ONLY CASE	-	The same procedures for Cash Assistance cases apply except the accretion date will be the month QMB coverage begins for both Part A and Part B.

209 SUPPORT ENFORCEMENT PROGRAM (SEP)

A. REFERRALS TO CHILD SUPPORT ENFORCEMENT (CSE)

All dependent children (including automatic Medicaid eligible newborns) who have absent parent(s) require referrals to Child Support Enforcement (CSE) for support enforcement services. Obtain a Non-Custodial Parent (NCP) form, 2906-EG, on each absent parent. CSE services include establishing paternity, securing child and medical support.

B. ACTION FOR FAILURE TO COOPERATE

If the person applying for Medicaid on the child's behalf refuses to cooperate in completing the Non-Custodial Parent (NCP) form, 2906-EG, or if information from CSE indicates non-cooperation (after referral was made), document in the case file, notify CSE and take no action to terminate the child's Medicaid eligibility.

However, if the person applying on the child's behalf is also receiving Medicaid under another category and non-cooperation with CSE is established, this person is ineligible for Medicaid.

If a pregnant woman is receiving Medicaid under a MAABD category and non-cooperation with CSE is established, she is eligible for medical services until two months after the birth of the baby and then terminate the case for non-cooperation with CSE. A case CLOG must be detailed about the action taken.

If CSE establishes non-cooperation on an associated TANF case, send an Insufficient Information form, 2429-EE, requesting the caretaker comply with CSE as a condition of their MAABD eligibility. If the caretaker does not comply, terminate the MAABD assistance allowing for adverse action.

If the client is reapplying for assistance and non-cooperation with CSE was established on a previous application, the client can be Medicaid eligible if he/she indicates a willingness to cooperate on the reapplication.

C. INFORMATION EXCHANGED BETWEEN MAABD AND CHILD SUPPORT ENFORCEMENT

1. INFORMATION RECEIVED FROM CSE

CSE informs the case manager of information affecting Medicaid eligibility and third party liability. Information to be transmitted by the IV-D Specialist or automated system includes (not all inclusive):

a. Absent parent's residence and mailing address, plus employer's name and address when known. Upon notification, send the Employer Group Health Insurance Questionnaire form, 2230-EM, to determine medical insurance coverage. Ensure NOMADS is updated with appropriate insurance information.

b. IV-D case closure, including the effective date and reason for closure.

c. Non-cooperation, including the case name, number, the reason for non-cooperation and documentary evidence.

d. Parentage determination indicating the results of parentage proceedings.

e. Support payments surrendered or initial payment received from the absent parent. This information will be submitted within three (3) working days of receipt of the collection.

f. The name and date of death of an absent parent.

2. INFORMATION SENT TO CSE

Within two working days of Medicaid approval, send Form 2906-EG to CSE on each absent parent and any available copies of court orders relating to parentage or support which have not been previously sent to CSE. The 2906-EG must be complete. A copy of the Third Party Coverage Information must be sent to CSE if medical coverage is being provided by an absent parent for his/her child.

Use Form 4801-EC "Exchange of Information" or Form 6009-AG, to inform CSE of:

a. Any new information obtained on an absent parent

b. Anytime the person applying for Medicaid on the child's behalf has agreed to cooperate with CSE after a previous refusal

c. good cause referrals with supporting documents

d. death of absent parent or child

e. non-cooperative caretaker; unable to sanction

210 COOPERATION

Clients or their representatives are the primary source of information.

Clients must inform the Division of the following (not all inclusive):

1. Application for SSI.

2. SSI eligibility determination.

3. Change of address.

4. Change in living arrangement.

5. Receipt of support payments or relative contributions.

6. Reporting income.

   a. Client Income

      All income or changes in income must be reported.

      Initial written requests to report/verify earnings and/or fluctuating income must allow 20 calendar days. Specify the date verification is due in the office, i.e., the 5th or 10th of the month.

   b. Spouse/dependent relative's income

      Income of the spouse/dependent relative is used in determining the spousal and family maintenances allowances, in deeming income to clients institutionalized less than 30 consecutive days, in deeming income for QMB/SLMB/QI financial eligibility, and in SSI financial eligibility determinations.

      All monthly income (first through the last day of the month) or any change in monthly income (increase, decrease or termination) received by the spouse/dependent relatives must be reported to the Welfare district office between the 1st and 5th day of the following month or any date requested. Initial written requests to clients must allow 20 calendar days.

      NOTE: A spouse whose income is countable for financial eligibility must sign an Interface Consent, form 2179-EE, allowing the Division to interface with other federal and state agencies for verification, unless the spouse has signed the application or has applied for assistance on a separate application.

7. Receipt, increase or reduction of Unemployment Insurance, Social Security, Veterans Administration benefits, retirement, Railroad Retirement, Employers Insurance Company of Nevada (EICON) benefits, or any other income.

8. Reporting new or changed resources.

If a third party refuses to supply information without a parent's/representative's permission, an Authorization for Release of Information form (2451) must be signed by the client/representative. Lack of third party cooperation must be documented in the case file.

Clients or their representatives are responsible for securing all information needed to determine eligibility/continued eligibility. Failure or refusal to supply all information requested will cause denial or termination.

A case may be selected by Quality Control and reviewed as to the accuracy of benefits paid or allotted. Clients are required to cooperate with the review process.

A. INTAKE ELIGIBILITY CASE PROCESSING

If the facility employee is the representative, require proof from the facility the responsible relative, if applicable, is sent a copy of the request.

Allow 20 calendar days from the mailing date for the applicant/representative to provide the necessary information unless the client/representative has agreed in writing to a shorter time allowance. When the due date falls on a weekend or holiday, the due date will be extended until the close of the next working day.

If the client/representative does not provide the requested information within the time period given, send a denial notice.

Should the representative/family member experience non-cooperation with a third-party, they must notify the office in writing and request assistance in obtaining the information prior to the 20-day deadline. Proof a request was made to the third-party is required.

Should additional information be required during the case processing period, allow 10 days to provide the additional information. Additional information is defined as information needed after the initial request or as a result of receiving information from the initial request.

B. ONGOING ELIGIBILITY CASE PROCESSING

Allow 10 calendar days from the mailing date for the client/representative to provide requested information. If the client/representative does not provide the requested information within the time period given, send a termination notice allowing the client/representative an additional 10 days to provide the information (the day after the notice date is the first day of the 10-day period).

If the client/representative provides the information within 10 days of the termination notice, assistance will be continued if all eligibility requirements are met.

NOTE: As long as the information/verifications are provided on or before the last day of the month, reinstate the case. Assistance will be continued if all eligibility requirements are met.

211 APPLYING FOR AVAILABLE BENEFITS

When benefits may be available to the client, notify the client/ representative in writing that application for such benefits must be made within 20 calendar days for intake case processing or 10 calendar days for ongoing case processing. To evaluate for potential eligibility for benefits from another Federal, State or local agency, see Appendix "B".

Failure to apply for, pursue and accept a claim or failure to provide information essential to establish the claim will result in denial or termination of assistance.

EXCEPTION: Persons qualifying under the QMB category do not have to apply for benefits they may be eligible for.

212 AUTHORIZING MEDICAID BENEFITS

A. AUTHORIZATION OF ASSISTANCE

The case manager's posting of an eligible version authorizes the issuance of the Medicaid card, any changes, or closure.

B. DUPLICATE ASSISTANCE

Assistance can only be provided from one Nevada program at a time.

Nevada Medicaid programs include: TANF, CHAP, CWS (DCFS), MAABD.

TANF	Temporary Assistance for Needy Families
CHAP	Child Health Assurance Program
CWS	Child Welfare Services *(Division of Child & Family Services)*
MAABD	Medical Assistance to the Aged, Blind and Disabled
CHIP	Child Health Insurance Program (Nevada Check Up)

Medicaid coverage will be given to otherwise eligible Nevada residents verified to be receiving Medicaid coverage from another state. Inform the other state of the clients' change in residence and require the clients to surrender their medical card from the other state, if available.

C. EFFECTIVE DATES OF MEDICAL ASSISTANCE

Eligibility begins with the first day of the month of the Medicaid application if all eligibility factors are met. A client may receive Medicaid for up to three months prior to the month of application. See Manual Section 102.

EXCEPTION: QMB coverage begins the month following the month of eligibility decision.

When a hearing determines Medicaid was improperly denied or discontinued, corrective Medicaid authorization is made.

213 INTERDISTRICT TRANSFERS

When a recipient moves to another district within the state, the new district will verify current SSI eligibility. Assistance will not be withheld pending this verification. The worker in the district where the client last received assistance will send the file to the new district office and will make the necessary changes in NOMADS.

214 CLOSURES

Prospectively determine ongoing Medicaid eligibility using the policy in effect for the future month.

When a Medicaid recipient can no longer meet the requirements of one of the eligible categories or has failed to cooperate in providing information, the case must be closed. When posting a termination, two future months must be posted in order to ensure closure in MMIS system.

NOTE: If the closure is due to an increase in income, and the recipient is pregnant, evaluate for eligibility as a Qualified Pregnant woman under the Child Health Assurance Program (CHAP) prior to terminating benefits.

If the requirements are met, or the client cooperates prior to the effective date of termination, Medicaid would continue.

When assistance is terminated, a Notice of Decision (NOD) must be sent to both the client and the representative/legal guardian a MINIMUM of 13 days before the proposed action is effective. In order to meet the 13-day time frame, cases must be posted at least 14 days prior to the end of the month. DO NOT SEND A NOD TO A DECEASED PERSON. Instead, send a NOD to the authorized representative of the deceased person.

A. CLOSURES WHICH DO NOT REQUIRE THE 13-DAY ADVANCE NOTICE PERIOD

The advance notice period is not required, but a NOD must be sent by the date of closure when:

1. The recipient requests termination in writing.

2. The recipient supplies written information which requires termination. Retain in the case file client's signed statement he/she understands the consequences of supplying such information and he/she waives the right to the advance notice period.

3. The recipient's address is <u>unknown</u>, AND:
   a) mail to the recipient is returned by the post office with no forwarding address, or
   b) information verifies the client is no longer at the address given.

4. It is verified a recipient has been approved for assistance in another state.

5. The recipient has been placed in an institution not covered by Medicaid.

6. The agency has information verifying a recipient is deceased.

B. HEARINGS

Hearing requests must be RECEIVED in writing within 90 days from the date of the Notice of Decision. The day after the notice date is the 1st day of the 90-day period.

Clients may request a hearing because:

1. of agency action to deny, reduce or terminate benefits; or

2. of agency action to make payments to a protective payee; or

3. they are aggrieved about an application was not acted on with reasonable promptness; or

4. due to exceptional circumstances resulting in significant financial duress, a higher minimum monthly maintenance needs allowance is needed to provide additional income to the community spouse; or

5. the community spouse resource allowance is inadequate to raise the community spouse's income level to the minimum monthly maintenance needs allowance without adding more resources which are income producing.

Continued benefits will be provided if a hearing request is RECEIVED in writing no later than the 10th day after the effective date of the proposed action. Assistance will continue unchanged until the hearing decision is made unless the client provides a written request asking benefits not be continued or the hearing officer makes a preliminary finding the sole issue is one of state or federal law requiring automatic benefit adjustments. See Welfare Administrative Manual Section 3100 for more detailed information regarding the hearing process.

INDEX
SECTION 220
TYPES OF EARNED AND UNEARNED INCOME

220 TYPES OF EARNED AND UNEARNED INCOME (not all inclusive)

If income is not identified as excluded, it should be counted. A garnishment or seizure is a withholding of an amount from earned or unearned income to satisfy a debt or legal obligation. Amounts withheld in this manner are counted in determining financial eligibility.

INCOME TYPE	DESCRIPTION
ACTION PROGRAMS 1. Earned/Unearned 2. Excluded in Financial 3. Excluded in Patient Liability	Payments to volunteers under Chapter 66 of Title 42 of the U.S. Code Domestic Volunteer Services, including: * University Year for Action (UYA) * Special and Demonstration Volunteer Program * Senior Companion Program Verification: (not all inclusive) - Copy of check - Documents from the agency paying benefits
ADVANCES 1. Earned 2. Counted in Financial 3. Counted in Patient Liability	Advanced income from the employer. Verification: (not all inclusive) - Form 2074 "Earnings Verification" - Copy of paycheck stub - Signed and dated statement from employer
AGENT ORANGE SETTLEMENTS 1. Unearned 2. Excluded in Financial 3. Excluded in Patient Liability	Payments pursuant to Public Law 101-201. Verification: (not all inclusive) - Copy of check - Documents from the agency paying benefits
ALASKA NATIVE CORPORATION 1. Earned/Unearned 2. Excluded in Financial 3. Excluded in Patient Liability	Pursuant to Public Law 100-241, none of the following received from a Native Corporation is counted as income to an Alaska Native or a descendant of an Alaska Native: Cash (including cash dividends on stock) to the extent it does not exceed $2,000 per individual per year. Verification: (not all inclusive) - Copy of check - Documents from the agency paying benefits

INCOME TYPE	DESCRIPTION
ALIMONY 1. Unearned 2. Counted in Financial 3. Counted in Patient Liability	Payments from an ex-spouse. Verification: (not all inclusive) - Court Ordered Decree - Copy of check or money order
ANNUAL LEAVE 1. Earned 2. Counted in Financial 3. Counted in Patient Liability	Income from the employer for annual leave time. Verification: (not all inclusive) - Form 2074 "Earnings Verification" - Paycheck stubs - Signed and dated statement from employer
ANNUITIES 1. Earned or Unearned 2. Counted in Financial 3. Counted in Patient Liability	Income from annuities which were purchased with an employee's funds are earned income. Other annuities purchased through a bank or insurance company are unearned income. These payments may continue for a fixed period of time or for as long as the individual lives. Verification: (not all inclusive) - Copy of check - Documents from the agency paying benefits
ASSISTANCE BASED ON NEED 1. Unearned 2. Excluded in Financial 3. Counted in Patient Liability	Any assistance from government agencies which is intended to supplement needs, and is NOT federally funded. Including, but not limited to: Family Preservation Program. Verification: (not all inclusive) - Copy of check - Documents from the agency paying benefits
AUSTRIAN SOCIAL INSURANCE PAYMENTS 1. Unearned	Austrian Social Insurance payments based, in whole or in part, on wage credits granted under Paragraphs 500-506 of the Austrian General Social Insurance act.

INCOME TYPE	DESCRIPTION
AUSTRIAN SOCIAL INSURANCE PAYMENTS (Cont'd) 2. Excluded in Financial 3. Excluded in Patient Liability	Interest earned on these payments is counted as income. Verification: (not all inclusive) - Copy of check - Documents from the agency paying benefits
BANK ACCOUNTS Checking, Saving, Time Certificates, Money Markets Certificates of Deposit (CD) 1. Earned/Unearned 2. Counted/Excluded in Financial or Patient Liability – Varies by income type Refer to Individual Development Account (IDA) section for consideration of funds deposited and interest earned on funds in an IDA savings account.	Money deposited to a bank account is considered income in the month it is deposited. (Then considered a resource beginning with the month following the month it is deposited.) **Exception:** In determining patient liability for spousal impoverishment cases only, income the payor designates as the client's is budgeted. Income of the other joint holder(s) (i.e., the spouse or anyone else) deposited into the account is not considered the client's income. **A. Sole Ownership** The client is designated as owner of the account, ALL the deposits are the client's income. **Exception**: If the client is acting as an agent for another individual. Deposits made for another individual for the intent purpose of disbursing those funds on behalf of the individual are not considered income. The client must provide proof deposits are made and used on behalf of another individual. **B. Shared Ownership (joint account)** **Account holders are:** - married couples - parent and minor child **When deeming applies** in determining eligibility for the coverage group (e.g., Public Laws, institutional less than 30 days, etc.), rebutting ownership is NOT REQUIRED because deeming income takes precedence.

INCOME TYPE	DESCRIPTION
BANK ACCOUNTS (Cont'd)	**When deeming does not apply** (e.g., Home Based Waivers, institutionalized at least 30 days, etc.), verify who owns the funds deposited in the account. Once the ownership of funds is known, only the income verified to be the client's is used in determining financial eligibility and patient liability. **Account holders are not:** - married couples - parent and minor child All deposits to the account will be presumed available to the client unless the client can successfully prove all or part of the funds are not his/hers. **Exception: when the client is acting as an agent for the other account holder(s).** If a bank account is owned jointly by more than one TANF/SSI/Medicaid applicant/recipient, any income deposited into the account is considered income to the person who is named payee by the source of payment. If more than one person is named payee, divide the amount equally among those named by the payment source. **Inform the individual: (using Form 2614)** 1. The deposits in the account belong to the applicant/recipient. 2. The implications are: All deposits are countable income when determining Medicaid eligibility. 3. Of his/her right to provide evidence rebutting the ownership if he/she disagrees. If an account holder is a minor or incompetent, at least one account holder and a third party who has knowledge of the circumstances surrounding the establishment of the joint account must complete the form. If the client does not complete and return Form 2614 by the specified date, deny or terminate the case for failure to cooperate. **C. Court Order Designating Income** A copy of the order must be sent with a request to the Chief of Eligibility and Payments for a determination of availability.

INCOME TYPE	DESCRIPTION
BANK ACCOUNTS (Cont'd)	**D. Court Order/Written Agreement** If a written agreement or court order designates ownership of the joint account to either spouse, the account will be considered the resource of that spouse. Deposits made or interest posted will be considered income to that spouse. Disproving ownership does not apply. **E. Equal Division of Income** If an equal division of TOTAL community income has been applied, consider only the one-half portion as income to the client in determining financial eligibility. Disproving ownership does not apply. **F. Client Chooses Not to Disprove Ownership (Form 2614 completed and in Case Record)** All deposits are countable income when determining eligibility and patient liability. **G. Disproving Ownership** If an individual wishes to disprove ownership, obtain his or her statement on Form 2615: ● who owns the funds; ● why there is a joint account; ● who has made deposits to and withdrawals from the account; and ● how withdrawals have been spent. A copy of a financial institution record such as a passbook, or bank statements which show the deposits, withdrawals, and interest for the period of time they are rebutting ownership. Proof of deposits, source of deposits, withdrawals, and how withdrawals were spent is required. Any unidentified deposits, deposits identified as the client's income and all withdrawals made by the client in excess of his/her own income, will be considered the client's income in that month.

INCOME TYPE	DESCRIPTION
BANK ACCOUNTS (Cont'd)	Vendor payments made on behalf of the client by the other account holder and loans made by the account holder to the client are not considered the client's income. The client has successfully disproved ownership when proof from the financial institution shows: 1) the client's name has been removed from the joint account; OR 2) access to the account has been restricted and the funds are not available to the client; OR 3) the account has been changed so only the client's money is in the account. If the client can show they are in the process of removing their name from the account, but the action cannot be completed for a time due to a specified reason, the client has successfully disproved ownership. The case should be future actioned to verify the account was closed/name removed. **EXAMPLE**: Client applies June 30 and wishes to disprove ownership of a joint checking account. On July 10, the statements made by the account holders report in June and July $800 of the money in the account was the client's funds. Verification of deposits substantiate their statement and there is proof the joint account is closed. When looking at the withdrawals from this account, however, the client actually used $1,000 in the month of June. Because the client has shown a portion of the funds were not his in June and has closed the account, he has successfully disproved ownership. However, in the month of June the evidence shows he used $200 more than his portion of the fund. Therefore, in June, $200 will be counted as income to the client when determining eligibility and patient liability. In cases where the client did not successfully disprove ownership, notify the client in writing that ownership was not disproved and explain how income and resources are being evaluated. **H. Client Does Not Disprove Ownershp** All deposits are countable income when determining eligibility and patient liability.

INCOME TYPE	DESCRIPTION
BONUS 1. Earned 2. Counted in Financial 3. Counted in Patient Liability	Bonuses paid by the employer. Verification: (not all inclusive) - Copy of check - Statement from employer
CASH CONTRIBUTIONS 1. Unearned 2. Counted in Financial 3. Counted in Patient Liability	Money received which is NOT determined to be a cash gift for holidays. If the amount is $20 or less, see INFREQUENT AND IRREGULAR INCOME for possible exclusions. Verification: (not all inclusive) - Statement from the source of payment
CASH GIFTS 1. Unearned 2. Excluded in Financial 3. Counted in Patient Liability	Money received for holidays (e.g., Christmas, birthdays, anniversary, etc.). Verification: (not all inclusive) - Statement from the person giving the gift - Form 2506
CENSUS INCOME 1. Earned 2. Excluded in Financial 3. Excluded in Patient Liability	Income received from working for the decennial census is exempt from the eligibility and post-eligibility process for all applicants applying for medical assistance. Verification: (not all inclusive) - Documents from the source of payment
CHILD SUPPORT 1. Unearned 2. Excluded in Financial (1/3) 3. Counted in Patient Liability	Child support paid to or on behalf of a child by an absent parent or stepparent shall be considered income to the child for which it is paid. However, <u>one-third</u> (1/3) of the support will be excluded in financial eligibility only. The full payment will be counted when determining patient liability. Child support arrears paid to the parent after the child turns 18 shall be considered income to the parent. Verification: (not all inclusive) - Copy of court order or check - Client's statement

INCOME TYPE	DESCRIPTION
CIVIL SERVICE ANNUITIES (CSA) 1. Unearned 2. Counted in Financial 3. Counted in Patient Liability	If the client has been a federal government employee or is the widow/widower or dependent child (under 18) of a deceased federal employee, Civil Service retirement or disability may be available. Cost-of-living increases usually occur effective March, reflected on April checks. Verification: (not all inclusive) - Copy of award letter - Copy of disallowance letter
COMMUNITY SPOUSE MONTHLY INCOME ALLOWANCE 1. Unearned 2. Counted in Financial	Income allocated to the community spouse for maintenance as required by the spousal impoverishment provisions. The case manager must advise the community spouse how this additional income allowance will affect other public assistance benefits such as SSI, QMB or Food Stamps. Verification: (not all inclusive) - Patient liability deduction amount from institutionalized spouse's case
COST OF LIVING ADJUSTMENT "COLA" (RSDI ONLY) 1. Unearned 2. Excluded in Financial 3. Counted in Patient Liability	For QMB/SLMB/QDWI coverage, the annual cost-of-living increase for RSDI benefits must be disregarded from January through March each calendar year. Effective April, the RSDI COLA is then compared to the new poverty income limit. The same disregard is applied to a spouse's RSDI for comparison to the couple limit. Verification: (not all inclusive) - SSA Benefit letter or SOLQ
DEATH BENEFITS 1. Unearned 2. Counted/Excluded in Financial or Patient Liability – Varies by Income Type	A Death Benefit is money a client receives as the result of another's death. These benefits include the following: - Proceeds of life insurance policies received due to the death of the insured; - Lump Sum Death Benefits from Social Security; - Railroad burial benefits; - VA burial benefits; - Cash inheritances; - Cash gifts from relatives, friends, or a community group to "help out" with expenses related to the death. **NOTE**: Recurring survivor benefits such as those received from Social Security, private pension programs, etc., are not death benefits.

INCOME TYPE	DESCRIPTION
DEATH BENEFITS (Cont'd)	Death benefits received by the client are income to the client in the month received, except for any portion the client verifies was used for the expenses of the deceased person's last illness and/or burial. Last illness and burial expenses include but are not limited to: related hospital and medical expenses, funeral, burial plot, and interment expenses, and other related expenses. Other related expenses include but are not limited to: new clothing to wear to the funeral, food for visiting relatives, taxi fare to and from the hospital and funeral home, etc. Any portion of the Death Benefits which is left after deducting these expenses is counted as income in the month of receipt. - Copy of life insurance - Award letter from SSA, RR, VA - Copy of Will - Statements from individuals giving money to the client - Bills and/or receipts - Contact with provider
DISABILITY 1. Unearned 2. Counted in Financial 3. Counted in Patient Liability	Benefits for disability received from a business, agency or organization. Verification: (not all inclusive) - Statement from agency or business establishment. - Form 2339
DISMISSAL PAY 1. Earned 2. Counted in Financial 3. Counted in Patient Liability	Final pay from an employer. Verification: (not all inclusive) - Copy of check - Statement from the employer, Form 2074

INCOME TYPE	DESCRIPTION
EARNINGS 1. Earned 2. Counted in Financial 3. Counted in Patient Liability	Income received through employment and/or tips. Verification: (not all inclusive) - Copy of check - Tip records - Statement from employer, Form 2074
EARNINGS (workshop) 1. Earned 2. Counted in Financial 3. Counted in Patient Liability	Wages from workshops or work activity centers such as WARC, ALPHA Industries, FAST, Opportunity Village and NAAH. Verification: (not all inclusive) - Copy of check - Statement from employer, Form 2074
EDUCATIONAL ASSISTANCE 1. Earned/Unearned 2. Counted/Excluded in Financial and Patient Liability – Varies by Income Type	Educational assistance is provided in many forms. For Medicaid purposes, treatment will vary depending on the nature and sometimes the use of the assistance. Specific types of educational assistance include Department of Education, Bureau of Indian Affairs, VA Educational Benefits, Grants, Scholarships and Fellowships, etc. Verification: (not all inclusive) - Copy of documents from source of payment. Call E&P Program Specialist for treatment of educational assistance.
EMERGENCY ENERGY CONSERVATION SERVICE AND ENERGY CRISIS ASSISTANCE PROGRAM 1. Unearned 2. Excluded in Financial 3. Counted in Patient Liability	Energy assistance payments to needy persons. Verification: (not all inclusive) - Statement from the source of payment

INCOME TYPE	DESCRIPTION
EMPLOYERS INSURANCE COMPANY OF NEVADA (EICON) 1. Unearned 2. Counted in Financial 3. Counted in Patient Liability	Nevada disability program benefits to employees Verification: (not all inclusive) - Copy of check - Copy of award or denial letter
FAMILY PRESERVATION PROGRAM	See income type "Assistance Based on Need".
FEDERAL EMERGENCY MANAGEMENT ADMIN. 1. Unearned 2. Excluded in Financial 3. Counted in Patient Liability	Funds for disaster relief, or comparable assistance provided by states, local governments (FEMA) or private disaster assistance organizations pursuant to Section 312 of the Stafford Act. Verification: (not all inclusive) - Statement from the source of payment
FEDERAL TAX REFUNDS 1. Excluded in Financial 2. Excluded in Patient Liability	Funds received December 31, 2009 or later, either as an advance or as a refund regardless of the tax year involved are excluded for a period of 12 months. Verification: (not all inclusive) - Copy of check - Copy of client's tax forms
FOSTER CARE PAYMENTS 1. Unearned 2. Excluded in Financial 3. Excluded in Patient Liability	Foster Grandparent Program are stipends from RSVP for being a substitute grandparent for needy children. Foster care payments are not budgeted in the foster parents' Medicaid determination. Verification: (not all inclusive) - Copy of check - Statement from the source of payment
HOLIDAY PAY 1. Earned 2. Counted in Financial 3. Counted in Patient Liability	Employer paid holiday pay. Verification: (not all inclusive) - Copy of pay check - Statement from Employer, Form 2074

INCOME TYPE	DESCRIPTION
HOUSING and URBAN DEVELOPMENT (HUD) 1. Unearned 2. Excluded in Financial 3. Counted in Patient Liability	Subsidized housing assistance. Provided by HUD. Verification: (not all inclusive) - Copy of check - Statement from HUD
INDIAN GENERAL ASSISTANCE (IGA) 1. Unearned 2. Counted in Financial 3. Counted in Patient Liability	Federal payments to needy American Indians. Verification: (not all inclusive) - Copy of check or award letter
INDIAN MONIES 1. Unearned 2. Excluded in Financial 3. Counted in Patient Liability	Judgment funds received by members of an Indian tribe and per capita payments made under Public Law. Per capita payment made under Public Law 108-270 "Western Shoshone Claims Distribution Act" is exempt in Patient Liability. Verification: (not all inclusive) - Copy of check or award letter
INDIAN TRUSTS OR RESTRICTED LANDS 1. Unearned 2. Excluded in Financial 3. Counted in Patient Liability	This income (often called individual Indian trust or lease income) generally comes from interests in lands that were allotted to individual Indians many years ago. Effective January 1, 1994, up to $2,000 per year in payments derived from individual interests in Indian trust or restricted lands is excluded from income. Verification: (not all inclusive) - Statement from the source of payment

INCOME TYPE	DESCRIPTION
INDIVIDUAL DEVELOPMENT ACCOUNT (IDA) 1. Earned/Unearned 2. Excluded in Financial Excluded in Patient Liability	Intended to improve the economic independence and stability of individuals and families and to promote and support the transition to economic self-sufficiency. An IDA participant can only deposit earned income into an IDA. Federal funds match the amount of earnings low-income working individuals and families deposit into an IDA. IDA savings are to be used for a first home purchase, post secondary educational expenses, or business capitalization. The Social Security Act provides for State Family Assistance Grant funds (i.e., TANF, WtW) to be used to establish IDA. The Assets for Independence Act (AFIA) provides for IDAs to be established under Head Start, Low Income Home Energy Assistance (LIHEA), and Community Services. Income in an IDA includes: - Participant contribution (earned income); - Interest earned on participant earned income contributions; - Matching funds; and - Interest accrued on matching funds.

NOTE: Count the participant's gross earned income MINUS the participant's contribution amount.
An individual, whose participation in the IDA program has terminated, voluntarily or otherwise, is no longer covered by the income exclusion.

INFREQUENT AND IRREGULAR INCOME 1. Earned/Unearned 2. Excluded in Financial 3. Counted in Patient Liability 4. If infrequent or irregular, exclude **first** $30 per calendar quarter of earned income; and **first** $60 per calendar quarter of unearned income.	Income excluded which is received either infrequently or irregularly. Irregular income is considered received if an individual cannot reasonably expect to receive it. Beginning September 8, 2006, income is considered infrequent if received only once during a calendar quarter from a single source *and* the individual did not receive it in the month immediately preceding that month or in the month immediately subsequent to that month, regardless of whether or not these payments occur in different calendar quarter.

INCOME TYPE	DESCRIPTION
INFREQUENT AND IRREGULAR INCOME (Cont'd)	
5. If infrequent or irregular, exclude **first** $30 per calendar quarter of earned income; and **first** $60 per calendar quarter of unearned income.	Between July 1, 2004 and September 7, 2006, infrequent income defined as income received no more than once in a calendar quarter from a single source.
6. $10 per month of earned income; and $20 per month of unearned income.	Prior to July 1, 2004, infrequent or irregular income is excluded provided the **total** of such income **does not** exceed. Verification: (not all inclusive) - Type, amount, frequency, or predictability of income. - Copy of check - Document from source of payment
IN-KIND WAGES 1. Earned 2. Counted in Financial 3. Counted in Patient Liability	The value of goods or services given to the client for work performed instead of cash payment. Verification: (not all inclusive) - Statement from employer
INTEREST/DIVIDENDS 1. Unearned 2. Counted in Financial (Conditional) 3. Counted in Patient Liability (Conditional)	Accrued interest and dividend payments are excluded in financial eligibility when posted quarterly, semi-annually or annually from a single source. For example: Insurance is one source; banking is one source; burial is one source; bonds are one source; Reparation payments are one source. Interest is counted as income for patient liability when the amount posted is $5 or more in any month. Interest and dividends paid monthly are counted in financial eligibility and patient liability. Verification: (not all inclusive) - Current bank statement - Computer printout from bank - Written statement from the bank

INCOME TYPE	DESCRIPTION
JOB CORP 1. Earned 2. Counted in Financial 3. Counted in Patient Liability	Paid from the Economic Opportunity Act. Verification: (not all inclusive) - Copy of check or award letter
JUDGMENTS 1. Unearned 2. Counted in Financial 3. Counted in Patient Liability	Any money paid to an employee from a judgment resulting from legal action for wages. Verification: (not all inclusive) - Copy of Judgment
LEASE INCOME 1. Unearned 2. Counted in Financial 3. Counted in Patient Liability	Gross lease income less expenses. Lease expenses may include interest on mortgage, property taxes, maintenance/repair costs, insurance on structure, advertising and utilities when paid by the landlord. Lease expenses do NOT include the amount of a mortgage applied toward the principal balance of the loan. Verification: (not all inclusive) - Copy of receipt book - Copy of check or money order - Tenant's statement of payment - Proof of operating expenses

INCOME TYPE	DESCRIPTION
LIFE INSURANCE PAYMENTS 1. Unearned 2. Counted in Financial 3. Counted in Patient Liability	Accelerated life insurance payments are proceeds paid to a policy holder PRIOR to death. These payments are income in the month received and a resource if retained into the following month. Verification: (not all inclusive) - Insurance policy - Form 2015 from insurance company - Written statement from insurance company
LOANS 1. Unearned 2. Excluded in Financial 3. Excluded in Patient Liability	Money a person borrows or money received as repayment of the principal of a loan is not counted. If a loan is NOT bona fide (not legally valid and made in good faith), the proceeds are counted in the month received. Interest received is also counted the month received. Verification: (not all inclusive) - Client's statement is acceptable - Form 2506
LONG TERM CARE INSURANCE 1. Unearned 2. Counted in Financial (conditional) 3. Counted in Patient Liability (conditional)	Long Term Care policies that pay directly to the facility should be considered a third party payment and not counted in financial eligibility or patient liability. Long Term Care policies that pay directly to the recipient without restriction on use of funds are counted as income in financial eligibility and patient liability. Long Term Care policies that pay directly to the recipient for reimbursement of care already paid for are considered third party payments and not counted in financial eligibility. These payments are counted in patient liability.

INCOME TYPE	DESCRIPTION
LUMP SUM PAYMENTS 1. Unearned 2. Counted in Financial 3. Counted in Patient Liability (not to exceed actual cost of care)	Lump sum payments are considered income in the month received. **Exception: SSI lump sum payments.** For retroactive Social Security Disability benefits which must be paid in installments due to the Drug Alcohol Addiction (DA&A) law, count the entire lump sum entitlement (sum of all installment payments) amount in the first month an installment payment is made. Verification: (not all inclusive) - Copy of check or money order - Legal documentation - Client's sworn and dated statement - Documents from public agencies (SSA, SIIS, VA, etc.)
MEDICAL INSURANCE CASH PAYMENTS 1. Unearned 2. Excluded in Financial 3. Excluded in Patient Liability	REIMBURSEMENT for medical costs paid by the client and medical insurance cash payments the client proves were applied toward medical bills. Verification: (not all inclusive) - Explanation of Benefits (EOB) from the insurance company - Receipts for medical payments
MEDICARE PREMIUM REIMBURSEMENTS 1. Unearned 2. Excluded in Financial 3. Excluded in Patient Liability	Medicare reimbursement are exempt ONLY if the client paid the premium. Verification: (not all inclusive) - Copy of the check or award letter
MILITARY DEPENDENT ALLOTMENTS 1. Unearned 2. Counted in Financial 3. Counted in Patient Liability	Enlisted service individuals may make an allowance for dependents. Verification: (not all inclusive) - SSA Benefit Record - Written statement from Military Allotment Branch

INCOME TYPE	DESCRIPTION
MILITARY HOSTILE FIRE PAY 1. Unearned 2. Excluded in Financial 3. Counted in Patient Liability	Hostile fire pay is a special type of pay to a service member who is: - subject to hostile fire or explosion of hostile mines; or - on duty in an area in which he/she is in imminent danger of being exposed to hostile fire or explosion of hostile mines, AND while on duty in that area, other service members in the same area are subject to hostile fire or explosion of hostile mines; or - killed, injured, or wounded by hostile fire, explosion of a hostile mine, or any other hostile action. Verification: (not all inclusive) - Copy of check - Documents from the source of payment
OLDER AMERICANS ACT 1. Earned 2. Counted in Financial 3. Counted in Patient Liability	The Federal Government through the Administration on Aging is involved in a variety of programs for older Americans. The programs may be operated by State or local governments or community organizations. Some program types include health and nutrition services, legal assistance and community service employment. A wage or salary paid under Chapter 35 of Title 42 of the U.S. Code, the Older Americans Act is earned income. **Anything other than a wage or salary is excluded in financial eligibility and patient liability.** Verification: (not all inclusive) - Copy of check - Documents from the source of payment

INCOME TYPE	DESCRIPTION
P.A.S.S. 1. Unearned 2. Excluded in Financial 3. Counted in Patient Liability	Income necessary to fulfill a Plan for Achieving Self-Support for BLIND and DISABLED individuals. The plan must be an individual plan in writing and approved by Social Security. Verification: (not all inclusive) - Award letter from Social Security
PENSIONS 1. Unearned 2. Counted in Financial 3. Counted in Patient Liability	Benefits paid to a pensioner following retirement from employment. Any portion of a pension paid directly to the spouse per a divorce settlement is not countable toward the client for financial eligibility or patient liability. (Divorce settlement must have occurred prior to Medicaid application.) Verification: (not all inclusive) - Copy of check or award letter - Form 2339
PROFIT SHARING PLAN 1. Earned 2. Counted in Financial 3. Counted in Patient Liability	Profit gained from shares owned in the business of employer. Verification: (not all inclusive) - Copy of financial statement or check
PROMISSORY NOTES, FORMAL WRITTEN AGREEMENTS AND PROPERTY AGREEMENTS 1. Unearned 2. Counted in Financial 3. Counted in Patient Liability	If the note or agreement is determined to be a resource, that portion of any payment received representing payment on the principal is also a resource. The portion of any payment which represents interest on the principal is unearned income. If the note or agreement is determined NOT to be a resource, total payments received, whether principal and/or interest, are unearned income. Verification: (not all inclusive) - Copy of the Note or Agreement

INCOME TYPE	DESCRIPTION
PUBLIC EMPLOYEES RETIREMENT (PERS) 1. Unearned 2. Counted in Financial 3. Counted in Patient Liability	If the client has been a public employee or is the widow/widower or dependent child (under 18) of a deceased public employee, retirement, survivors, or disability benefits may be available. Verification: (not all inclusive) - Copy of Award letter or Form 2339 - SSA Benefit Record
PUBLIC LAW 92-336 (1972 RSDI DISREGARD) 1. Unearned 2. Excluded in Financial 3. Counted in Patient Liability	Disregard the amount of the October 1972 twenty percent (20%) RSDI increase. Verification: (not all inclusive) - Copy of Check or Award Letter - Statement from SSA
RADIATION EXPOSURE PAYMENTS 1. Unearned 2. Excluded in Financial 3. Excluded in Patient Liability	Payments made under the Radiation Exposure Compensation Act. Verification: (not all inclusive) - Documents from the source payment.
RAILROAD RETIREMENT BENEFITS 1. Unearned 2. Counted in Financial 3. Counted in Patient Liability	Persons who may be eligible must apply to the Railroad Retirement Board District Office. Cost-of-living increases usually occur effective December, reflected on January checks. Verification: (not all inclusive) - Copy of Award Letter - SSA Benefit Record - Form 2339
REFUND ON TAXES 1. Unearned 2. Excluded in Financial 3. Counted in Patient Liability	Taxes refunded to the client from the federal or state government. Verification: (not all inclusive) - Documents from the source of payment

INCOME TYPE	DESCRIPTION
REIMBURSEMENTS; REFUNDS FOR DEPOSITS AND OVERCHARGES 1. Unearned 2. Excluded in Financial 3. Excluded in Patient Liability	Reimbursements, deposits and overcharges refunded to the client from any source. Verification: (not all inclusive) - Documents from the source of payment
RELOCATION ASSISTANCE 1. Unearned 2. Excluded in Financial 3. Counted in Patient Liability	Assistance provided under TITLE II of the UNIFORM RELOCATION ASSISTANCE and REAL PROPERTY ACQUISITIONS POLICIES ACT of 1970 from a federal or federally-assisted project. RELOCATION AS provided by a state or local government or through a state-assisted or locally-assisted project is excluded effective May 1, 1991. Verification: (not all inclusive) - Copy of check or award letter
RENTAL INCOME (aka Roomer/Boarder Income) 1. Unearned 2. Counted in Financial 3. Counted in Patient Liability	Applicants must own or be purchasing the home to consider "rental income." When all household members are renting a dwelling, it is considered shared expenses, not rental income. When a recipient receives contributions for shared expenses that exceed the household's total expenses, the excess is considered unearned income to the recipient. Rental income is determined by using gross rental income less rental expenses. Rental expenses may include interest on mortgage, property taxes, maintenance/repair costs, insurance on structure, advertising and utilities when paid by the landlord. Rental expenses are prorated in roomer/boarder situations. Prorate expenses based on the number of rooms designated for rent compared to the number of rooms in the house (do not count bathrooms, basements and attics). Verification: (not all inclusive) - Copy of receipt book, check (money order), tenants' statement of payment or proof of operating expenses.

INCOME TYPE	DESCRIPTION
REPARATION PAYMENTS 1. Unearned 2. Excluded in Financial 3. Excluded in Patient Liability	REPARATION PAYMENTS from the FEDERAL REPUBLIC OF GERMANY received on or after 11/1/84. WAR REPARATIONS paid under the AUSTRIAN government pension system. However, any interest earned on these payments is countable income. REPARATION PAYMENTS issued to JAPANESE INTERNEES (EXCEPT INTEREST) and ALEUTS pursuant to Public Law 100-383. However, any interest earned on these payments is countable income. Verification: (not all inclusive) - Award letter or copy of check
REPLACEMENT/REPAIR DESTROYED OR DAMAGED PROPERTY 1. Unearned 2. Excluded in Financial 3. Excluded in Patient Liability	The amount of money received for replacement or repair of lost, destroyed, damaged or stolen resources is considered a change in type of resource and is not counted as income. Verification: (not all inclusive) - Copy of check - Documents from source of payment - Receipts for expenses
RETIRED SENIOR VOLUNTEER (RSVP) 1. Unearned 2. Excluded in Financial 3. Excluded in Patient Liability	Stipends received for services rendered. Verification: (not all inclusive) - Copy of check - Documents from source of payment
RETIREMENT PAY 1. Unearned 2. Counted in Financial 3. Counted in Patient Liability	Benefits paid to a retiree by the company they worked for: Verification: (not all inclusive) - Copy of check - Documents from source of payment

INCOME TYPE	DESCRIPTION
RETIREMENT, SURVIVORS, DISABILITY INSURANCE (RSDI) 1. Unearned 2. Counted in Financial 3. Counted in Patient Liability	Persons who may be eligible must apply at the local Social Security office. Budget the gross amount. Cost-of-living increases usually occur effective December, reflected on January checks. Verification: (not all inclusive) - Copy of award letter - Copy of disallowance letter - SSA Benefit Record - SOLQ
REVERSE MORTGAGES 1. Unearned 2. Excluded in Financial 3. Excluded in Patient Liability	A reverse mortgage is a type of home equity loan, which allows a person to convert some of the equity in their home into cash while retaining home ownership. Funds obtained from a reverse mortgage may be used for any purpose, including meeting housing expenses such as taxes, insurance, fuel, and maintenance costs. The funds may be received in a lump sum, in monthly advances, through a line-of-credit or in a combination of distribution methods. Depending on the agreement with the lender, the loan becomes due with interest when the individual moves, sells the home, dies, or reaches the end of the pre-selected loan term. Verification: (not all inclusive) - A copy of the reverse mortgage agreement with the lender - Documentation of the payments and source

INCOME TYPE	DESCRIPTION
SELF-EMPLOYMENT WAGES - Wages - Business income 1. Earned 2. Counted in Financial 3. Counted in Patient Liability	Gross income from self-employment less expenses is self-employment wages. Gross business income less all business operating costs is gross wages from self-employment. The client is responsible for keeping all necessary records. Verification: (not all inclusive) - Copy of ledger sheets receipts and/or income tax records
SENIOR COMPANION PROGRAM 1. Unearned 2. Excluded in Financial 3. Excluded in Patient Liability	Stipends received for services rendered. (See also Action Programs) Verification (not all inclusive) - Copy of check - Documents from source of payment
SEVERANCE PAY 1. Earned 2. Counted in Financial 3. Counted in Patient Liability	Final payment to employees laid off or terminated. Verification: (not all inclusive) - Copy of check stubs - Statement from employer, Form 2074
SICK PAY 1. Earned 2. Counted in Financial 3. Counted in Patient Liability	Employer paid sick leave. Verification: (not all inclusive) - Statement from employer, Form 2074 - Copy of paystub

INCOME TYPE	DESCRIPTION
SPINA BIFIDA ALLOWANCES 1. Unearned 2. Excluded in Financial 3. Counted in Patient Liability	Children of Vietnam veterans who are born with spina bifida are eligible to receive a monthly allowance ranging from $200 to $1,200 per month, effective October 1, 1997. n/a These payments are excluded from income and resources. Verification: (not all inclusive) - Documents from source of payment - Documents from the Veterans Administration or Department of Veterans Affairs
STUDENT/CHILD EARNED INCOME 1. Earned 2. Conditional Exclusion in Financial 3. Counted in Patient Liability	**Exclusions:** If a child is under 22, not the head of a household, regularly attending school, and has never been married, exclude $1,200 per calendar quarter from the earned income, not to exceed $1,620 per calendar year. Verification: (not all inclusive) - Copy of check, Form 2074 - School statement
SUPPLEMENTAL SECURITY INCOME (SSI) 1. Unearned 2. Excluded in Financial 3. Excluded in Patient Liability	Benefits based on need for aged, blind and disabled individuals. Verification: (not all inclusive) - SOLQ - SSA Benefit Record - SDX - Copy of award or denial letter See "Cost of Living Adjustments" (COLAs) for evaluating increases to SSI.

INCOME TYPE	DESCRIPTION
SUPPORTED LIVING ARRANGEMENT (SLA) 1. Unearned 2. Counted in Financial 3. Counted in Patient Liability	Supported Living Arrangement (SLA) payments are funds authorized by state legislation to assist individuals with disabilities or mentally disabled SSI applicants/recipients so they can live in the community. - exempt payments to or received on behalf of an SSI recipient, and - exempt payments for medical needs that are not paid by Medicaid.
NOTE: SLA vendor payments and reimbursements for receipted expenditures are not considered income. MH/MR may also refer to SLA as Supplemental Living Assistance; however, this is the same as Supported Living Arrangement.	
TRIBAL GAMING INCOME 1. Count as unearned income Conditional exclusion 2. Count in financial 3. Count in Patient Liability	Funds paid in a lump sum to eligible tribal individual from tribal casino revenues. In month received, credited to individual's account, or set aside for the individual's use.
4. Exclude first $60 per calendar quarter	Beginning September 8, 2006, income is considered infrequent if received only once during a calendar quarter from a single source *and* the individual did not receive it in the month immediately preceding that month or in the month immediately subsequent to that month, regardless of whether or not these payments occur in different calendar quarter.
5. Exclude first $60 per calendar quarter	Between July 1, 2004 and September 7, 2006, infrequent income defined as income received no more than once in a calendar quarter from a single source.
6. Exclude if does *not* exceed $20 per month	Prior to July 1, 2004, infrequent or irregular income is excluded provided the total does not exceed. Verification: (not all inclusive) - Type, amount, frequency, or predictability of income - Copy of check - Document from source of payment

INCOME TYPE	DESCRIPTION
TRUST FUNDS 1. Unearned 2. Counted in Financial 3. Counted in Patient Liability	All trusts are referred through the Eligibility and Payments Unit to the Deputy Attorney General for a decision on availability. The case manager must obtain the trust document with all attachments to send with the request. Trusts established prior to August 11, 1993 by an individual or the individual's spouse, under which the individual is the recipient of all or part of any payments from the trust, are called Medicaid Qualifying Trusts (MQTs). MQT assets (income/ resources) are "deemed" available to the client. The following are types of payments from a trust fund: 1. Interest income as it becomes available, if the client has a right to the interest on the principal, whether or not the client is currently receiving it. 2. Payments from the trust which are being made to: ● The client; or ● The representative/legal guardian of the client; or ● A vendor on behalf of the client. 3. Payments which are being or could be made to the client from a Medicaid Qualifying Trust. The maximum payment which could be made to the client will be counted whether it is being paid or not. Verification: (not all inclusive) - Verification: (not all inclusive) - Copy of trust document with all attachments - Copy of trust account ledgers - Statement from guardian - Memorandum from Chief of E&P

INCOME TYPE	DESCRIPTION
UNIFORM GIFTS TO MINORS	Uniform Gifts to Minors Act permits gifts to minors which are free of tax burdens.
1. Real/Personal Property 2. Conditional Exclusions	An individual (donor) makes an irrevocable gift of money or other property to a minor (the donee). The gift, plus any earnings it generates, is under the control of a custodian until the donee reaches the age of majority by state law (18 years for Nevada). The custodian has discretion to provide to the minor or spend for the minor's support, maintenance, benefit or education, as much of the assets as he/she deems equitable. The donee automatically receives control of the assets upon reaching the age of majority. The gift, including any additions or earnings, is not income to the donee. The custodian's disbursements to the donee are income to the minor. All property becomes available to the donee and subject to income rules in the month the donee reaches the age of majority. The month following the month of majority, the property is subject to resource evaluation. Verification: (not all inclusive) - Copy of the document of ownership, e.g., deed, CD, savings passbook, etc.

INCOME TYPE	DESCRIPTION
UNEMPLOYMENT BENEFITS 1. Unearned 2. Counted in Financial 3. Counted in Patient Liability	Any unemployment benefits being received from Nevada or any other state. Verification: (not all inclusive) - ESD printout - Copy of check stub - Form 2339
VACATION PAY 1. Earned 2. Counted in Financial 3. Counted in Patient Liability	Income from employer for vacation time off. Verification: (not all inclusive) - Copy of check - Statement from employer, Form 2074
VENDOR PAYMENTS 1. Unearned 2. Excluded in Financial 3. Excluded in Patient Liability	Payments made to business/organization on behalf of the client. Verification: (not all inclusive) - Statement from person making payment
VETERAN'S BENEFITS 1. Unearned a. Counted in Financial & Patient Liability b. Exclude UME first then count in Financial & Patient Liability c. Exclude in Financial & Patient Liability	Veteran's benefits include the following types: (Benefit increases usually occur effective December, reflected on January checks.) VA Compensation for Service Connected Disability, DIC or VA Survivor benefits . VA Pension – Pension to wartime veterans, a non-service-connected disability benefit, or a benefit to survivors of wartime veterans. Evaluate for UME using Form 2039 and the VA award letter which indicates medical expenses were used to determine benefit amounts. Aid and Attendance or Housebound benefits are paid to certain veterans and/or widows(ers) of veterans when these persons are unable to fully care for themselves physically. **The $90 reduced pension is considered Aid and Attendance benefits.**

INCOME TYPE	DESCRIPTION
VETERAN'S BENEFITS (Cont'd)	
d. Exclude in Financial & Patient Liability	A reimbursement of Unusual Medical Expenses (UME) is paid to veterans and/or widow(ers) of veterans when they show their medical expenses exceeded 5% of the maximum annual VA payment rate. This payment could be made as a lump sum payment or be prorated over the next year and be a part of the regular monthly VA check. Verification: (not all inclusive) - Copy of award letter or amended award letter - Copy of disallowance letter - SSA Benefit Record - Written statement from Veteran's Administration Regional Office - Form 2339 or 2038 "Benefit" Certification" - Form 2339 "VA UME Budget" **Exception**: Veterans residing in a State Veteran's Home do not have their pension reduced to $90. However, their Veteran's benefits are excluded from financial eligibility. Their pension is used for patient liability, including any portions designated as UME or Aid and Attendance.
VICTIMS OF CRIME 1. Unearned 2. Excluded in Financial 3. Counted in Patient Liability	Payments received from a fund established by a state to aid victims of crime. Verification: (not all inclusive) - Copy of check or award letter - Statement from the agency making payment
VOLUNTEERS IN SERVICE TO AMERICA (VISTA) 1. Unearned 2. Excluded in Financial 3. Excluded in Patient Liability	A federal domestic volunteer agency service program: Verification: (not all inclusive) - Copy of check - Statement from VISTA

INCOME TYPE	DESCRIPTION
WAGES 1. Earned 2. Counted in Financial 3. Counted in Patient Liability	Salary and/or tips from employment. Verification: (not all inclusive) - Copy of check - Statement from employer, Form 2074
WORK STUDY PROGRAMS 1. Earned 2. Counted in Financial 3. Counted in Patient Liability	Income from Work Study Programs. Verification: (not all inclusive) - Copy of check - Statement from employer, Form 2074
WORK TRAINING PROGRAMS 1. Earned 2. Counted in Financial 3. Counted in Patient Liability	Income from a Work Training Program. Verification: (not all inclusive) - Copy of check - Statement from source of payment

INDEX
SECTION 230
TYPES OF RESOURCES

230 TYPES OF RESOURCES (not all inclusive)

RESOURCE TYPE	DESCRIPTION
ANNUITIES 1. Personal Property 2. Conditional Exclusion	Annuities are usually purchased to provide a source of income for retirement. A lump sum of money is paid to a bank or insurance company and in return, the individual is promised regular payments of income. These payments continue for a fixed period or for as long as the individual lives, thus creating an ongoing income stream. The value of an annuity is the amount of money an individual can currently withdraw from the fund after the penalty deduction. This amount, if any, is a countable resource. Verification: (not all inclusive) - Documents from the source of payment - Copy of the annuity agreement
BANK ACCOUNTS Checking, Savings, Time Certificates, Money Markets, Certificates of Deposit (CD) 1. Personal Property 2. Counted Refer to Individual Development Account (IDA) section for consideration of funds deposited and interest earned on funds in an IDA savings account.	To determine the countable resource amount, consider the low balance of the account on any given day of the calendar month. Any income/interest deposits in a calendar month are not a resource until the month following the month it is posted to the account. Rebutting ownership does not apply for spousal resource determinations. **A. Ownership** The person designated as owner of the account owns all the funds in the account. **Exception**: If the owner is acting as an agent for another individual, monies deposited and disbursed on behalf of that individual are not countable. **B. Shared Ownership (joint account)** **Account holders are:** - married couples - parent and minor child **When deeming applies** in determining eligibility for the coverage group (e.g., Public Laws, institutionalized less than 30 days, etc), rebutting ownership is NOT REQUIRED because deeming resources takes precedence.

RESOURCE TYPE	DESCRIPTION

BANK ACCOUNTS
(Cont'd)

When deeming does not apply (e.g., Home Based Waivers, institutionalized at least 30 days, etc.), the account resource balance will be presumed available to the client unless the client can successfully prove all or part of the funds are not his/hers. **Exception: cases where spousal impoverishment applies, equal division of resources applies or when the client is acting as an agent for the other account holder(s); rebutting ownership is NOT REQUIRED.**

Account holders ARE NOT:

- married couples
- parent and minor child

The account resource balance will be presumed available to the client unless the client can successfully prove all or part of the funds are not his/hers. **Exception: when the client is acting as an agent for the other account holder(s).**

Inform the Individual: (using Form 2614)

1. The funds in the account belong to the applicant/recipient.

2. The implications are: All funds are a countable resource when determining Medicaid eligibility.

3. Of his/her right to provide evidence rebutting the ownership if he/she disagrees.

   If an account holder is a minor or incompetent at least one account holder and a third party who has knowledge of the circumstances surrounding the establishment of the joint account must complete the form.

   If the client does not complete and return Form 2614 by the specified date, deny or terminate the case for failure to cooperate.

C. Court Order/Written Agreement

If a written agreement or court order designates ownership of the joint account to either spouse, the account will be considered the resource of that spouse. Disproving Ownership does not apply.

D. Client Chooses Not to Disprove Ownership (Form 2614 completed and in case record)

The account will be considered the client's resource.

RESOURCE TYPE	DESCRIPTION

BANK ACCOUNTS (Cont'd)

E. Disproving Ownership

If an individual wishes to disprove ownership, obtain his or her statement, on Form 2615:

- who owns the funds;
- why there is a joint account;
- who has made deposits to and withdrawals from the account; and
- how withdrawals have been spent

The client has successfully disproved ownership for all months of requested coverage when proof from the financial institution shows: 1) the client's name has been removed from the joint account; OR 2) access to the account has been restricted and the funds are not available to the client; OR 3) the account has been changed so only the client's money is in the account.

If the client can show they are in the process of removing their name from the account, but the action cannot be completed for a time due to a specified reason, the client has successfully disproved ownership. The case should be future actioned to verify the account was closed/name removed.

EXAMPLE: Client and daughter are joint account owners. The client's SSA is directly deposited into the account. Client disproves ownership of the account and provides a statement from Social Security she has requested her check go directly to another account in her name and a statement from the bank requesting the removal of her name from the account. The statement from the bank indicates they will not remove her name until Social Security gets the direct deposit transferred to the other account which will take approximately two months. If all other criteria are met, the account is successfully disproved. The case would be processed and future actioned to verify the removal of her name from the account.

In cases where the client did not successfully disprove ownership, notify the client in writing that ownership was not disproved and explain how income and resources are being evaluated.

RESOURCE TYPE	DESCRIPTION
BANK ACCOUNTS (Cont'd)	**F. Client Does Not Disprove Ownership** The account will be considered the clients resource. Verification: (not all inclusive) - For Public Guardianship cases only, the ledger card (aka PA Transaction Journal, PA Journal Report or PA Transaction Report) is the primary source for verifying liquid resources. - Copy of bank statement - Copy of deposits and withdrawals - Copy of canceled checks
BURIAL FUNDS 1. Personal Property 2. Conditional Exclusion	Funds set aside for burial include burial insurance, revocable burial contracts, burial trusts, and any separately identifiable assets which are clearly designated for expenses connected with burial, cremation, or other funeral arrangement. ("Separately Identifiable" means the funds must be kept separate from the individual's other assets.) Only financial instruments can be claimed by the client/representative to be funds set aside for burial and must be clearly designated as such. Financial instruments include cash, burial contracts, financial institution accounts, stocks, bonds, life insurance policies, etc. Burial funds cannot be co-mingled with any nonburial related assets. Note: If money is withdrawn from funds designated as set aside for burial, these funds are no longer considered "designated" and cannot meet the burial exclusion. Designation is either by legend on an account or by declaration. Declaration is a signed statement under penalty stating the purpose for which the funds were set aside and the date on which the funds were set aside. Within the statement is the value and the owner of the assets, for whose burial, the form in which the funds are held and the date on which the person first considered the funds set aside for burial. The funds can be excluded effective with the latest of: a. The date of application (if the funds were considered set aside before the month of application); OR b. The month following the month in which the funds were considered set aside, unless there is evidence the funds were used and replaced after that date.

RESOURCE TYPE	DESCRIPTION

BURIAL FUNDS
(Cont'd)

Dedicated-cumulative burial fund accounts permit monies from different individuals to be placed into one account as long as all the money in the account is for a dedicated purpose. The money deposited into this account must consist of burial funds only. These accounts, their use, establishment and protocol must be approved by the Chief of Eligibility & Payments. The dedicated-cumulative burial fund utilized by the Public Administrator's Office of Clark County has been approved for use.

THE FOLLOWING EXCLUSIONS APPLY TO BURIAL FUNDS:

a. Any interest accrued in burial accounts which is not paid but left to accumulate as part of the funds;

b. Up to the maximum of $1,500 each for the client and/or client's spouse.

Only the Cash Surrender Value (CSV), less interest, of the policy, contract or insurance OWNED by the client/client's spouse is applied towards the $1,500 exclusion. Obtain verification from the mortuary/insurance company of the CSV. Burial funds in excess of $1,500 will be a countable resource.

THE $1,500 MAXIMUM MUST BE REDUCED BY:

1) The amount of funds held in an irrevocable burial trust, irrevocable burial contract or other irrevocable arrangement available to meet burial expenses.

NOTE: **Any burial trusts, contracts or other arrangements issued in Nevada are not considered irrevocable by state law. These are available resources**.

Other burial arrangements issued outside of Nevada may be considered irrevocable. Verify with the state where they were issued to determine availability.

2) The **FACE** value of any life insurance policy owned by the client/client's spouse if the CSV was excluded in determining countable resources. NOTE: Life insurance with no provision for a CSV will not affect the burial exclusion.

EXAMPLE: Client has a life insurance policy with a FACE value of $1,200 and a CSV of $500. Because the FACE value was less than $1,500, the $500 was excluded as a resource.

RESOURCE TYPE	DESCRIPTION
BURIAL FUNDS (Cont'd)	The client also has funds set aside for burial in the amount of $2,000 (i.e., CSV of a burial policy). To determine the amount of burial which can be excluded: a) Subtract the $1,200 FACE value of the excluded life insurance policy from the $1,500 leaving $300 left of the exclusion. b) Subtract the remaining $300 exclusion from the $2,000 burial funds, leaving a balance of $1,700. The $1,700 is counted toward the resource limit. Verification: (not all inclusive) – Copy of policy, contract, trust, financial instrument, etc. – Form 2006 designating burial funds – Form 2605 Insurance Policy Information
BURIAL SPACES AND RELATED ITEMS 1. Personal Property 2. Excluded	A burial space or item held for the burial of the client, client's spouse, or any other member of the client's immediate family is an excluded resource, regardless of value. The burial space exclusion is in addition to and has no effect on the burial funds exclusion. a. Burial spaces are defined as burial plots, gravesites, crypts, mausoleums, caskets, urns, niche or other repositories customarily used for the remains of deceased persons. Burial items may include, but are not limited to vaults, headstones, markers, or plaques, burial containers (e.g., for caskets) and arrangements for the opening and closing of the gravesite and endowment care. b. Immediate family includes a client's minor and adult children, stepchildren, and adopted children; brothers, sisters, parents, adoptive parents and spouses of those persons. Verification: (not all inclusive)

RESOURCE TYPE	DESCRIPTION
CASH ON HAND 1. Personal Property 2. Counted	Currency held by client at home, on their person, etc. Verification: (not all inclusive – Client's statement
DEATH BENEFITS 1. Personal Property 2. Conditional Exclusion	Death benefits, including gifts and inheritances, to the extent they are not income because they are to be spent on costs resulting from the last illness and burial expenses of the deceased, are not resources for the calendar month following the month of receipt. If retained until the second calendar month following receipt, they become a resource. Verification: (not all inclusive) – Documents from source of payment
ENTRANCE FEES 1. Personal Property 2. Conditional	Fees paid to continuing care retirement communities (CCRCs), or life care communities (LCCs) where a range of living arrangements from independent living through skilled nursing facility care is provided. These facilities require potential residents provide information about their finances, resources and income, before being accepted for admission. The value is determined taking into account spousal impoverishment rules, where appropriate. Effective February 8, 2006, considered an available resource if all three conditions are met: – Individual can use them to pay for care when other income and assets are insufficient; and – Refundable upon death of the resident or termination of residency in the facility; and – Fees do not confer (give) any ownership interest in the CCRC or LCC Verification: (not all inclusive) – Client's statement – Copy of signed contract – Receipt of funds paid
FEDERAL TAX REFUNDS 1. Personal Property 2. Conditional Exclusion	An unspent federal tax refund or payment is excluded from resources for a period of 12 months following the month of receipt of the payment. Verification: (not all inclusive) – Copy of check – Copy of IRS Filing Form

RESOURCE TYPE	DESCRIPTION
HOME EQUITY 1. Personal Property 2. Conditional Exclusion	Individuals whose equity interest in their home exceeds $506,000 are ineligible for long-term care and HCBW services, unless: – The individual's spouse, dependent child under age 21, or blind/disabled child resides in the home; or – Equity is reduced below $506,000 due to a home equity loan or reverse mortgage. Effective with applications filed on or after January 1, 2006. The value is the current market price of the home, or the amount for which it can reasonably be expected to sell on the open market. An encumbrance is a legally binding debt against the resource, like a mortgage, reverse mortgage, home equity loan, or other debt secured by the home. Refer to 240,G for potential transfer of assets. Verification: (not all inclusive) – Written statement from county assessor's office – Tax lists – Copy of mortgage papers/escrow documents – Copy of deed – Real Estate Appraisal
HOUSEHOLD GOODS AND PERSONAL EFFECTS 1. Personal Property 2. Excluded	Household goods are items of personal property customarily found in the home and used in connection with the maintenance, use, and occupancy of the premises as a home. They include, but are not to: furniture, appliances, televisions, carpets, cooking and eating utensils, dishes, etc. Personal effects are items of personal property that are worn or carried by an individual or that have an intimate relation to him or her. They include, but are not limited to: clothing, jewelry, personal care items, prosthetic devices, and educational or recreational items such as books, musical instruments, or hobby materials. Prosthetic devices, wheelchairs, hospital beds, dialysis machines and other items required by a person's physical condition are excluded. Verification: (not all inclusive) – Client's statement
INCOME PLACED IN AN ACCOUNT IDENTIFIED AS EXCLUDED INCOME	Any excluded income placed in a financial institution when clearly identified as excluded income.

RESOURCE TYPE	DESCRIPTION
1. Personal Property 2. Conditional Exclusion	Verification: (not all inclusive) – Source of income – Copy of account statement – Source of deposits
INDIAN LAND 1. Real Property 2. Conditional Exclusion	ALL INDIAN PROPERTY under authority of the Bureau of Indian Affairs has a restricted title. **A. ASSIGNED LAND** – An assignment allows the use of tribal land by a member of the tribe. Assigned land will not be considered a resource. **B. ALLOTTED LAND** – This type of land can be sold by the individual upon approval by the Bureau of Indian Affairs. Allotted land is not a resource until the property is sold or transferred. **C. UNRESTRICTED LAND** – Land owned by the individual and not controlled by the Bureau of Indian Affairs. This land is an available resource. Verification: (not all inclusive) – Tax rolls – Copy of Deed – Bureau of Indian Affairs – Client's statement
INDIAN MONEY 1. Personal Property 2. Conditional Exclusion	Per capita share payments granted to Western Shoshone Indians pursuant to Public Law 108-270 are an exempt resource.
INDIVIDUAL DEVELOPMENT ACCOUNT (IDA) 1. Earned/Unearned 2. Excluded in Financial 3. Excluded in Patient Liability	Intended to improve the economic independence and stability of individuals and families and to promote and support the transition to economic self-sufficiency. An IDA participant can only deposit earned income into an IDA. Federal funds match the amount of earnings low-income working individuals and families deposit into an IDA. IDA savings are to be used for a first home purchase, post secondary educational expenses, or business capitalization. The Social Security Act provides for State Family Assistance Grant funds (i.e., TANF, WtW) to be used to establish IDAs. The Assets for Independence Act (AFIA) provides for IDAs to be established under Head Start, Low Income Home Energy Assistance (LIHEA), and Community Services. Income in an IDA includes: - Participant contribution (earned income); - Interest earned on participant earned income contributions; - Matching funds; and - Interest accrued on matching funds. An individual whose participation in the IDA program has terminated, voluntarily or otherwise, is no longer covered by the resource exclusion.

RESOURCE TYPE	DESCRIPTION
LIFE ESTATES 1. Personal Property 2. Conditional Exclusion	A life estate gives an individual for his/her lifetime certain rights in property. These rights are the right of possession, the right to use the property, the right to obtain profits from the property (i.e., collection of rents) and the right to sell his or her life estate interest. A contract establishing a life estate may restrain one or more of these rights. The owner(s) of a life estate do not have title to the property and do not have the right to sell the property. The value of a client's life estate is determined by: 1) the age of the client, 2) the number of owners, and 3) the fair market value of the property. The above information must be verified and then sent to the Chief of E&P requesting a determination of the life estate value. **Exception: A life estate in the principal place of residence is an excluded resource and determining its value is not necessary.** Refer to 240,G for potential transfer of assets. Verification: (not all inclusive) – Signed and dated statement from a licensed real estate broker – Written statement from county assessor's office – Tax lists – Copy of mortgage papers – Copy of deed – Copy of life estate contract
LIFE INSURANCE POLICIES 1. Personal Property 2. Conditional Exclusion	A life insurance policy is a contract. Its purchaser (the owner) pays premiums to the company that provides the insurance (the insurer). In return, the insurer agrees to pay a specified sum to a designated beneficiary upon the death of the insured (the person on whom, or on whose life, the policy exists). Face Value (FV) is the amount of basic death benefit contracted for at the time the policy is purchased. A policy's cash surrender value (CSV) is a form of equity value that it acquires over time. The owner of a policy can obtain its CSV only by turning the policy in for cancellation before it matures or the insured dies. A loan against a policy reduces its CSV. A life insurance policy is a resource if it has a CSV. Its value as a resource is the amount of the CSV. Life insurance which does not have a cash surrender value (e.g., term life insurance) is excluded from all computations.

RESOURCE TYPE	DESCRIPTION
LIFE INSURANCE POLICIES (Cont'd)	Any life insurance policy with a CSV must be evaluated for the FV. If the total FV of the policy or combined FV of multiple policies the individual owns total $1,500 or less, exclude them as a resource. If the total FV of the policy or policies exceeds $1,500, the total CSV for each policy is counted. Accelerated life insurance payments are proceeds paid to a policyholder PRIOR to death. Because an individual receives proceeds from the policy (not the policy's resource value, which is its cash surrender value), the receipt of an accelerated payment is not treated as a conversion of a resource. Since accelerated payments can be used to meet the individual's needs, the payments are income in the month received and a resource if retained into the following month. Most accelerated payment plans fall into three basic types, depending on the circumstances which cause or "trigger" the payments to be accelerated. These are the: ● Long–term care model, which allows policy- holders to access their death benefits should they require extended confinement in a care facility or, in some instances, health care services at home; ● Dread disease or catastrophic illness model, which allows policy holders to access their death benefits if they contract or acquire one of a number of specified covered conditions; and ● Terminal illness model, which allows policy holders to access their death benefits following a diagnosis of terminal illness where death is likely to occur within a specified number of months. Some companies refer to these types of payments as "living needs" or "accelerated death" payments. Depending on the type of accelerated payment plan, receipt of accelerated payments may reduce the policy's FV by the amount of the payments and may reduce CSV in a manner proportionate to the reduction in FV. In some cases, a lien may be attached to the policy in the amount of the accelerated payments and a proportionate reduction in CSV results. Verification: (not all inclusive) – Insurance policy/rider – Form 2015 from insurance company – Written statement from insurance company **NOTE:** If the CSV is excluded in determining countable resources the FACE value of the life insurance policy may reduce an applicant's burial exclusion. See Burial Funds.

RESOURCE TYPE	DESCRIPTION
LIQUIDATED RESOURCE 1. Real/Personal Property 2. Counted/Excluded	If a resource is liquidated, the money received is not budgeted as income, it is still considered a resource. Apply the countable/ exclusion rules governing the new form the liquidated resource has taken, i.e., cash on hand, bank account, vehicle, stocks, etc. Verification: (not all inclusive) – Sales receipt – Proof of purchase documents – Financial statements
MACHINERY AND EQUIPMENT 1. Personal Property 2. Counted	Machinery and equipment not established as property essential for self–employment/self–support is counted at market value less encumbrances. Verification: (not all inclusive) – Client's statement is accepted unless the case manager has reason to question the client's statement. Verification is required ONLY when the case manager has reason to question the client's statement. – Written statement from county assessor's office – Written dealer's estimate – Written estimate from agricultural agent
MEDICAL SAVINGS ACCOUNTS (employee) 1. Personal Property 2. Conditional Exclusion	An employer may elect to provide health care benefits for an employee through a medical savings account program. The account is available and therefore countable to the employee after the last business day of the year in an amount equal to the amount contributed during that year. The account is also available and therefore countable when the individual is no longer employed by the employer. Disbursements may be made during a given year by the administrator of the account to pay medical expenses of the employee or his/her dependent, or to reimburse the employee for paid medical expenses. Verification: (not all inclusive) - Written statement from the employer

RESOURCE TYPE	DESCRIPTION
MINERAL RIGHTS 1. Real/Personal Property 2. Counted	Mineral rights represent ownership interest in natural resources such as coal, oil, or natural gas, which are normally extracted from the ground. If the individual owns the land to which the mineral rights pertain, the market value of the land should include the value of any mineral rights too. If the individual does not own the land to which the mineral rights pertain, obtain the market value from a knowledgeable source. Verification: (not all inclusive) – The Bureau of Land Management – U.S. Geological Survey – Mining Companies holding leases
MONEY FROM SALE OF EXCLUDED HOME	Money received from the sale of an excluded home is disregarded if used to purchase another excludable home within 3 months after the money is received. When the money is received in increments over a period of time, amounts applied to principal are considered a resource and amounts applied to interest are unearned income. Verification: (not all inclusive) – Escrow documents – Copy of check – Bill of sale
PATIENT TRUST ACCOUNTS	To determine the countable resource amount, consider the low balance of the account on any given day of the calendar month. Any income deposits in a calendar month are not a resource. If the facility rebuts the trust account balance due to a delay in posting patient liability or other expenses, they must provide a statement which includes the following: a. The total balance of the patient trust account; and b. What portion of the balance is not available and why. The unavailable portion must be itemized showing the amounts which are encumbered and the source of the encumbrance; and c. It must be clear the encumbered portion would not be released to the client if a request were made by the client.

RESOURCE TYPE	DESCRIPTION
PATIENT TRUST ACCOUNTS (Cont'd)	If a statement is provided with all of the above, the portion the facility states is unavailable will not be counted as a resource in determining eligibility. Verification: (not all inclusive) - Patient Trust Account Ledgers - Medical Facility Information Form 2547-EE
PENSION FUNDS 1. Person Property 2. Conditional Exclusion	Pension funds are funds held in individual retirement accounts (IRA) (as described by the IRS), or in work–related pension plans (including Keogh plans). A vested retirement account is an account to which an employee makes contributions for a specified period of time, as defined by the employer. The money contributed by the employee is not matched by the employer until the defined period of time ends. Count money in an IRA or Keogh as a resource, even if there is a penalty for early withdrawal. Deduct the early withdrawal penalty and count the remainder as a resource. Do not count Keogh plans as a resource if there is a contractual withdrawal agreement with other people who are not household members, but share the same fund. Consider this resource inaccessible. Count money in a vested retirement account as a resource, unless early withdrawal is prohibited. If a vested retirement account is attached and distribution or availability of funds is blocked by a court order due to divorce or child support, consider this resource inaccessible. Count money in a 401K plan as a resource. Any retirement fund is not a resource if an individual must terminate employment to obtain any payment. Pension funds of the client's ineligible spouse are excluded, unless spousal impoverishment rules apply. Verification: (not all inclusive) – Financial statements – Tax return documents

RESOURCE TYPE	DESCRIPTION
PROMISSORY NOTES, FORMAL WRITTEN LOAN AGREEMENTS AND PROPERTY AGREEMENTS 1. Personal Property 2. Conditional Exclusion	Generally, promissory notes, property agreements and loan agreements may be sold or discounted. If the client's statement of value, either alone or combined with other resources, exceeds the resource limit, there is no need to verify current market value. Presume the value is its outstanding principal balance unless reliable evidence shows current market value (CMV) is less. Refer to 240,G,1 a. and b. to determine if a transfer of resource exists. If the individual alleges the item is for sale, promissory notes, formal written loan agreements and property agreements are excluded when the client verifies the item is for sale at market value and no offers to purchase have been received. The item must remain for sale while the client receives assistance. "Good Faith" efforts must be made by or on behalf of the client to qualify under this exclusion. These efforts must continue for the exclusion to remain in effect. Federal regulations state "good faith efforts" to sell resources consist of taking all necessary and reasonable steps to sell it in the geographic area covered by media (radio, television, and newspaper, etc.) serving the area where the property is located. "Necessary and reasonable" steps to sell this resource will be to utilize a licensed realtor to list the resource for sale OR advertise the resource is for sale through at least one media source covering the area where the resource is located and posting a 'for sale' sign on the property if applicable. The frequency in advertising property for sale will be at least twice a month. **Example:** Newspaper advertisements should appear twice in a month with each length of time the decision of the client/ representative. A bonafide negotiable agreement is a resource. The portion of any payment received representing payment on the principal is also a resource. The portion of any payment which represents interest on the principal is unearned income. An agreement which is not bonafide or negotiable is not a resource. The total payments received, whether principal and/or interest, are unearned income. Verification: (not all inclusive) – Bank or other financial institution – Title company – Private investor – Real estate broker

RESOURCE TYPE	DESCRIPTION
RADIATION EXPOSURE PAYMENTS	Payments made under the Radiation Exposure Compensation Act.
1. Personal Property 2. Excluded	Verification: (not all inclusive) – Documents from Source of Payment – Verify how the resources are held
REAL PROPERTY	Real property is land, including buildings or immovable objects attached permanently to the land.
1. Real Property 2. Conditional Exclusion	Real property is excluded: a. When the property is the client's principal place of residence. A principal place of residence is defined as a home (including a mobile home or contiguous land) in which a client is residing or has resided in the past. Land is contiguous to the home when not separated by property owned by another person. The home exclusion applies to all buildings on the land. A principal place of residence is/was a permanent living arrangement of at least one full calendar month prior to his/her absence. When a client has ownership interest in more than one residence, determine which is primary by obtaining evidence such as, but not limited to: 1. How much time is spent at each residence; 2. Where he/she is registered to vote; 3. Which address he/she uses as a mailing address or for tax purposes. Determine the primary residence accordingly and document in the permanent section of the casefile. The exemption continues to apply when the client is absent from the home but: 1) Intends to return. If the client or his authorized representative states in writing the client intends to return to the home, regardless of whether there is medical evidence showing this is a probability, the home will be exempt; OR 2) The home is occupied by a spouse or dependent (e.g., financially, medically dependent) relative; OR 3) The home ownership is transferred to a Revocable Trust. The transfer of a primary residence by an institutionalized individual, including SSI recipients, must be evaluated for potential transfer of resource penalty. Refer to 240.

RESOURCE TYPE	DESCRIPTION
REAL PROPERTY (Cont'd)	b. For all non-business property up to $6,000 of the client's equity if the property is producing a net annual income of at least 6 percent of the excluded equity. The amount of equity exceeding $6,000 is counted as a resource. Income from this property is counted; OR c. When the client verifies the property is for sale at market value AND no offers to purchase have been received (the property must remain for sale while the client receives assistance), or the property has been sold and escrow has not been completed. "Good Faith" efforts must be made by or on behalf of the client in order for property to qualify under this exclusion. These efforts must continue for the exclusion to remain in effect. Federal regulations state "good faith efforts" to sell property consist of taking all necessary and reasonable steps to sell it in the geographic area covered by media (radio, television, and newspaper, etc.) serving the area where the property is located. "Necessary and reasonable" steps to sell this resource will be to utilize a licensed realtor to list the property for sale OR advertise the property is for sale through at least one media source covering the area where the property is located and posting a 'for sale' sign on the property. The frequency in advertising property for sale will be at least twice a month. Example: Newspaper advertisements should appear twice in a month with each length of time the decision of the client/representative. Verification: (not all inclusive) – Signed and dated statement from a licensed real estate broker – Written statement from county assessor's office – Tax lists – Copy of mortgage papers – Copy of deed – Letter from mobile home dealer

RESOURCE TYPE	DESCRIPTION
REIMBURSABLE MEDICAL EXPENSES 1. Unearned 2. Excluded in Financial 3. Excluded in Patient Liability	Reimbursement for expenses already paid for by the individual (pre-paid institutional care) is not countable as income, but IS countable as a resource following the month of receipt. Other types of cash received for medical expenses (reimbursed prescription expenses) are not countable as income, and are not countable as resources until the second month following receipt. Verification: (not all inclusive) - Documents from the source of payment
RELOCATION ASSISTANCE PAYMENTS 1. Personal Property 2. Conditional Exclusion	Unspent relocation assistance payments from a state or local government are excluded from resources for 9 months beginning the month after the month in which they received these funds. For example, if an individual receives relocation assistance in January, the assistance can be excluded beginning February through October. Verification: (not all inclusive) – Documents from Source of Payment
REPLACEMENT/REPAIR FUNDS 1. Personal Property 2. Conditional Exclusion	When monies are received for replacement or repair of destroyed, damaged, or stolen **excluded** resources, the amount of money received is disregarded from resources for 9 months. When monies are received for replacement or repair of destroyed, damaged or stolen resources, the amount of money received is considered a change in type of resource and remains a resource, not income. Verification: (not all inclusive) – Documents from source of payment – Receipts and canceled check copies
REVERSE MORTGAGE 1. Personal Property 2. Counted	Payments received from a reverse mortgage are exempt income in the month received. Any portion of the payments retained the month following the month of receipt is considered a countable resource. **Note**: Refer to MBD 240 for potential transfer of assets.
SAFE DEPOSIT BOXES	Safe deposit boxes may contain copies of deeds, insurance policies, money and other countable resources. The client's statement on the application as to the contents may be taken unless questionable. If the contents are questionable, they must be verified. EXCEPTION: If the contents are questionable or unknown, and there is no way to verify the contents because the client is incapable of opening the box and there is no other way to verify the contents, the contents will be considered inaccessible. Verification: (not all inclusive) – The case manager viewing the contents – A written statement verifying the contents

RESOURCE TYPE	DESCRIPTION
SELF-SUPPORT RESOURCES 1. Real/Personal Property 2. Conditional Exclusion	Resources necessary to fulfill a Plan for Achieving Self–Support (PASS) for the blind and disabled as long as the plan remains in effect. The plan must be an individual plan, in writing, approved by the Social Security Administration. Verification: (not all inclusive) – Written documents from the Social Security Administration
SELF-EMPLOYMENT RESOURCES 1. Real/Personal Property 2. Conditional Exclusion	Property essential for self–employment/self-support. All property used in a trade or business and all property used by an employee in connection with employment, regardless of the amount of equity an individual has in the property or whether the property is producing a reasonable rate of return (e.g., real property, buildings, inventory, equipment, tools, machinery, vehicles, etc.). The property must be in current use or returned to use (or in the case of a deceased person, was expected to have been returned to use) within one year. Verification: (not all inclusive) – Income Tax Records – Business Records – Client's statement
SSI/RSDI RETRO PAYMENTS 1. Personal Property 2. Conditional Exclusion	SSI/RSDI Retroactive payments are excluded from resources for 6 months following the month of receipt. For example, a retroactive RSDI payment received in January is unearned income for January when determining financial eligibility and patient liability. The RSDI retroactive payment is excluded from resources effective February through July. These payments are no longer excluded when converted to another resource such as stocks, bonds, etc. Verification: (not all inclusive) – SSA Award Letter – Verify how the resources are held

RESOURCE TYPE	DESCRIPTION
STOCKS AND BONDS 1. Personal Property 2. Conditional Exclusion (Stocks Only)	Shares of stock represent ownership in a business corporation. Their value shifts with demand and may fluctuate widely. Exclude shares of stock which cannot be sold. U.S. Savings Bonds are obligations of the Federal Government. Unlike other government bonds, they are not transferable; they can only be sold back to the Federal Government. U.S. Saving Bonds cannot be redeemed for six months after the issue date specified on the face of the bond. A municipal bond is the obligation of a state or a locality (county, city, town, village or special purpose authority such as a school district). A corporate bond is the obligation of a private corporation. Verification: (not all inclusive) – Newspaper reporting stock closing prices – Local Securities Firm – Written statement from firm's accountants – Table of redemption values for U.S. Savings Bonds – Telephone call to local bank
TRUST FUNDS 1. Personal Property 2. DAG Opinion Required	All trusts are referred to the Eligibility and Payments Unit for an evaluation and decision on availability. Obtain the trust document with all attachments to send with the request. Trusts established prior to August 11, 1993 by an individual or the individual's spouse, under which the individual is the recipient of all or part of any payments from the trust are called Medicaid Qualifying Trusts (MQTs). MQT assets (income/resources) are "deemed" available to the client. When the evaluation determines that principal of the trust is not available to meet the needs of the client, it is an excludable resource. Verification: (not all inclusive) – Trust documents/agreements – Memorandum from Chief of E&P

RESOURCE TYPE	DESCRIPTION
UNIFORM GIFTS TO MINORS 1. Real/Personal Property 2. Conditional Exclusion	Uniform Gifts to Minors Act permits gifts to minors which are free of tax burdens. An individual (donor) makes an irrevocable gift of money or other property to a minor (the donee). The gift, plus any earnings it generates, is under the control of a custodian until the donee reaches the age of majority by state law (18 years for Nevada). The custodian has discretion to provide to the minor or spend for the minor's support, maintenance, benefit or education, as much of the assets as he/she deems equitable. The donee automatically receives control of the assets upon reaching the age of majority. The gift, including any additions or earnings, is not income to the donee. The custodian's disbursements to the donee are income to the minor. All property becomes available to the donee and subject to income rules in the month the donee reaches the age of majority. The month following the month of majority, the property is subject to resource evaluation. Verification: (not all inclusive) – Copy of the document of ownership, e.g., deed, CD, savings passbook, etc.
VEHICLES 1. Personal Property 2. Conditional Exclusion	Vehicles include passenger cars, trucks, boats, snowmobiles, trailers, recreational vehicles, etc. The fair market value (FMV) less encumbrances of all types of vehicles for which the total or partial value has not been excluded. The FMV is determined by the "average trade–in" value or the current "wholesale blue book" value of the vehicle excluding optional equipment and mileage. If the vehicle is no longer listed in the blue book or the vehicle is inoperable or extensively damaged, the client's statement of value is acceptable. **ALWAYS obtain FMV of vehicles which are collectible or antique.** For vehicles used to provide transportation such as passenger cars, trucks, boats, snowmobiles, animal drawn vehicles, etc., apply the following exclusions in the following order.

RESOURCE TYPE	DESCRIPTION
VEHICLES (Cont'd)	This does not include recreational vehicles or vehicles not used for transportation. a. Exclude the TOTAL value of ONE vehicle for the client or member of the client's household if: 1) It is necessary for employment; 2) It is necessary for transportation to or from medical treatment of a specific or regular medical problem; 3) The vehicle has been modified for operation by or transportation of the handicapped client/household member; 4) It is necessary because of climate, terrain, or distance to provide transportation to perform essential daily activities (such as going to the grocery store, going to the post office, etc.). b. When NO vehicle has been excluded under 1, 2, 3 or 4 above, the current market value (CMV), NOT allowing any encumbrances, of ONE vehicle up to $4,500 will be excluded. When the market value exceeds $4,500, the excess amount is divided equally among all owners and the client's share is applied toward the resource limit. c. The market value of any OTHER vehicles less encumbrances is divided equally among all owners and the client's share is applied toward the resource limit. d. Exclude the TOTAL value of the client's vehicle(s) essential for producing income including vehicles used in a trade or business. Verification: (not all inclusive) – Client's statement regarding the number of vehicles owned, ownership status and availability is acceptable unless the case manager has reason to question the statement. Possible sources of verification are: – Kelley Blue Book – Copy of bill of sale – Copy of vehicle registration – Written statement from county tax assessor – Estimate from auto dealer
VICTIMS OF CRIME 1. Personal Property 2. Conditional Exclusion	Payments received from a fund established by a state to aid victims of crime are excluded for a 9–month period beginning the month after the payments are received. Verification: (not all inclusive) – Documents from source of payment

240 TRANSFER OF ASSETS (Not applicable to QMB-Section 310, Public Law-Section 330 and Prior Medical-Section 380)

A. INTRODUCTION

For purposes of this section, assets include all income and resources of the individual and of the individual's spouse. This includes income or resources which the individual or the individual's spouse is entitled to but does not receive because of any action by:

- The individual or the individual's spouse;
- A person, including 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
- Any person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

For purposes of this section, the term "assets an individual or spouse is entitled to" includes assets to which the individual is entitled or would be entitled if action had not been taken to avoid receiving the assets.

The following are examples of actions which would cause income or resources not to be received:

- Irrevocably waiving pension income;
- Waiving the right to receive an inheritance;
- Not accepting or accessing injury settlements;
- Tort settlements which are diverted by the defendant into a trust or similar device to be held for the benefit of an individual who is a plaintiff; and
- Refusal to take legal action to obtain a court ordered payment that is not being paid, such as child support or alimony.

Failure to cause assets to be received does not entail a transfer of assets for less than fair market value in all instances. For example, the individual may not be able to afford to take the necessary action to obtain the assets. Or the cost of obtaining the assets may be greater than the assets are worth, thus effectively rendering the assets worthless to the individual. Examine the specific circumstances of each case before making a decision whether an uncompensated asset transfer occurred.

B. DEFINITIONS

1. TRANSFER OF ASSETS – Assets (income/resources) which are given away, sold or disposed of for less than fair market value to obtain or retain Medicaid eligibility. This includes all income and resources to which the client or spouse is entitled or would be entitled if action had not been taken to avoid receiving the assets.

The home of an applicant/recipient (principal place of residence) can only be transferred in the specific instances outlined in section 240.K.5 whether the home is excludable or not.

2. INSTITUTIONALIZED INDIVIDUAL - Any person who is residing in a medical facility, including SSI recipients, or persons who fall into any category considered institutionalized recipients, such as Home and Community Based Waiver clients.

3. FAIR MARKET VALUE - The current market value of the asset AT THE TIME OF TRANSFER.

4. COMPENSATION - All money, real or personal property, food, shelter, or services received by the applicant/recipient at or after the time of transfer in exchange for the asset. Items received prior to the transfer will be considered compensation only if they were provided pursuant to a binding contract (verbal or written) to provide such items in exchange for payment.

5. UNCOMPENSATED VALUE - The Fair Market Value of the asset AT THE TIME OF TRANSFER, minus the amount of compensation received by the applicant/recipient or spouse in exchange for the asset.

6. LEGAL REPRESENTATIVE - Parent of a minor child, power of attorney, legal guardian, or anyone legally authorized to execute a contract for the client/spouse.

   Assets transferred by anyone acting in place of or on behalf of or at the request or direction of the client or spouse, are considered to be transferred by the client or spouse.

7. UNDUE HARDSHIP - Undue hardship is when there is no means, legal or otherwise, by which the applicant/recipient is able to have the asset transferred back to his/her ownership or receive further compensation.

8. SPOUSE – Person legally married to another under state law. In Nevada, a person is married until divorced.

9. COMMUNITY SPOUSE – A spouse who is not living in a medical institution, nursing facility, or receiving HBW services.

10. DRA – or Deficit Reduction Act of 2005, Public Law 109-171, which amended Section 1917(c)(1)(B)(i) of the Social Security Act.

11. PENALTY – Institutionalized individuals are denied coverage of certain Medicaid services during the transfer of asset penalty period. The individual remains eligible for Medicaid and can receive certain services not subject to the penalty. Eligibility codes C and D are used to indicate a penalty period.

C. GENERAL RULE

If an institutionalized individual (see definition in subsection "B" above), his/her spouse, or their legal representative has given away, sold or disposed of assets for less than fair market value, it is presumed the asset was disposed of for the purpose of becoming eligible for or to remain eligible for Medicaid.

D. LOOK BACK PERIOD

1. Asset Transfers Prior to February 8, 2006

Asset transfers must be evaluated during the 36-month 'look-back' period beginning the month of application OR if the individual is/was Medicaid eligible at the time he/she began receiving Home and Community Based Waiver (HCBW) or Long Term Care (LTC) Services the 36-month 'look-back' period begins with the month the HCBW or LTC Services begin.

Asset transfers must also be evaluated at anytime after the individual begins receiving HCBW or LTC services or anytime after the individual applies for Medicaid.

A 'look-back' period is extended to 60 months when there is a transfer of assets involving a trust. If, in the case of a revocable trust, a portion is disbursed to someone other than the grantor or for the benefit of the grantor, that portion is treated as a transfer of assets. If, in the case of an irrevocable trust, all or a portion of the trust cannot be disbursed to or on behalf of the individual, that portion is treated as a transfer of assets.

2. Asset Transfers On or After February 8, 2006

The DRA provides that for *any* transfer of assets made on or after February 8, 2006, the look-back period is *60 months* from the date the individual applied for Medicaid and was institutionalized or began receiving Home and Community Based Waiver services.

Asset transfers must also be evaluated at anytime after the individual begins receiving HCBW or LTC services.

E. TREATMENT OF INCOME AS ASSETS

When an individual's income is given or assigned in some manner to another person, such a gift or assignment can be considered a transfer of assets for less than fair market value.

If income or the right to receive income has been transferred, a penalty period must be imposed. If the income is a single lump sum, the penalty period is calculated on the basis of the amount of the payment.

If a stream of income or the right to such income is transferred, a determination of value will be made by the Chief of Eligibility and Payments and based on an actuarial projection of the individual's life expectancy.

F. TREATMENT OF JOINTLY OWNED ASSETS

When an asset is held by an individual in common with another person or persons via joint tenancy, tenancy in common, joint ownership or a similar arrangement, the asset (or affected portion of the asset) is considered to be transferred by the individual when any action is taken, either by the individual or any other person, that reduces or eliminates the individual's ownership or control of the asset.

When a transfer of assets situation is identified, individuals must be allowed an opportunity to rebut the presumption of ownership. Either individual can provide convincing evidence the assets transferred were the sole property of the other person.

The account resource balance will be presumed available to the individual unless the individual can successfully prove the funds are not his/hers. This portion will be considered a transfer of assets subject to a transfer penalty if withdrawn by the other individual or given away by the individual.

In the event of a divorce of an institutionalized applicant or recipient of Medicaid, a copy of the divorce decree and property settlement agreement must be provided to the case manager.

In the event that the court made an unequal disposition of the community property and failed to find a compelling reason set forth in writing for making such unequal disposition as required in state statute, this will be deemed to be a transfer of assets for less than fair market value to the extent of the unequal division. A penalty period will be imposed accordingly. (NRS 125.150)

G. TREATMENT OF CERTAIN KINDS OF ASSET TRANSFERS

1. Life Estates, Promissory Notes, Loans or Mortgages

a. Treatment of Life Estates Prior to April 1, 2006:

In a transaction involving a life estate, a transfer of assets has occurred whenever the value of the transferred asset is greater than the value of the rights conferred (given) by the life estate.

b. Treatment of Life Estates and Promissory Note, Loan or Mortgage Purchases on or after April 1, 2006:

1) In a transaction involving a life estate, a transfer of assets has occurred:

a) When the individual purchasing a life estate in another individual’s home has *not* actually resided in the home for a period of *at least* one year *after* the date of purchase.
b) When payment exceeds the fair market value of the life estate.
c) When an individual makes a gift or transfers interest in a life estate.

The amount of the transfer is the *entire* amount used to purchase the life estate.

This amount is *not* reduced or prorated to reflect an individual's residency for any time less than a year.

2) In a transaction involving a promissory note, loan, or mortgage, a transfer of assets has occurred unless *all* of the following criteria are met:

a) Unless the repayment term is actuarially sound;
b) Payments are made in equal amounts during the term of the loan with no deferral of payments and no balloon payments; and
c) The cancellation of the balance of the note, loan, or mortgage upon the death of the lender is prohibited.

If above criteria are not met, the amount of the transfer is the value of the outstanding balance due as of the date of the individual's application for Medicaid coverage of LTC or HCBW services.

2. Annuities

An annuity is a contract between an individual and a commercial company in which the individual invests funds and, in return, is guaranteed fixed substantially equal installments for life or a specified number of years.

A determination must be made regarding the purpose of the annuity. The annuity must have an expected return commensurate (equal) with the life expectancy of the beneficiary to be deemed actuarially sound.

If the individual is not expected to live longer than the guarantee period of the annuity, the individual will not receive fair market value and is subject to a transfer of assets penalty.

a. Treatment of annuities purchased prior to October 1, 2000.

1) An annuity purchased prior to October 1, 2000 is not an available resource if it is annuitized (yields monthly fixed, equal installments for a specified number of years, not to exceed the life expectancy of the client, or for the life of the client) and regular returns are being received by the annuitant. The funds received are income in the month received.
2) If the annuity purchased by the applicant/ client or his/ her spouse has not been annuitized it shall be considered an available resource regardless of the irrevocable status.

b. Treatment of annuities purchased on or after October 1, 2000.

1) The purchase of an annuity shall be considered as a transfer of assets without fair consideration unless the following criteria are met:

a) The annuity is purchased from a life insurance company or other commercial company that sells annuities as part of its normal course of business; and
b) The annuity is annuitized for the applicant/ client or his/her spouse; and
c) The annuity is purchased on the life of the applicant/client or his/her spouse; and
d) The annuity provides payments for a period not exceeding the annuitant's projected life.

2) Staff shall determine the maximum spousal need allowance of the community spouse, if applicable. If the monthly payment amount provided by the annuity to the community spouse exceeds the maximum spousal need allowance, the amount of the annuity which causes the monthly annuity payment to exceed the maximum spousal need allowance shall be considered a transfer without fair consideration in determining the institutionalized spouse's eligibility. This subsection applies only to the extent the transferred amount causes the community spouse resource allowance to exceed the maximum.

3) Staff shall determine if the applicant/client is receiving substantially equal installments from the annuity for the period of the annuity. If the annuity is not paid in substantially equal installments, the original purchase price of the annuity shall be considered as a transfer without fair consideration.

4) If an annuity was purchased more than 36 months prior to the date of application, the penalty period for a transfer without fair consideration has expired. Any income received from the annuity shall be considered as income in the month received.

5) If an irrevocable annuity is purchased by a Medicaid applicant/client, or their spouse, and the return or benefit from the annuity is transferred to a third party, a transfer of assets without fair consideration exists for the total amount of the annuity.

6) If a revocable annuity is purchased by a Medicaid applicant/client, or their spouse, the total amount invested in the annuity is considered as a countable resource. Once it has been determined a transfer of assets without fair consideration exists, the penalty period shall be calculated as shown in Section I below.

7) An annuity purchased by the applicant/client must name their spouse as the beneficiary, and if unmarried, Medicaid is the beneficiary, otherwise a transfer of assets without fair consideration exists for the total amount of the annuity.

c. Treatment of annuities purchased on or after February 8, 2006.

1) Application Requirements

a) Disclosure of interest in an annuity is required for Medicaid coverage for HCBW and long term care services at application or redetermination. The individual is required to disclose any interest they or their community spouse may have in an annuity regardless if it is irrevocable or is treated as an asset.

1. If the individual, spouse, or representative refuses to disclose information related to any annuity, the case manager will deny or terminate eligibility for long-term care services only.

2. Information regarding the income and/or resources related to an annuity must be collected and verified to establish Medicaid eligibility.

(a) There is no option to withhold information about annuities.
(b) If the individual fails to provide enough information about an annuity to allow a determination of Medicaid eligibility, the case manager will deny the application based on the individual's failure to cooperate.
(c) When an unreported annuity is discovered *after* eligibility has been established *and* after payment for long-term care services has been made, terminate eligibility for long-term care services based on the applicant's failure to cooperate.

b) The state must be named as a remainder beneficiary in annuities in which the applicant or spouse is the annuitant.

1. The case manager will notify the issuer of any annuity disclosed of the state's right as a *preferred* remainder beneficiary.

2. The issuer is required to notify the state of any changes in disbursement of income or principal from the annuity; and

3. The issuer may disclose information about the state's position as remainder beneficiary to others who have a remainder interest in the annuity.

d. Evaluation and treatment of certain *transactions* related to annuities on or after February 8, 2006.

1) Annuity-Related Transactions Other Than Purchases

a) Transactions that occur on or after February 8, 2006 may make an annuity, including one purchased *before* that date, subject to the DRA transfer of assets, if the transaction includes:

(1) Any action taken by the individual that changes the course of payments, or
(2) Any action taken by the individual that changes the treatment of the income, or principal.

b) For annuities purchased prior to February 8, 2006, routine changes and automatic events that do not require any action or decision after February 8, 2006 are not considered transactions that would subject the annuity to the DRA transfer of asset provisions include:

(1) Notice of address change, or
(2)) Death or divorce of a remainder beneficiary, and other similar circumstance, or
(3) Changes that occur based on the terms of the annuity which existed prior to February 8, 2006, and which do not require a decision election or action to take effect. For example, if an annuity purchased in June 2001 included terms that require distribution to begin five

years from the date of purchase, and payouts consequently begin, as scheduled, in June 2006, it would not be considered a transaction subject to the DRA transfer provision, since no action was required to initiate the change.

(4) Changes that are beyond the control of the individual, such as a change in law, change in the policies of the issuer, or a change in the terms based on other factors such as the issuer's economic conditions.

2) Requirement to Name the State as a Remainder Beneficiary on Annuities

a) The annuity shall be treated as a transfer of assets for less than fair market value unless the state is named as remainder beneficiary in the first position. Applies unless there is:

(1) A community spouse, and/or,
(2) A minor or disabled child. A child is considered disabled if he or she meets the definition of disability as described by Social Security.
(3) If (1) and/or (2), the state is named in the next position *after* (1) or (2), but
(4) If (1) or (2), or their representative disposed of any of the remainder of the annuity for less than fair market value, the state is named in the first position.

b) As a remainder beneficiary the state may receive up to the total medical assistance, LTC, or HCBW services paid on behalf of an individual.

(1) Case manager notifies the issuer of the annuity of the state's right as the *preferred* remainder beneficiary, and requests verification the state is named as a remainder beneficiary in the correct position.
(2) The issuer is required to notify the state if and when there is a change in the amount of income or principal being withdrawn.
(3) If the state is *not* named as a remainder beneficiary in the correct position, the full purchase value of the annuity is considered a transfer for less than fair market value.

3) Annuities Purchased by or on Behalf of an Annuitant Who Applies for Medical Assistance

a) The purchase shall be treated as a transfer of assets for less than fair market value *unless* the annuity meets the following criteria:

(1) The community spouse is the annuitant: and
(2) The state is named in the proper position as a remainder beneficiary.

b) The purchase shall be treated as a countable resource *if* it meets one *or* both of the following:

(1) The annuity can be cancelled or revoked, or
(2) The annuity is assignable.

c) The purchase will *not* be treated as a transfer of assets *if* the annuity meets any of the following conditions:

(1) Is either:

(a) An individual retirement annuity (according to Section 408(b) of the Internal Revenue Code of 1986 (IRC); or
(b) A deemed Individual Retirement Account (IRA) under a qualified employer plan (according to Section 408(q) of the IRC).

Or

(2) Is purchased with proceeds from one of the following:

(a) A traditional IRA (IRC Section 408a); or
(b) Accounts or trusts that are treated as traditional IRAs (IRC Section 408 §(c)); or
(c) A simplified retirement account (IRC Section 408 §(p)); or
(d) A simplified employee pension (IRC Section 408 §(k)); or
(e) A Roth IRA (IRC Section 408A),

Or

(3) Meets *all* the following requirements:

(a) Is irrevocable and non-assignable:
(b) Is actuarially sound:

(c) Provides payments in equal amounts, with no deferred or balloon payments.

d) The burden of proof is upon the individual or their representative to verify if the annuity meets the provisions of (c) (1) and (2). Absent proof, the full purchase value of the annuity is considered a transfer of assets.

e) Refer annuities established under (c) (3) to the Chief of Eligibility and Payments to determine actuarial soundness.

Note: Even if an annuity meets the requirements of (c) (1), (2), or (3), and the *purchase* is not treated as a transfer, if the annuity or the income stream from the annuity is transferred, except to a spouse or to another individual for the sole benefit of the spouse, child, or trust, that transfer may be subject to penalty.

Send all documents of the life estate, promissory note, loan, mortgage, and/or annuity to the Chief of Eligibility and Payments for review.

3. Home and Community Based Waiver (HCBW) and Miller Trust (QIT)

Effective July 1, 2005 individuals with a Miller Trust (QIT) are not eligible for HCBW services because a QIT requires all income be applied for certain SSI allowable expenditures including patient liability. Because a HCBW individual is not assessed a patient liability, the individual would not be able to spend the income deposited in the QIT account each month. Funds would accumulate in the QIT account and a Transfer of Assets would apply since such HCBW individuals would be ineligible for Home Based Waiver Services due to a transfer of assets.

4. Resources

For the purposes of this section, the definition of resources is the same definition used by the Supplemental Security Income (SSI) program, except that the home is not excluded for any institutionalized individuals. Refer to Section 230 for resource exclusions.

H. PURSUING A POSSIBLE TRANSFER

1. Transfer/Disposal of Asset Notification (Form 2601)

Send Form 2601 in addition to imposing the transfer penalty in NOMADS, informing the individual the Division presumes the asset was transferred to become/remain eligible for Medicaid LTC or HCBW Services. The amount of the uncompensated value is the amount of the transfer. Allow 20 days for the individual to:

a. Rebut the presumption of transfer as outlined in #2, OR
b. Request an undue hardship as outlined in #3.

The notice to the individual advises them of the undue hardship exceptions.

If the client does not respond within the 20-day time limit, the case manager will assume he/she does not want to rebut the presumption of transfer or request an undue hardship waiver. The penalty period will remain imposed and long term care benefits will not be paid by Medicaid. Applicants/recipients of HBW services will be denied or terminated, unless eligible under another category of Medicaid. If denying, use code "N", and free-form text stating the specific reason for denial or termination.

If a rebuttal or undue hardship request is submitted, follow the steps in #2 or #3 as appropriate. (*) See Note in #3.

2. Rebuttal

If the individual rebuts the presumption of the transfer, it is their responsibility to present convincing evidence responding specifically to each of the following listed points that the asset was transferred EXCLUSIVELY for some reason other than to become eligible or retain eligibility for Medicaid, LTC or HCBW services. The rebuttal must include:

a. A written statement from the client/authorized representative and the other individual(s) involved in the transfer, stating the reason for the transfer;

b. Verification of the attempts to dispose of the asset at fair market value, if applicable;

c. Documentation fair market value was received if that is the contention or the reasons for accepting less than fair market value;

d. The client's relationship, if any, to the person(s) to whom the resource was transferred;

e. The client's plans for self-support after the transfer;

f. Any relevant documentation regarding the transfer such as legal documents, correspondence, statements from other individuals, receipts, etc.

Once a rebuttal and all the necessary information to substantiate the claim is received, the case manager must determine if the information specifically addresses points (a) through (f) and as described on Form 2601. If the client fails to address a point or points, advise the client that before a decision can be made, the following point(s) need(s) to be addressed.

Upon receipt of the information, send the rebuttal to the Chief of Eligibility and Payments requesting a decision on whether a transfer of assets occurred and include a Form 6009 with the following information:

- The name and case number of the applicant/recipient;
- The application date;
- The date the client began receiving HCBW of LTC Services;
- A brief description of the circumstances of the transfer.
- Verification of the Fair Market Value of the asset AT THE TIME OF TRANSFER.

3. Undue Hardship

If undue hardship is claimed, the individual will be responsible for providing convincing evidence the penalty period would cause an undue hardship as defined in Section 240(B)(7). The evidence must include:

a. A written statement from the client/authorized representative, or facility staff person (upon consent of the individual or the individual's authorized representative) stating the reason they feel undue hardship applies;

b. Verification, if possible, there is no means, legal or otherwise, by which the client is able to have the asset transferred back to his/her ownership or receive further compensation; and

c. The client's relationship if any to the person(s) to whom the asset was transferred.

Once the undue hardship request and all the necessary information to substantiate the claim is received, send all the information along with Form 6009 with the information below to the Chief of Eligibility and Payments requesting a decision on whether undue hardship exists.

- The name and case number of the applicant/recipient;
- The application date;
- The date the client began receiving LTC or HCBW Services; and
- A brief description of the circumstances of the transfer and why it would be an undue hardship if the penalty period were imposed.

Denial of eligibility would work an undue hardship against the client when ALL of the following conditions exist:

1. The client is otherwise eligible for Medicaid; AND

2. The client has insufficient funds to cover the cost of institutionalized care; AND

3. The person(s) who have the asset(s) has refused to make such asset(s) available to the client; AND

4. The client has exercised all reasonable efforts and all possible avenues to recover and/or access the assets by returning the assets to his/her ownership or to receive further compensation; AND

5. Without Medicaid, the client would be forced to go without life sustaining medical care as determined by an individual licensed to practice medicine in the State of Nevada.

A decision whether a transfer of assets occurred or an undue hardship waiver is granted will be made within forty five (45) days from the date the Form 6009 and all pertinent information is received by the Chief of Eligibility and Payments, unless extenuating circumstances exist. An adverse determination may be appealed if received by the hearing officer within ninety (90) days from the date of the transfer of assets or undue hardship decision.

*NOTE: If the individual follows the steps in #2 and provides a rebuttal to the presumption of transfer, but is unsuccessful in rebutting the presumption of transfer, the individual may request an undue hardship waiver if the request is made within twenty (20) days after the adverse decision of the Chief of Eligibility and Payments *or* the Hearing Officer on the presumption of transfer issue.

If the individual's request for an undue hardship waiver is received timely, continue with steps in #3, through the decision making of the Chief of Eligibility and Payments noted in the above paragraph.

4. Return of Assets

When all assets transferred for less than fair market value are returned to the individual, no penalty for transferring assets can be assessed. Full Medicaid eligibility must be restored for any months a penalty was assessed if the return of assets does not cause ineligibility for other reasons.

If counting the returned income/assets results in the individual being ineligible for some or all the months of the penalty period (because of excess income/resources) do not restore full Medicaid for months that would now be ineligible due to the excess income/resource.

I. PENALTY PERIOD

1. Application of Penalties For Transfers Made Prior to February 8, 2006

Transfer of asset penalties do not apply to home and community based waiver recipients when the transfer was made prior to February 8, 2006.

The penalty period begins the first day of the month in which the asset was transferred, provided that date does not occur during an existing penalty period.

The length of the penalty period is based solely on the value of the assets transferred and the average cost of private nursing care.

The length of the penalty period is calculated by dividing the value of the transferred asset (at the time of transfer) by the average cost of care (at the time of application).

A new penalty period cannot begin until an existing penalty period has expired.

A penalty period runs continuously regardless whether the individual remains in or leaves the institution or waiver program.

The penalty period can be shortened if:

- Verification is received the asset has been returned to the client.

- The applicant/recipient receives additional compensation for the transferred asset. Verification of the additional compensation must be obtained by the case manager. The uncompensated value will be reduced by the amount of the additional compensation paid.

  If the uncompensated value is reduced to a point that when dividing the remaining amount by the average cost of private nursing care only a partial month remains, the case may be eligible beginning with that partial month if all other eligibility criteria is met.

A penalty is not imposed when one amount or many amounts of transfer(s) in one month is less than the monthly cost of the nursing facility care.

A penalty is not imposed when a series of transfers, <u>each</u> less than the private nursing facility rate for a month, is made by an individual.

When a single asset is transferred or a number of assets are transferred during the same month, the penalty period is calculated using the total value of the asset(s) divided by the average monthly cost of nursing facility care.

When multi-transfers in separate months occur, use the following methods for calculating the penalty periods.

a. Penalty periods overlap – calculate the individual penalty periods and impose them sequentially.

Example – An individual transfers $20,000 in January, $20,000 in February and $20,000 in March, all of which are uncompensated. Calculate the individual penalty periods and impose them sequentially: $20,000/$4,583 (2004) equals a 4-month penalty. The penalty for the first transfer extends from January through April, the second extends May through August, and the third extends from September through December.

b. Penalty periods do not overlap – when multiple transfers in multiple months occur where the penalty periods for each do not overlap, treat each transfer as a separate event with its own penalty period.

Example – An individual transfers $12,000 in January, $12,000 in May and $12,000 in October, all of which are uncompensated.

Using the current nursing facility cost of $4,583, calculate each transfer $10,000/$4,583 (2004) to determine each penalty period. In this example, the penalty periods for transfers are a 2-month period, respectively, the months of January through February, the months of May through June, and the months of October through November.

2. Application of Penalties For Transfers Made On or After February 8, 2006

The length of the penalty period is calculated by dividing the value of the transferred asset (at the time of transfer) by the average cost of care (at the time of application).

a. The period of ineligibility will *not* always be the first day of the month following the month in which the transfer occurred but:

1) The first day of the month following the month which assets have been transferred for less than fair market value; *or*
2) The date on which the individual is eligible for Medicaid or LTC services *whichever is later*.

b. Asset transfers are also evaluated *anytime after* the individual begins receiving nursing facility or home and community based services. Apply the transfer of assets penalty to the first month administratively possible allowing for adverse.

c. *"Rounding down* or *disregarding any fractional period"* of ineligibility is prohibited. Therefore, calculate the percentage to continue the penalty into the next month.

For example: An applicant/recipient is eligible to receive Medicaid coverage for long-term care effective July 2007. This individual made a transfer for less than market value of $20,000 in May 2007. The penalty is calculated by dividing the $20,000 by $5,714 (state's average cost of care in 2007). The result is 3.50. The penalty would be imposed for July 2007 through September 2007, plus 15 days of October 2007 (31 days times .50 equals 15 days.)

d. Any transfer of assets for less than market value must have a penalty imposed even if only for a *"partial month."* To determine the penalty period, case managers will divide the monthly cost of care by the number of days in the month the penalty is to be imposed, to establish a daily rate of care. The amount of the transfer is then divided by the daily rate to determine the total days for a fractional penalty period.

For example: An applicant/recipient is eligible to receive Medicaid coverage for long-term care effective July 2007. In May 2007, the individual made a transfer for less than fair market value of $2,000. The month of July has 31 days with a daily rate of cost of care at $184.32. This results in a penalty of 11 (10.85) days for July 2007.

e. If an individual or the individual's spouse has made *"multiple transfers"* within the look-back period, regardless of whether the value exceeds the state's average cost of care, combine the values for a cumulative total and impose a penalty as if it were one transfer.

f. The penalty period cannot begin until the expiration of any existing penalty period.

g. Once a penalty period is imposed, it cannot be interrupted or temporarily suspended regardless if the individual remains in or leaves long-term care or the waiver program.

h. *Exceptions.* These transfers of assets policies shall *not* apply:

1) To medical assistance provided for services furnished prior to February 8, 2006;
2) Assets disposed of on or before February 8, 2006;
3) Trusts established prior to February 8, 2006; or
4) To transactions involving a partial month, multiple transfers, a life estate, or promissory note, loan or mortgage prior to April 1, 2006.

J. PENALTY PERIOD - SPOUSE INVOLVEMENT

When a spouse transfers an asset resulting in a penalty period for the client, in the following circumstances the penalty period must be apportioned between spouses:

1. The spouse is eligible for Medicaid as an institutionalized individual; and

2. Some portion of the penalty against the client remains at the time the above condition is met.

The remaining penalty period existing for the client will be divided in one-half and that one-half period of time will apply to the client and the spouse.

If for some reason one spouse is no longer subject to a penalty, the remaining penalty period applicable to both spouses must be served by the remaining spouse.

K. SITUATIONS UNDER WHICH TRANSFER OF ASSET PROVISIONS DO NOT APPLY (not all inclusive)

1. Assets which are excluded AT THE TIME OF TRANSFER. (See Manual Sections 220/230 for excludable assets.)

   EXCEPTION: The home of an institutionalized applicant/recipient (principal place of residence) can only be transferred in the specific instances outlined in #5.

2. When the client's name is removed from a joint bank account in accordance with joint banking policy.

3. Assets which have been divided equally or by the legal portions owned, between legal owners.

4. When the client provides verification they made a purchase(s) for themselves. If someone else made the purchase(s) for the client, the Chief of Eligibility and Payments must make the final decision in accordance with the transfer procedures.

5. When the client's home is transferred to:

   a. The spouse of the applicant/recipient.
   b. A child of the client who is under 21, or over 21 and is blind or disabled.
   c. A sibling of the applicant/recipient who has equity interest in the home AND was residing in the home for at least one year immediately preceding the client becoming institutionalized or receiving Home and Community Based Services.

d. A son or daughter who does not meet "b" above, who resided in the home for at least two years immediately preceding the client becoming institutionalized (including Home and Community Based Services) AND who (as determined by the state) provided care to the client which permitted the client to reside at home rather than in an institution or facility.

6. When the asset is transferred to the client's spouse or to their child who is blind or disabled.

7. Assets placed in an **exempt trust** for a disabled individual or assets placed in a trust which are used to benefit the disabled individual AND the trust purchases items and services for the disabled individual at fair market value. An exempt trust is a "special needs" or a "pooled" trust as described in subsection TREATMENT OF TRUSTS.

If 3. or 4. above instances apply, the case manager supervisor must sign off on the case prior to the case being approved.

L. DECISION

Forward Form 6009 with all attached documents to the Chief of Eligibility and Payments for cases requiring a decision from the Chief of Eligibility and Payments. A memo will be issued to the district office notifying them of the decision. If the decision is that no transfer occurred, the case can be approved/ continued if all other eligibility factors are met. If the decision is that a transfer took place, the memo will identify the penalty period to be applied.

250 TREATMENT OF TRUSTS (Not applicable to SSI-Section 320)

A. DEFINITIONS

1. Trust

Any arrangement in which a grantor transfers assets to a trustee(s) with the intention it be held, managed, or administered by the trustee(s) for the benefit of the grantor or certain designated individuals (beneficiaries).

2. Legal Instrument or Device Similar to a Trust

Any legal instrument, device or arrangement which is similar to a trust. That is, it involves a grantor who transfers assets to an individual or entity with fiduciary obligations (trustee) with the intention that it be held, managed, or administered by the trustee(s) for the benefit of the grantor or others. This can include but not limited to, escrow accounts, investment accounts, pension funds, and other similar devices managed by an individual or entity with fiduciary obligations.

3. Trustee

Any individual(s) or entity (such as an insurance company or bank) that manages a trust or similar device and has fiduciary responsibilities (held or found in trust or confidence).

4. Grantor

Any individual who creates a trust. This includes:

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

5. Revocable Trust

A trust which can be revoked (recalled) by the grantor. This includes trusts which can only be modified or terminated by a court and trusts called irrevocable but terminate if some action is taken by the grantor.

6. Irrevocable Trust

A trust which cannot, in any way, be revoked by the grantor.

7. Beneficiary

Is any individual(s) in the trust benefiting in some way from the trust. Beneficiary can be the grantor himself, another individual(s), or a combination of any of these parties, excluding the trustee or any other individual whose benefit consists only of reasonable fees or payments for managing or administering the trust.

8. Payment

A payment from a trust is any disbursal from the corpus (principal) of the trust or from income generated by the trust. A payment may include actual cash, as well as noncash or property disbursements, such as the right to use and occupy real property.

9. Annuity

This is a right to receive fixed, periodic payments, either for the life or a term of years.

10. Assets

Assets are all income and resources of the individual including assets which the individual is entitled or would be entitled if action had not been taken to avoid receiving the assets.

B. EFFECTIVE DATE

Trusts established prior to October 1, 1993 are "deemed" available to the client and therefore countable, without regard to normal program exclusions, when determining income or resource eligibility. Exception: Medicaid Qualifying Trusts established prior to April 7, 1986 SOLELY for the benefit of a mentally retarded individual who resides in an ICF/MR.

Trusts established October 1, 1993 and later may be considered unavailable when determining resource eligibility.

C. APPLICATION OF TRUST PROVISIONS

Trusts established October 1, 1993 and later, the following rules apply to trusts without regard to:

- The purpose for which the trust is established;
- Whether the trustee(s) can exercise any discretion under the trust;
- Any restrictions on when or whether distributions can be made from the trust;
- Any restrictions on the use of the distributions from the trust.

This means any trust can be counted in determining Medicaid eligibility no matter how specifically a clause or requirement in the trust precludes a trust from being considered under Medicaid rules.

Placement of the home of an institutionalized individual in a trust does not result in the home becoming a countable resource. The home continues to be an excluded resource.

D. TYPES OF TRUSTS

How trusts are treated depend on the terms and conditions of the trust. The following are rules for counting various types of trusts.

1. Revocable Trust

a. The entire corpus (principal) of the trust is counted as an available resource;
b. Any payments from the trust made to or for the benefit of the individual are counted as income;
c. Any payments from the trust which are not made to or for the benefit of the individual are considered assets disposed of for less than fair market value and a "look-back" period of 60 months applies.

2. Irrevocable Trust - Payment Can Be Made to Individual

If there is any circumstance under which payment can be made to or for the benefit of the individual from all or a portion of the trust, the following rules apply.

a. Payments from income or from the corpus (principal) made to or for the benefit of the individual are treated as income;
b. Income from the corpus of the trust which could be paid to or for the benefit of the individual are treated as an available resource;
c. The portion of the corpus that could be paid to or for the benefit of the individual is treated as an available resource;
d. Payments from income or the corpus not paid to or for the benefit of the individual are treated as a transfer of assets for less than fair market value and a "look-back" period of 60 months applies.

3. Irrevocable Trust - Payment Cannot Be Made to Individual

When all or a portion of the corpus or income of the trust cannot be paid to or for the benefit of the individual, treat all or any such portion or income as a transfer of assets for less than fair market value and a "look-back" period of 60 months applies.

4. Special Needs Trust

The trust must be irrevocable and must contain the assets of an individual under age 65 who is disabled and which trust is established for the *sole* benefit of the disabled individual by a parent, grandparent, legal guardian of the disabled individual, or a court. In addition to the assets of the individual, the trust may also contain the assets of individuals other than the disabled individual.

The trust must specify that upon the death of the disabled individual, the state receive all amounts remaining in the trust up to an amount equal to the total amount of medical assistance paid on behalf of the disabled individual.

If the trust meets all the above requirements, the corpus of the trust is not considered available when determining resource eligibility.

However, any liquid funds, e.g., cash paid out of the trust that are used for items other than the supplemental or special needs of the individual, are considered income in the month paid out for financial eligibility and patient liability. Administrative and trust fees are allowed as deductions without counting as income or a transfer in the month paid out.

Any non-liquid resource, e.g., retitle of home from the trust to an individual, removed from the trust may convert an exempt resource to a countable resource in the month it is removed from the trust. Any non-liquid resource removed from the trust not for supplemental or special needs of the individual are considered assets disposed of for less than fair market value and a transfer of assets penalty will apply.

If the trust is used to purchase a residence for a beneficiary, the fair market rental value for others living in the home will be considered income each month that others live in the home, unless the trust is paid fair market rental value for such other persons.

The trustee must immediately inform the DWSS of any expenditure of the trust that exceeds $5,000. It must be for the *sole* benefit of the individual. The trustee is also required to provide a reconciled financial accounting of the expenditures made from the trust on an annual basis or as otherwise requested by the DWSS. A justification of the expenditures must accompany the financial record to ensure the expenditures were used to or for the *sole* benefit of the individual. A transfer of assets penalty may apply.

The trustee must immediately notify the case manager when the disabled individual passes away and must no later than three-months after the individual passes away *or* if the trust exemption is terminated, repay the state up to the amount of the individual's cost of care.

Any addition to or augmentation of funds to the trust after age 65 involves assets which are not subject to the resource exemption.

5. Pooled Trusts

The trust must be irrevocable, and must contain the assets of a disabled individual, is established and managed by a non-profit association, as defined in section 501(c) of the Internal Revenue Code (IRC) and which has tax-exempt status under section 501(a) of the IRC.

Separate accounts are maintained for each beneficiary of the trust (like a bank that holds the assets of individual accountholders) but assets are "pooled" for investing and management purposes. An account established for the sole benefit of the disabled individual, by the individual, or by the parent(s), grandparent(s), legal guardian(s) or a court. If the account provides a benefit to any other individual, this exception does not apply.

The trust must also specify that upon the death of the disabled individual, the state receive all amounts remaining in the trust up to an amount equal to the total amount of medical assistance paid on behalf of the disabled individual.

If the trust meets all the above requirements, the corpus of the trust is not considered available when determining resource eligibility and the transfer of assets provision may apply. For example, funds added to the trust after the disabled individual is aged sixty-five or funds used to pay for family vacations will be considered a transfer of asset.

Any non-liquid resources, e.g., retitle of home from the trust to an individual, removed from the trust may convert an exempt resource to a countable resource in the month it is removed from the trust. Any resources removed from the trust not for the supplemental or special needs of the individual are considered assets disposed of for less than fair market value and a transfer of assets penalty will apply.

Administrative and trust fees are allowed as deductions without counting as income in the month paid out.

6. Miller Type or Qualified Income Reduction Trusts - QIT

A trust established to enable individuals with income, which exceeds the income limit, to become eligible for Medicaid by placing their income into a Miller Trust.

Trust Requirements

Must be irrevocable.

Must be established from income of the recipient, composed only of the individual's pensions, Social Security, and any other unearned income which the individual receives, from whatever source, including accumulated interest in the trust.

No resources can be used to establish or augment the trust. Inclusion of resources voids the exception.

Must specify the only payments allowed from the trust are those permitted in 42 C.F.R. 435.725 which include patient liability, personal needs allowance, spousal/family allowance and certain unreimbursed medical expenses.

Must not provide for the payment of guardianship fees, attorney fees or trustee fees as a deduction from the trust or from the patient liability owed by the individual.

Must specify that upon the death of the individual, the state receive all amounts remaining in the trust up to an amount equal to the total amount of medical assistance paid on behalf of the individual.

Resource

If the trust meets all the above requirements, the corpus of the trust is not considered available to the recipient when determining resource eligibility.

Income

All income must be deposited to the QIT. Any income deposited to a QIT is not counted in the Financial Eligibility determination. Case managers must complete appropriate NOMADS UNIN screen(s) to ensure financial eligibility is properly determined. Any income not deposited is considered income. Any withdrawals from the QIT, to or for the benefit of the client or spouse, are counted in Financial Eligibility, excluding withdrawals for items defined by SSI as not income, for example, PNA, spousal and family allowance, medical expenses or Patient Liability.

Patient Liability

The client's total available income (subject to regular PL exclusion rules, see manual section 220, Income Type), regardless of whether or not deposited in the QIT, is used to determine the client's share of the cost of care.

Transfer of Assets

Income deposited to a QIT is considered a Transfer of Assets, unless used to or for the benefit of the applicant. Payment towards the cost of care is considered to or for the benefit of the client/applicant, thus avoids a transfer of assets penalty.

When income placed in a QIT exceeds the amount paid out of the trust for the individual's monthly cost of care, the excess income is subject to a transfer of assets penalty.

Central Office Review

When an individual has an income trust or court document, a copy of the trust or document must be sent to the Chief of Eligibility & Payments to determine if it meets the requirements for an exempt trust.

If the trust document fails to meet the requirements of a Miller Trust (QIT), the individual will be served a timely denial/termination notice. The individual will be allowed 90 days from the date of the notice to apply for undue hardship.

E. UNDUE HARDSHIP

The trust provisions may not apply when it is determined such application would work an undue hardship.

If undue hardship is claimed, the individual will be responsible for providing convincing evidence that application of the trust provisions would cause an undue hardship. The evidence must include:

1. A written statement from the individual/authorized representative stating the reason they feel undue hardship applies.
2. Verification there is no means, legal or otherwise, by which the individual is able to recover and/or access assets held in the trust.
3. The individual's relationship, if any to the person(s) who are trustees of the trust.

Once the undue hardship request and all the necessary information to substantiate the claim is received, send all the information along with Form 6009 with the information below to the Chief of Eligibility and Payments requesting as decision on whether an undue hardship exists.

- The name and case number of the applicant/recipient;
- The applicant date;
- The date the client began receiving LTC or HCBW Services; and
- A brief description of the circumstances why it would be an undue hardship if the trust provisions were applied.

Denial of eligibility would work an undue hardship against the individual when ALL of the following conditions exist:

1. The individual is otherwise eligible for Medicaid; AND
2. The trustee has refused to make such income/resources available to the individual; AND
3. The individual has sufficient funds to cover the cost of institutionalized care; AND
4. Without Medicaid, the individual would be forced to go without life sustaining medical care; AND
5. Where the individual has the ability to amend the trust so it contains the provision, upon death of the individual the state receives an amount equal to the total amount of medical assistance paid on behalf of the individual; AND

6. The client has exercised all reasonable efforts and all possible avenues to recover and/or access the assets held in the trust.

A decision whether an undue hardship waiver will be granted should be made within forty-five (45) days from the date the Form 6009 and all pertinent information is received by the Chief of Eligibility and Payments, unless extenuating circumstances exist. An adverse determination may be appealed if received by the hearing officer within ninety (90) days from the date of the undue hardship decision.

300 ELIGIBLE CATEGORIES

When determining eligibility, the case manager must consider all eligible categories before denying the application. If a client is pending an SSI decision, determine eligibility for Home Based Waivers, Katie Beckett and QMB categories only. Do not consider eligibility in any other category until the SSI decision is received.

Whenever a change in circumstance occurs, evaluate eligibility under all eligible categories.

If SSI is pending and the applicant is determined eligible in another category, the prior SSI pending months remain pending until an SSI decision is received.

305 CONVERSIONS

During a period of eligibility, there may be changes in case circumstances where another category of eligibility must be evaluated. Converting between categories does not require a new application, but may require additional forms to be completed.

The following types of conversions identify procedures required to re-evaluate factors of eligibility. Verification used to re-establish Medicaid eligibility must be current (within the last 45 days). Refer to appropriate manual section for eligibility factors for each category.

When eligibility under the current category is ending and eligibility under the new category cannot be established prior to adverse action, the case must be closed and then placed in a pending intake status until eligibility or ineligibility is established.

CONVERTING TO INSTITUTIONAL ELIGIBILITY

1. Evaluate current resources and compare to institutional resource limit. When the applicant is married (living separate or together); request couples' current resources and complete a spousal resource assessment.

2. Evaluate current income; do not request verification unless a change in income due to institutionalization occurs. Include spousal impoverishment determination if community spouse is involved. If recipient is SSI eligible and payment has not been reduced to the $30.00 institutional level, notify Social Security using form 3911.

3. Ensure the medical facility is added as an authorized representative (category 4 if not signed on as primary or secondary by applicant).

4. Evaluate case for transfer of resources.

5. Evaluate court orders, income trusts if applicable.

6. Evaluate for other possible benefits; veterans or widow of a veteran, may be eligible for Aid and Attendance or have VA insurance benefits. The pension of a Veteran residing in a Nevada State Veteran's home is not reduced to $90.

7. Complete a review of eligibility if one is due.

8. Update the appropriate screens in NOMADS, view and post versions to update to appropriate aid and eligibility code. Allow adverse action for any reduction in benefits, including QMB.

   NOTE: Clients have multiple GRIN screens when they enter/leave different facilities. One screen should be entered for each facility stay.

9. Notify the client and authorized representative of the change in benefits and patient liability amount. Add free form text to ensure a notice is generated.

10. Evaluate for parental financial obligation for children under 18.

CONVERTING TO HOME BASED WAIVER ELIGIBILITY

1. Ensure Form 2734 that authorizes Home Based Services is completed and if the client is under age 65, there is a current disability decision by SSA or NMO through Form 3004.

2. Evaluate current resources and compare to the institutional resource limit. When the applicant is married (living separate or together); request couples' current resources and complete a spousal resource assessment.

3. Evaluate current income; do not request verification unless a change in income occurs.

4. Ensure the appropriate agency is added as an authorized representative.

5. Evaluate case for transfer of resources.

6. Evaluate court orders, income trusts. See MAABD 250.

7. Complete a review of eligibility if it is due.

8. Update the appropriate screens in NOMADS, view and post versions to update appropriate aid and eligibility code.

9. Notify the client and authorized representative of the change in benefits. Allow adverse action for any reduction in QMB benefits. Add free form text to ensure a notice is generated.

10. Evaluate for parental financial obligation for children under 18 if there is no deeming of parental income/resources in determining eligibility.

NOTE: When a client is converting from Institutional to a Home and Community Based Waiver in the middle of a month, post the HBW aid code for the waiver approval month. The GRIN screen must be completed with the date they leave the facility to allow Medicaid to pay the facility bills as well as provide Home based services in the same month. Use form 2817 Partial month to advise DHCFP of the partial institutional month.

OTHER MEDICAID (including TRM/CHAP) TO SSI CASE

1. Verify SSI eligibility. Terminate eligibility under current case and approve SSI eligibility for the following month. View and post a correct version to update the aid code, eligibility code and notify the client of the change in benefits.

2. Create a sub-case if SSI recipient is not head of household or others in household have Medicaid.

3. Evaluate for parental financial obligation for children under 18 if there is no deeming of parental income/resources in determining eligibility.

SSI ELIGIBILITY TERMINATING

1. When SSI eligibility terminates, evaluate each public law category. See PUBLIC LAW CASES. Update the appropriate information/STAT screens in NOMADS, view and post a correct version to update the aid code, eligibility code, and to notify the client of the change in benefits.

2. Evaluate eligibility for Medicare Beneficiary programs.

3. If Public Law criteria are not met and the recipient is a disabled child under age 18, terminate eligibility allowing 13 days adverse action time. Advise the client to re-apply for possible Medicaid eligibility under 1902(e)(3) of the Social Security Act (Katie Beckett).

QMB/SLMB/QI1 ONLY TO MEDICAID-QMB/SLMB

1. Establish eligibility for the appropriate Medicaid category, e.g., SSI, State Institutional, etc.

2. Evaluate income and resources if applicable for Medicaid category.

3. Determine Patient Liability (P/L).

4. Update the appropriate information/STAT screens in NOMADS, view and post a correct version to update the aid code, eligibility code, and notify the client of the change in benefits. Ensure QMB/SLMB eligibility code is not removed if posting past months.

MEDICAID ONLY TO MEDICAID-QMB/SLMB

1. Verify current Medicare Part A enrollment/effective date of entitlement.

2. Update the appropriate MEDI-STATE screens in NOMADS, view and post a correct version to update the aid and eligibility code. Notify the client of the change in benefits.

MEDICAID-QMB/SLMB TO QMB/SLMB/QI1 ONLY

1. Update the appropriate information/STAT screens in NOMADS, view and post a correct version to update the aid and eligibility code. Notify the client of the change in benefits.

MEDICAID-QMB/SLMB TO MEDICAID ONLY

1. Evaluate current income; do not request verification unless a change in income occurs.

2. Evaluate current resources and compare to Medicaid resource limit.

3. Notify the client of the change in benefits allowing for adverse action.

KATIE BECKETT TO SSI

1. If a child becomes SSI eligible, terminate eligibility under Katie Beckett and approve SSI eligibility the following month.

OTHER MEDICAID (including TANF related Medicaid) CATEGORIES TO QDWI

1. Countable income must be within QDWI limitations and current enrollment in the special Medicaid hospital insurance must be verified. Eligibility to QDWI coverage cannot be in the same month as any other Medicaid category. Update the appropriate information/STAT screens in NOMADS, view and post a correct version to update the aid code, eligibility code, and notify the client of the increase or decrease in benefits.

The following are examples of help clarify conversions:

1. Applicant applies in December as a state institutional case and is currently enrolled in Medicare Part A. The client cooperates and is determined eligible as a state institutional case in December. Because this client has Medicare Part A, the case manager must also determine whether the client is eligible for QMB coverage. If the client's income and resources meet QMB criteria, QMB coverage is effective January.

2. Applicant applies January and has $250 SSA disability income. The client has not applied for SSI, but is probably eligible. The client meets all the other requirements of a QMB.

   Request the client apply for SSI and give the normal time limit for applying. However, once the worker is able to determine the client is eligible for QMB coverage (all verifications needed are in), the case would be approved as a QMB only case. The case would be future actioned for the SSI information. If the client failed to cooperate in applying for SSI, or was determined ineligible, the case would remain open as a QMB only case as long as he continued to meet the criteria. If the client were approved for SSI, the case would be converted to an SSI case effective with the month of SSI eligibility (this could include prior months).

Additionally, if the person also has Part B Medicare, notify E&P in Central Office so Buy-In coverage can begin with the first month of SSI eligibility.

3. Applicant applies and is approved for QMB coverage. Sometime after approval, the client enters the hospital for seven (7) days. The case would continue as QMB and NO PATIENT LIABILITY would be determined, UNLESS the client qualified as a state institutional case (if income is less than SSI payment level, the client does not have to be in 30 consecutive days). If the case qualifies as a state institutional case, the case would be converted and client would receive full Medicaid coverage and QMB coverage for the month of hospital stay. When the client is released from the institution, the case would be converted back to a QMB only case, allowing adverse action, as long as all requirements were still met.

FORMS USED FOR CONVERSION

2796 – Spousal Housing, Income and Resource Questionnaire: Used to request spousal income and resources to determine spousal maintenance allowance.

2179 – Interface Consent: Request when spouse did not sign the application. Needed to access interfaces for verifying spouse's income.

2734 – Home and Community Based Waiver Eligibility Status Form: Must be filed in permanent section to verify recipient meets level of care requirements.

3004 – Disability/Incapacity Determination Request: Must be filed in permanent section to verify recipient meets disability criteria. Applicable to institutional less than 30 days, Home and Community Based waivers, Emergency medical, Katie Beckett, prior medical.

INDEX
SECTION 310
MEDICARE BENEFICIARIES

310 MEDICARE BENEFICIARIES (QMBs, SLMBs and QDWIs)

A. OVERVIEW

1. QUALIFIED MEDICARE BENEFICIARIES (QMB)

P.L. 100-360 (Medicare Catastrophic Coverage Act of 1988) mandates Medicaid cover only Medicare's co-insurance, premium and deductible charges for individuals who:

a. Are currently enrolled or eligible to enroll in Medicare Part A. To consider a client "eligible" to enroll in Medicare Part A, the client must be enrolled and paying (or Nevada is paying) for Medicare Part B; and
b. Have net countable income at or below 100% of poverty; and
c. Have countable resources at or below $6,680 if they are an individual or $10,020 if they are a couple. **NOTE**: Individuals eligible for SSI should not be required to provide verification of resources. SSI recipients are considered to have met the resource requirements for QMB. If the client loses their eligibility for SSI, then you must verify resources to determine their continued eligibility for QMB.

This category of assistance is different from all other categories. In addition to not being eligible for Medicaid:

— They do not have to pay patient liability if they are institutionalized, unless the case is converted to a state institutional or Home Based Waiver case.
— They are eligible beginning the month immediately following the month the decision is made (they are not eligible for prior med). **NOTE: If it is found QMB coverage was denied in error, use the denial decision date and approve benefits the month following this date. If QMB is terminated in error, reinstate coverage so there is no break in benefits.**
— They do not have to apply for benefits which may be available to them.

Individuals with QMB coverage receive a Medicaid card for billing Medicare co-pays and deductibles only. If a QMB eligible reports they are pregnant, evaluate them for Medicaid under the most appropriate program.

2. SPECIAL LOW-INCOME MEDICARE BENEFICIARIES (SLMB)

The Omnibus Budget Reconciliation Act (OBRA) of 1990 mandates Medicaid cover only the Part B Medicare premium payment for aged and disabled individuals who:

a. Are entitled (eligible to enroll) to Medicare Part A; and
b. Have net countable income 100% - 120% of poverty; and
c. Have countable resources at or below $6,680 for an individual or $10,020 for a couple.

This category is different from the QMB category in two ways. First, coverage begins with the application month and prior medical coverage is available for up to three months prior to the application month to cover the Medicare premiums. Second, SLMB does not pay for co-payments and deductibles.

A Medicaid card will not be issued for SLMB only eligibles. A SLMB eligible may receive a medical card if they are eligible for Medicaid under another category.

If the client appears to be eligible under another category of assistance, the worker will also obtain all the necessary information needed to determine eligibility under that category. If a SLMB eligible reports they are pregnant, evaluate them for Medicaid under the most appropriate program.

If all information needed to determine QMB/SLMB eligibility is received, approve the case as a QMB/SLMB only case and future action the case for determining eligibility under the other category. If the client is later determined eligible under the other category, the case is approved with the first month of eligibility.

If the client states in writing they do not want the Medicaid coverage and only want the QMB/SLMB coverage, the worker will convert the case to a QMB/SLMB only case (a new application is not needed unless an RD is due). QMB coverage includes having their Part A premium paid for by the Division, and payment for deductibles and co-insurance for services covered by Medicare but not normally covered by Medicaid.

When the client is determined ineligible for the other category for any reason, the client may be eligible for QMB/SLMB only coverage as long as all the requirements are met and all the necessary information for QMB/SLMB coverage has been obtained. The QMB/SLMB only coverage CANNOT be denied because the client did not meet a requirement or did not cooperate in providing verifications specifically needed for the other category.

3. QUALIFIED INDIVIDUALS (QIs)

a. The Balanced Budget Act (BBA) of 1997 mandates Medicaid cover only the Part B Medicare premium payment for aged and disabled individuals who:

1) Are entitled (eligible to enroll) to Medicare Part A;
2) Have net countable income 120% - 135% of poverty; an
3) Have countable resources at or below $6,680 for an individual or $10,020 for a couple;
4) Are not eligible under any other Medicaid category.

This category is different from the QMB category. Coverage begins with the application month and prior medical coverage is available for up to three months prior to the application month, but not prior to January 1998.

This category is different from the regular SLMB category only in the net countable income amount and eligibility remains only as long as federal funds are available. A qualified participant is known as Qualified Individual 1 or QI1.

Under this category of assistance, a Medicaid card is not issued. This individual cannot be eligible for Medicaid under another category and be eligible as a qualified individual.

4. QUALIFIED DISABLED WORKING INDIVIDUALS (QDWIs)

The Omnibus Budget Reconciliation Act (OBRA) 1989 mandates Medicaid cover ONLY a special Medicare (Part A) hospital insurance premium for disabled individuals who lost their free hospital coverage due solely to earnings which exceed the Substantial Gainful Activity (SGA) limits. These individuals must be under age 65, continue to meet Social Security's disability criteria and not otherwise be entitled to Medicare hospital coverage.

At the time premium free Medicare coverage ends, Social Security will mail a notice informing individuals of their right to enroll in the special Medicare hospital insurance (now at a cost) and their potential eligibility to have the premium paid by Medicaid. They will have a seven-month period to enroll beginning with the month of notice. If they do not enroll during this time, they may still enroll during the annual general enrollment period (January through March) if they continue to meet the special requirements. Entitlement to this special Medicare hospital insurance can begin no earlier than July 1, 1990.

Medicaid coverage of the Medicare hospital insurance premium is limited to individuals who:

a. have "enrolled" in the special Medicare hospital insurance at the SSA office; and
b. have net countable income below 200% of poverty; and
c. have countable resources which do not exceed $4,000 if they are an individual or $6,000 if they are a couple.
d. are NOT otherwise eligible for medical assistance under another Medicaid category.

Under this category of assistance, a Medicaid card will NOT be issued.

Coverage of the special Medicare premium can begin the month of application (including three months prior to the month of application) if ALL eligibility criteria is met (but no earlier than July 1, 1990). For example, if an applicant applies for benefits on October 5th and is already enrolled in the special Medicare hospital insurance, eligibility can begin effective October (including three months prior). However, if in this example, the applicant's enrollment is not effective until November 1st, the applicant is not eligible any earlier than November.

If the client appears to be eligible under another category of assistance, pursue eligibility under that category first. If the client is determined eligible under the other category, the client cannot be eligible as a Qualified Disabled Working Individual. If, however, the client is not found/cannot be eligible under any other Medicaid category, determine eligibility as a Qualified Disabled Working Individual.

5. ELIGIBILITY EXCEPTION

An inmate of a public institution is ineligible for Medicaid (for Medicare Beneficiaries, Medicaid is defined as the payment of Part B Medicare premiums, co-payments and/or deductibles), UNLESS the institution is a medical institution. An inmate of a penal institution is never eligible for Medicaid while in the custody of law enforcement officials, UNLESS admitted as an inpatient to a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility. This individual **is** eligible for Medicaid and any Medicaid covered services provided to them while an **inpatient** in these facilities. If this individual becomes an inpatient of a long-term care facility, they must meet level of care and plan of care assessments to become eligible.

B. AGED, BLIND, DISABLED

Persons must be aged (65 or older) or blind/disabled as determined by SSA criteria.

C. TIME FRAMES

An eligibility decision must be made within 45 days from date of application, unless extenuating circumstances exist.

D. SOCIAL SECURITY NUMBER (SSN)

Social Security numbers must be provided by every applicant and recipient. See manual section 204 for exceptions.

E. IDENTIFICATION

All applicants must be identified.

F. NEVADA RESIDENT

Clients must be living in Nevada with the intention of making Nevada their home permanently or for an indefinite period (no expected end date) OR must be living in Nevada with a job commitment or seeking employment. Clients do not have to have a fixed place of residence to meet this requirement.

The ability to indicate intent to reside in Nevada is not to be taken lightly or stand by itself. A statement or indication of intent to reside in Nevada must be supported by additional verification or collateral material to substantiate the intent if residency is questionable. Manual Section 205,D,5 is not all inclusive. See Manual Section 205,A for more detail.

Nevada residency continues when a client is temporarily absent IF he/she intends to return to Nevada when the purpose of the absence has been accomplished. Document in the case file the temporary absence situation and obtain the client/representative's statement concerning the intent of residency and the purpose of the absence.

G. CITIZENSHIP

To qualify for assistance, applicants must be a U.S. citizen or a non-citizen in an eligible category. See manual section 206 for citizenship requirements.

H. PRIOR MEDICAL

Does not apply to QMB coverage, however, possible eligibility under another category may exist.

Prior medical coverage is available for QDWI coverage, but not prior to July 1990.

Prior medical coverage is available for SLMB coverage, but not prior to January 1993.

I. THIRD PARTY LIABILITY (TPL)

Medicaid is always payor of last resort whenever any other resource may be responsible for payment.

When insurance coverage is available at no cost to the client (e.g., through employment or Tricare), request the client to enroll.

First Health must be notified of all Third Party Liability by submitting information on the insurance onto the MINS screen or MEDI screen.

J. RESERVED

K. SUPPORT ENFORCEMENT PROGRAM (SEP)

All dependent children (including automatic Medicaid eligible newborns) who have absent parent(s) require referrals (completed SEP Cover Sheet Form 4000-EC/A and application Form 4000-EC) to Support Enforcement Program (SEP) for support enforcement services.

L. INCOME

Income means the receipt of money in the month for which an eligibility determination is being made. All income or changes in income must be reported. All income must be evaluated for financial eligibility.

1. AVAILABILITY

a. Individual

All income which a payor designates as the clients, will be considered in determining eligibility.

When a benefit or income is received for more than one person or family member, only the client's portion of the income is considered.

Determine financial eligibility using the "Individual" or second column on the "Medicare Beneficiaries Budget" Form 2203-EM.

b. Couple (Individual with Spouse)

1) Couple Computation

If the client is married, and living with his/her eligible spouse, evaluate their combined income using the third column on the "Medicare Beneficiaries Budget" Form 2203-EM.

2) Deeming

If the client is married and living with his/her ineligible spouse, use the first column on the "Medicare Beneficiaries Budget" Form 2203-EM to determine if deeming applies.

Exception: Do not deem income from a spouse receiving Medicaid under a Waiver. A spouse who is under a Waiver is considered to be institutionalized.

3) Dividing: Does not apply.

4) Court Order: Does not apply

5) Monies received by the client in his/her capacity as a agent are not income to him/her. An agent is a person acting on behalf of someone, i.e., representative payee, guardian, conservator. etc.

2. TREATMENT OF INCOME (BUDGETING)

When determining financial eligibility, budget income for the month it is received.

Regular unearned income deposited directly into a financial institution is considered received in the month for which it is intended to be received.

a. Intake Cases

Individually determine financial eligibility for each month of requested coverage.

b. Ongoing Cases

Financial eligibility is always determined prospectively (future month). When information becomes known which causes ineligibility prospectively, terminate benefits allowing adverse action time.

3. LIMITS

See MAABD income standard chart in Appendix C.

4. BUDGET METHOD

Use Medicare Beneficiary Budget Form 2203 (side 2) to determine QMB, SLMB, QI1, or QDWI eligibility.

a. Income Consideration

Determine whether the client is considered an individual or a member of a couple with a QMB/SLMB/QI/QDWI eligible spouse by applying the definitions in this section.

When the client is considered an individual, only the client's income is counted. Additionally, when the client is considered a member of a couple, the spouse's income is counted in the eligibility determination.

Exceptions:

- Do not count income of a spouse who is receiving assistance under a Waiver.
- If a client is entitled to both Social Security and an additional income source such as long-term disability which offsets the amount of Social Security the client receives, budget only the resulting Social Security amount and the gross amount of the additional income source.

When income of the spouse must be considered, the income will be verified. If impossible to verify the spouse's income, document the circumstances and accept the client's statement.

b. Definitions

1) Eligible Spouse

The client's spouse who meets the requirements in both a. and b. below:

a) Has applied for, is receiving, or would be eligible to receive SSI/QMB/SLMB/QI/QDWI:

To determine if the spouse would have been eligible for one of these categories, the spouse:

(1) must be aged, blind or disabled; and
(2) must be determined financially eligible.

b) Is living in the same household as the client.

2) Ineligible Spouse

The client's spouse who meets the requirements in a. or b. below:

a) Is not receiving or has not applied for SSI/QMB/SLMB/QI/QDWI; or

b) Exceeds the income limit for couple computation.

c) Is living in the same household as the client.

3) Individual

Consider clients as individuals when they are:

a) NOT married.

b) Married but have been separated from their spouse for a specified time frame.

The client will be considered an individual beginning the month after the month they cease living together.

c. Medicare Beneficiaries Budget Form 2203-EM

1) Member of Couple with Eligible Spouse

Any time the spouse appears eligible for SSI or a Medicare Beneficiary category, treat them as eligible until determined otherwise.

Use the MEMBER OF A COUPLE WITH ELIGIBLE SPOUSE column. If ineligibility results, consider the spouse ineligible and go through the Deeming computation, using the MEMBER OF A COUPLE WITH INELIGIBLE SPOUSE column to determine if deeming applies.

2) Member of Couple with Ineligible Spouse

Use the MEMBER OF A COUPLE WITH INELIGIBLE SPOUSE column to determine if deeming applies. Deeming never applies when the Ineligible spouse receives TANF, VA pension or other federal or state assistance based on need.

If deeming does not apply, proceed to the INDIVIDUAL column of the budget.

3) Individual

Use the INDIVIDUAL column when the person meets the definition of an individual.

d. Budgeting – Specific Instructions

1) Deeming Computation

a) Determine the ineligible spouse's total unearned income.

b) Determine if an ineligible child allocation is applicable. To apply this, the child must:

(1) be under age 18 or age 22, and a student regularly attending a school, college, university or vocational/technical training to prepare for gainful employment; and
(2) not be receiving TANF, VA pension or other federal or state assistance based on need (SNAP is not considered assistance based on need for SSI budgeting purposes).

c) If the allocation deduction is applicable, subtract any unearned income of the child from the Child Allocation Amount. Add the remaining amounts and subtract the total from the ineligible spouse's unearned income.

d) Determine the ineligible spouse's gross earned income.

e) Subtract the balance of any allocation for ineligible children not offset by unearned income.

f) Add the remaining unearned income to the earned income after the allocation deduction.

g) Compare the total income after allocations to the Deeming Indicator Amount.

If less than the Deeming Indicator Amount, deeming does not apply. Proceed to the INDIVIDUAL column of the budget using only the client's income.

If equal to or greater than the Deeming Indicator Amount, deeming does apply. Continue through the second section in this column adding the deemed unearned income to the client's unearned and the deemed earned income to the client's earned income.

2) QMB/SLMB/QI/QDWI Eligibility Determination

In this section of the budget, use only the client's income when using the INDIVIDUAL column. Use combined income of the client and the eligible or ineligible spouse when using either of the columns for a couple.

a) Determine unearned income. This may be the individual's own income or include income of a spouse.

b) Subtract the general income exclusion of $20 to arrive at the remaining unearned income.

c) Determine total gross earned income.

d) Subtract any balance of the general exclusion not offset by unearned income.

e) Subtract the work expense exclusion of $65.

f) Subtract one half (1/2) of the remaining earned income after the above deductions.

g) Determine the total COUNTABLE income by adding the total unearned and earned income.

h) Compare the total COUNTABLE income to the income limit for the appropriate Medicare Beneficiaries category.

If countable net income is less than or equal to the income limit, the client is QMB/SLMB/QI1/QDWI eligible.

NOTE: Use the income limit for a COUPLE if spousal income was computed or deemed.

M. RESOURCES

Resources are defined as those assets, both real and personal, which an individual owns and can apply, either directly or by sale, to meet basic needs of food, clothing, and shelter and medical costs.

Real property is land, including buildings or immovable objects attached permanently to the land.

Personal property is any property that is not real property. The term encompasses such things as cash, tools, life insurance policies, mobile homes, automobiles, etc.

Any income which is retained the month following the month of receipt and later, is subject to resource evaluation.

Resources are evaluated at market value less encumbrances. When the combined value of all countable resources does not exceed the resource limit, verification of encumbrances is not necessary.

When the value of countable resources is under the resource limit on any day of the month, the client is eligible for that month.

All changes in resources must be reported.

1. OWNERSHIP/AVAILABILITY

a. Sole Ownership

Sole ownership of real or personal property means only one person may sell, transfer or otherwise dispose of the property. All of the resource evaluated at market value less encumbrances is available to the client.

b. Shared Ownership

Shared ownership of real or personal property means two or more people own it simultaneously. The following are common types of shared ownership:

1) Tenancy-In-Common

Two or more persons each have an undivided fractional interest in the whole property for the duration of the tenancy. These interests are not necessarily equal. One owner may sell, transfer or otherwise dispose of his/her

share of the property without permission of the other owner(s); but cannot take these actions with the entire property. If a tenant-in-common dies, the deceased's interest passes to his/her estate or heirs. Count the fair market value less encumbrances of the client's property share.

2) Joint Tenancy

Each of two or more persons have one and the same undivided ownership interest and possession of the whole property for the duration of the tenancy. This means each owner owns ALL the property. If a joint tenant dies, the survivor becomes the sole owner. If more than one joint tenant survives, the survivors become joint tenants of the entire property interest. Count the total fair market value less encumbrances of the entire property.

3) Tenancy By The Entirety (Married Couples only**)**

This type of ownership can only exist between married couples. The wife and husband as a unit own the entire property and can be sold only with the consent of both parties. However, if a legal divorce occurs, the former spouses become tenants-in-common and one can sell his/her share without the consent of the other. If one spouse dies, the survivor becomes the sole owner. Verify whether the client's spouse will give permission to sell the property. If permission cannot be obtained, DO NOT count the client's one-half share of the property.

4) Exceptions

When a resource is owned jointly by more than one TANF/Medicaid applicant/recipient (other than a community spouse), divide the resource equally among those applicants/recipients to whom available.

When a client is representative payee or legal guardian managing someone else's funds, these funds are not considered the client's resource when they are kept in an account separate and apart from the client's monies AND can be identified as being received and designated for someone other than the client.

5) Inaccessible Resources

The cash value of resources which are not legally available to the household are exempt. If the Medicaid applicant/recipient or authorized representative is able to verify a resource is unavailable due to the client's inability to access the resource due to incapacity and no one else has the ability to access the resource on their behalf, exempt the value of the resource as long as reasonable and timely steps are being taken to access the account on the client's behalf (i.e., referral to the public guardian's office). Once the resource becomes accessible, the resource becomes countable and eligibility must be reevaluated for future months.

c. Treatment of Resources

1) Deeming: Applies if the applicant/recipient is married and living with his/her spouse.

The value of the client's and spouse's countable resources (whether owned separately by each or jointly by both) are counted. Only one automobile and home may be excluded per couple. Apply the couple resource limit to all countable resources of both spouses to determine eligibility.

Deeming applies from spouse to spouse when they live together in the same household. Deeming stops the month following the month of institutionalization in a medical facility. Deeming begins the month following the month the spouse returns home from a medical facility.

Do not deem resources to the client if the spouse or parent(s) are recipients of SSI, TANF, Medicaid, Refugee Assistance, General Assistance (GA) or VA Pension, VA Compensation as a surviving parent of a veteran, VA Aid and Attendance and VA Payment for Unusual Medical Expenses. This is because these benefits are paid based on need, not entitlement.

2) Dividing: Does not apply.

3) Court Order: Does not apply.

2. TRANSFER OF ASSETS

Does not apply to QMB/SLMB/QI1/QDWI only coverage.

3. TREATMENT OF TRUSTS (Refer to Section 250)

4. LIMITS

Resource limits for QMB, SLMB and QI are $6,680 for an individual OR $10,020 for a couple when one OR both spouses are applying. When countable resources exceed the limit, the client is ineligible.
Resource limits for QDWI are $4,000 for an individual or $6,000 for a couple when one OR both spouses are applying.

N. PATIENT LIABILITY

Does not apply unless a conversion to another program occurs.

O. REVIEW OF ELIGIBILITY

1. QMB/SLMB/QI1/QDWI Only Cases

A review of eligibility is required at least every 12 months. Information received between redeterminations which may affect eligibility must be evaluated and acted on when applicable. A review of eligibility must be completed no later than the month it is due except when future actions are necessary. Clients are the primary source of information regarding their eligibility. If a client is unable to obtain information, the office may assist. Office interviews and home visits are optional and can be done at the discretion of the Unit Supervisor or Social Welfare Office Manager.

Income, resources and eligibility factors (including Medicare Part A entitlement) must be reevaluated and necessary action taken only when a change is reported.

Form 2426-EE asks the recipients to identify any changes in household circumstances. If there are no changes in circumstances, no verifications will be required. When changes are reported during the review of eligibility process, request verification of the changes that effect eligibility.

Terminate benefits if the 2426-EE or other application form is not received by the due date.

The Review of Eligibility Form 2426-EE informs the client about their choices concerning an authorized representative (A/R). If any change in the A/R is indicated on Form 2930-EM, send the client form 2525-EE to complete and return. If the A/R area on Form 2426-EE is blank, assume there is **NO** change in the status of the A/R for the client.

2. Dual Eligibles

If the applicant has dual eligibility, i.e., SSI/QMB or HBW/SLMB, see the appropriate manual section for the other category of eligibility for review of eligibility requirements.

P. LOW INCOME SUBSIDY REFERRALS

The Social Security Administration transmits applicant information from Low Income Subsidy applicants to DWSS on a daily basis. DWSS must treat this data as an application for the Medicare Beneficiary programs.

Application processing timeframes are determined by the date the file is received by DWSS. The eligibility determination is established based on the date the LIS application was received by Social Security. QMB effective dates remain the same when processing LIS referral applications.

Example: LIS file is received by DWSS on January 29, 2010. Application effective date (date LIS application is received at Social Security) is December 2, 2009. Applicant meets all eligibility requirements for QI eligibility, decision date is February 20, 2010, first month of eligibility would be December 2009.

If the same applicant was determined eligible for QMB, first month of eligibility would be March 2010.

CASE EXAMPLES FOR QMB

The following are examples to help clarify this eligible category:

1. Applicant applies 12/3 as a state institutional case and is currently enrolled in Medicare Part A. The client cooperates and is determined eligible as a state institutional case. Because this client has Medicare Part A, the case manager must also determine whether the client is eligible for QMB coverage. If the client's income and resources meet QMB criteria, they will qualify for both Medicaid and QMB coverage.

2. Applicant applies 12/3 and has $250 SSA disability income. The client has not applied for SSI, but is probably eligible. The client meets all the other requirements of a QMB.

   Request the client apply for SSI and give the normal time limit for applying. However, once the worker is able to determine the client is eligible for QMB coverage (all verifications needed are in), the case would be approved as a QMB only case. The case would be future actioned for the SSI information. If the client failed to cooperate in applying for SSI, or was determined ineligible, the case would remain open as a QMB only case as long as he continued to meet the criteria. If the client were approved for SSI, the case would be converted to an SSI case effective with the month of SSI eligibility (this could include prior med).

   Additionally, if the person also has Part B Medicare, a Form 1056 must be sent to E&P in Central Office so Buy-In coverage can begin with the first month of SSI eligibility.

3. Applicant applies and is approved for QMB coverage. Sometime after approval, the client enters the hospital for 7 days. The case would continue as QMB and NO PATIENT LIABILITY would be determined, UNLESS the client qualified as a state institutional case (if income is less than SSI payment level, the client does not have to be in 30 consecutive days). If the case qualifies as a state institutional case, the case would be converted and client would receive full Medicaid coverage and QMB coverage. When the client is released from the institution, the case would be converted back to a QMB only case, allowing adverse action, as long as all requirements were still met.

4. Applicant applies 12/29. The case manager is able to determine eligibility on January 10 and approve as a QMB case. The case would be eligible beginning February 1.

   If in this same example, the client qualified under another category, the other category would be approved effective December with the regular Medicaid eligibility code, and beginning in February, the code would change to the Medicaid and QMB eligibility code.

INDEX
SECTION 320
SUPPLEMENTAL SECURITY INCOME (SSI)

320 SUPPLEMENTAL SECURITY INCOME (SSI)

A. OVERVIEW

Applicants are eligible for Medicaid when they are:

– Verified SSI recipients; or
– Recipients of presumptive SSI payments; or
– In CO1 pay status per SOLQ/SDX but without monetary payment, due to an overpayment collection; or
– In EO2 status per SOLQ/SDX the month(s) prior to CO1 status; AND

apply for Medicaid and meet the requirements under Cooperation, Residency, and Insurance Coverage.

Note: When SSI is suspended, and a payment is not being issued, Medicaid must be terminated. (See manual section 214 for procedures on terminations)

SSI Recipients could be living:

– Independently in the community;
– In an Adult Group Care Facility (AGCF) or in appropriate settings as determined by Medicaid;
– In a medical facility when countable income is less than $30 a month.

All SSI cases must be evaluated for Qualified Medicare Beneficiary (QMB) eligibility.

ELIGIBILITY EXCEPTIONS

1. Individuals determined by SSI to have received SSI payments for which they were not eligible, <u>are eligible</u> for Medicaid for the period in which SSI payments were made on their behalf.

2. Individuals under 65 who are residing in an Institution for Mental Disease (IMD) i.e., free standing psychiatric hospital, **are not** eligible for Medicaid. EXCEPTION: Children under 22 when SSI eligible. (See chapter Addendum listing IMD facilities)

   An Institution for Mental Diseases (IMD) is defined as a hospital, nursing facility or other institution of more than 16 beds which is **primarily** engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Individuals are severely psychotic, emotionally ill, suicidal and a danger to themselves, others or property. In Nevada, IMDs are commonly referred to as "psychiatric hospitals." **An institution for the mentally retarded IS NOT an institution for mental disease.**

3. An inmate of a public institution is ineligible for Medicaid UNLESS the institution is a medical institution. An inmate of a penal institution is NEVER eligible for Medicaid while in the custody of law enforcement officials, UNLESS admitted as an inpatient to a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility. This individual is eligible for any Medicaid covered services provided to them while an **inpatient** in these facilities and they are Medicaid-eligible. If this individual becomes an inpatient of a long-term care facility, they must meet level of care and plan of care assessments to become eligible.

   NOTE: Inmates under house arrest, and supervised by Parole and Probation, may qualify for SSI as long as the penal institution is not supplying their food and shelter. Persons who are released on parole from a penal institution are not considered a resident of a public institution and therefore may be eligible for SSI if they meet all other eligibility requirements.

4. Individuals under 22 receiving inpatient psychiatric services in a Residential Treatment Center (RTC) are eligible for Medicaid when SSI eligible. (See chapter Addendum listing RTC facilities).

   RTCs specialize in treating children with conduct, personality and emotional disorders, depression, hyperactivity, academic failure, and/or mild learning disabilities. Medicaid will pay for services provided in the RTC if the referral resulted from a "Healthy Kids" screening and the admission was prior authorized/certified by Medicaid's Peer Review Organization (PRO).

B. AGED, BLIND, DISABLED

Persons must be aged (65 or older) blind or disabled as determined by Social Security Administration criteria.

C. TIME FRAMES

An eligibility decision must be made within 10 working days from the date the case manager receives the SSI determination, unless extenuating circumstances exist.

D. SOCIAL SECURITY NUMBER (SSN)

Social Security numbers must be provided by every applicant and recipient. See manual section 204.

E. IDENTIFICATION

All applicants for Medicaid must be identified.

F. NEVADA RESIDENCY

1. NON-INSTITUTIONAL PERSONS (INCLUDES SSI RECIPIENTS NOT RECEIVING SSP)

   Clients must be living in Nevada with the intention of making Nevada their home permanently or for an indefinite period (no expected end date) OR must be living in Nevada with a job commitment or seeking employment. Clients do not have to have a fixed place of residence to meet this requirement.

   Nevada residency continues when a client is temporarily absent IF he/she intends to return to Nevada when the purpose of the absence has been accomplished. Document in the case file the temporary absence situation and obtain the client/representative's statement concerning the intent of residency and the purpose of the absence.

2. SSI RECIPIENTS RECEIVING A STATE SUPPLEMENTARY PAYMENT (SSP) FROM ANOTHER STATE

   When the client is receiving SSI/SSP through another state, the state paying the State Supplementary Payment is the state of residence UNLESS SSA acknowledges Nevada residency. Use SSA's effective date of Nevada residency.

3. SSI RECIPIENTS NOT RECEIVING A STATE SUPPLEMENT FROM ANOTHER STATE

   If a client is receiving SSI from another state but that state is <u>not</u> paying a supplementary payment (SSP) establish residency per "1 or 4."

4. INSTITUTIONALIZED PERSONS (INCLUDES SSI RECIPIENTS NOT RECEIVING SSP)

   a. DEFINITIONS

      1) INCAPABILITY OF INDICATING INTENT TO RESIDE

         Persons are considered incapable of indicating their intent to reside when they:

         a) Have an IQ of 49 or less or have a mental age of 7 or less; or
         b) Are found incapable of indicating their intent to reside based on and verified through medical documentation by a physician or licensed psychologist; or
         c) Are judged legally incompetent.

2) EMANCIPATED

Persons are considered emancipated when they are:

a) 18 or over; or
b) Married; or
c) Enlisted in the armed services; or
d) Emancipated by court order.

3) ABANDONED

Persons are considered abandoned when:

a) Location of parents is unknown; or
b) Parental rights have been terminated.

b. INDIVIDUALS PLACED IN AN INSTITUTION BY A STATE

Residence is the state making or arranging placement. Any agency of the state, including an entity recognized under state law as being under contract with the state for such purposes, that arranges for an individual to be placed in an institution (including foster care homes) located in another state, is recognized as acting on behalf of the state making a placement.

c. COMPETENCY AND RELATIONSHIP TO AGE 21

Residency requirements are based on clients' competency, ability to indicate intent and age. When a client is incompetent, or unable to indicate intent, the age at which (s)he became incompetent or unable to indicate intent must also be determined.

1) PERSONS CAPABLE OF INDICATING INTENT AT AGE 21 OR OVER; OR PERSONS UNDER AGE 21 AND EMANCIPATED

The state of residence is that in which the client is living with the intention of making his/her home permanently or for an indefinite period of time. An indefinite period has no expected end date.

The ability to indicate intent to reside in Nevada is not to be taken lightly or stand by itself. A statement or indication of intent to reside in Nevada must be supported by additional verification or collateral material to substantiate the intent if residency is questionable. Manual Section 205,D,5 is not all inclusive. See Manual Section 205,A for more detail.

2) PERSONS WHO BECAME INCAPABLE OF INDICATING INTENT BEFORE AGE 21

The state of residence is:

a) That of the parent applying for Medicaid on the individual's behalf, IF the parents reside in separate states (if a legal guardian has been appointed and parental rights are terminated, the state of residence is that of the guardian instead of the parent's);

b) The parent's or legal guardian's state of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the state of residence is that of the guardian instead of the parent's); or

The current state of residence of the parent or legal guardian who files the application if the individual is institutionalized in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence is that of the guardian instead of the parent's).

c) The state of residence of the individual or party who files an application if the individual has been abandoned by his/her parent(s), does not have a legal guardian and is institutionalized in that state.

3) PERSONS UNDER AGE 21 AND NOT EMANCIPATED

a) The parent's or legal guardian's state of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the state of residence is that of the guardian instead of the parent's); or

The current state of residence of the parent or legal guardian who files the application if the individual is institutionalized in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence is that of the guardian instead of the parent's).

b) The state of residence of the individual or party who files an application if the individual has been abandoned by his/her parent(s), does not have a legal guardian and is institutionalized in that state.

4) PERSONS WHO BECAME INCAPABLE OF INDICATING AT AGE 21 OR LATER

The state of residence is the state in which the individual is physically present.

d. DISPUTED RESIDENCY

When Nevada Medicaid determines a client is a resident of another state and that state disagrees, the following procedures apply:

1) Require the client to provide a copy of the disputing state's denial/termination letter.

2) Process the Nevada Medicaid application to determine eligibility.

3) Notify the Chief of E&P by memo. Include:

a) Case name and number.
b) Copy of denial/termination letter from the disputing state.
c) Copy of 2400 showing approval/denial.

5. VERIFICATION (not all inclusive)

a. Rent/Mortgage receipt

b. Landlord statement

c. Statement from the nursing facility in which the client resides

d. Nevada driver's license

e. Nevada vehicle registration

f. Utility bills/receipts

g. Employer's statement

h. Statement from a friend, relative or other person who is knowledgeable about the client's residency

G. CITIZENSHIP

To qualify for assistance, applicants must be a U.S. citizen or a non-citizen in an eligible category. See manual section 206 for citizenship requirements.

H. PRIOR MEDICAL

Clients may apply for prior medical coverage for up to 3 months prior to the month of Medicaid application.

1. Prior Medicaid coverage must be requested; AND

2. There must be evidence that medical care or services were provided in the month(s) for which Medicaid is requested.

When clients request prior medical, first determine if they are eligible for prior medical as an SSI recipient.

If they are not an SSI recipient, determine if they would have been eligible for SSI had Social Security Administration made a determination (See PRIOR MEDICAL DETERMINATIONS ONLY - WOULD HAVE BEEN ELIGIBLE FOR SSI). This category of eligibility is used only after all other eligibility categories have been considered.

Do not make an independent SSI determination IF there is a pending SSI application covering the month(s) Medicaid is requested. Wait for the SSI decision.

Use SSI/SSA's disability decision (the disability on–set date) for any month of requested prior medical assistance. All other factors of eligibility, e.g., residency, citizenship, income, resources, etc., must be evaluated by the case manager.

I. THIRD PARTY LIABILITY (TPL)

Medicaid is always payor of last resort whenever any other resource may be responsible for payment.

When insurance coverage is available at no cost to the client (e.g., through employment or Tricare), request the client to enroll.

Assistance will be denied or terminated if the client refuses to apply for, pursue, or provide information necessary to establish insurance coverage/claims and/or fails to cooperate in the collection process from a third party. See manual section 208 regarding Medicare.

Do not deny coverage for a SSI eligible child if the parent refused to provide insurance information.

J. PENDING SSI DETERMINATIONS

When a pending SSI application is denied by SSI, deny the pending Medicaid application. If the applicant requests reinstatement of a denied Medicaid application, request proof of filing a timely reconsideration with Social Security, if provided return the Medicaid application to pending status. The timely reconsideration must be for the same Social Security application that the original Medicaid application was based on and not a new claim.

Do not request verification of citizenship during the pending SSI period. If the applicant is approved for SSI, they will meet the exemption from citizenship documentation.

If the applicant moves out of state while pending SSI, terminate ongoing eligibility months for no residency and leave previous months pending the SSI determination. At SSI approval, verify the Nevada SSI months.

If the applicant becomes eligible in another Medicaid category while pending SSI, terminate the SSI pending months for duplicate assistance and continue pending any months not covered by another category until the SSI determination is made.

Do not approve SSI eligibility for months the applicant was eligible under another Medicaid category. Terminate the other Medicaid eligibility and begin the SSI eligibility in the next available month.

K. CHILD SUPPORT ENFORCEMENT (CSE)

All dependent children (including automatic Medicaid eligible newborns) who have absent parent(s) require referrals to Child Support Enforcement (CSE) for support enforcement services. See manual section 209.

L. INCOME

Income means the receipt of money in the month for which an eligibility determination is being made. All income must be reported.

All income will be evaluated by Social Security Administration.

M. RESOURCES

Resources are defined as those assets, both real and personal, which an individual owns and can apply, either directly or by sale, to meet basic needs of food, clothing, shelter and medical costs.

All resources must be reported. All resources will be evaluated by Social Security Administration.

1. TRANSFER OF RESOURCES

If an SSI recipient has an inpatient stay in a medical facility, see Transfer of Resource policy in the State Institutional Section.

2. RESOURCE LIMITS

Resource limits are $2,000 for an individual and $3,000 for a couple. When countable resources exceed the limit, notify the Social Security Administration of the assets, using form 3911.

N. PATIENT LIABILITY

Patient liability is determined for Medicaid eligible persons residing in a medical facility. There is no patient liability for any portion of institutionalization (full or partial month stays) in a VA hospital, AGCF, FCH, freestanding psychiatric hospital or RTC.

There are six freestanding psychiatric hospitals in Nevada, they are:

- Charter Hospital
- Desert Willow Treatment Center
- Montevista Hospital
- Nevada Mental Health Institute (NMHI)
- Southern Nevada Adult Mental Health (SNAMH)
- West Hills Hospital

1. TREATMENT OF INCOME, DEDUCTIONS AND EXPENSES

When determining patient liability for initial and ongoing cases, budget income for the month it is received and deductions/expenses for the month in which they are paid/incurred.

When unanticipated income is received, patient liability will be adjusted for the month in which it was received.

Regular unearned income deposited directly into a financial institution is considered received in the month for which it is intended to be received.

2. PARTIAL MONTH PRORATION

The amount of patient liability is prorated according to the number of days the client was in a facility when the person is institutionalized less than a full calendar month due to:

a. Month of admission.

b. Discharge to independent living, VA hospital, AGCF, FCH, free-standing psychiatric hospital or RTC.

c. Death.

Determine what the patient liability would be for a full month. Divide that full month amount by the number of days in the month of partial institutionalization to determine the daily amount of patient liability. Multiply this daily amount by the number of days the client was institutionalized in that month (include the day of admission but not the day of discharge/death. The result is the amount of patient liability due for the partially institutionalized month.

3. EFFECTIVE DATE OF PATIENT LIABILITY

a. SSI recipients with no countable income: No patient liability assessed.

b. SSI/QMB recipients with countable income:

Hospital Stay Only: For inpatient hospital stays under 90 consecutive days, do not calculate or send notice of patient liability. This is because Medicare will cover up to 90 days in a hospital and Medicaid must pay the hospital deductible and co-pay charges. If hospitalized beyond the 150 day time period, begin patient liability the first of the month following the 90 days.

c. SSI recipients with countable income:

When a SSI recipient goes from private living to an institution, patient liability is effective the first month of institutionalization.

d. Deceased Clients

The facility is notified of the patient liability amount due for the month of death. The facility will collect only for charges actually incurred. Any unused patient liability will be deposited in the Patient Trust Fund Account.

4. BUDGETING PROCEDURES - FORM 2220-EM

a. Determine the client's TOTAL gross countable monthly income **(less involuntary mandatory deductions)**.

b. Subtract the following items from TOTAL MONTHLY INCOME in the following order:

1) PERSONAL NEEDS ALLOWANCE

Deduct $35 Personal Needs Allowance (PNA) for each month of institutionalization.

2) MAINTENANCE ALLOWANCES

Clients do not have to request the maintenance allowance for their spouse/dependents. The case manager will automatically request the information necessary to determine the maintenance allowance when there is a spouse or dependents at home.

a) MAINTENANCE ALLOWANCE FOR THE SPOUSE AT HOME

Clients whose spouse is living in the community, may receive a maintenance allowance deduction from their income. Verification of the spouse's income must be obtained.

A Spouse Maintenance Allowance Deduction will be effective the first month Patient Liability is established.

(1) Determine spouse's gross earned income

(2) Subtract from gross earned income:
- (a) Federal and Social Security (FICA) taxes as deducted by the employer.
- (b) Retirement: Do not deduct FICA taxes when a retirement plan substitutes for FICA.
- (c) Union dues, meals and payroll deductions which are a condition of employment.
- (d) Individual work expenses when requested and verified.

(3) Determine total unearned income.

(4) To determine the Maintenance Allowance Deduction, subtract the Total NET income from the Total Need.

See the MAABD income standard chart in Appendix C.

b) MAINTENANCE ALLOWANCE FOR A FAMILY AT HOME

Clients whose spouse and/or dependent children (under age 21) are living in the community, may receive a maintenance allowance deduction from their income. Verification of the spouse and/or children's income must be obtained.

The spouse/dependent children maintenance allowance will be effective the first month Patient Liability is established.

(1) Determine spouse/dependent children's gross earned income.

(2) Subtract from gross earned income:
- (a) Federal and Social Security (FICA) taxes as deducted by the employer.
- (b) Retirement: Do not deduct FICA taxes when a retirement plan substitutes for FICA.
- (c) Union dues, meals and payroll deductions which are a condition of employment.
- (d) Individual work expenses when requested and verified.

(3) Determine total unearned income.

(4) To determine the Maintenance Allowance Deduction subtract Total NET Income from Total Need.

See the MAABD income standard chart at the end of this Chapter for need amounts.

If verifications needed to determine the Maintenance Allowance are not returned by the required date, the case will be completed without allowing a maintenance allowance. The client will be notified on the Notice of Decision, the patient liability was determined without a Maintenance Allowance Deduction.

3) EXPENSES INCURRED FOR HEALTH INSURANCE PREMIUMS, DEDUCTIBLES AND CO-INSURANCE CHARGES

Deduct Health Insurance Premiums, Deductibles and Co-insurance expenses incurred by the client. Clients/ Representatives must advise the agency of medical insurance and provide proof of expenses. These expenses must not be paid or subject to payment by a third party.

Medicare premiums are subject to payment by a third party, therefore, do not allow the Medicare premium as a deduction.

4) EXPENSES INCURRED FOR MEDICAL CARE

Deduct expenses incurred by the client for necessary medical care recognized under the State law but not covered under the Medicaid Program. This includes medical expenses incurred more than three months prior to the date of application. Clients/Representatives must advise the agency and submit proof of the expenses.

The case manager will attach a copy of the medical bill to Form 2536 and submit to NMO for approval. These expenses must not be paid or subject to payment by a third party. An NMO approval is required to assure the deduction is for necessary care payable to reasonable limits.

c. The deficit, if any, is the client's share of facility cost (PATIENT LIABILITY).

5. NOTIFICATION OF PATIENT LIABILITY

When patient liability is established or changes, the client and facility are notified on a Notice of Decision of the amount and effective date.

O. REVIEW OF ELIGIBILITY

A review of eligibility is required at least every 12 months. Information received between reviews which may affect eligibility must be evaluated and acted on when applicable. A review of eligibility must be completed no later than the month it is due except when future actions are necessary. Clients are the primary source of information regarding their eligibility. If a client is unable to obtain information, the case manager may assist. Office interviews and home visits are optional and can be done at the discretion of the Unit Supervisor or Office Manager.

The Review of Eligibility form (2426-EE) informs the client about their choices concerning an authorized representative (A/R). If any change in the A/R is indicated on Form 2426-EE or 2930-EM, send the client Form 2525-EE to complete and return. If the A/R area on the form is blank, assume there is **NO** change in the status of the A/R for the client.

Additionally, ensure the correct aid codes, eligibility codes, case type codes and Medicare claim numbers and buy-in are correct in the system.

Verification used to re-establish Medicaid eligibility must be current (within the last 45 days).

1. SSI CASES and SSI/QMB

Conduct a desk review of the case using MAABD Only Redetermination (2930-EM) or Review of Eligibility (2426-EE) to ensure the client is currently receiving SSI and the mailing address agrees with DWSS records. If there is no current SDX or SOLQ record, some other current verification from Social Security must be used.

If the client has a telephone number, contact the client to determine third party liability (TPL) and subrogation information. You must ask the client the following questions and document their response on Form 2930-EM, MAABD Only Redetermination or Review of Eligibility Form 2426-EE.

1. Other than Medicaid, do you have any other medical/dental insurance? YES?, NO? If YES, enter the insurance coverage information into NOMADS.

2. Have you been involved in an accident in the past twelve months? YES?, NO? If YES, send Form 2511-EE to the client to complete.

If the client cannot be reached by telephone, does not have a telephone number, *or you do not wish to conduct a desk audit*, document this in the case narrative and send the Review of Eligibility, Form 2426-EE. Give the client ten (10) days to respond.

Upon receipt of the completed review and any necessary verifications, take the appropriate action and document this in the case narrative.

Take the appropriate action based on the information provided by the client. If additional verifications are needed for QMB coverage, request them using Form 2429-EE, allowing the client ten (10) days to respond. If either SSI or Medicare has terminated, follow the instructions listed in "p" of this section: CONVERSIONS.

If information of a change is received that indicates the client may no longer be eligible for SSI, but records show the client is still in CO1 status, do not terminate Medicaid. Notify Social Security Administration of the change using Form SSA-3911. If they terminate SSI as a result of this information, then terminate the Medicaid.

Do not terminate the SSI case for failure to provide income and resource verification.

If the client does not return the completed review, send a termination notice allowing for adverse action. If verifications are provided on or before the last day of the month, reinstate eligibility. (SSI cases may be closed if the client fails to provide information on the TPL or subrogation.)

The Application for Assistance Form 2905-EG or Form2930-EM, may be used in lieu of the desk audit to verify eligibility through the review process when SNAP benefits are involved.

NEVADA MEDICAID RESIDENTIAL TREATMENT CENTER (RTC) SERVICE PROVIDERS

Benchmark Hospital
592 West 1350 South
Woods Cross, Utah 84087
(801) 299-5300

Brown Schools, Inc.-Cedar Springs Ctr
22135 Southgate Road
Colorado Springs, Colorado 80906
(719) 633-4114

Brown Schools, Inc.-Laurel Ridge Trtmt Ctr
17720 Corporate Woods Drive
San Antonio, Texas 78259-3509
(210) 491-9400

Brown Schools, Inc.-San Marcos Trtmt Ctr
One Bert Brown Road
San Marcos, Texas 78667
(512) 396-8500

Brown Schools, Inc.-The Oaks Trtmt Ctr
1407 Stassney Lane
Austin, Texas 78745
(512) 444-9561

Cathedral Home for Children
P.O. Box 520
Laramie, Wyoming 82073-0520
(307) 745-8997

Cleo Wallace Center
430 Gold Pass Heights
Colorado Springs, Colorado 80906
(719) 527-1600
(Denver Campus - (303) 466-7391

Copper Hills at St. George
115 West 1470 South, Suite B
St. George, Utah 84770
(435) 634-1730

Copper Hills Youth Center
5899 West Rivendell Dr
West Jordan, Utah 84080
(801) 561-3377

Desert Willow Treatment Center (RTC)
6171 West Charleston Boulevard
Las Vegas, Nevada 89146
(702) 486-8900

Primary Childrens Medical Center RTC
497 South Colorow Way
Salt Lake City, Utah 84108
(801) 588-4980

Provo Canyon School
P.O. Box 1441
Provo, Utah 84603
(801) 227-2000

San Diego Center for Children
3002 Armstrong Street
San Diego, California 92111
(619) 277-9550

Spring Mountain Treatment Center
7000 West Spring Mountain Road
Las Vegas, Nevada 89117
(702) 873-2400

Vista Care RTC
4120 East Ramsey Road
Hereford, Arizona 85615
(520) 378-6466

Willow Springs Center
P.O. Box 30012
Reno, Nevada 89520
(702) 323-3303

NEVADA MEDICAID PSYCHIATRIC HOSPITAL SERVICE PROVIDERS

Charter Hospital
7000 West Spring Mountain Road
Las Vegas, Nevada 89117
(702) 876-4356

Desert Willow Treatment Center (RTC)
6171 West Charleston Boulevard
Las Vegas, Nevada 89146
(702) 486-8900

Montevista Hospital
5900 West Rochelle Avenue
Las Vegas, Nevada 89103
(702) 364-1111

Nevada Mental Health Institute
480 Galletti Way
Sparks, Nevada 89431
(702) 688-2001

Southern NV Adult Mental Health
6161 West Charleston Blvd.
Las Vegas, Nevada 89102
(702) 486-6000

West Hills Hospital
1240 East Ninth Street
Reno, Nevada 89520
(702) 323-0478

NEVADA MEDICAID PSYCHIATRIC HOSPITAL SERVICE PROVIDERS

Charter Hospital
7000 West Spring Mountain Road
Las Vegas, Nevada 89117
(702) 876-4356

Desert Willow Treatment Center (RTC)
6171 West Charleston Boulevard
Las Vegas, Nevada 89146
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Montevista Hospital
5900 West Rochelle Avenue
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480 Galletti Way
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(702) 323-0478

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SECTION 330
PUBLIC LAWS

330 PUBLIC LAW CASES

A. OVERVIEW

Certain individuals who have lost SSI eligibility, but would still be eligible for SSI if some of their income were disregarded, may be Medicaid eligible if all other eligible requirements are met. Public law dictates what income is disregarded for each group.

Special attention is required so these individuals so they do not have their Medicaid eligibility interrupted.

1. PICKLE AMENDMENT - PUBLIC LAW 94-566

Under Section 503 of P.L. 94-566, the Pickle Amendment, clients are eligible for Medicaid if:

a. They currently receive RSDI, AND

b. After April 1977 they were **eligible for and receiving** SSI and **entitled to** RSDI in the same month, AND

c. They became ineligible for SSI for any reason, AND

d. They would now be eligible for SSI if RSDI cost-of-living increases received after they were last **eligible for and received** SSI and **entitled to** RSDI in the same month are excluded from their countable income, AND

e. All other eligibility factors are met.

Entitlement to RSDI benefits can be determined by:

a. Being "eligible for and receiving" the RSDI benefit; OR

b. Being eligible for the RSDI benefit without receiving the benefit due to the "windfall off–set" requirements of Social Security.

The purpose of the "windfall off–set" is to ensure the individual who is currently eligible for either SSI or RSDI AND subsequently becomes retroactively eligible for the other benefit does not receive more benefits than he/she would have received if payments for both benefits (SSI & RSDI) had been paid when regularly due.

FOR EXAMPLE: A client applies for Medicaid this month. The client was **eligible for and receiving** SSI and **entitled to** RSDI in April 1982. Excess resources caused him to become ineligible for SSI in May 1982. The client's resources are now within the current resource limitations and if all RSDI cost-of-living increases made after May 1982 are excluded from his countable income, the client would be eligible for SSI. Therefore, the client is categorically eligible for Medicaid under the Pickle Amendment.

When a client applies for Medicaid and does not receive SSI or reside in a medical facility, use the above criteria to determine if they may be eligible under the Pickle Amendment.

When an RSDI cost-of-living increase occurs, a special SDX will be produced for ongoing SSI recipients who may become eligible under this Public Law. These cases are identified in the SDX Public Law column by Alpha Code "B."

If the client resides with his/her spouse and spousal deeming applies, deduct the RSDI cost–of–living increases from the Spouse's RSDI income which were received after the client last received SSI. The last RSDI amount the client was **entitled to** can be obtained through the Social Security Administration using Form 2022–EM, Pickle Amendment Certification or the RSDI Computation Worksheet Form 2645–EE. Disabled persons must continue to meet disability criteria. Verification used to support "Pickle" status must remain in the permanent section of the casefile.

When re–evaluating eligibility because of changes in income/amounts, if the client would now be eligible for SSI (using SSI rules) before disregarding cost–of–living increases, they no longer meet the criteria for Medicaid eligibility under Public Law 94–566 (Pickle Amendment).

These cases must also be evaluated for QMB/SLMB eligibility.

NOTE: To be eligible for Medicaid under the Pickle Amendment, HCFA has always interpreted SSI eligibility to mean receipt of an actual cash benefit, not just eligible to receive a benefit.

However, SSA has made the following clarification: "Disabled individuals who work can continue to receive SSI, and categorical Medicaid, even though their earned income exceeds the substantial gainful activity (SGA) limits." SSI confers no cash benefit in these situations, but only eligibility for Medicaid as if the individual was receiving an SSI payment.

SSA considers eligibility under these circumstances to be a benefit under the Social Security Law and qualifies an individual for eligibility under the Pickle Amendment, provided all of the other requirements for eligibility under the Pickle Amendment are met.

2. ADULT DISABLED CHILD - PUBLIC LAW 99-643

Public Law 99-643 continues Medicaid eligibility for certain blind/disabled individuals age 18 years or older if:

a. They received SSI benefits which were based upon a disability or blindness which began prior to the individual turning age 22; and

b. They lost SSI eligibility on or after July 1, 1987 solely because they became eligible for SSA benefits as an "adult disabled child" or because of an increase in their "adult disabled child" SSA benefits; and
c. They would now be eligible for SSI if the Social Security "adult disabled child" benefit or the increase in their "adult disabled child" benefits received after July 1, 1987 was excluded from their countable income; and
d. All other eligibility factors are met.

NOTE: The SSI benefits did not have to begin prior to age 22, only the disability or blindness on which the SSI was based had to begin before age 22.

Social Security will identify individuals who are possibly eligible under this category with a "D" in the SDX Public Law column. If an SDX is received identifying an individual as such, it is the responsibility of the case manager to determine if the individual meets the above criteria. If a subsequent SDX is received and the Alpha Code “D” has disappeared, it is the responsibility of the case manager to determine if the individual continues to meet the above criteria. The case manager must document the case and Social Security should be contacted to verify ongoing eligibility status.

The case manager shall document the case to show what amount of benefit is being disregarded. If the case manager cannot tell from the SDX what amount should be disregarded, Social Security should be contacted to verify.

These cases must also be evaluated for QMB eligibility.

3. WIDOW/WIDOWERS - PUBLIC LAW 100-203

Public Law 100-203 (OBRA 87), mandates Medicaid assistance to widow and widowers who:

a. Are at least 60 years of age but not yet 65; and

b. Are eligible for SSA Widow's or Widower's benefits or are eligible for SSA Widow's or Widower's benefits in combination with another SSA Benefit(s); and

c. Lost SSI eligibility because of the receipt of the SSA Widow/Widower's benefits or combination of Widow/Widower's benefits and other SSA Benefits; and

d. Are **not** entitled to Medicare Part A; and

e. Would now be eligible for SSI if the Widow/Widower's benefits, and other SSA benefits were disregarded (SSA Disability benefits are not disregarded); and

f. All other eligibility criteria are met.

When an individual is terminated from SSI who is a widow/widower, their termination letter will inform them of their possible eligibility for Medicaid. The following verifications from Social Security must be in file to determine eligibility under this category:

– The date and reason SSI was terminated. If SSI was terminated more than a year from the date of the Medicaid application, an NMO disability determination must be done to verify the person is still disabled, unless they are currently receiving SSA Disability benefits.
– What type of Social Security benefits the person is receiving.
– The amount of each Social Security benefit.
– Whether the person is entitled to Medicare Part A.

Individuals eligible for Medicaid under this provision will lose Medicaid eligibility at the time they reach age 65 or become eligible for Medicare, whichever comes first, UNLESS they are found to be eligible for Medicaid under another category.

4. WIDOWS, WIDOWERS AND SURVIVING DIVORCED SPOUSES – PUBLIC LAW 101–508

Effective January 1, 1991, Section 5103 of Public Law 101-508 authorizes Medicaid coverage to disabled widows, widowers and surviving divorced spouses who lose SSI because of receipt of Title II (RSDI) benefits from the changed disability criteria. These individuals are deemed to be receiving SSI if:

a. They were receiving SSI for the month prior to the month they began receiving Title II benefits; and

b. They would continue to be eligible for SSI if the amount of the Title II benefit were not counted as income; and

c. They are NOT entitled to Medicare Part A hospital insurance.

Social Security will identify individuals who are possibly eligible under this category with an "S" in the SDX Public Law column. If an SDX is received identifying an individual as such, it is the responsibility of the case manager to determine if the individual meets the above criteria.

Individuals eligible for Medicaid under this provision will lose Medicaid eligibility at the time they become eligible for Medicare, whichever comes first, UNLESS they are found to be eligible for Medicaid under another category.

The case manager shall document the case to show what amount of benefit is being disregarded. If the case manager cannot tell from the SDX what amount should be disregarded, Social Security should be contacted to verify.

These cases must also be evaluated for QMB eligibility.

5. SUSPENSION OF SSI DUE TO INCOME – PUBLIC LAW 96-265

Eligibility for Medicaid will continue for certain disabled/blind persons whose SSI is suspended due to excess earned income. The Social Security Administration will determine this Public Law status and identify these cases via the SDX. When the Payment status code is NO1 or PO1 and SSA has determined the case to be one which falls under Public Law 96-265, Alpha Code "I" will appear in the SDX Public Law column. If a subsequent SDX is received and the Alpha Code "I" has disappeared, it is the responsibility of the case manager to determine if the individual continues to meet the above criteria. The case manager must document the case and Social Security should be contacted to verify ongoing eligibility status.

These cases must also be evaluated for QMB eligibility.

6. ELIGIBILITY FOR CHILDREN WHO LOSE SSI BUT REMAIN ON MEDICAID

The Balanced Budget Act (BBA) of 1997 reinstated Medicaid to children (under age 18) who lost their SSI benefits because of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996.

Medicaid coverage for a disabled child who was receiving SSI benefits as of August 22, 1996 continues despite having their SSI eligibility terminate because they do not meet the new, more strict SSI childhood disability criteria.

Children covered by the BBA whose eligibility was terminated because of PRWORA must have their Medicaid eligibility reinstated. A child who loses SSI after August 22, 1996 for a non-disability reason is not protected by the BBA change. Redetermine Medicaid eligibility of the child under another eligibility group.

If a child lost SSI/Medicaid because of PRWORA, determine whether the child meets the non-disability eligibility criteria, or qualifies for Medicaid on some other basis, and reinstate Medicaid. Do not examine the issue of disability at this time.

Subsequent, regularly scheduled redetermination will evaluate disability (send to NMO) and all other eligibility criteria. NOTE on 3004-EM that request for decision is for child who lost SSI because of PRWORA.

A child who has had their Medicaid reinstated due to the Balanced Budget Act (BBA) will always be evaluated under the less stringent disability rules in effect before PRWORA. The loss of Medicaid eligibility by the child for any reason and for any period of time will still be evaluated under the less stringent disability rules provided prior to PRWORA if the child reapplies before they turn 18. Check the lists provided to your office on every child who SSI has denied as N07. If their name appears on any of the lists, and they meet all other eligibility requirements, send NMO Form 3004-SM and indicate the child lost SSI because of PRWORA by writing SSI-N07 on the form. This will advise Medicaid to review this child's disability under the less stringent disability requirements.

7. PERSONS INELIGIBLE FOR SSI DUE TO ALIEN SPONSOR DEEMING

Aged and disabled individuals who are ineligible for SSI due to alien sponsor deeming are considered SSI eligible, and therefore, Medicaid eligible IF they can meet all other eligibility requirements.

Obtain verification of SSI ineligibility due to sponsor deeming. Persons under age 65 require a disability decision from Nevada Medicaid Office (NMO). Parent and spouse deeming requirements still apply. Determine any contributions which may be provided by the sponsor(s) to the client.

Future action the case file for when sponsor deeming no longer applies, then refer the client to apply for SSI. If SSI eligible, convert to and SSI case. If not SSI eligible, terminate Medicaid benefits unless the client is eligible under another Medicaid eligible group.

B. AGED, BLIND, DISABLED

Persons must be aged (65 or older), blind or disabled as determined by Social Security Administration criteria.

C. TIME FRAMES

An eligibility decision must be made within forty-five (45) days from the date of application unless extenuating circumstances exist.

D. SOCIAL SECURITY NUMBER (SSN)

Social Security numbers must be provided by every applicant and recipient. See manual section 204.

E. IDENTIFICATION

All applicants for Medicaid must be identified.

F. NEVADA RESIDENCY

Clients must be living in Nevada with the intention of making Nevada their home permanently or for an indefinite period (no expected end date) OR must be living in Nevada with a job commitment or seeking employment. Clients do not have to have a fixed place of residence to meet this requirement.

The ability to indicate intent to reside in Nevada is not to be taken lightly or stand by itself. A statement or indication of intent to reside in Nevada must be supported by additional verification or collateral material to substantiate the intent if residency is questionable. Manual section 205,D,5 is not all inclusive. See manual section 205,A for more detail.

Nevada residency continues when a client is temporarily absent IF he/she intends to return to Nevada when the purpose of the absence has been accomplished. Document in the case file the temporary absence situation and obtain the client/representative's statement concerning the intent of residency and the purpose of the absence.

G. CITIZENSHIP

To qualify for assistance, applicants must be a U.S. citizen, or a non-citizen in an eligible category. See manual section 206 for citizenship requirements.

H. PRIOR MEDICAL

Clients may apply for prior medical coverage for up to 3 months prior to the month of Medicaid application.

1. Prior Medicaid coverage must be requested in writing; AND

2. There must be evidence that medical care or services were provided in the month(s) for which Medicaid is requested.

When clients request prior medical first determine if they are eligible for prior medical as an SSI recipient or State Institutional case.

If they are not eligible in either of those categories determine if they would have been eligible for SSI had SSA made a determination. This category of eligibility is used only after all other eligibility categories have been considered.

Do not make an independent SSI determination IF there is a pending SSI application covering the month(s) Medicaid is requested. Wait for the SSI decision.

Use SSI/SSA's disability decision (the disability on–set date) for any month of requested prior medical assistance. All other factors of eligibility, e.g., residency, citizenship, income, resources, etc., must be evaluated by the case manager.

I. THIRD PARTY LIABILITY (TPL)

Medicaid is always payor of last resort whenever any other resources may be responsible for payment.

When insurance coverage is available at no cost to the client (e.g., through employment or Tricare), request the client to enroll. See manual section 208 regarding Medicare.

Notify the fiscal intermediary of third party liability and any changes to such by recording all known information on the NOMADS MINS and MEDI screens.

J. RESERVED

This program is no longer available.

K. CHILD SUPPORT ENFORCEMENT (CSE)

All dependent children (including automatic Medicaid eligible newborns) who have absent parent(s) require referrals to CSE for support enforcement services. Support Enforcement services include establishing paternity, securing child support and medical support. See manual section 209.

L. INCOME

Income means the receipt of money in the month for which an eligibility determination is being made. All income or changes in income must be reported. All income must be evaluated for financial eligibility.

1. OWNERSHIP/AVAILABILITY

a. Sole Ownership

All income which a payor designates as the clients, will be considered in determining eligibility.

When a benefit or income is received for more than one person or family member, only the client's portion of the income is considered.

b. Shared Ownership

1) Deeming
If the client is married and living with his/her spouse deem the spouse's income using Form 2646-EE.
2) Dividing: Does not apply.
3) Court Orders: Does not apply.
4) Exceptions:
Monies received by the client in his/her capacity as an agency are not income to him/her. A "agent" is a person acting on behalf of someone, i.e., representative payee, guardian, conservator, etc.

2. TREATMENT OF INCOME

When determining financial eligibility, budget income for the month it is received.

Regular unearned income deposited directly into a financial institution is considered received in the month for which it is intended to be received.

a. Intake Cases

Individually determine financial eligibility for each month of requested coverage.

b. Ongoing Cases

Financial eligibility is always determined prospectively (future month). When information becomes known which causes ineligibility prospectively, terminate benefits allowing adverse action time.

3. INCOME LIMITS

Countable net income must be less than the applicable SSI Payment Amounts (SPA).

4. INCOME DISREGARDS BY PUBLIC LAW

a. PICKLE AMENDMENT – PUBLIC LAW 94–566

Exclude from countable income the RSDI cost–of–living increases received after the client was last **eligible for and received** SSI and **entitled to** RSDI in the same month.

If the client resides with his/her spouse and spousal deeming applies, deduct the RSDI cost–of–living increases from the Spouse's RSDI income which were received after the client last received SSI.

The last RSDI amount received when the client was **entitled to** can be obtained through the Social Security Administration using Form 2022-EM, Pickle Amendment Certification, the annual Pickle Report or by using the RSDI Computation Worksheet Form 2654-EE. Verification used to support "Pickle" status must remain in the permanent section of the case file.

When there are changes in income and/or amounts, recompute eligibility excluding only the RSDI cost–of–living increases received after the client was last **eligible for and received** SSI and **entitled to** RSDI in the same month.

If the client would now be eligible (based on SSI rules) for SSI before disregarding cost–of–living increases, they no longer meet the criteria for Medicaid eligibility under Public Law 94–566 (Pickle Amendment). Refer the client to apply for SSI benefits.

Transfer the net countable income to the SSI Budget.

b. ADULT DISABLED CHILD – PUBLIC LAW 99–643

Disregard the adult disabled child benefit or the increase in this benefit received after July 1, 1987.

When there are changes in income and/or amounts, recompute eligibility excluding the adult disabled child benefit or the increase in this benefit received after July 1, 1987.

If the client would now be eligible (based on SSI rules) for SSI before disregarding cost–of–living increases, they no longer meet the criteria for Medicaid eligibility under Public Law 99-643 (Adult Disabled Child). Refer the client to apply for SSI benefits.

Transfer the net countable income to the SSI Budget.

c. WIDOW/WIDOWERS – PUBLIC LAW 100–203

Disregard the Widow/Widower's benefits in addition to other SSA benefits which are not disability benefits.

When there are changes in income and/or amounts, recompute eligibility excluding the widow/widower's benefits in addition to the other SSA benefits which are not disability benefits.

If the client would now be eligible (based on SSI rules) for SSI before disregarding cost–of–living increases, they no longer meet the criteria for Medicaid eligibility under Public Law 100-203 (Widow/Widowers). Refer the client to apply for SSI benefits.

Transfer the net countable income to the SSI Budget.

d. WIDOWS, WIDOWERS AND SURVIVING DIVORCED SPOUSES – PUBLIC LAW 101–508

Disregard the Title II (RSDI) disability benefit which was based on application of new disability criteria.

When there are changes in income and/or amounts, recompute eligibility excluding the Title II disability benefit which was based on application of new disability criteria.

If the client would now be eligible (based on SSI rules) for SSI before disregarding cost–of–living increases, they no longer meet the criteria for Medicaid eligibility under Public Law 101-508 (Widow, Widows and Surviving Divorced Spouses). Refer the client to apply for SSI benefits.

Transfer the net countable income to the SSI Budget.

5. BUDGETING PROCEDURES FOR SSI FINANCIAL ELIGIBILITY – SSI BUDGET FORM 2646–EE (Spouse to Spouse Deeming)

a. INCOME CONSIDERATION

Determine whether the client is considered an individual or a member of a couple with an SSI eligible or ineligible spouse by applying the definitions in this section.

When the client is considered an individual only the client's income is counted. Additionally, when the client is considered a member of a couple the spouse's income is counted for a specified time period.

Spouses **separated temporarily** for economic (employment) or emergency reasons (hospitalization), vacations or visits are NOT considered "separated" (ceased living together) for purposes of income consideration. The separation must be expected to continue. A temporary absence is one where the individual leaves and returns to the household in the same month or the following month.

When income of the spouse must be considered the income will be verified. If impossible to verify the spouse's income, document the circumstances and accept the client's statement.

b. DEFINITIONS

1) SSI Eligible Spouse

The client's spouse who meets the requirements in both a) and b) below:

a) Is pending SSI, received SSI or would have been eligible for SSI:

To determine if the spouse would have been eligible for SSI, the spouse:

(1) must have been aged, blind or disabled. Blindness and disability is established when the spouse has been determined eligible for any type of permanent disability/blind benefits (e.g., SSA, VA, or Retirement Disability Benefits), and

(2) must be determined financially eligible per subsection "d" below.

b) Is living with the client or has not been separated longer than the specified time frames:

Consider the client a MEMBER OF A COUPLE WITH AN ELIGIBLE SPOUSE only for the month they ceased living together.

2) SSI Ineligible Spouse

The client's spouse who is not pending SSI, not receiving SSI and would not have been eligible for SSI.

When the spouse is not aged or has not been determined eligible for some type of permanent disability/ blindness benefits consider the spouse an SSI ineligible spouse.

The ineligible spouse's income must always be considered when the client is living with the spouse. When the client and ineligible spouse are separated, the ineligible spouse's income is only considered the month of separation.

3) Individual

Consider clients as individuals when they are:

a) NOT married;

b) Married but have been separated from their SSI ELIGIBLE spouse for a specified time frame:

The client will be considered an individual beginning the month after the month they ceased living together.

c) Married but have been separated from their SSI INELIGIBLE spouse for a specified time frame:

Consider the client an individual the month FOLLOWING the month they ceased living together;

d) Had an SSI INELIGIBLE spouse who received TANF, VA pension or other assistance based on need for the month Medicaid is requested.

c. SSI BUDGET FORM 2646–EE – GENERAL INSTRUCTIONS

1) Member of Couple with Eligible Spouse

Any time the spouse appears potentially SSI eligible, treat as an eligible spouse until determined ineligible.

Use the MEMBER OF A COUPLE, WITH ELIGIBLE SPOUSE column. If ineligibility results, consider the spouse ineligible and go through the deeming computation (using the MEMBER OF A COUPLE WITH INELIGIBLE SPOUSE column) to determine if deeming applies. If deeming doesn't apply, proceed to Part B using the INDIVIDUAL column. If deeming does apply, proceed with the budget under the MEMBER OF A COUPLE WITH INELIGIBLE SPOUSE column. If this process also results in ineligibility, the client is ineligible for Medicaid.

2) Member of Couple with Ineligible Spouse

Use the MEMBER OF A COUPLE, WITH INELIGIBLE SPOUSE column, items A-1 through 3 to determine if deeming applies.

If deeming doesn't apply, proceed to the INDIVIDUAL column of the budget. Deeming never applies when the SSI ineligible spouse received TANF, VA pension or other federal or state assistance based on need.

3) Individual

Use the INDIVIDUAL column, when the person meets the definition of an individual.

d. SSI BUDGET SPECIFIC INSTRUCTIONS

1) Deeming Computation

Deeming never applies when the SSI ineligible spouse received TANF, VA pension or other federal or state assistance based on need.

a) Determine the ineligible spouse's total unearned income.

b) Determine if an SSI ineligible child(ren) allocation is applicable. The allocation is applicable if there are any dependent children who are:

(1) Under age 18 OR under age 22 and are students regularly attending a school, college or university or a course of vocational or technical training to prepare for gainful employment; AND
(2) The child(ren) are <u>not</u> receiving TANF, VA pension or other federal or state assistance based on need.

c) If the allocation deduction is applicable, for each ineligible child, subtract the child's income from the Child Allocation Amount. Subtract the remainder from the ineligible spouse's unearned income.

d) Determine the ineligible spouse's gross earned income.

e) Subtract the balance of any allocation for ineligible children not offset by unearned income.

f) Add the remaining unearned income to the remaining earned income, after the allocation deductions.

g) Compare the total income after allocations to the Deeming Indicator Amount.

If less than the Deeming Indicator Amount, deeming does not apply, proceed to Part B, INDIVIDUAL column of the SSI budget using only the client's income.

If equal to or more than the Deeming Indicator Amount, deeming DOES APPLY. Proceed to Part B MEMBER OF A COUPLE WITH AN INELIGIBLE SPOUSE column adding the unearned income after allocations to the client's unearned income and the remaining earned income to the client's earned income.

2) SSI Eligibility Determination

In this section of the budget, use only the client's income when using the INDIVIDUAL column. Use combined incomes of the client and eligible or ineligible spouse when using the MEMBER OF A COUPLE WITH AN ELIGIBLE OR INELIGIBLE SPOUSE column.

a) Determine unearned income.

b) Subtract the general income exclusion of $20 to arrive at the remaining unearned income.

c) Determine total gross earned income.

d) Subtract any balance of the general exclusion not offset by unearned income.

e) Subtract the work expense exclusion of $65.

f) Impairment–Related Work Expenses (IRWE). This exclusion is applied to earned income of disabled (but not blind) individuals under age 65.

The expense must be reasonable; for items/services which are directly related to enabling an impaired individual to work, and which are necessarily incurred by the individual because of a physical or mental impairment.

IRWEs are encludable when the cost is paid by the disabled individual and is not reimbursable from another source.

g) Subtract 1/2 of the remaining earned income after the above deductions.

h) Determine the total countable income by adding Items B-1-b and B-2-e.

i) Compare the total countable income (Item B-3) to the appropriate SSI payment amount (SPA).

If the amount is equal to or greater than the SPA in the MEMBER OF A COUPLE WITH INELIGIBLE SPOUSE or INDIVIDUAL columns, the client is ineligible for Medicaid.

If ineligible in the MEMBER OF A COUPLE WITH ELIGIBLE SPOUSE column, proceed to the MEMBER OF A COUPLE WITH INELIGIBLE SPOUSE column to complete the eligibility determination.

M. RESOURCES

Resources are defined as those assets, both real and personal, which an individual owns and can apply, either directly or by sale, to meet basic needs of food, clothing, shelter and medical costs.

Real property is land, including buildings or immovable objects attached permanently to the land.

Personal property is any property that is not real property. The term encompasses such things as cash, tools, life insurance policies, mobile homes, automobiles, etc.

Any income which is retained the month following the month of receipt and later, is subject to resource evaluation.

Resources are evaluated at market value less encumbrances. When the combined value of all countable resources does not exceed the resource limit, verification of encumbrances is not necessary.

When the value of countable resources is under the resource limit on any day of the month, the client is eligible for that month.

All resources must be reported.

1. OWNERSHIP/AVAILABILITY

a. Sole Ownership

Sole ownership of real or personal property means only one person may sell, transfer or otherwise dispose of the property. All of the resource evaluated at market value less encumbrances is available to the client.

b. Shared Ownership

Shared ownership of real or personal property means two or more people own it simultaneously. The following are common types of shared ownership:

1) Tenancy-In-Common

Two or more persons each have an undivided fractional interest in the whole property for the duration of the tenancy. These interests are not necessarily equal. One owner may sell, transfer or otherwise dispose of his/her share of the property without permission of the other owner(s); but cannot take these actions with the entire property. If a tenant-in-common dies, the deceased's interest passes to his/her estate or heirs. Count the fair market value less encumbrances of the client's property share.

2) Joint Tenancy

Each of two or more persons have one and the same undivided ownership interest and possession of the whole property for the duration of the tenancy. This means each owner owns ALL the property. If a joint tenant dies, the survivor becomes the sole owner. If more then one joint tenant survives, the survivors become joint tenants of the entire property interest. Count the total fair market value less encumbrances of the entire property.

3) Tenancy By The Entirety (Married Couples only)

This type of ownership can only exist between married couples. The wife and husband as a unit own the entire property and can be sold only with the consent of both parties. However, if a legal divorce occurs, the former spouses become tenant-in-common and one can sell his/her share without the consent of the other. If one spouse dies, the survivor becomes the sole owner. Verify whether the client's spouse will give permission to sell the property. If permission cannot be obtained, DO NOT count the client's one-half share of the property.

4) Exceptions

When a resource is owned jointly by more than one AFDC/Medicaid applicant/recipient (other than a community spouse), divide the resource equally among those applicants/recipients to whom available.

When a client is representative payee or legal guardian managing someone else's funds, these funds are not considered the client's resource when they are kept in an account separate and apart from the client's monies AND can be identified as being received and designated for someone other than the client.

c. Treatment of Resources

1) Deeming

If the applicant/recipient is married and living with his/her spouse, spouse to spouse deeming rules apply. Use the resource limit for a couple for all months eligibility is being determined.

The value of the client's and spouse's countable resources (whether owned separately by each or jointly by both) are counted. Only one automobile and home may be excluded per couple.

Deeming applies from spouse to spouse when they live together in the same household. Deeming stops the month following the month of institutionalization in a medical facility. Deeming begins the month following the month the spouse returns home from a medical facility.

Do not deem resources to the client if the spouse is a recipient of SSI, TANF, Medicaid, Refugee Assistance, General Assistance (GA) or VA Pension, VA Compensation as a surviving parent of a veteran, VA Aid and Attendance and VA Payment for Unusual Medical Expenses. This is because these benefits are paid based on need, not entitlement.

2) **Dividing**: Does not apply.

3) **Court Order**: Does not apply.

4) **Inaccessible Resources**

The cash value of resources which are not legally available o the household are exempt. If the Medicaid applicant/recipient or authorized representative is able to verify a resource is unavailable due to the client’s inability to access the resource due to incapacity and no one else has the ability to access the resource on their behalf, exempt the value of the resource as long as reasonable and timely steps are being taken to access the account on the client’s behalf, (i.e., referral to the public guardian’s office). Once the resource becomes

accessible, the resource becomes countable and eligibility must be reevaluated for future months.

2. TRANSFER OF ASSETS

If the client has an inpatient stay in a medical facility, see transfer of resource policy in the State Institutional section. Exception: Public Law 96–265.

3. TREATMENT OF TRUSTS (Refer to Section 250)

4. RESOURCE LIMITS

Resource limits are $2,000 for an individual and $3,000 for a couple. When countable resources exceed the limit, the client is ineligible.

N. PATIENT LIABILITY

Patient liability is determined for Medicaid eligible persons residing in a medical facility. There is no patient liability for any portion of institutionalization (full or partial month stays) in a VA hospital, AGCF, FCH, freestanding psychiatric hospital or RTC.

There are six freestanding psychiatric hospitals in Nevada, they are:

- Charter Hospital
- Montevista Hospital
- Nevada Mental Health Institute (NMHI)
- Southern Nevada Adult Mental Health (SNAMH)
- West Hills Hospital

1. TREATMENT OF INCOME, DEDUCTIONS AND EXPENSES

When determining patient liability for initial and ongoing cases, budget income for the month it is received and deductions/ expenses for the month in which they are paid/incurred.

When unanticipated income is received, patient liability will be adjusted for the month in which it was received.

Regular unearned income deposited directly into a financial institution is considered received in the month for which it is intended to be received.

2. PARTIAL MONTH PRORATION

The amount of patient liability is prorated according to the number of days the client was in a facility when the person is institutionalized less than a full calendar month due to:

a. Month of admission.

b. Discharge to independent living, VA hospital, AGCF, FCH, freestanding psychiatric hospital or RTC.

c. Death.

Determine what the patient liability would be for a full month. Divide that full month amount by the number of days in the month of partial institutionalization to determine the daily amount of patient liability. Multiply this daily amount by the number of days the client was institutionalized in that month (include the day of admission but not the day of discharge/death. The result is the amount of patient liability due for the partially institutionalized month.

3. EFFECTIVE DATE OF PATIENT LIABILITY

a. SSI recipients with no countable income: No patient liability assessed.

b. Public Law/QMB recipients with countable income:

Hospital Stay Only: For inpatient hospital stays under 90 consecutive days, do not calculate or send notice of patient liability. This is because Medicare will cover up to 90 days in a hospital and Medicaid must pay the hospital deductible and co-pay charges. If hospitalized beyond the 90 day time period, begin patient liability the first of the month following the 90 days.

c. Public Law recipients with countable income:

When a Public Law recipient goes from private living to an institution, patient liability is effective the first month of institutionalization.

d. Deceased Clients

The facility is notified of the patient liability amount due for the month of death. The facility will collect only for charges actually incurred. Any unused patient liability will be deposited in the Patient Trust Fund Account.

4. BUDGETING PROCEDURES - FORM 2220-EM

a. Determine the client's TOTAL gross countable monthly income **(less involuntary mandatory deductions)**.

b. Subtract the following items from TOTAL MONTHLY INCOME in the following order:

1) PERSONAL NEEDS ALLOWANCE

Deduct $35 Personal Needs Allowance (PNA) for each month of institutionalization.

2) MAINTENANCE ALLOWANCES

Clients do not have to request the maintenance allowance for their spouse/dependents. The case manager will automatically request the information necessary to determine the maintenance allowance when there is a spouse or dependents at home.

a) MAINTENANCE ALLOWANCE FOR THE SPOUSE AT HOME

Clients whose spouse is living in the community, may receive a maintenance allowance deduction from their income. Verification of the spouse's income must be obtained.

A Spouse Maintenance Allowance Deduction will be effective the first month Patient Liability is established.

(1) Determine spouse's gross earned income

(2) Subtract from gross earned income:

(a) Federal and Social Security (FICA) taxes as deducted by the employer.
(b) Retirement: Do not deduct FICA taxes when a retirement plan substitutes for FICA.
(c) Union dues, meals and payroll deductions which are a condition of employment.
(d) Individual work expenses when requested and verified.

(3) Determine total unearned income.

(4) To determine the Maintenance Allowance Deduction, subtract the Total NET income from the Total Need.

See the MAABD income standard chart in Appendix C for need amounts.

b) MAINTENANCE ALLOWANCE FOR A FAMILY AT HOME

Clients whose spouse and/or dependent children (under age 21) are living in the community, may

receive a maintenance allowance deduction from their income. Verification of the spouse and/or children's income must be obtained.

The spouse/dependent children maintenance allowance will be effective the first month Patient Liability is established.

(1) Determine spouse/dependent children's gross earned income.

(2) Subtract from gross earned income:

(a) Federal and Social Security (FICA) taxes as deducted by the employer.
(b) Retirement: Do not deduct FICA taxes when a retirement plan substitutes for FICA.
(c) Union dues, meals and payroll deductions which are a condition of employment.
(d) Individual work expenses when requested and verified.

(3) Determine total unearned income.

(4) To determine the Maintenance Allowance Deduction subtract Total NET Income from Total Need.

See the MAABD income standard chart in Appendix C for need amounts.

If verifications needed to determine the Maintenance Allowance are not returned by the required date, the case will be completed without allowing a maintenance allowance. The client will be notified on the Notice of Decision, the patient liability was determined without a Maintenance Allowance Deduction.

3) EXPENSES INCURRED FOR HEALTH INSURANCE PREMIUMS, DEDUCTIBLES AND CO-INSURANCE CHARGES

Deduct Health Insurance Premiums, Deductibles and Co-insurance expenses incurred by the client. Clients/ Representatives must advise the agency of medical insurance and provide proof of expenses. These expenses must not be paid or subject to payment by a

third party. Medicare premiums are subject to payment by a third party, therefore, do not allow the Medicare premium as a deduction.

4) EXPENSES INCURRED FOR MEDICAL CARE

Deduct expenses incurred by the client for necessary medical care recognized under the State law but not covered under the Medicaid Program. This includes medical expenses incurred more than three months prior to the date of application. Clients/Representatives must advise the agency and submit proof of the expenses.

The case manager will attach a copy of the medical bill to Form 2536 and submit to NMO for approval. These expenses must not be paid or subject to payment by a third party. An NMO approval is required to assure the deduction is for necessary care payable to reasonable limits.

c. The deficit, if any, is the client's share of facility cost (PATIENT LIABILITY).

5. NOTIFICATION OF PATIENT LIABILITY

When patient liability is established or changes, the client, facility and Blue Shield of Nevada are notified on a Notice of Decision of the amount and effective date.

O. REDETERMINATIONS

Redeterminations of eligibility are required at least every 12 months. Use MAABD Only Redetermination, Form 2930-EM, when there is no Food Stamp case involved. Information received between redeterminations which may affect eligibility must be evaluated and acted on when applicable. Redeterminations must be completed no later than the month it is due except when future actions are necessary. Clients are the primary source of information regarding their eligibility. If a client is unable to obtain information, the case manager may assist. Office interviews and home visits are optional and can be done at the discretion of the Unit Supervisor or office manager.

The MAABD Only Redetermination form (2930-EM) informs the client about their choices concerning an authorized representative (A/R). If any change in the A/R is indicated on Form 2930-EM, send the client Form 2525-EE to complete and return. If the A/R area on Form 2930-EM is blank, assume there is **NO** change in the status of the A/R for the client.

Additionally, ensure the correct aid codes, eligibility codes, case type codes and Medicare claim numbers are in the system.

Verification used to re-establish Medicaid eligibility must be current (within the last 45 days).

PUBLIC LAW 94–566 CASES: Verification used to support the Public Law status must remain in the permanent section of the case file.

Income & resources are re-evaluated. Financial eligibility is determined using SSI Budget Form 2646. Exclude from countable income RSDI cost of living increases received after client was last **eligible for and receiving** SSI and **entitled to** RSDI in the same month.

PUBLIC LAW 99–643 CASES: Verification used to support Public Law status must remain in the permanent section of the casefile.

Income and resources are re-evaluated. Financial eligibility is determined using SSI Budget Form 2646. Exclude from countable income the 'adult disabled child' benefit OR the increase in their 'adult disabled child' benefit received after July 1, 1987.

PUBLIC LAW 100–203 CASES: Verification used to support Public Law status must remain in the permanent section of the casefile.

Income and resources are re-evaluated. Financial eligibility is determined using SSI Budget Form 2646. Exclude from countable income widow/widower's benefits and SSA retirement/survivors benefits (SSA Disability benefits are not disregarded). They cannot be entitled to Medicare Part A hospital insurance.

PUBLIC LAW 101–508 CASES: Verification used to support Public Law status must remain in the permanent section of the casefile.

Income and resources are re-evaluated. Financial eligibility is determined using SSI Budget Form 2646. Exclude from countable income the Title II disability benefits. They cannot be entitled to Medicare Part A hospital insurance.

PUBLIC LAW 96–265 CASES: The most current SDX must contain Public Law Code "I". If it does not, the client is not eligible for Medicaid under this public law.

PUBLIC LAW 103-296 CASES: The most current SDX must contain Public Law Code "A". If it does not, the client is not eligible for Medicaid under this public law.

SPONSOR DEEMING CASES: Verification used to support Public Law status must remain in the permanent section of the casefile.

Income and resources are re-evaluated. Financial eligibility is determined using SSI Budget Form 2646. Disability for persons under age 65 may need re-evaluation by NMO (see most recent Form 3004). Parent and spouse deeming requirements may apply. Determine any contributions by the sponsor(s). Case file should have an indicator when sponsor deeming ends for a referral to apply for SSI.

INDEX
SECTION 340
PERSONS INSTITUTIONALIZED
LESS THAN 30 CONSECUTIVE DAYS

340 PERSONS INSTITUTIONALIZED LESS THAN 30 CONSECUTIVE DAYS

A. OVERVIEW

A client in this group must have countable income below SSI payment levels and must be an inpatient in a skilled nursing facility (SNF), intermediate care facility (ICF or ICF/MR), or hospital and meet all eligibility requirements.

In determining the number of days in a medical institution for eligibility proposes, include the day of admission, but not the day of discharge/death.

An "outpatient" stay is less than a 24–hour period regardless of the hour of admission, whether or not a bed is used or whether or not the patient remains in the facility past midnight.

ELIGIBILITY EXCEPTIONS

1. All individuals under age 65 who are inpatients in an Institution for Mental Disease (IMD), i.e., freestanding psychiatric hospital, **are not** eligible for Medicaid in this category. (See chapter Addendum listing IMD facilities)

   An Institution for Mental Diseases (IMD) is defined as a hospital, nursing facility or other institution of more than 16 beds which is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Individuals are severely psychotic, emotionally ill, suicidal and a danger to themselves, others or property. In Nevada IMDs are commonly referred to as "psychiatric hospitals." **An institution for the mentally retarded IS NOT an institution for mental disease.**

2. An inmate of a public institution is ineligible for Medicaid UNLESS the institution is a medical institution. An inmate of a penal institution is NEVER eligible for Medicaid while in the custody of law enforcement officials, UNLESS admitted as an inpatient to a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility. This individual is eligible for any Medicaid covered services provided to them while an **inpatient** in these facilities and they are Medicaid-eligible. If this individual becomes an inpatient of a long-term care facility, they must meet level of care and plan of care assessments to become eligible.

3. Individuals under 22 receiving inpatient psychiatric services in a Residential Treatment Center (RTC) **are** eligible for Medicaid in this category. (See chapter Addendum listing RTC facilities)

   RTCs specialize in treating children with conduct, personality and emotional disorders, depression, hyperactivity, academic failure, and/or mild learning disabilities. Medicaid will pay for services provided in a RTC if the referral resulted from a "Healthy Kids" screening and the admission was prior authorized/certified by Medicaid's Peer Review Organization (PRO).

These cases must also be evaluated for QMB eligibility.

B. AGED, BLIND, DISABLED

Persons must be aged (65 or older), blind or disabled as determined by Social Security Administration criteria.

C. TIME FRAMES

An eligibility decision must be made within 45 days from the Medicaid application date for the aged and 90 days for the blind/disabled, unless extenuating circumstances exist.

D. SOCIAL SECURITY NUMBER (SSN)

Social Security numbers must be provided by every applicant and recipient. See manual section 204.

E. IDENTIFICATION

All applicants for Medicaid must be identified.

F. NEVADA RESIDENCY

Clients must be living in Nevada with the intention of making Nevada their home permanently or for an indefinite period OR must be living in Nevada with a job commitment or seeking employment. Clients do not have to have a fixed place of residence to meet this requirement.

The ability to indicate intent to reside in Nevada is not to be taken lightly or stand by itself. A statement or indication of intent to reside in Nevada must be supported by additional verification or collateral material to substantiate the intent if residency is questionable. Manual Section 205,D,5 is not all inclusive. See Manual Section 205,D for more detail.

G. CITIZENSHIP

To qualify for assistance, applicants must be a U.S. citizen or a non-citizen in an eligible category. See manual section 206 for citizenship requirements.

H. PRIOR MEDICAL

Clients may apply for prior medical coverage for up to 3 months prior to the month of Medicaid application.

1. Prior Medicaid coverage must be requested; AND

2. There must be evidence that medical care or services were provided in the month(s) for which Medicaid is requested.

When clients request prior medical first determine if they are eligible for prior medical as an SSI recipient or State Institutional case.

If they are not eligible in either of those categories determine if they would have been eligible for SSI had SSA made a determination. See "Prior Medical Determinations Only - Would Have Been Eligible For SSI."

Do not make an independent SSI determination IF there is a pending SSI application covering the month(s) Medicaid is requested. Wait for the SSI decision.

Use SSI/SSA's disability decision (the disability on–set date) for any month of requested prior medical assistance. All other factors of eligibility, e.g., residency, citizenship, income, resources, etc., must be evaluated by the case manager.

I. THIRD PARTY LIABILITY (TPL)

Medicaid is always payor of last resort whenever any other resource may be responsible for payment.

When insurance coverage is available at no cost to the client (e.g., through employment or Tricare), request the client to enroll. See manual section 208 regarding Medicare.

Notify the fiscal intermediary of third party liability and any changes to such by recording all known information on the NOMADS MINS and MEDI screens.

J. RESERVED

This program is no longer available.

K. CHILD SUPPORT ENFORCEMENT (CSE)

All dependent children (including automatic Medicaid eligible newborns) who have absent parent(s) require referrals to CSE for support enforcement services. Support Enforcement services include establishing paternity, securing child support and medical support. See manual section 209.

L. INCOME

Income means the receipt of money in the month for which an eligibility determination is being made. All income or changes in income must be reported. All income must be evaluated for financial eligibility.

1. OWNERSHIP/AVAILABILITY

a. Sole Ownership

All income which a payor designates as the client's, will be considered in determining eligibility.

When a benefit or income is received for more than one person or family member, only the client's portion of the income is considered.

Determine financial eligibility using the "Individual" column of "SSI Budget" Form 2646-EE. Only the client's income is budgeted.

b. Shared Ownership

If the client qualifies for both budget methods (deeming or dividing), the case manager must apply both budget methods before denying due to excess income.

1) Deeming:

If the client is married and living with his/her spouse, deem the spouse's income using Form 2646-EE. If income is deemed, use the couple SPA limit.

If the client is a child (under age 18) and was living with his/her parent(s) at the time of institutionalization, deem the parent(s) income using "Parent to Child Deeming Budget" Form 2646-EE/A.

2) Dividing:

If it is in the applicant's best interests for financial eligibility, the case manager will divide the total income of spouses who are living separate and apart (due to institutionalization only) equally between them. Only the applicant's share of the income will be considered when determining eligibility. However, if a portion of the spouse's income is made available to the applicant, that portion would be counted as income to the client in determining eligibility.

If income is divided, use the individual SPA limit.

3) Court Order: Does not apply.

4) Exceptions:

Monies received by the client in his/her capacity as an agent are not income to him/her. An "agent" is a person acting on behalf of someone, i.e., representative payee, guardian, conservator, etc.

2. TREATMENT OF INCOME

When determining financial eligibility, budget income for the month it is received.

Regular unearned income deposited directly into a financial institution is considered received in the month for which it is intended to be received.

a. Intake Cases

Individually determine financial eligibility for each month of requested coverage.

b. Ongoing Cases

Financial eligibility is always determined prospectively (future month). When information becomes known which causes ineligibility prospectively, terminate benefits allowing adverse action time.

3. INCOME LIMITS

Countable net income must be less than the applicable SSI payment amounts (SPA).

4. BUDGETING PROCEDURES FOR SSI FINANCIAL ELIGIBILITY SSI BUDGET FORM 2646-EE (Spouse to Spouse Deeming)

a. INCOME CONSIDERATION

Determine whether the client is considered an individual or a member of a couple with an SSI eligible or ineligible spouse by applying the definitions in this section.

When the client is considered an individual only the client's income is counted. Additionally, when the client is considered a member of a couple the spouse's income is counted for a specified time period.

Spouses **separated temporarily** for economic (employment) or emergency reasons (hospitalization), vacations or visits are NOT considered "separated" (ceased living together) for purposes of income consideration. The separation must be expected to continue. A temporary absence is one where the individual leaves and returns to the household in the same month or the following month.

When income of the spouse must be considered, the income will be verified. If impossible to verify the spouse's income, document the circumstances and accept the client's statement.

b. DEFINITIONS

1) SSI Eligible Spouse

The client's spouse who meets the requirements in both a) and b) below:

a) Is pending SSI, received SSI or would have been eligible for SSI;

To determine if the spouse would have been eligible for SSI, the spouse:

(1) must have been aged, blind or disabled. Blindness and disability is established when the spouse has been determined eligible for any type of permanent disability/blind benefits (e.g., SSA, VA, or Retirement disability benefits); and
(2) must be determined financially eligible.

b) Is living with the client or has not been separated longer than the specified time frames:

Consider the client a MEMBER OF A COUPLE WITH AN ELIGIBLE SPOUSE only for the month they ceased living together.

2) SSI Ineligible Spouse

The client's spouse who is not pending SSI, not receiving SSI and would not have been eligible for SSI.

When the spouse is not aged or has not been determined eligible for some type of permanent disability/blindness benefits consider the spouse an SSI ineligible spouse.

The ineligible spouse's income must always be considered when the client is living with the spouse. When the client and ineligible spouse are separated, the ineligible spouse's income is only considered the month of separation.

3) Individual

Consider clients as individuals when they are:

a) NOT married;

b) Married but have been separated from their SSI ELIGIBLE spouse for a specified time frame:

The client will be considered an individual beginning the month after the month they cease living together.

c) Married but have been separated from their SSI INELIGIBLE spouse for a specified time frame:

Consider the client an individual the month FOLLOWING the month they ceased living together;

d) Had an SSI INELIGIBLE spouse who received TANF, VA pension or other assistance based on need for the month Medicaid is requested.

c. SSI BUDGET FORM 2646–EE – GENERAL INSTRUCTIONS

1) Member of Couple With Eligible Spouse

Any time the spouse appears potentially SSI eligible, treat as an eligible spouse until determined ineligible.

Use the MEMBER OF A COUPLE, WITH ELIGIBLE SPOUSE column. If ineligibility results, consider the spouse ineligible and go through the deeming computation (using the MEMBER OF A COUPLE, WITH INELIGIBLE SPOUSE column) to determine if deeming applies. If deeming doesn't apply, proceed to Part B using the INDIVIDUAL column. If deeming does apply, proceed with the budget under the MEMBER OF A COUPLE WITH INELIGIBLE SPOUSE COLUMN. If this process also results in ineligibility, the client is ineligible for Medicaid.

2) Member of Couple With Ineligible Spouse

Use the MEMBER OF A COUPLE, WITH INELIGIBLE SPOUSE column, items A–1 through 3 to determine if deeming applies.

If deeming doesn't apply, proceed to the INDIVIDUAL column of the budget. Deeming never applies when the SSI ineligible spouse received TANF, VA pension or other federal or state assistance based on need.

3) Individual

Use the INDIVIDUAL column, when the person meets the definition of an individual.

d. SSI BUDGET SPECIFIC INSTRUCTIONS

1) Deeming computation

Deeming never applies when the SSI ineligible spouse received TANF, VA pension or other federal or state assistance based on need.

a) Determine the ineligible spouse's total unearned income.

b) Determine if an SSI ineligible child(ren) allocation is applicable. The allocation is applicable if there are any dependent children who are:

(1) Under age 18 OR under age 22 and are students regularly attending a school, college or university or a course of vocational or technical training to prepare for gainful employment; AND
(2) The child(ren) are <u>not</u> receiving TANF, VA pension or other federal or state assistance based on need.

c) If the allocation deduction is applicable, for each ineligible child, subtract the child's income from the Child Allocation Amount. Subtract the remainder from the ineligible spouse's unearned income.

d) Determine the ineligible spouse's gross earned income.

e) Subtract the balance of any allocation for ineligible children not offset by unearned income.

f) Add the remaining unearned income to the remaining earned income, after the allocation deductions.

g) Compare the total income after allocations to the Deeming Indicator Amount.
If less than the Deeming Indicator Amount, deeming does not apply, proceed to Part B, INDIVIDUAL column of the SSI budget using only the client's income.

If equal to or more than the Deeming Indicator Amount, deeming DOES APPLY. Proceed to Part B MEMBER OF A COUPLE WITH AN INELIGIBLE SPOUSE column adding the unearned income after allocations to the client's unearned income and the remaining earned income to the client's earned income.

2) SSI Eligibility Determination

In this section of the budget, use only the client's income when using the INDIVIDUAL column. Use combined incomes of the client and eligible or ineligible spouse when using the MEMBER OF A COUPLE WITH AN ELIGIBLE OR INELIGIBLE SPOUSE column.

a) Determine unearned income.

b) Subtract the general income exclusion of $20 to arrive at the remaining unearned income.

c) Determine total gross earned income.

d) Subtract any balance of the general exclusion not offset by unearned income.

e) Subtract the work expense exclusion of $65.

f) Impairment–Related Work Expenses (IRWE). This exclusion is applied to earned income of disabled (but not blind) individuals under age 65.

The expense must be reasonable; for items/services which are directly related to enabling an impaired individual to work, and which are necessarily incurred by the individual because of a physical or mental impairment.

IRWEs are excludable when the cost is paid by the disabled individual and is not reimbursable from another source.

g) Subtract 1/2 of the remaining earned income after the above deductions.

h) Determine the total countable income by adding Items B–1–b and B–2–e.

i) Compare the total countable income (Item B–3) to the appropriate SSI payment amount (SPA). If the amount is equal to or greater than the SPA in the MEMBER OF A COUPLE WITH INELIGIBLE SPOUSE or INDIVIDUAL columns, the client is ineligible for Medicaid.

If ineligible in the MEMBER OF A COUPLE WITH ELIGIBLE SPOUSE column, proceed to the MEMBER OF A COUPLE WITH INELIGIBLE SPOUSE column to complete the eligibility determination.

5. BUDGETING PROCEDURES FOR SSI FINANCIAL ELIGIBILITY OF CHILDREN – PARENT TO CHILD DEEMING BUDGET – FORM 2646–EE/A

a. GENERAL DEEMING PROVISIONS

If the child is under age 18 OR under age 21 and regularly attending school, college, university or technical training designed to prepare him/her for gainful employment AND living in the same household with the natural/adoptive parent(s) or natural/adoptive parent and a stepparent; all income of the ineligible parent(s) will be considered in determining eligibility for the child.

Deeming applies from a parent to a child when they live together in the same household. Deeming stops the month following the month of institutionalization in a medical facility. Deeming begins the month following the month the child returns home from a medical facility.

Deeming applies even when the child is temporarily absent from the home. A temporary absence exists when:

1) The child leaves the household but intends to, and does, return in the same month or the following month; OR

2) The child is away at school but returns home on some weekends, holidays, or vacations AND is subject to parental control.

Consider the parent(s) or stepparent an ineligible parent when they are not pending SSI, receiving SSI or would not have been eligible for SSI.

To determine if the parent would have been eligible for SSI, the parent must be aged, blind or disabled. Blindness and disability is established when the parent has been determined eligible for any type of permanent disability/blind benefits (e.g., SSA, VA, or Retirement Disability Benefits), and is determined financially eligible.

When the parent is not aged or has not been determined eligible for some type of permanent disability/blindness benefits, consider the parent an SSI ineligible parent.

If the child is only living with a stepparent (natural/adoptive parent is not in the home) deeming does not apply. If the child is living with a natural/adoptive parent and a stepparent, deeming will apply.

b. PARENT TO CHILD DEEMING BUDGET – GENERAL INSTRUCTIONS

Section 220 applies when evaluating countable and excluded income. In addition, the following types of parental income is excluded when determining the amount of deemed income:

1) Any portion of a grant, scholarship or fellowship used to pay tuition or fees;

2) Money received for providing foster care to an ineligible child;

3) Any income used to comply with the terms of court–ordered support or support payments enforced under Title IV–D;

4) Disaster Assistance.

Deeming never applies when the parent(s) or stepparent receives TANF, VA pension or other federal or state assistance based on need.

c. DEEMING COMPUTATION

1) Determine the ineligible parent/stepparent's total unearned income.

2) Determine if an SSI ineligible child(ren) allocation is applicable. The allocation is applicable if there are a dependent (natural or adoptive) child(ren) who are:

a) Under age 18 OR under age 21 and are students regularly attending a school, college or university or a course of vocational or technical training to prepare for gainful employment; AND

b) The child(ren) are <u>not</u> receiving TANF, VA pension or other federal or state assistance based on need.

3) If the allocation deduction is applicable, for each ineligible child, subtract the ineligible child's income **(includes the total child support for the ineligible child)** from the Child Allocation Amount. Subtract the remainder from the ineligible parent/stepparent's unearned income.

4) Determine the ineligible parent/stepparent's gross earned income.

5) Subtract the balance of any allocation for ineligible children not offset by unearned income.

6) Subtract $20 (general income exclusion) from the remaining unearned income.

7) Subtract any balance of the general income exclusion not offset by unearned income from earned income.

8) Subtract the work expense exclusion of $65.

9) Impairment–Related Work Expenses (IRWE). This exclusion is applied to earned income of disabled (but not blind) individuals under age 65.

The expense must be reasonable; for items/services which are directly related to enabling an impaired individual to work, and which are necessarily incurred by the individual because of a physical or mental impairment.

IRWEs are excludable when the cost is paid by the disabled individual and is not reimbursable from another source.

10) Subtract 1/2 of the remaining earned income after the above deductions.

11) Add the countable unearned and earned income to arrive at total countable income.

12) Then subtract the Parent Allocation Amount.

13) The net amount (if any) is the deemed income to the child.

d. ELIGIBILITY DETERMINATION

1) Add the child's own unearned income to the deemed income from the ineligible parent/stepparent.

2) Subtract $20 (general income exclusion).

3) If the child has earnings subtract any balance of the general income exclusion not offset by the child's unearned income from the child's earned income.

4) Subtract the work expense exclusion of $65.

5) Impairment–Related Work Expenses (IRWE). This exclusion is applied to earned income of disabled (but not blind) individuals under age 65.

The expense must be reasonable; for items/services which are directly related to enabling an impaired individual to work, and which are necessarily incurred by the individual because of a physical or mental impairment.

IRWEs are excludable when the cost is paid by the disabled individual and is not reimbursable from another source.

6) Subtract 1/2 of the remaining earned income after the above deductions.

7) Add countable unearned and earned income to arrive at total countable income.

8) Compare the total countable income to the individual SSI Payment Amount (SPA). If the amount is equal to or greater than the SPA, the child is ineligible for Medicaid.

M. RESOURCES

Resources are defined as those assets, both real and personal, which an individual owns and can apply, either directly or by sale, to meet basic needs of food, clothing, shelter and medical costs.

Real property is land, including buildings or immovable objects attached permanently to the land.

Personal property is any property that is not real property. The term encompasses such things as cash, tools, life insurance policies, mobile homes, automobiles, etc.

Any income which is retained the month following the month of receipt and later, is subject to resource evaluation.

Resources are evaluated at market value less encumbrances. When the combined value of all countable resources does not exceed the resource limit, verification of encumbrances is not necessary.

When the value of countable resources is under the resource limit on any day of the month, the client is eligible for that month.

All resources must be reported.

1. OWNERSHIP/AVAILABILITY

a. Sole Ownership

Sole ownership of real or personal property means only one person may sell, transfer or otherwise dispose of the property. All of the resource evaluated at market value less encumbrances is available to the client.

b. Shared Ownership

Shared ownership of real or personal property means two or more people own it simultaneously. The following are common types of shared ownership:

1) Tenancy-In-Common

Two or more persons each have an undivided fractional interest in the whole property for the duration of the tenancy. These interests are not necessarily equal. One owner may sell, transfer or otherwise dispose of his/her share of the property without permission of the other owner(s); but cannot take these actions with the entire property. If a tenant-in-common dies, the deceased's interest passes to his/her estate or heirs. Count the fair market value less encumbrances of the client's property share.

2) Joint Tenancy

Each of two or more persons have one and the same undivided ownership interest and possession of the whole property for the duration of the tenancy. This means each owner owns ALL the property. If a joint tenant dies, the survivor becomes the sole owner. If more than one joint tenant survives, the survivors become joint tenants of the entire property interest. Count the total fair market value less encumbrances of the entire property.

3) Tenancy By The Entirety (Married Couples only)

This type of ownership can only exist between married couples. The wife and husband as a unit own the entire property and can be sold only with the consent of both parties. However, if a legal divorce occurs, the former spouses become tenants-in-common and one can sell his/her share without the consent of the other. If one spouse dies, the survivor becomes the sole owner. Verify whether the client's spouse will give permission to sell the property. If permission cannot be obtained, DO NOT count the client's one-half share of the property.

4) Exceptions:

When a resource is owned jointly by more than one TANF/Medicaid applicant/recipient (other than a community spouse), divide the resource equally among those applicants/recipients to whom available.

When a client is representative payee or legal guardian managing someone else's funds, these funds are not considered the client's resource when they are kept in an account separate and apart from the client's monies AND can be identified as being received and designated for someone other than the client.

c. Treatment of Resources

1) Spouse to Spouse Deeming

If the applicant/recipient is married and living with his/her spouse, spouse to spouse deeming rules apply. Use the resource limit for a couple when determining resource eligibility.

The value of the client's and spouse's countable resources (whether owned separately by each or jointly by both) are counted. Only one automobile and home may be excluded per couple.

Deeming applies from spouse to spouse when they live together in the same household. Deeming stops the month following the month of institutionalization in a medical facility. Deeming begins the month following the month the spouse returns home from a medical facility.

2) Parent to Child Deeming

Deeming applies from a parent to a child when they live together in the same household. Deeming stops the month following the month of institutionalization in a medical facility. Deeming begins the month following the month the child returns home from a medical facility.

Deeming does not apply:

a) If the child lives with only a stepparent;

b) Beginning the month following the month the child turns 18;

c) If the spouse or parent(s) are recipients of SSI, TANF, Medicaid, Refugee Assistance, General Assistance (GA) or VA Pension, VA Compensation as a surviving parent of a veteran, VA Aid and Attendance and VA Payment for Unusual Medical Expenses. This is because these benefits are paid based on need, not entitlement.

Determine the value of countable resources of the child's natural/adoptive parent(s) or spouse of a parent.

Subtract from the value of the parent(s)' or spouse of a parent's countable resources, the resource limit of:

– an individual, if one natural/adoptive parent lives in the home; or
– a couple, if two parents (or one natural/adoptive parent and a spouse of that parent) live in the home.

The remaining value of resources is considered the child's own countable resources. Apply the individual resource limit to the child's countable resources to determine eligibility.

3) Dividing:

If a married person is living separate and apart from his/her spouse and they enter into written agreement dividing the total resources of both spouses equally between them, only the portion the agreement specifies as the clients will be counted in determining/continuing eligibility.

The agreement will be effective the month it is signed as long as the spouses were living separate and apart at least part of the month. An agreement cannot be effective for months prior to the date the arrangement was signed.

Married persons are considered to be living separate and apart when both spouses are residing in a medical facility.

The written agreement must include the following:

a) A specific listing of all resources being divided.

b) A statement specifying which resources are being given to whom. EXAMPLE: A couple has resources totaling $2,000. The resources consist of $1,000 in savings, $500 in a CD and $500 in stocks. The agreement must specify exactly which resources the agreement is designating as the client's and which are the spouse's. They cannot simply state $1,000 of the total resources belong to the client and $1,000 belong to the spouse.

In this example, an acceptable written agreement would:

– Designate to the client $500 of the savings account and the $500 CD.

– Designate to the spouse $500 of the savings account and $500 in stocks.

Do not require couples to liquidate resources when considering an equal division. As long as the written agreement specifically designates which resources or a portion of resources belong to the client and spouse.

c) The signature of the client and the client's spouse or the signature of a legal representative of the client and the client's spouse. A legal representative is defined as a person who has legal authority such as a legal guardian, power of attorney, etc. Being an authorized representative does not give that person legal authority.

If the spouse of the client makes a portion of his/her resources available to the client, that portion will be counted as a resource to the client.

4) Court Order

When a court order **equally** divides resources between spouses, only the portion the court order specifies as the clients will be counted when determining eligibility, UNLESS, the spouse makes a portion of his/her resources available to the client. The portion made available to the client will be counted as a resource in determining eligibility.

If the client has a court order dividing resources **unequally**, a copy of the court order must be sent to the Chief of Eligibility and Payments for a decision on whether Nevada State Division of Welfare and Supportive Services (DWSS) can recognize the court order.

5) Inaccessible Resource

The cash value of resources which are not legally available to the household are exempt. If the Medicaid applicant/recipient or authorized representative is able to verify a resource is unavailable due to the client's inability to access the resource due to incapacity and no one else has the ability to access the resource on their behalf, exempt the value of the resource as long as reasonable and timely steps are being taken to access the account on the client's behalf, (i.e., referral to the public guardian's office). Once the resource becomes accessible, the resource becomes countable and eligibility must be reevaluated for future months.

2. TRANSFER OF ASSETS (Refer to Section 240)

3. TREATMENT OF TRUSTS (Refer to Section 250)

4. RESOURCE LIMITS

Resource limits are $2,000 for an individual and $3,000 for a couple. When countable resources exceed the limit, the client is ineligible.

N. PATIENT LIABILITY

Patient liability is determined for eligible persons in a medical facility. There is no patient liability for any portion of institutionalization in a VA hospital, AGCF, FCH, freestanding psychiatric hospital or RTC.

There are six freestanding psychiatric hospitals in Nevada, they are:

- Charter Hospital
- Desert Willow Treatment Center
- Montevista Hospital
- Nevada Mental Health Institute (NMHI)
- Southern Nevada Adult Mental Health (SNAMH)
- West Hills Hospital

1. TREATMENT OF INCOME, DEDUCTIONS AND EXPENSES

When determining patient liability for initial and ongoing cases, budget income for the month it is received and deductions/expenses for the month in which they are paid/incurred.

When unanticipated income is received, patient liability will be adjusted for the month in which it was received.

Regular unearned income deposited directly into a financial institution is considered received in the month for which it is intended to be received.

2. PARTIAL MONTH PRORATION

The amount of patient liability is prorated according to the number of days the client was in a facility when the person is institutionalized less than a full calendar month due to:

a. Month of admission

b. Discharge to independent living, VA hospital, AGCF, FCH, freestanding psychiatric hospital or RTC.

c. Death

Determine what the patient liability would be for a full month. Divide that full month amount by the number of days in the month of partial institutionalization to determine the daily amount of patient liability. Multiply this daily amount by the number of days the client was institutionalized in that month

(include the day of admission but not the day of discharge/ death). The result is the amount of patient liability due for the partially institutionalized month.

3. EFFECTIVE DATE OF PATIENT LIABILITY

a. STATE INSTITUTIONAL

Patient liability is effective the first month of eligibility (this includes requested months prior to the application month).

b. STATE INSTITUTIONAL/QMB (SLMB)

Hospital Stay Only: For inpatient hospital stays under 90 consecutive days, do not calculate or send notice of patient liability. This is because Medicare will cover up to 90 days in a hospital and Medicaid must pay the hospital deductible and co–pay charges. If hospitalized beyond the 90 day time period, begin patient liability the first of the month following the 90 days.

c. TRANSFERS

The discharging facility collects patient liability for charges incurred. The admitting facility collects the balance if any is due.

d. Deceased Clients

The facility is notified of the patient liability amount due for the month of death. The facility will collect only for charges actually incurred. Any unused patient liability will be deposited in the Patient Trust Fund Account.

4. NOTIFICATION OF PATIENT LIABILITY/CASE STATUS

When a case is approved or patient liability changes, the client, facility and Blue Shield of Nevada are notified on a Notice of Decision of the amount and effective date.

Send a Medicaid Eligibility Status Form (2214) to those medical facilities not participating in the Electronic Verification of Eligibility (EVE) system, notifying them of the case status. This form must be sent upon receipt of an application, upon approval or denial, when ongoing assistance is terminated and when a denied or terminated case is reinstated to pending or approved status.

When the client moves from one facility to another, notify the facilities of the current case status and MONTHLY patient liability when this information has not already been provided them in or for that month.

5. BUDGETING PROCEDURES – FORM 2220–EM

a. Determine the client's TOTAL gross countable monthly income.

1) Subtract income excluded in Patient Liability

b. Subtract the following items from TOTAL MONTHLY INCOME in the following order:

1) Personal Needs Allowance

a) Deduct $35 Personal Needs Allowance (PNA) for each month of institutionalization.

b) Additional personal needs – Institutionalized individuals with **no** community spouse living in the home but with other dependent family members in the home are allowed an additional personal needs allowance based on household size. The additional personal needs amount is determined by subtracting the 1996 needs standard of $459 from the current TANF need standard for the household size. **NOTE**: this requires a NOMADS work around.

2) Community Spouse Monthly Income Allowance
Income allocated to the community spouse for maintenance. This amount (if any) is determined by subtracting the community spouse's income which is considered available (including need based assistance like TANF, SSI, etc.) from the Monthly Maintenance Allowance.
DO NOT count VA UME as income considered available to the community spouse.
Clients do not have to request the maintenance allowance for their spouse/dependents. The case manager will automatically request the information necessary to determine the maintenance allowance when there is a spouse or dependents at home.

a) Definitions

(1) Monthly Maintenance Needs Allowance
An amount determined by adding together the Federal minimum Maintenance Need Standard (150% of poverty for 2 persons) and an excess shelter allowance. This amount cannot exceed the Federal Maximum Maintenance Needs Standard except when authorized by findings of an Administrative Review/ Hearing.

(2) Housing Costs (principal place of residence)

The community spouse's expenses for rent or mortgage payment (including principal and interest), property taxes and mortgage/rental insurance. In situations where a maintenance charge is required, allow only that portion which does not include personal or individual utility expenses.

(3) Standard Utility Allowance (SUA)

An amount established under SNAP which is the statewide average of total monthly utility costs.

Do not allow SUA if utilities are included with the rent and cannot be separately identified.

If the telephone service is the only utility, allow the telephone allowance instead of the full SUA.

(4) Excess Shelter Allowance

An amount (if any) determined by subtracting the Federal Excess Shelter Deduction (30% of 150% poverty for two persons) from the community spouse's housing costs plus the SUA.

Verification of the community spouse's gross income and housing costs must be obtained. If income verifications are not returned by the required date, the case will be completed without allowing a maintenance allowance. If verification of housing costs and/or utility expense is not provided, compute the spousal income allowance without it.
The client will be notified on the Notice of Decision, the patient liability was determined without a Maintenance Allowance Deduction. If, however, the verifications are received after the required date, the maintenance allowance deduction will be allowed beginning the month the verification was received.

The Community Spouse Monthly Income Allowance deduction will be discontinued if information is received the spouse is not receiving the Maintenance Allowance.

3) Family Allowance (Spousal Impoverishment)

Family members must be a dependent child, dependent parent(s) or dependent sibling(s). The child, parent or sibling must be residing in the home of the community spouse AND claimed by the community spouse or institutionalized spouse as dependents for Federal Income Tax purposes.

The amount determined to be the Family Allowance is deducted from the institutionalized spouse's countable income effective with the first month in which the continuous period of institutionalization is met OR if this deduction was not previously allowed the deduction will be allowed effective the first month following the month in which the change is reported.

The Family Allowance deduction need not be determined IF the $35 personal needs allowance in combination with the Community Spouse Monthly Income Allowance zero's out the patient liability.

Verification of each family member's gross income must be obtained.

(a) Subtract the family member's gross income from Minimum Needs Allowance (150% of poverty).
(b) Divide the amount from (1) above by three. This is <u>one</u> family member's allowance.

Repeat this calculation for each family member. If there is only one family member, the amount from 2) will be the Family Allowance deduction. If there is more than one family member, add each family member's allowance to determine the Family Allowance Deduction.

4) Dependent Allowance (Non-Spousal Impoverishment)

A monthly income allowance for each dependent family member living in the institutionalized individual’s home with **no** community spouse living in the home. Calculated by subtracting the dependents total income from the need standard (100% Need Standard) for the household size.

5) Expenses Incurred For Health Insurance Premiums, Deductibles and Co–Insurance Charges

Deduct Health Insurance Premiums, Deductibles and Co–insurance expenses incurred by the client. Clients/ Representatives must advise the agency of medical insurance and provide proof of expenses. These expenses must not be paid or subject to payment by a third party.

Medicare premiums are subject to payment by a third party.

Any institutional case where the client is not a SSI recipient and will not receive a reimbursement for Medicare cost from any source, may have the Medicare premium deducted as an expense for months immediately preceding the second month after the month of approval.

EXAMPLE #1 (Medicaid Only): Client applied June 2nd and requests 3 months prior medical. Case is approved July 10th. Medicare premiums may be deducted from March through August. Beginning September, we cannot deduct the Medicare premium as it is then subject to third–party payments.

EXAMPLE #2 (Medicaid/QMB): Client applied for Medicaid/QMB on June 2nd and requests 3 months prior medical. In June, QMB eligibility is established and benefits begin effective July 1st. Then Medicaid eligibility is established July 20th back to March. Medicare premiums may be deducted for March, April, May and June only. Effective July and ongoing, the premiums are subject to third–party payments as QMB coverage began in July.

6) Expenses Incurred For Medical Care

Deduct expenses incurred by the client for necessary medical care recognized under the State law but not covered under the Medicaid Program. This includes medical expenses incurred more than three months prior to the date of application. Client/Representatives must advise the agency and submit proof of the expenses. The case manager will attach a copy of the medical bill plus all related medical records to Form 2536 and submit to the NMO for approval. These expenses must not be paid or subject to payment by a third party. An NMO approval is required to assure the deduction is for necessary care payable to reasonable limits.

The case manager will attach a copy of the medical bill plus all related medical records to Form 2536 and submit to the NMO for approval. These expenses must not be paid or subject to payment by a third party. An NMO approval is required to assure the deduction is for necessary care payable to reasonable limits.

c. The deficit, if any, is the client's share of facility cost (PATIENT LIABILITY).

O. REDETERMINATIONS

Does not apply.

NEVADA MEDICAID RESIDENTIAL TREATMENT CENTER (RTC) SERVICE PROVIDERS

Benchmark Hospital
592 West 1350 South
Woods Cross, Utah 84087
(801) 299-5300

Brown Schools, Inc.-Cedar Springs Ctr
22135 Southgate Road
Colorado Springs, Colorado 80906
(719) 633-4114

Brown Schools, Inc.-Laurel Ridge Trtmt Ctr
17720 Corporate Woods Drive
San Antonio, Texas 78259-3509
(210) 491-9400

Brown Schools, Inc.-San Marcos Trtmt Ctr
One Bert Brown Road
San Marcos, Texas 78667
(512) 396-8500

Brown Schools, Inc.-The Oaks Trtmt Ctr
1407 Stassney Lane
Austin, Texas 78745
(512) 444-9561

Cathedral Home for Children
P.O. Box 520
Laramie, Wyoming 87073-0520
(307) 745-8997

Cleo Wallace Center
430 Gold Pass Heights
Colorado Springs, Colorado 80906
(719) 527-1600
(Denver Campus - (303) 466-7391

Copper Hills at St. George
115 West 1470 South, Suite B
St. George, Utah 84770
(435) 634-1730

Copper Hills Youth Center
5899 West Rivendell Dr
West Jordan, Utah 84080
(801) 561-3377

Desert Willow Treatment Center (RTC)
6171 West Charleston Boulevard
Las Vegas, Nevada 89146
(702) 486-8900

Primary Childrens Medical Center RTC
497 South Colorow Way
Salt Lake City, Utah 84108
(801) 588-4980

Provo Canyon School
P.O. Box 1441
Provo, Utah 84603
(801) 227-2000

San Diego Center for Children
3002 Armstrong Street
San Diego, California 92111
(619) 277-9550

Spring Mountain Treatment Center
7000 West Spring Mountain Road
Las Vegas, Nevada 89117
(702) 873-2400

Vista Care RTC
4120 East Ramsey Road
Hereford, Arizona 85615
(520) 378-6466

Willow Springs Center
P.O. Box 30012
Reno, Nevada 89520
(702) 323-3303

NEVADA MEDICAID PSYCHIATRIC HOSPITAL SERVICE PROVIDERS

Charter Hospital
7000 West Spring Mountain Road
Las Vegas, Nevada 89117
(702) 876-4356

Desert Willow Treatment Center (RTC)
6171 West Charleston Boulevard
Las Vegas, Nevada 89146
(702) 486-8900

Montevista Hospital
5900 West Rochelle Avenue
Las Vegas, Nevada 89103
(702) 364-1111

Nevada Mental Health Institute
480 Galletti Way
Sparks, Nevada 89431
(702) 688-2001

Southern NV Adult Mental Health
6161 West Charleston Blvd.
Las Vegas, Nevada 89102
(702) 486-6000

West Hills Hospital
1240 East Ninth Street
Reno, Nevada 89520
(702) 323-0478

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SECTION 350
PERSONS INSTITUTIONALIZED
AT LEAST 30 CONSECUTIVE DAYS

350 PERSONS INSTITUTIONALIZED AT LEAST 30 CONSECUTIVE DAYS

A. OVERVIEW

The client must be an inpatient in a Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF or ICF/MR), or hospital and meet all eligibility requirements. Time spent in an institution for mental disease (IMD) is considered when determining institutionalization for 30 consecutive days when going to or from the IMD. If, when going from the IMD to a SNF, ICF or hospital, the client was only temporarily transferred and not actually discharged, the time in the IMD cannot be counted toward length of time institutionalized.

The individual must be in the institution at least thirty (30) consecutive days. In determining the number of days in a medical institution for eligibility purposes, include the day of admission, but not the day of discharge/death. Applications may be processed under this category prior to the 30th day based on a licensed physician's statement the client is likely to be in the institution at least thirty (30) days. Eligibility will begin the first day of the month in which the client entered the medical facility, provided application is made and all other eligibility requirements are met.

An "outpatient" stay is less than a 24–hour period regardless of the hour of admission, whether or not a bed is used or whether or not the patient remains in the facility past midnight.

All cases must be evaluated for QMB (SLMB) eligibility.

ELIGIBILITY EXCEPTIONS

1. All individuals under age 65 who are inpatients in an Institution for Mental Disease (IMD), i.e., freestanding psychiatric hospital **are not** eligible for Medicaid in this category. (See chapter Addendum listing IMD facilities.)

   An Institution for Mental Diseases (IMD) is defined as a hospital, nursing facility or other institution of more than 16 beds which is **primarily** engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Individuals are severely psychotic, emotionally ill, suicidal and a danger to themselves, others or property. In Nevada IMDs are commonly referred to as "psychiatric hospitals." **An institution for the mentally retarded IS NOT an institution for mental disease.**

2. An inmate of a public institution is ineligible for Medicaid UNLESS the institution is a medical institution. An inmate of a penal institution is NEVER eligible for Medicaid while in the custody of law enforcement officials, UNLESS admitted as an inpatient to a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility. This individual is eligible for any Medicaid covered services provided to them while an **inpatient** in these facilities and they are Medicaid-eligible. If this individual becomes an inpatient of a long-term care facility, they must meet level of care and plan of care assessments to become eligible.

3. Individuals under 22 receiving inpatient psychiatric services in a Residential Treatment Center (RTC) **are** eligible for Medicaid in this category. (See chapter Addendum listing RTC facilities)

RTCs specialize in treating children with conduct disorders, personality disorders, depression, hyperactivity, academic failure, and/or mild learning disabilities. Medicaid will pay for services provided in the RTC if the admission was prior authorized/certified by Medicaid's Peer Review Organization (PRO).

B. AGED, BLIND, DISABLED

Persons must be aged (65 or older), blind or disabled as determined by Social Security Administration criteria.

C. TIME FRAMES

An eligibility decision must be made within 45 days from the Medicaid application date for the aged and 90 days for the blind/disabled, unless extenuating circumstances exist.

D. SOCIAL SECURITY NUMBER (SSN)

Social Security numbers must be provided by every applicant and recipient. See manual section 204.

E. IDENTIFICATION

All applicants for Medicaid must be identified.

F. NEVADA RESIDENCY

1. SSI RECIPIENTS RECEIVING A STATE SUPPLEMENTARY PAYMENT (SSP) FROM ANOTHER STATE

State Supplementary Payments are funds paid in addition to the Federal SSI payment. SSP entitlement and amounts differ from state to state.

When the client is receiving SSI/SSP through another state, the state paying the State Supplementary Payment is the state of residence UNLESS SSA acknowledges Nevada residency. In this instance only, use SSA's effective date of residency.

2. SSI RECIPIENTS NOT RECEIVING A STATE SUPPLEMENT FROM ANOTHER STATE

If a client is receiving SSI from another state but that state is <u>not</u> paying a supplementary payment (SSP) establish residency per "3" below.

3. INSTITUTIONALIZED PERSONS (INCLUDES SSI RECIPIENTS NOT RECEIVING SSP)

a. Definitions

1) **Incapability** of Indicating Intent To Reside

Persons are considered incapable of indicating their intent to reside when they:

a) Have an IQ of 49 or less or have a mental age of 7 or less: or
b) Are found incapable of indicating their intent to reside based on and verified through medical documentation by a physician or licensed psychologist: or
c) Are judged legally incompetent.

2) Emancipated

Persons are considered emancipated when they are:

a) 18 or over; or
b) Married; or
c) Enlisted in the armed services; or
d) Emancipated by court order.

3) Abandoned

Persons are considered abandoned when:

a) Location of parents is unknown; or
b) Parental rights have been terminated.

b. Individuals **Placed In An Institution** By A State

Residence is the state making or arranging placement. Any agency of the state, including an entity recognized under state law as being under contract with the state for such purposes, that arranges for an individual to be placed in an institution (including foster care homes) located in another state, it is recognized as acting on behalf of the state making a placement.

c. Competency and Relationship To Age 21

Residency requirements are based on client's competency, ability to indicate intent and age. When a client is incompetent or unable to indicate intent, the age at which (s)he became incompetent or unable to indicate intent must also be determined.

1) Persons **Capable** of Indicating Intent At Age 21 or Over; or Persons **Under Age 21 And Emancipated**

The state of residence is that in which the client is living with the intention of making his/her home permanently or for an indefinite period of time. An indefinite period has no expected end date.

The ability to indicate intent to reside in Nevada is not to be taken lightly or stand by itself. A statement or indication of intent to reside in Nevada must be supported by additional verification or collateral material to substantiate the intent if residency is questionable. Manual Section 205,D,5 is not all inclusive. See Manual Section 205,D for more detail.

2) Persons Who Became **Incapable** of Indicating Intent **Before Age 21**

The state of residence is:

a) That of the parent applying for Medicaid on the individual's behalf, IF the parents reside in separate states (if a legal guardian has been appointed and parental rights are terminated, the state of residence is that of the guardian instead of the parent's);

The parent's or legal guardian's state of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's); or

b) The current state of residence of the parent or legal guardian who files the application if the individual is institutionalized in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's).

c) The state of residence of the individual or party who files an application if the individual has been abandoned by his/her parent(s), does not have a legal guardian and is institutionalized in that state.

3) Persons **Under Age 21 and Not Emancipated**

The state of residence is:

a) The parent's or legal guardian's state of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's); or

The current state of residence of the parent or legal guardian who files the application if the individual is institutionalized in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's).

b) The state of residence of the individual or party who files an application if the individual has been abandoned by his/her parent(s), does not have a legal guardian and is institutionalized in that state.

4) Persons Who Became **Incapable** of Indicating Intent **At Age 21 or Later**

The state of residence is the state in which the individual is physically present.

d. Disputed Residency

When Nevada Medicaid determines a client is a resident of another state and that state disagrees, the following procedures apply:

1) Require the client to provide a copy of the disputing state's denial/termination letter.

2) Process the Nevada Medicaid application to determine eligibility.

3) Notify the Chief of E&P by memo. Include:

a) Case name and number.
b) Copy of denial/termination letter from the disputing state.
c) Copy of 2400 showing approval/denial.

G. CITIZENSHIP

To qualify for assistance, applicants must be a U.S. citizen or a non-citizen in an eligible category. See manual section 206 for citizenship requirements.

H. PRIOR MEDICAL

Clients may apply for prior medical coverage for up to 3 months prior to the month of Medicaid application.

1. Prior Medicaid coverage must be requested; AND

2. There must be evidence that medical care or services were provided in the month(s) for which Medicaid is requested.

When clients request prior medical, first determine if they are eligible for prior medical as an SSI recipient or State Institutional case.

If they are not eligible in either of those categories determine if they would have been eligible for SSI had SSA made a determination. See Prior Medical Determinations.

Do not make an independent SSI determination IF there is a pending SSI application covering the month(s) Medicaid is requested. Wait for the SSI decision.

Use SSI/SSA's disability decision (the disability on–set date) for any month of requested prior medical assistance. All other factors of eligibility, e.g., residency, citizenship, income, resources, etc., must be evaluated by the case manager.

I. THIRD PARTY LIABILITY (TPL)

Medicaid is always payor of last resort whenever any other resource may be responsible for payment.

When insurance coverage is available at no cost to the client (e.g., through employment or Tricare), request the client to enroll.

If Individual is enrolled in Medicare ensure a MEDI screen is entered for each month of eligibility. See MAABD 208 regarding effective dates for buy-in.

Notify the fiscal intermediary of third party liability and any changes to such by recording all known information on the NOMADS MINS and MEDI screens.

J. RESERVED

This program is no longer available.

K. CHILD SUPPORT ENFORCEMENT (CSE)

All dependent children (including automatic Medicaid eligible newborns) who have absent parent(s) require referrals to CSE for support enforcement services. Support Enforcement services include establishing paternity, securing child support and medical support. See manual section 209.

L. INCOME

Income means the receipt of money in the month for which an eligibility determination is being made. All income or changes in income must be reported. All income must be evaluated for financial eligibility.

1. OWNERSHIP/AVAILABILITY

a. Sole Ownership

All income which a payor designates as the clients, will be considered in determining eligibility.

When a benefit or income is received for more than one person or family member, only the client's portion of the income is considered.

b. Shared Ownership

1) Deeming:

If the client is a child (under age 18) and was living with his/her parent(s) at the time of institutionalization, deem the parent(s)' income using Form 2646-EE/A.

Deeming applies from a parent to a child when they live together in the same household. Deeming stops the month following the month of institutionalization in a medical facility. Deeming begins the month following the month the child returns home from a medical facility.

2) Dividing:

If it is in the applicant's best interests for financial eligibility, the case manager will divide the total income of spouses who are living separate and apart (due to institutionalization only) equally between them. Only the applicant's share of the income will be considered when determining eligibility. However, if a portion of the spouse's income is made available to the applicant, that portion would be counted as income to the client in determining eligibility.

Dividing income takes precedence over the joint bank account procedures in Manual Section 220. Therefore, income deposited in a joint bank account held by both spouses will NOT be considered "being made available."

3) Court Order/Trust:

If the client has a court order or trust, a copy must be sent to the Chief of Eligibility & Payments for a decision on whether Division of Welfare and Supportive Services (DWSS) can recognize the court order or trust.

4) Exceptions:

Monies received by the client in his/her capacity as an agent are not income to him/her. An "agent" is a person acting on behalf of someone, i.e., representative payee, guardian, conservator, etc.

2. TREATMENT OF INCOME

When determining financial eligibility, budget income for the month it is received. Do not deem income from a community spouse to an institutionalized spouse for any month of institutionalization.

Regular unearned income deposited directly into a financial institution is considered received in the month for which it is intended to be received.

When a one-time lump sum payment is received and it will not affect ongoing benefits, adjust patient liability for the month of receipt, not to exceed the actual cost of care for the month.

a. Intake Cases

Individually determine financial eligibility for each month of requested coverage.

b. Ongoing Cases

Financial eligibility is always determined prospectively (future month). When information becomes known which causes ineligibility prospectively, terminate benefits allowing adverse action time.

3. INCOME LIMITS

See MAABD income chart in Appendix C.

4. BUDGETING PROCEDURES FOR FINANCIAL ELIGIBILITY - FORM 2203-EM

Perform the gross income test to determine if an individual is eligible as an Institutional case. Perform the net income test to determine which aid code is applicable.

a. Gross Countable Income Test

1) Enter the countable amount of all unearned income.

2) Enter the gross earned income.

3) Determine TOTAL GROSS COUNTABLE INCOME by adding items I-A and I-B.

4) Compare the total gross countable income to the income limit.

If gross countable income is less than or equal to the income limit, the client is eligible as State Institutional case.

If gross countable income exceeds the income limit and the client is married, apply the equal division of income rules. If one-half of countable gross marital income exceeds the income limit, the client is ineligible for Medicaid.

b. Net Income Determination

1) Enter the countable amount of all unearned income (or one-half of marital unearned income).

2) Subtract the $20 General Income Exclusion from countable unearned income.

3) Enter the gross amount of all earnings or one-half of marital earnings and subtract the following.

a) Any remaining General Exclusion amount not offset by unearned income; AND

b) The Earnings Exclusion of $65; AND

c) Impairment–Related Work Expenses (IRWE). This exclusion is applied to earned income of disabled (but not blind) individuals under age 65.

The expense must be reasonable; for items/services which are directly related to enabling an impaired individual to work, and which are necessarily incurred by the individual because of a physical or mental impairment.

IRWEs are excludable when the cost is paid by the disabled individual and is not reimbursable from another source.

d) One-half of the remaining earned income.

4) Determine TOTAL COUNTABLE NET INCOME by adding items II-A-2 and II-B-2.

5) Aid Code Determination – See appendix D for current benefit levels.

SSI Institutional (SS) – Individuals receiving Institutional $30.00 SSI payment.

Would be SSI Eligible (WB) – Individuals with countable net income greater than $30.00 but less than SSI payment level, who would be receiving SSI or a State Supplement if not residing in long term care.

Special Income (SI) – Individuals with countable net income between the SSI payment level and 142% of SSI payment level.

County Match (CM) – Individuals with countable net income exceeding the County Match Income Limit (142% of SSI payment level). The County will pay the non-federal amount of assistance.

M. RESOURCES

Resources are defined as those assets, both real and personal, which an individual owns and can apply, either directly or by sale, to meet basic needs of food, clothing, shelter, and medical costs.

Real property is land, including buildings or immovable objects attached permanently to the land.

Personal property is any property that is not real property. The term encompasses such things as cash, tools, life insurance policies, mobile homes, automobiles, etc.

Any income which is retained the month following the month of receipt and later, is subject to resource evaluation.

Resources are evaluated at market value less encumbrances. When the combined value of all countable resources does not exceed the resource limit, verification of encumbrances is not necessary.

When the value of countable resources is under the resource limit on any day of the month, the client is eligible for that month.

All resources must be reported.

1. OWNERSHIP/AVAILABILITY (Nonspousal Impoverishment)

Single individuals and married persons who began a "continuous period of institutionalization" prior to September 30, 1989.

a. Sole Ownership

Sole ownership of real or personal property means only one person may sell, transfer or otherwise dispose of the property. All of the resource evaluated at market value less encumbrances is available to the client.

b. Shared Ownership

Shared ownership of real or personal property means two or more people own it simultaneously. The following are common types of shared ownership:

1) Tenancy-In-Common

Two or more persons each have an undivided fractional interest in the whole property for the duration of the tenancy. These interests are not necessarily equal. One owner may sell, transfer or otherwise dispose of his/her share of the property without permission of the other owner(s); but cannot take these actions with the entire property. If a tenant-in-common dies, the deceased's interest passes to his/her estate or heirs. Count the fair market value less encumbrances of the client's property share.

2) Joint Tenancy

Each of two or more persons have one and the same undivided ownership interest and possession of the whole property for the duration of the tenancy. This means each owner owns ALL the property. If a joint tenant dies, the survivor becomes the sole owner. If more than one joint tenant survives, the survivors become joint tenants of the entire property interest. Count the total fair market value less encumbrances of the entire property.

3) Tenancy By The Entirety (Married Couples only)

This type of ownership can only exist between married couples. The wife and husband as a unit own the entire property and can be sold only with the consent of both parties. However, if a legal divorce occurs, the former spouses become tenants-in-common and one can sell his/her share without the consent of the other. If one spouse dies, the survivor becomes the sole owner. Verify whether the client's spouse will give permission to sell the property. If permission cannot be obtained, DO NOT count the client's one-half share of the property.

4) Exceptions

When a resource is owned jointly by more than one TANF/Medicaid applicant/recipient (other than a community spouse), divide the resource equally among those applicants/recipients to whom available.

When a client is representative payee or legal guardian managing someone else's funds, these funds are not considered the client's resource when they are kept in an account separate and apart from the client's monies AND can be identified as being received and designated for someone other than the client.

c. Treatment of Resources

1) Parent to Child Deeming

Deeming applies from a parent to a child when they live together in the same household. Deeming stops the month following the month of institutionalization in a medical facility. Deeming begins the month following the month the child returns home from a medical facility.

Deeming does not apply:

a) If the child lives with only a stepparent;

b) The month following the month the child turns 18;

c) If the spouse or parent(s) are recipients of SSI, TANF, Medicaid, Refugee Assistance, General Assistance (GA) or VA Pension, VA Compensation as a surviving parent of a veteran, VA Aid and Attendance and VA Payment for Unusual Medical Expenses. This is because these benefits are paid based on need, not entitlement.

Determine the value of countable resources of the child's natural/adoptive parent(s) or spouse of a parent.

Subtract from the value of the parent(s)' or spouse of a parent's countable resources, the resource limit of:

(1) an individual, if one natural/adoptive parent lives in the home; or

(2) a couple, if two parents (or one natural/adoptive parent and a spouse of that parent) live in the home.

The remaining value of resources is considered the child's own countable resources. Apply the individual resource limit to the child's countable resources to determine eligibility.

2) Dividing:

If a married person is living separate and apart from his/her spouse and they enter into written agreement dividing the total resources of both spouses equally between them, only the portion the agreement specifies as the clients will be counted in determining eligibility.

The agreement will be effective the month it is signed as long as the spouses were living separate and apart at least part of the month. An agreement cannot be effective for months prior to the date the arrangement was signed.

The written agreement must include the following:

a) A specific listing of all resources being divided.
b) A statement specifying which resources are being given to whom.

EXAMPLE: A couple has resources totaling $2,000. These resources consists of $1,000 cash, $500 in a CD and $500 in stocks. The agreement must specify exactly which resources the agreement is designating as the clients and which are the spouses. They cannot simply state $1,000 of the total resources belong to the client and $1,000 belong to the spouse.

In this example, an acceptable written agreement would:

– designate to the client $500 of the savings account and the $500 CD.
– designate to the spouse $500 of the savings account and $500 in stocks.

Do not require couples to liquidate resources when considering an equal division. As long as the written agreement specifically designates which resources or a portion of resources belong to the client and spouse.

c) The signature of the client and the client's spouse or the signature of a legal representative of the client and the client's spouse. A legal representative is defined as a person who has legal authority such as a legal guardian, power of attorney, etc. Being an authorized representative does not give that person legal authority.

If the spouse of the client makes a portion of his/her resources available to the client, that portion will be counted as a resource to the client.

3) Court Order

When a court order **equally** divides resources between spouses, only the portion the court order specifies as the clients will be counted when determining eligibility, UNLESS, the spouse makes a portion of his/her resources available to the client. The portion made available to the client will be counted as a resource in determining eligibility.

If the client has a court order dividing resources **unequally**, a copy of the court order must be sent to the Chief of Eligibility and Payments for a decision on whether Division of Welfare and Supportive Services (DWSS) can recognize the court order.

4) Inaccessible Resource

The cash value of resources which are not legally available to the household are exempt. If the Medicaid applicant/recipient or authorized representative is able to verify a resource is unavailable due to the client’s inability to access the resource due to incapacity and no one else has the ability to access the resource on their behalf, exempt the value of the resource as long as reasonable and timely steps are being taken to access the account on the client’s behalf, (i.e., referral to the public guardian’s office). Once the resource becomes accessible, the resource becomes countable and eligibility must be reevaluated for future months.

Resources held in Probate are considered inaccessible until the Administrator or Executor distributes the property.

2. RESOURCE PROVISIONS FOR SPOUSAL IMPOVERISHMENT CASES

This section applies to ALL persons who begin a "continuous period of institutionalization" (medical/mental institution or a combination of both) on or after September 30, 1989 and who have a spouse in an independent living situation. These rules apply regardless of State laws relating to community property or to the division of marital property.

If the community spouse dies prior to an eligibility decision, spousal impoverishment rules do not apply. Treat the case as a non-spousal case and apply the treatment of resource rules accordingly for all requested months of coverage.

If the institutional spouse dies prior to an eligibility decision, **spousal impoverishment rules do apply. Treat the case as a spousal case from the date of application through the date of death of the institutional spouse.**

a. Definitions

1) Institutionalized Spouse – a married person residing in a medical facility at least 30 consecutive days who has a spouse in an independent living situation.

2) Community Spouse – a married person who is not in a medical facility whose spouse has been residing in a medical facility at least 30 consecutive days.

3) Spouse – person legally married to another under state law. In Nevada, a person is married until divorced.

4) Undue Hardship – when excess resources results in the denial of eligibility when applying spousal impoverishment rules or the home equity interest provision.

5) Medical Facility – a facility for skilled nursing or intermediate care or a hospital.

6) Spousal Share – an amount equal to one-half of the total resources (separately and jointly held) at the time of the spouse's institutionalization.

7) Community Spouse Resource Allowance – an amount of resources allocated to the community spouse for his/her maintenance.

8) Continuous Period of Institutionalization – institutionalized at least 30 consecutive days. To determine whether spousal impoverishment resource provisions apply, a continuous period ends when the client is absent from an institution for 30 consecutive days.

9) Designation of Resources through a Court Order – resources and/or portions of resources ordered to the community spouse by a court of competent jurisdiction.

10) Liquid resources are cash and other items which can reasonably be converted to cash within 20 workdays. Non–liquid resources are items which are not cash and cannot be converted to cash within 20 workdays.

b. Ownership/Availability

1) Sole Ownership

All of the resource evaluated at market value less encumbrances is available to the applicant/recipient or community spouse.

2) Shared Ownership

a) Resource Jointly Owned Between Spouses

(1) Liquid Resources (bank accounts, certificates of deposit, stocks, bonds, etc.).

All liquid resources held jointly between spouses are considered available in their entirety to the institutionalized spouse only. They are not considered an "available resource" to the community spouse when determining the Community Spouse Resource Allowance.

(2) Non–liquid Resources (real property, vehicles, etc.).

When non–liquid resources are held jointly between spouses, consider only one–half as available to each spouse when determining the Community Spouse Resource Allowance.

b) Resources Jointly Held With Someone Other Than A Spouse

(1) When the client or community spouse is able to sell or dispose of a resource without another person's signature of approval, all of the resource is evaluated at market value less encumbrances and considered available to the client or community spouse.

(2) When the client or community spouse is able to sell or dispose of his/her share of a resource without another person's signature of approval, that portion evaluated at market value less encumbrances is available to the client or community spouse.

c) Exceptions

When a resource is owned jointly by more than one TANF/Medicaid applicant/recipient (other than a community spouse), divide the resource equally among those applicants/recipients to whom available.

When the client is representative payee or legal guardian for managing someone else's funds, these funds are not considered the client's resource when they are kept in an account separate and apart from the client's monies AND can be identified as being received and designated for someone other than the client.

d) If the client has a court order dividing resources, a copy of the order must be sent to the Chief of Eligibility and Payments for a decision on whether Division of Welfare and Supportive Services (DWSS) can recognize the order.

c. Resource Determination

1) Spousal Impoverishment Resource Determination – An assessment of couples total resources completed at the time of institutionalization.

This determination is only completed <u>once</u> at the beginning of the <u>first</u> continuous period of institutionalization (beginning on or after 9/30/89).

The institutionalized spouse, community spouse or their representatives may submit a written and signed request to the Division to determine the total value of their resources. The determination shall be made whether or not the institutionalized spouse is applying for Medicaid.

Determine and verify the total value of all countable resources owned separately or jointly by the institutionalized spouse and the community spouse as of the beginning of a "continuous period of institutionalization."

If the request is not part of an application, the determination must be completed within 45 days from the date of request unless delays are due to non–receipt of documentation/verification from the requesting party or third party. Make up a casefile for each assessment. The casefile shall contain the written request, the signed statement of resources owned by both spouses (Form 2794–EM), documentation and verification of the market value less encumbrances of all countable resources and Form 2793–EM "Assessment and Documentation of Resources." These files will be kept alphabetically and retained indefinitely.

When an applicant applies for assistance and provides a spousal resource assessment completed from another state, the assessment must be reviewed. If the assessment is done correctly, use the assessment as provided.

However, if an error(s) is found on the assessment, redetermine the resource assessment based on the error(s) only. Once the information in error is corrected, the assessment can be accepted. If more than one resource assessment is provided, review all assessments to determine acceptability.

2) Spousal Share of Resources **At The Time of Institutionalization** (Section I of Form 2797–EM)

This determination is only completed <u>once</u> at the beginning of the <u>first</u> continuous period of institutionalization (beginning on or after 9/30/89). (Exception see M.S. 350.M.2.c.1)

a) Enter the Community Spouse's separate resources.
b) Enter the Institutionalized Spouse's separate resources.
c) Enter joint resources between spouses.
d) Divide TOTAL resources equally.
This one–half portion of total resources is the "spousal share."

3) Community Spouse Resource Allowance (Section II of Form 2797–EM)

a) Enter the State Medicaid Maximum.
b) Enter the spousal share (one–half of resources at the time of the <u>first</u> continuous period of institutionalization) up to the Federal Maximum.
c) Enter the Administrative Hearing decision amount (if applicable).

d) Enter the court ordered amount (if applicable).
e) Enter the greatest of a, b, c, or d above.

The State Medicaid and Spousal Share Maximums change annually. Use the annual amounts applicable to the year associated with the months of requested coverage.

The amount of resources (if any) determined from this computation is the Community Spouse Resource Allowance.

4) Assignment of Resources **At The Time of Application** For Medicaid (Section III of Form 2797–EM)

Complete Section III for each month of requested Medicaid coverage.

a) Enter the Community Spouse's separate resources.
b) Enter the Institutionalized Spouse's separate resources.
c) Enter joint resources between spouses.
d) Total ALL resources.

Subtract the total amount of Section II, item "e" from the total countable resources of both spouses. The difference (if any) will be the amount of resources applied toward the institutionalized spouse's resource limit. If the value exceeds the resource limit, the client is ineligible. If the value is within the resource limit, the client is resource eligible.

CAUTION: There are situations where the client has separate resources and/or joint resources with their spouse (Section III b & c) which exceed the $2,000 resource limit (ineligible). This situation occurs even though the protected resource amount puts the countable resources for the client's eligibility (Section III f) within the $2,000 resource limit.

The notice to the community spouse must advise them to place an amount of resources into their name which will leave the client's resources under the $2,000 resource limit.

5) Permitting Transfer of Resources To The Community Spouse

An amount up to the Community Spouse Resource Allowance must be transferred to the community spouse's name only within 30 days from the date of the approval notice.

In situations where transferring the resource(s) cannot reasonably occur within the 30–day period, the client, spouse and/or their representatives must substantiate the circumstances and provide an expected date the transfer will take place. The case manager must monitor, document and verify the situation until the transfer occurs.

The client, spouse and/or their representatives must continue to make every effort and take all possible steps to successfully transfer the resource(s) to the community spouse. Failure to comply will cause the resources to be counted towards the institutionalized spouse's resource limit.

Effective October 1, 1993 State law is amended regarding court orders giving state courts guidelines when protecting income and resources for the community spouse. The guidelines provide for an equal division of income and resources OR a protection of income not to exceed the Federal Maximum Monthly Maintenance Needs Allowance and a protection of resources which does not exceed the Federal Maximum Spousal Share.

The court may order a greater amount of income for the support of the community spouse upon finding exceptional circumstances resulting in significant financial duress. The court may also transfer a greater amount of resources, in relation to the amount of income generated by the resource, if resources up to the Federal Maximum are not enough to fund the amount of income ordered.

The Transfer of Resources policy DOES NOT apply to transfers made under these provisions.

6) Separate Treatment of Resources After Eligibility is Established

During the "continuous period" of institutionalization AND after the client has been determined eligible, no resources of the community spouse are available to the client, unless actually made available to the client.

If the community spouse dies in an on-going case, the only assets available to the institutionalized spouse are items received by a will after an order of the Probate Court or anything that was held in joint tenancy.

7) Undue Hardship

An undue hardship determination can be requested at any time when applying spousal impoverishment rules, transfer of asset provisions, or when applying the home equity interest provision.

If undue hardship is claimed as a result of a denial of eligibility for excess resources under spousal impoverishment rules, the applicant may be determined eligible in spite of having excess resources if ALL of the following conditions exist:

a) The institutionalized spouse is otherwise eligible for Medicaid without applying spousal impoverishment rules; AND

b) The community spouse is the sole owner of liquid resources OR non–liquid joint resources valued in excess of the Federal Maximum; AND

c) The community spouse has refused to make the resources available to the institutionalized spouse; AND

d) The institutional spouse has insufficient funds to cover the cost of institutionalized care; AND

e) Without Medicaid, the institutionalized spouse would be forced to go without life sustaining medical care as determined by an individual licensed to practice medicine in the State of Nevada.

Send undue hardship requests to the Chief of E&P for evaluation and decision.

8) Additional Resources Following Initial Eligibility

If the institutionalized spouse acquires a new countable resource following the initial eligibility determination, his/her resource eligibility must be re–evaluated.

Apply the ownership/availability rules as outlined in Part "b" of this section to the newly acquired resource.

Determine how much, if any, of the Spousal Protected Resources (Line II "e") was used to transfer resources in the community spouse's name only. If there is a balance remaining, more resources countable to the institutionalized spouse can be protected for the community spouse so the institutionalized spouse remains resource eligible.

First determine if the Spousal Protected Resources has an unused balance in an amount equal to or more than the new resource. If not, and the excess of resources is over the resource limit, terminate Medicaid coverage allowing the appropriate adverse action time. If the balance of the Spousal Protected Resources is enough to cover the new resource, apply the transfer provisions as outlined in Part "c,5" of this section.

EXAMPLE #1: LIQUID RESOURCES

The community Spousal Protected Resources was determined to be $12,000. After approval, the community spouse transferred $8,600 of resources to his/her name only. This leaves a balance of $3,400 in Spousal Protected Resources. Later, the institutionalized spouse receives a retroactive VA benefit check in the amount of $13,000; $10,000 remains the month after receipt and must be considered a countable resource. Since the balance of the Spousal Protected Resources is $3,400, this is the maximum that be protected. The difference of $6,600 ($10,000 – $3,400) remains a countable resource to the institutionalized spouse and renders him/her ineligible for Medicaid.

EXAMPLE #2: NON–LIQUID RESOURCES

The institutionalized and community spouse receive an inheritance of vacant land valued at $5,000. One–half is considered available to each spouse ($2,500). The Spousal Protected Resources was computed to be $12,000. Of this $12,000, the community spouse used $6,000 to transfer resources in his/her name after approval. Therefore, the community spouse has a $6,000 balance in resource protection.

One–half of the vacant land ($2,500) must be considered available to the community spouse. Since there is a balance of $6,000 in protected resources, the institutionalized spouse remains resource eligible by protecting his/her share of the vacant land. His/her share of the vacant land ($2,500) must now be transferred to the community spouse. In this example, the new balance of the Spousal Protected Resources would then be $3,500.

3. TRANSFER OF ASSETS (Refer to Section 240)

4. TREATMENT OF TRUSTS (Refer to Section 250)

5. RESOURCE EXEMPTIONS

One vehicle must be excluded without regard to use or value.

An individual who has received benefits under a Qualified Long-term Care Partnership insurance policy is eligible for a resource disregard equal to the amount of insurance benefits paid to or on behalf of the individual at the time of Medicaid application. The resource disregard is allowed, even if additional benefits remain available under the terms of the policy.

Only Qualified Long-term Care Partnership policies purchased after January 1, 2007 will meet the resource exemption rules. Beneficiaries must provide a certificate indicating the amount of benefits issued and certifying the policy as a Qualified Partnership Policy. The state will not seek adjustment or recovery from the individual's estate for the amount of assets or resources disregarded.

NOTE: LTC resource exclusion does apply to home equity in excess of $506,000.

6. RESOURCE LIMITS

The value of all countable resources of the client cannot be more than $2,000. When the resource limit is exceeded, the case is ineligible. Individuals with home equity interest exceeding $506,000 are ineligible for long-term care services.

N. PATIENT LIABILITY

Patient liability is a post eligibility calculation to determine the total amount of the institutionalized individual's income that must be applied to the cost of institutional care. There is no patient liability for any portion of institutionalization (full or partial month stays) in a VA hospital, AGCF, FCH, freestanding psychiatric hospital or RTC.

There are six freestanding psychiatric hospitals in Nevada, they are:

- Charter Hospital
- Desert Willow Treatment Center
- Montevista Hospital
- Nevada Mental Health Institute (NMHI)
- Southern Nevada Adult Mental Health (SNAMH)
- West Hills Hospital

If the community spouse dies prior to an eligibility decision, spousal impoverishment rules to not apply. Treat the case as a non-spousal case and apply patient liability rules accordingly for all requested months of coverage.

If the institutional spouse dies prior to an eligibility decision, spousal impoverishment rules do apply. Treat the case as a spousal case from the date of application through the date of death of the institutional spouse.

1. TREATMENT OF INCOME, DEDUCTIONS AND EXPENSES

When determining patient liability for initial and ongoing cases, budget income for the month it is received and deductions/expenses for the month in which they are paid/incurred.

When unanticipated income is received, patient liability will be adjusted for the month in which it was received not to exceed the actual cost of care for the month.

The division of income policy DOES NOT APPLY when determining patient liability. All income which the payor designates as the institutionalized spouse's will be considered when determining patient liability unless it can be excluded.

If the payor designates payment to both the institutionalized and community spouse, one-half of the income shall be considered available to each of them.

If the payor designated payment in the names of the institutionalized and community spouse, or both, and to another person(s), the income shall be considered available to each person in proportion to the person's interest. If payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse.

If the client has a court order granting spousal maintenance allowance, a copy of the order must be sent to the Chief of Eligibility and Payments for a decision on whether the Division of Welfare and Supportive Services (DWSS) can recognize the order. The response from the Chief takes precedence.

Regular unearned income deposited directly into a financial institution is considered received in the month for which it is intended to be received.

2. PARTIAL MONTH PRORATION

The amount of patient liability is prorated according to the number of days the client was in a facility when the person is institutionalized less than a full calendar month due to:

a. Month of admission.

b. Discharge to independent living, VA hospital, AGCF, FCH, freestanding psychiatric hospital or RTC.

c. Partial month of eligibility due to transfer of asset penalty.

d. Death.

Determine what the patient liability would be for a full month. Divide that full month amount by the number of days in the month of partial institutionalization to determine the daily amount of patient liability. Multiply this daily amount by the number of days the client was institutionalized in that month (include the day of admission but not the day of discharge/death). The result is the amount of patient liability due for the partially institutionalized month.

3. EFFECTIVE DATE OF PATIENT LIABILITY

a. State Institutional

Patient liability is effective the first month of eligibility (this includes requested months prior to the application month).

b. State Institutional/QMB

Hospital Stay: Establish patient liability effective the first day of institutionalization and send the appropriate notice(s). The Fiscal Intermediary will make the decision when patient liability will be collected and will advise the facility when they can begin collecting it.

c. Transfers

The discharging facility collects patient liability for charges incurred. The admitting facility collects the balance if any is due.

d. Income Changes (ongoing cases)

Adjust patient liability beginning with the month after the change is known to the agency. Retroactive adjustments to patient liability will only be made when a change in income and/or deductions results in an adjustment of $25.00 or more.

e. Deceased clients

The facility is notified of the patient liability amount due for the month of death. The facility will collect only for charges actually incurred. Any unused patient liability will be deposited in the Patient Trust Fund Account.

4. NOTIFICATION OF PATIENT LIABILITY/CASE STATUS

When a case is approved or patient liability changes, the client, facility and Fiscal Intermediary are notified on a Notice of Decision of the amount and effective date.

When the client moves from one facility to another, notify the facilities of the current case status and MONTHLY patient liability when this information has not already been provided them in or for that month.

5. BUDGETING PROCEDURES – FORM 2220–EM/A

a. Determine the client's TOTAL gross countable monthly income.
1) Subtract income excluded in Patient Liability

b. Subtract the following items from TOTAL MONTHLY INCOME in the following order:

1) Personal Needs Allowance
a) Deduct a $35 Personal Needs Allowance (PNA) for each month of institutionalization.
b) Additional personal needs – Institutionalized individuals with **no** community spouse living in the home but with other dependent family members in the home are allowed an additional personal needs allowance based on household size. The additional personal needs amount is determined by subtracting the 1996 needs standard of $459 from the current TANF need standard for the household size. **NOTE**: this requires a NOMADS work around.

2) Community Spouse Monthly Income Allowance
Income allocated to the community spouse for maintenance. This amount (if any) is determined by subtracting the community spouse's income which is considered available (including need based assistance like TANF, SSI, etc.) from the Monthly Maintenance Allowance.
DO NOT count VA UME as income considered available to the community spouse.
Clients do not have to request the maintenance allowance for their spouse/dependents. The case manager will automatically request the information necessary to determine the maintenance allowance when there is a spouse or dependents at home.

a) Definitions

(1) Monthly Maintenance Needs Allowance
An amount designated by a court order or together the Federal minimum Maintenance Need Standard (150% of poverty for 2 persons) and an excess shelter allowance. This amount cannot exceed the Federal Maximum Maintenance Needs Standard except when authorized by findings of an Administrative Review/ Hearing.

(2) Housing Costs (principal place of residence)

The community spouse's expenses for rent or mortgage payment (including principal and interest), property taxes and mortgage/rental insurance. In situations where a maintenance charge is required, allow only that portion which does not include personal or individual utility expenses.

(3) Standard Utility Allowance (SUA)

An amount established under SNAP which is the statewide average of total monthly utility costs.

Do not allow SUA if utilities are included with the rent and cannot be separately identified.

If the telephone service is the only utility, allow the telephone allowance instead of the full SUA.

(4) Excess Shelter Allowance

An amount (if any) determined by subtracting the Federal Excess Shelter Deduction (30% of 150% poverty for two persons) from the community spouse's housing costs plus the SUA.

Verification of the community spouse's gross income and housing costs must be obtained. If income verifications are not returned by the required date, the case will be completed without allowing a maintenance allowance. If verification of housing costs and/or utility expense is not provided, compute the spousal income allowance without it.

The client will be notified on the Notice of Decision, the patient liability was determined without a Maintenance Allowance Deduction. If, however, the verifications are received after the required date, the maintenance allowance deduction will be allowed beginning the month the verification was received.

The Community Spouse Monthly Income Allowance deduction will be discontinued if information is received the spouse is not receiving the Maintenance Allowance.

3) Family Allowance (Spousal Impoverishment)

Family members must be a dependent child, dependent parent(s) or dependent sibling(s). The child, parent or sibling must be residing in the home of the community spouse AND claimed by the community spouse or institutionalized spouse as dependents for Federal Income Tax purposes.

The amount determined to be the Family Allowance is deducted from the institutionalized spouse's countable income effective with the first month in which the continuous period of institutionalization is met OR if this deduction was not previously allowed the deduction will be allowed effective the first month following the month in which the change is reported.

The Family Allowance deduction need not be determined IF the $35 personal needs allowance in combination with the Community Spouse Monthly Income Allowance zero's out the patient liability.

Verification of each family member's gross income must be obtained.

(a) Subtract the family member's gross income from Minimum Needs Allowance (150% of poverty).
(b) Divide the amount from (1) above by three. This is <u>one</u> family member's allowance.

Repeat this calculation for each family member. If there is only one family member, the amount from 2) will be the Family Allowance deduction. If there is more than one family member, add each family member's allowance to determine the Family Allowance Deduction.

4) Dependent Allowance (Non-Spousal Impoverishment)

A monthly income allowance for each dependent family member living in the institutionalized individual’s home with **no** community spouse living in the home. Calculated by subtracting the dependents total income from the need standard (100% Need Standard) for the household size.

5) Expenses Incurred For Health Insurance Premiums, Deductibles and Co–Insurance Charges

Deduct Health Insurance Premiums, Deductibles and Co–insurance expenses incurred by the client. Clients/ Representatives must advise the agency of medical insurance and provide proof of expenses. These expenses must not be paid or subject to payment by a third party.

Medicare premiums are subject to payment by a third party.

Any institutional case where the client is not a SSI recipient and will not receive a reimbursement for Medicare cost from any source, may have the Medicare premium deducted as an expense for months immediately preceding the second month after the month of approval.

EXAMPLE #1 (Medicaid Only): Client applied June 2nd and requests 3 months prior medical. Case is approved July 10th. Medicare premiums may be deducted from March through August. Beginning September, we cannot deduct the Medicare premium as it is then subject to third–party payments.

EXAMPLE #2 (Medicaid/QMB): Client applied for Medicaid/QMB on June 2nd and requests 3 months prior medical. In June, QMB eligibility is established and benefits begin effective July 1st. Then Medicaid eligibility is established July 20th back to March. Medicare premiums may be deducted for March, April, May and June only. Effective July and ongoing, the premiums are subject to third–party payments as QMB coverage began in July.

6) Expenses Incurred For Medical Care

Deduct expenses incurred by the client for necessary medical care recognized under the State law but not covered under the Medicaid Program. This includes medical expenses incurred more than three months prior to the date of application. Client/Representatives must advise the agency and submit proof of the expenses. The case manager will attach a copy of the medical bill plus all related medical records to Form 2536 and submit to the NMO for approval. These expenses must not be paid or subject to payment by a third party. An NMO approval is required to assure the deduction is for necessary care payable to reasonable limits.

The case manager will attach a copy of the medical bill plus all related medical records to Form 2536 and submit to the NMO for approval. These expenses must not be paid or subject to payment by a third party. An NMO approval is required to assure the deduction is for necessary care payable to reasonable limits.

c. The deficit, if any, is the client's share of facility cost (PATIENT LIABILITY).

O. REVIEW OF ELIGIBILITY

A revise of eligibility is required at least every 12 months. Use Review of Eligibility, Form 2426 or MAABD Only Redetermination, Form 2930-EM. Information received between redeterminations which may affect eligibility must be evaluated and acted on when applicable. A review of eligibility must be completed no later than the month it is due except when future actions are necessary. Clients are the primary source of information regarding their eligibility. If a client is unable to obtain information, the case manager will assist. Office interviews and home visits are optional and can be done at the discretion of the unit supervisor, or office manager.

The Review of Eligibility, Form 2426, informs the client about their choices concerning an authorized representative (A/R). If any change in the A/R is indicated, send the client Form 2525-EE to complete and return. If the A/R area is blank, assume there is **NO** change in the status of the A/R for the client.

Form 2426 requests recipients to identify any changes in household circumstances. If there are no changes in circumstances, no further verifications will be required. If changes are reported, send the client a 2429 requesting verification of the changes only. Verification used to re-establish Medicaid eligibility must be current (within the last 45 days).

NEVADA MEDICAID RESIDENTIAL TREATMENT CENTER (RTC) SERVICE PROVIDERS

Benchmark Hospital
592 West 1350 South
Woods Cross, Utah 84087
(801) 299-5300

Brown Schools, Inc.-Cedar Springs Ctr
2135 Southgate Road
Colorado Springs, Colorado 80986
(719) 633-4114

Brown Schools, Inc.-Laurel Ridge Trtmt Ctr
17720 Corporate Woods Drive
San Antonio, Texas 78259-3509
(210) 491-3517

Brown Schools, Inc.-San Marcos Trtmt Ctr
120 Bert Brown Road
San Marcos, Texas 78666
(512) 396-8500

Brown Schools, Inc.-The Oaks Trtmt Ctr
1407 Stassney Lane
Austin, Texas 78745
(512) 464-0200

Cathedral Home for Children
4989 North 3rd Street
Laramie, Wyoming 82072-9548
(307) 745-8997

Devereoux Cleo Wallace Center
8405 Church Ranch Boulevard
Westminister, Colorado 80021
(303) 466-7391

Copper Hills Treatment Center
5899 West Rivendell Drive
West Jordan, Utah 84088
(801) 561-3377

Desert Willow Treatment Center (DCFS)
6171 West Charleston Boulevard, Bldg 17
Las Vegas, Nevada 89146
(702) 486-6100

Primary Childrens RTC
497 South Colorow Way
Salt Lake City, Utah 84108
(801) 588-4980

UHS of Provo Canyon
1350 East 750 North
Orem, Utah 84097
(801) 227-2100

Spring Mountain Treatment Center
7000 West Spring Mountain Road
Las Vegas, Nevada 89117
(702) 873-2400

Vista Care RTC
4120 East Ramsey Road
Hereford, Arizona 85615
(520) 378-6466

Willow Springs Center
P.O. Box 30012
Reno, Nevada 89520
(702) 323-0478

NEVADA MEDICAID PSYCHIATRIC HOSPITAL SERVICE PROVIDERS

Charter Hospital
7000 West Spring Mountain Road
Las Vegas, Nevada 89117
(702) 876-4356

Desert Willow Treatment Center (RTC)
6171 West Charleston Boulevard
Las Vegas, Nevada 89146
(702) 486-8900

Montevista Hospital
5900 West Rochelle Avenue
Las Vegas, Nevada 89103
(702) 364-1111

Nevada Mental Health Institute
480 Galletti Way
Sparks, Nevada 89431
(702) 688-2001

Southern NV Adult Mental Health
6161 West Charleston Boulevard
Las Vegas, Nevada 89102
(702) 486-6000

West Hills Hospital
1240 East Ninth Street
Reno, Nevada 89520
(702) 323-0478

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SECTION 360
HOME AND COMMUNITY BASED SERVICES

360 HOME AND COMMUNITY BASED SERVICES

A. OVERVIEW

This category of eligibility allows Medicaid to be given to aged, blind or disabled individuals who require a level of care provided in a medical facility but who can appropriately be cared for at home or in a community setting for less cost.

1. ELIGIBLE GROUPS

Eligibility under each waiver is determined in combination with the agency administering the waiver.

a. Aged Individuals - Living in the Community

Waiver for the Frail Elderly (aka Community Home Based Initiatives Program (CHIP)

1) Administration – Aging and Disability Services Division.
2) Aid Code – HC

b. Aged Individuals – Living in an Adult Group Care Facility

Waiver for Elderly Adult in Residential Care (WEARC)

1) Administration – Aging and Disability Services Division.
2) Aid Code – HG

c. Aged Individuals – Living in Assisted Living Facility

Assisted Living Waiver

1) Administration – Aging and Disability Services Division.
2) Aid Code – AL
3) Eligibility for this waiver is limited to Clark County.

d. Blind/Disabled Individuals

Waiver for Persons with Physical Disabilities (aka Waiver for Independent Nevadans (WIN)

1) Administration – Division of Health Care Financing and Policy district offices.
2) Aid Code – HD

e. Persons With Mental Retardation

Waiver for Persons with Mental Retardation and Related Conditions.

1) Administration – Mental Health and Development Services.
2) Aid Code – HR

2. IDENTIFICATION OF APPLICANTS/RECIPIENTS WHO MAY BE ELIGIBLE

Individuals eligible for this category of assistance will be identified in the following ways.

a. Individuals referred to the administering division will be pre-screened for nursing home level of care. The screening is completed by the administering division staff.
b. Medicaid applications or inquiries which do not appear eligible in any other category and have indicated a need for home based services, will be referred by the case manager to the appropriate division for pre-screening.

B. ELIGIBILITY REQUIREMENTS

1. Individuals applying under this category must meet each of the following:

CHIP Waiver – Aged Individuals – Living in the Community

a. Be age 65 or over;
b. Be living at home;
c. Require a level of care provided in a nursing facility (determined by NMO or ADSD);
d. Have medical costs for home care, which are less than if the client were institutionalized, (determined by ADSD),
e. Be approved, eligible for and receiving Home Based Services (determined by NMO); and
f. Meet all financial and non-financial eligibility criteria of an institutional case except for residing in an institution.

WEARC Waiver – Aged Individuals – Living in an Adult Group Care Facility

a. Be age 65 or over;
b. Currently residing in a hospital, nursing facility, the community at large, or receiving waiver services in their home;
c. Meet all of the income and resource eligibility criteria of an institutional case except they reside in a group home rather than an acute care or skilled nursing facility;

d. Require a level of care provided in a nursing facility (determined by NMO or ADSD);
e. Demonstrate he/she would be safe in a group care environment (determined by ADSD).

AL Waiver – Aged Individuals – Living in Assisted Living Facility – Clark County only

a. Be age 65 or over;
b. Meet the criteria for placement in an Assisted Living Facility;
c. Meet all of the income and resource eligibility criteria of an institutional case except they reside in an assisted living facility;
d. Require a level of care provided in a nursing facility (determined by NMO or Aging Services); and
e. Demonstrate he/she would be safe in an assisted living environment.

WIN Waiver – Blind/Disabled Individuals

a. Be living at home;
b. Meet blindness/physical disability criteria;
Blindness/disability criteria are the same as the Social Security Administration's.

If the client is currently receiving disability benefits through SSA, use disability onset date as verification of disability.

If the client is not receiving Social Security Disability or if the client is pending a disability decision through SSA, the DHCFP case manager will initiate Form NMO-3004 and send with medical records to the NMO waiver team. NMO will determine if the applicant meets the criteria for the physically disabled. Division of Welfare and Supportive Services case manager will receive the original NMO-3004 form and a copy of Form NMO-2734 approving or denying waiver admission.
c. Require a level of care provided in a nursing facility (determined by Medicaid District Office staff);
d. Be approved, eligible for and receiving Home Based Services (determined by NMO); and
e. Meet all eligibility criteria of an institutional case except for residing in an institution

MR Waiver - Persons with Mental Retardation

a. Be diagnosed as having mental retardation, or related condition or evaluated and certified to need placement in an intermediate care facility for the mentally retarded (ICF-MR) within 30 to 60 days if Waiver Services were not available (determination made by MHDS);
b. Be living at home, in a foster home, group care home OR a Supported Living Arrangement (SLA) which is overseen by MHDS; AND

c. Meet all eligibility criteria of an institutional case except for residing in an institution.

2. ELIGIBILITY DETERMINATION PROCESS

Two separate eligibility determinations must be made on these cases:

Administering division – The administering division will have the individual complete an application packet and send with the NMO-2734 to the Division of Welfare and Supportive Services and DHCFP central office waiver team when the applicant/recipient is pending approval for waiver admission to their program. Responsible for completing an assessment to determine if the recipient meets the need for an appropriate level of care.

DWSS – Responsible for determining if applicant meets all financial and non-financial Medicaid eligibility criteria.

DHCFP Central Office - The DHCFP waiver team will review the application/packet with the NMO-2734 and approve or deny waiver admission, notifying the administering division and the Division of Welfare and Supportive Services by sending Form NMO-2734.

Medicaid cannot be approved/continued under this category unless the client is found eligible in both areas.

To make the Medicaid eligibility determination, the following steps must then be taken:

a. If the applicant is not eligible for Medicaid, the case manager will deny the case. A copy of the Notice of Decision with Form NMO-2734 will be sent to the administering division and DHCFP central office notifying them of the denial.

b. If the Home Based Services are denied, the administering division will send the denial information via the NMO-2734. The Medicaid application will then be denied if the applicant does not qualify for another

c. If the waiver team denies waiver admission, the Medicaid application will be denied for the reason given on the 2734, unless the applicant qualifies for another category of eligibility.

d. If the administering division determines the individual meets the criteria for the home based services, they must request waiver admission from the DHCFP waiver unit in DHCFP central office. The waiver unit will send NMO-2734 to the DWSS and the administering division case managers with the decision.

e. If waiver admission is approved, the DHCFP waiver unit completes the NMO-2734 and sends it to the DWSS and the administering division case managers. The DWSS case manager will approve Medicaid eligibility and apply the appropriate Aid Code, using the effective date provided on the 2734 if all other eligibility criteria are met.
DWSS case worker will send NMO-2734 verifying approval back to the administering division and notify DHCFP waiver unit in central office via email within two (2) days of approval.
If the application was previously denied for non-cooperation and later reapplies and/or cooperates with verifications, contact the administering agency prior to approval to determine the waiver slot is still available.

f. If the NMO-2734 indicates the individual is eligible but on a waiting list, and the individual meets financial eligibility, the case will remain pending up to the 45 day processing timeframe. Contact the administering division case manager at 45 days to determine if the waiver slot has become available. If no slot is available deny eligibility.

g. The DHCFP waiver unit will enter the individual's benefit plan into the MMIS database when email notification of approval is received. The plan will start on the date listed on the NMO-2734 or the date Medicaid eligibility is established, whichever date is later.

h. The waiver benefit will remain in MMIS until/unless the DHCFP waiver team in DHCFP central office is notified by the case manager to terminate the benefit, or until the individual loses Medicaid eligibility. DWSS case manager should notify DHCFP waiver unit of all waiver approval, termination and reinstatements via email within two (2) business days.

i. If a case terminates and is subsequently reinstated prior to the end of the month (effective date of closure), the client's *approved* waiver admission will continue in MMIS.

j. If a case is reinstated after the end of the month, email the DHCFP waiver team, who will determine the status of the prior approved waiver. If the waiver team finds the waiver admission open, an NMO-2734 will be sent and Medicaid eligibility will be reinstated, and the prior approved waiver continues. If the waiver team finds the prior approved waiver admission ended, the individual must complete and submit another application packet with an NMO-2734 through the administering division case manager to the waiver team for waiver admission.

k. Copies of all notices, such as approvals, denials, and P/L, which are usually sent to the institution, will be sent to the administering division by entering them as the secondary representative in the Authorized Representative screen.

NOTE: If the applicant falls into another eligible category, such as SSI, QMB or SLMB, approve the case under that category and do not wait for the Home Based Services decision. Notify the administering division the case has been approved under another category of Medicaid. If it appears the person may be eligible for SSI, refer them to apply, but do not hold the case if they can be approved sooner under this category.

C. TIME FRAMES

An eligibility decision must be made within forty-five days from the Medicaid application date for the aged and 90 days for the blind and disabled, unless extenuating circumstances exist.

D. SOCIAL SECURITY NUMBER (SSN)

Social Security numbers must be provided by every applicant and recipient. See manual section 204.

E. IDENTIFICATION

All applicants for Medicaid must be identified.

F. NEVADA RESIDENCY

1. NON-INSTITUTIONAL PERSONS (INCLUDES SSI RECIPIENTS NOT RECEIVING SSP)

Clients must be living in Nevada with the intention of making Nevada their home permanently or for an indefinite period (no expected end date) OR must be living in Nevada with a job commitment or seeking employment. Clients do not have to have a fixed place of residence to meet this requirement.

The ability to indicate intent to reside in Nevada is not to be taken lightly or stand by itself. A statement or indication of intent to reside in Nevada must be supported by additional verification or collateral material to substantiate the intent if residency is questionable. Manual section 205, D, 5 is not all inclusive. See manual section 205, D for more detail.

Nevada residency continues when client is temporarily absent IF he/she intends to return to Nevada when the purpose of the absence has been accomplished. Document in the case file the temporary absence situation and obtain the client/representative's statement concerning the intent of residency and the purpose of the absence.

2. SSI RECIPIENTS RECEIVING A STATE SUPPLEMENTARY PAYMENT (SSP) FROM ANOTHER STATE

State Supplementary Payments are funds paid in addition to the Federal SSI payment. SSP entitlement and amounts differ from state to state.

When the client is receiving SSI/SSP through another state, the state paying the State Supplementary Payment is the state of residence UNLESS SSA acknowledges Nevada residency. In this instance only, use SSA's effective date of residency.

3. SSI RECIPIENTS NOT RECEIVING A STATE SUPPLEMENT FROM ANOTHER STATE

If a client is receiving SSI from another state but that state is not paying a supplementary payment (SSP) establish residency per "1" above.

G. CITIZENSHIP

To qualify for assistance, applicants must be a U.S. Citizen or a non-citizen in an eligible category. See manual section 206 for citizenship requirements.

H. PRIOR MEDICAL

Clients may apply for prior medical coverage for up to 3 months prior to the month of Medicaid application.

1. Prior Medicaid coverage must be requested; AND

2. There must be evidence that medical care or services were provided in the month(s) for which Medicaid is requested.

When clients request prior medical, first determine if they are eligible for prior medical as an SSI recipient or State Institutional case.

If they are not eligible in either of those categories determine if they would have been eligible for SSI had SSA made a determination. See "Prior Medical Determinations Only - Would Have Been Eligible For SSI."

Do not make an independent SSI determination IF there is a pending SSI application covering the month(s) Medicaid is requested. Wait for the SSI decision.

Use SSI/SSA's disability decision (the disability on-set date) for any months of requested prior medical assistance. All other factors of eligibility, e.g., residency, citizenship, income, resources, etc., must be evaluated.

I. THIRD PARTY LIABILITY (TPL)

Medicaid is always payer of last resort whenever any other resources may be responsible for payment.

When insurance coverage is available at no cost to the client (e.g., through employment or Campus), request the client to enroll. See manual section 208 regarding Medicare.

Notify the fiscal intermediary of third party liability and any changes to such by recording all known information on the NOMADS MINS and MEDI screens.

J. RESERVED

This program is no longer available.

K. CHILD SUPPORT ENFORCEMENT (CSE)

All dependent children (including automatic Medicaid eligible newborns) who have absent parent(s) require referrals to CSE for support enforcement services. Support Enforcement services include establishing paternity, securing child support and medical support. See manual section 209.

L. INCOME

Income means the receipt of money in the month for which an eligibility determination is being made. All income or changes in income must be reported. All income must be evaluated for financial eligibility.

1. OWNERSHIP/AVAILABILITY

a. Sole Ownership

All income, which a payer designates as the client's, will be considered in determining eligibility.

When a benefit or income is received for more than one person or family member, only the client's portion of the income is considered.

b. Shared Ownership

1) Deeming: Does not apply.

2) Dividing:

If it is in the applicant's best interests for financial eligibility, the case manager will divide the total income of spouses who are living separate and apart (due to institutional status of Waiver program) equally between them. Only the applicant's share of the income will be considered when determining eligibility. However, if a portion of the spouse's income is made available to the applicant, that portion is counted as income to the client in determining eligibility.

Married persons are considered to be living separate and apart when both spouses are residing in a medical facility and when qualifying under the Home and Community Based Waiver category.

Dividing income takes precedence over the joint bank account procedures in manual section 220. Therefore, income deposited in a joint bank account held by both spouses will NOT be considered "being made available."

3) Court Orders:

If the client has a court order designating spousal income and/or client income trust document, a copy of the court order and/or trust must be sent to the Chief of Eligibility and Payments for a decision on whether the Division of Welfare and Supportive Services can recognize the court order or trust.

4) Exceptions:

Monies received by the client in his/her capacity as an agent are not income to him/her. An "agent" is a person acting on behalf of some, i.e., representative payee, guardian, conservator, etc.

2. TREATMENT OF INCOME

When determining financial eligibility, budget income for the month it is received.

Regular unearned income deposited directly into a financial institution is considered received in the month for which it is intended to be received.

Effective July 1, 2005 individuals with a Miller Trust (QIT) are not eligible for HCBW services because a QIT requires all income be applied for certain SSI allowable expenditures including patient liability. Because a HCBW individual is not assessed a patient liability, the individual would not be able to spend the income deposited in the QIT account each month.

Funds would accumulate in the QIT account and a Transfer of Assets would apply since such HCBW individuals would be ineligible for Home Based Waiver Services due to a transfer of assets. (See MAABD 240(G) (3).

When a one-time lump sum payment is received, evaluate as a resource in future months.

a. Intake Cases

Individually determine financial eligibility for each month of requested coverage.

b. Ongoing Cases

Financial eligibility is always determined prospectively (future month). When information becomes known which causes ineligibility prospectively terminate benefits allowing adverse action.

3. INCOME LIMITS

See MAABD income chart in Appendix C.

4. BUDGETING PROCEDURES FOR FINANCIAL ELIGIBILITY-FORM 2203-EM

a. Gross Countable Income Test

1) Enter the countable amount of all unearned income.
2) Enter the gross earned income.
3) Determine TOTAL GROSS COUNTABLE INCOME by adding items I-A and I-B.
4) Compare the total gross countable income to the income limit.

If gross countable income is less than or equal to the income limit, the client is eligible under the Home and Community Based Waiver category.

If gross countable income exceeds the income limit, the client is not eligible under the Home and Community Based Waiver category.

If gross countable income exceeds the income limit and the client is married, apply the equal division of income rules. If one-half of countable gross marital income exceeds the income limit, the client is ineligible for Medicaid.

M. RESOURCES

Resources are defined as those assets, both real and personal, which an individual owns and can apply, either directly or by sale, to meet basic needs of food, clothing, shelter and medical costs.

Real property is land, including buildings or immovable objects attached permanently to the land.

Personal property is any property that is not real property. The term encompasses, but is not limited to, such things as cash, tools, life insurance policies, mobile home, automobiles, etc.

Any income, which is retained the month following the month of receipt and later, is subject to resource evaluation.

Resources are evaluated at market value less encumbrances. When the combined value of all countable resources does not exceed the resource limit, verification of encumbrances is not necessary.

When the value of countable resources is under the resource limit on any day of the month, the client is eligible for that month.

All resources must be reported.

1. OWNERSHIP/AVAILABILITY

a. Sole Ownership

Sole ownership of real or personal property means only one person may sell, transfer or otherwise dispose of the property. All of the resource evaluated at market value less encumbrances is available to the client.

b. Shared Ownership

Shared ownership of real or personal property means two or more people own it simultaneously. The following are common types of shared ownership:

1) Tenancy-In-Common

Two or more persons each have an undivided fractional interest in the whole property for the duration of the tenancy. These interests are not necessarily equal. One owner may sell, transfer or otherwise dispose of his/her share of the property without permission of the other owner(s); but cannot take these actions with the entire property. If a tenant-in-common dies, the deceased's interest passes to his/her estate or heirs. Count the fair market value less encumbrances of the client's property share.

2) Joint Tenancy

Each of two or more persons has one and the same undivided ownership interest and possession of the whole property for the duration of the tenancy. This means each owner owns ALL the property. If a joint tenant dies, the survivor becomes the sole owner. If more than one joint tenant survives, the survivors become joint tenants of the entire property interest. Count the total fair market value less encumbrances of the entire property.

3) Tenancy by the Entirety (Married Couples only)

This type of ownership can only exist between married couples. The wife and husband as a unit own the entire property and can be sold only with the consent of both parties. However, if a legal divorce occurs, the former spouses become tenants-in-common and one can sell his/her share without the consent of the other. If one spouse dies, the survivor becomes the sole owner. Verify whether the client's spouse will give permission to sell the property. If permission cannot be obtained, DO NOT count the client's one-half share of the property.

4) Exceptions

When a resource is owned jointly by more than one TANF/Medicaid applicant/recipient (other than a community spouse), divide the resource equally among those applicants/ recipients to whom available.

When a client is representative payee or legal guardian managing someone else's funds, these funds are not considered the client's resource when they are kept in an account separate and apart from the client's monies AND can be identified as being received and designated for someone other than the client.

c. Treatment of Resources

1) Deeming: Does not apply.

2) Dividing:

If a married person is living separate and apart from his/her spouse and they enter into written agreement dividing the total resources of both spouses equally between them, only the portion the agreement specifies as the clients is counted in determining eligibility.

The agreement is effective the month it is signed as long as the spouses were living separate and apart at least part of the month. An agreement cannot be effective for months prior to the date the arrangement was signed.

Married persons are considered to be living separate and apart when both spouses qualify under the Home Based Waiver category.

The written agreement must include the following:

a) A specific listing of all resources being divided.

b) A statement specifying which resources are being given to whom. EXAMPLE: A couple has resources totaling $2,000. These resources consist of $1,000 cash in savings, $500 in a CD and $500 in stocks. The agreement must specify exactly which resources the agreement is designating as the client's and which are the spouse's. They cannot simply state $1,000 of the total resources belong to the client and $1,000 belong to the spouse.

In this example, an acceptable written agreement would:

- designate to the client $500 of the savings account and the $500 CD.
- designate to the spouse $500 of the savings account and $500 in stocks.

Do not require couples to liquidate resources when considering an equal division, as long as the written agreement specifically designates which resources or a portion of resources belongs to the client and spouse.

c) The signature of the client and the client's spouse or the signature of a legal representative of the client and the client's spouse. A legal representative is defined as a person who has legal authority such as a legal guardian, power of attorney, etc. Being an authorized representative does not give that person legal authority.

If the spouse of the client makes a portion of his/her resources available to the client, that portion is counted as a resource to the client.

3) Court Order

When a court order **equally** divides resources between spouses, only the portion the court order specifies as the client's is counted when determining eligibility, UNLESS, the spouse makes a portion of his/her resources available to the client. The portion made available to the client is counted as a resource in determining eligibility.

If the client has a court order dividing resources **unequally** a copy of the court order must be sent to the Chief of Eligibility & Payments for a decision on whether the Division of Welfare and Supportive Services can recognize the court order.

4) Inaccessible Resources

The cash values of resources, which are not legally available to the household, are exempt. If the Medicaid applicant/recipient or authorized representative is able to verify a resource is unavailable due to the client's inability to access the resource due to incapacity and no one else has the ability to access the resource on their behalf, exempt

the value of the resource as long as reasonable and timely steps is being taken to access the account on the client's behalf, (i.e., referral to the public guardian's office). Once the resource becomes accessible, the resource becomes countable and eligibility must be reevaluated for future months.

2. RESOURCE PROVISIONS FOR SPOUSAL IMPOVERISHMENT CASES

This section applies to ALL persons who are likely to begin a "continuous period of services" under a Home Based Waiver on or after September 30, 1989 and who have a spouse in an independent living situation (e.g., the spouse is not receiving Home Based Waiver services or is not residing in a nursing facility).

If the community spouse dies prior to an eligibility decision, spousal impoverishment rules do not apply. Treat the case as a non-spousal case and apply the treatment of resource rules accordingly for all requested months of coverage.

If the institutional spouse dies prior to an eligibility decision, **spousal impoverishment rules do apply. Treat the case as a spousal case from the date of application through the date of death of the institutional spouse.**

a. Definitions

1) Institutionalized Spouse - a married person residing in a medical facility at least 30 consecutive days **(includes a home based waiver client)** who has a spouse in an independent living situation.

2) Community Spouse - a married person who is not in a medical facility nor receiving Home Based Waiver services whose spouse has been residing in a medical facility or receiving Home Based Waiver services at least 30 consecutive days.

3) Medical Facility - a facility for skilled nursing or intermediate care or a hospital.

4) Spousal Share – an amount equal to one-half of the total resources (separately and jointly held) at the time of the client's institutionalization/application for Home Based Waiver services.

5) Community Spouse Resource Allowance – an amount of resources allocated to the community spouse for his/her maintenance.

6) Continuous Period of Institutionalization – institutionalized for 30 days or determined to meet the level of care for Home Based services.

7) Designation of Resources through a Court Order – resources and/or portions of resources ordered to the community spouse by a court of competent jurisdiction.

8) Liquid resources are cash and other items which can reasonably be converted to cash within 20 workdays.

Non-liquid resources are items which are not cash and cannot be converted to cash within 20 workdays.

b. Ownership/Availability

1) Sole Ownership
All of the resource evaluated at market value less encumbrances is available to the applicant/ recipient or community spouse.

2) Shared Ownership

a) Resources Jointly Owned Between Spouses

(1) Liquid Resources (bank accounts, certificates of deposit, stocks, bonds, etc.). All liquid resources held jointly between spouses are considered available in their entirety to the institutionalized/home based waiver client only. They are not considered an "available resource" to the community spouse when determining the Community Spouse Resource Allowance.

(2) Non-liquid Resources (real property, vehicles, etc.)

When non-liquid resources are held jointly between spouses, consider only one-half as available to each spouse when determining the Community Spouse Resource Allowance.

b) Resources Jointly Held With Someone Other Than A Spouse

(1) When the client or community spouse is able to sell or dispose of a resource without another person's signature of approval, all of the resource is evaluated at market value less encumbrances and considered available to the client or community spouse.

(2) When the client or community spouse is able to sell or dispose of his/her share of a resource without another person's signature of approval, that portion evaluated at market value less encumbrances is available to the client or community spouse.

3) Exceptions

When a resource is owned jointly by more than one TANF/Medicaid applicant/recipient (other than a community spouse), divide the resource equally among those applicants/recipients to whom available.

When a client is representative payee or legal guardian managing someone else's funds, these funds are not considered the client's resource when they are kept in an account separate and apart from the client's monies AND can be identified as being received and designated for someone other than the client.

If the client has a court order dividing resources, a copy of the order must be sent to the Chief of Eligibility and Payments for a decision on whether the Division of Welfare and Supportive Services can recognize the order.

c. Resource Determination

1) Spousal Impoverishment/Resource Determination – An assessment of a couples total resources completed at **The Time of Institutionalization/Application for Home Based Waiver Services.**

This determination is only completed <u>once</u> at the beginning of the <u>first</u> application for Home Based Waiver services (beginning on or after 9/30/89).

The Home Based Waiver client, community spouse or their representatives may submit a written and signed request to the Division of Welfare and Supportive Services to determine the total value of their resources. The determination shall be made whether or not the Home Based Waiver client is applying for Medicaid.

Determine and verify the total value of all countable resources owned separately or jointly by the Home Based Waiver client and the community spouse as of the beginning of a continuous period of institutionalization or as of the date the client is eligible for home based waiver services.

If the request is not part of an application, the determination must be completed within 45 days from the date of request unless delays are due to non-receipt of documentation/verification from the requesting party or third party. Make up a case file for each assessment. The case file shall contain the written request, the signed statement of resources owned by both spouses (Form 2794-EM), documentation and verification of the market value less encumbrances of all countable resources and Form 2793-EM "Assessment and Documentation of Resources." These files will be kept alphabetically and retained indefinitely.

When an applicant applies for assistance and provides a spousal resource assessment completed from another state, the assessment must be reviewed. If the assessment is done correctly, use the assessment as provided.

However, if an error(s) is found on the assessment, redetermine the resource assessment based on the error(s) only. Once the information in error is corrected, the assessment can be accepted. If more than one resource assessment is provided, review all assessments to determine acceptability.

2) Spousal Share of Resources At The Time of Application for Home Based Waiver Services (Section I of Form 2797-EM)

This determination is only completed once at the beginning of the first application for Home Based Waiver services (beginning on or after 9/30/89). (Exception see M.S. 360.M.2.C.1).

a) Enter the community spouse's separate resources.
b) Enter the Home Based Waiver client's separate resources.
c) Enter joint resources between spouses.
d) Divide total resources equally.

This one-half portion of total resources is the "Spousal Share."

3) Community Spouse Resource Allowance (Section II of Form 2797-EM)

a) Enter the State Medicaid Maximum.
b) Enter the spousal share (one-half of resources at the time of the first continuous period of institutionalization or the first application for Home Based Waiver services) up to the Federal Maximum.

c) Enter the Administrative Hearing decision amount (if applicable).
d) Enter the court ordered amount (if applicable).
e) Enter the greatest of a, b, c or d above.

The State Medicaid and Spousal Share Maximums change annually. Use the annual amounts applicable to the year associated with the months of requested coverage.

The amount of resources (if any) determined from this computation is the Community Spouse Resource Allowance.

4) Assignment of Resources At The Time of Application For Medicaid (Section III of Form 2797-EM)

Complete Section III for each month of requested Medicaid coverage.

a) Enter the Community Spouse's separate resources.
b) Enter the Home Based Waiver client's separate resources.
c) Enter joint resources between spouses.
d) Total all resources.

Subtract the total amount of Section II item "e" from the total countable resources of both spouses. The difference (if any) will be the amount of resources applied toward the Home Based Waiver client's resource limit.

If the value exceeds the resource limit, the client is ineligible. If the value is within the resource limit, the client is resource eligible.

CAUTION: There are situations where the client has separate resources and/or joint resources with their spouse (Section III, b, &c) which exceed the $2,000 resource limit (ineligible). This situation occurs even though the protected resource amount puts the countable resources for the client’s eligibility (Section III, f) within the $2,000 resource limit.

The notice to the community spouse must advise them to place an amount of resources into their name which will leave the client’s resources under the $2,000 resource limit.

5) Permitting Transfer of Resources To The Community Spouse

An amount up to the Community Spouse Resource Allowance must be transferred to the community spouse's name only within 30 days from the date of the approval notice.

In situations where transferring the resource(s) cannot reasonably occur within the 30-day period, the client, spouse and/or their representatives must substantiate the circumstances and provide an expected date the transfer will take place. The case manager must monitor, document and verify the situation until the transfer occurs. The client, spouse and/or their representatives must continue to make every effort and take all possible steps to successfully transfer the resource(s) to the community spouse. Failure to comply will cause the resources to be counted towards the Home Based Waiver client's resource limit.

Effective October 1, 1993 State law is amended regarding court orders giving state courts guidelines when protecting income and resources for the community spouse. The guidelines provide for an equal division of income and resources OR a protection of income not to exceed the Federal Maximum Monthly Maintenance Needs Allowance and a protection of resources which does not exceed the Federal Maximum Spousal Share.

The court may order a greater amount of income for the support of the community spouse upon finding exceptional circumstances resulting in significant financial duress. The court may also transfer a greater amount of resources, in relation to the amount of income generated by the resource, if resources up to the Federal Maximum are not enough to fund the amount of income ordered.

The Transfer of Resources policy DOES NOT apply to transfers made under these provisions.

6) Separate Treatment of Resources After Eligibility is Established

During the "continuous period" of institutionalization AND after the client has been determined eligible, no resources of the community spouse are available to the client, unless actually made available to the client.

7) Undue Hardship

If undue hardship is claimed as a result of a denial of eligibility for excess resources under spousal impoverishment rules, the applicant may be determined eligible in spite of having excess resources if ALL of the following conditions exist:

a) The Home Based Waiver client is otherwise eligible for Medicaid without applying spousal impoverishment rules; AND

b) The community spouse is the sole owner of liquid resources OR non-liquid joint resources valued in excess of the Federal maximum; AND

c) The community spouse has refused to make the resources available to the Home Based Waiver client; AND

d) The Home Based Waiver client has insufficient funds to cover the cost of Home Care; AND

e) Without Medicaid, the Home Based Waiver client would be forced to go without life sustaining medical care as determined by an individual licensed to practice medicine in the State of Nevada.

Send Undue Hardship requests to the Chief of E&P for evaluation and decision.

8) Additional Resources Following Initial Eligibility

If the Home Based Waiver client acquires a new countable resource following the initial eligibility determination, his/her resource eligibility must be re-evaluated.

Apply the ownership/availability rules as outlined in Part "b" of this section to the newly acquired resource.

Determine how much, if any, of the Spousal Protected Resources (Line II, "e") was used to transfer resources in the community spouse's name only. If there is a balance remaining, more resources countable to the Home Based Waiver client can be protected for the community spouse so the Home Based Waiver client remains resource eligible.

Determine how much, if any, of the Spousal Protected Resources (Line II, "e") was used to transfer resources in the community spouse's name only. If there is a balance remaining, more resources countable to the Home Based Waiver client can be protected for the community spouse so the Home Based Waiver client remains resource eligible.

First determine if the Spousal Protected Resources has an unused balance in an amount equal to or more than the new resource. If not, and the excess of resources is over the resource limit, terminate Medicaid coverage allowing the appropriate adverse action time. If the balance of the Spousal Protected Resources is enough to protect the new resource from being counted toward the resource limit, apply the transfer provisions as outlined in Part "c,5)" of this section.

EXAMPLE #1: LIQUID RESOURCES

The community Spousal Protected Resources was determined to be $12,000. After approval, the community spouse transferred $8,600 of resources to his/her name only. This leaves a balance of $3,400 in Spousal Protected Resources. Later, the Home Based Waiver client receives a retroactive VA benefit check in the amount of $13,000; $10,000 remains the month after receipt and must be considered a countable resource. Since the balance of the Spousal Protected Resources is $3,400, this is the maximum that can be protected. The difference of $6,600 ($10,000 - $3,400) remains a countable resource to the Home Based Waiver client and renders him/her ineligible for Medicaid.

EXAMPLE #2: NON-LIQUID RESOURCES

The Home Based Waiver client and community spouse receive an inheritance of vacant land valued at $5,000. One-half is considered available to each spouse ($2,500). The community Spouse Protected Resources was computed to $12,000. Of this $12,000, the community spouse used $6,000 to transfer resources in his/her name after approval. Therefore, the community spouse has a $6,000 balance in Resource Protection.

One-half of the vacant land ($2,500) must be considered available to the community spouse. Since the community spouse has a balance of $6,000 in Spousal Protected Resources, the Home Based Waiver client remains resource eligible by protecting his share of the vacant land.

His/her share of the vacant land ($2,500) must now be transferred to the community spouse. In this example, the new balance of the Spousal Protected Resources would then be $3,500.

3. TRANSFER OF ASSETS (Refer to Section 240)

4. TREATMENT OF TRUSTS (Refer to Section 250)

5. RESOURCE EXEMPTIONS

One vehicle must be excluded without regard to use or value.

An individual who has received benefits under a qualified long-term care insurance policy is eligible for a resource disregard equal to the amount of insurance benefits paid to or on behalf of the individual. The resource disregard is allowed, even if additional benefits remain available under the terms of the policy.

Only qualified long-term care policies purchased after January 1, 2007 will meet the resource exemption rules. Beneficiaries will need to provide a certificate indicating the amount of benefits issued and certifying the policy as a qualified "partnership policy". The state will not seek adjustment or recovery from the individual's estate for the amount of assets or resources disregarded.

6. RESOURCE LIMITS

The value of all countable resources of the client cannot be more than $2,000. When the resource limit is exceeded, the case is ineligible.

Refer to Section 230 for Home Equity Limit.

N. PATIENT LIABILITY

Individuals who are approved under the Home and Community Based Waiver category are entitled to a maintenance allowance to take care of their needs (rent, utilities, etc.) The needs allowance is currently set at 300% of SSI (Appendix C), which is equal to the income limit, resulting in zero patient liability.

If the client is admitted to a hospital or nursing facility for "long-term care," adjust the patient liability deduction to the $35 Personal Needs Allowance beginning with the month following the month of institutionalization.

Applicants leaving a medical facility to enter the Home Based Waiver Program, adjust the patient liability deduction to the Home Based Maintenance Allowance effective the month following the month of discharge.

O. REVIEW OF ELIGIBILITY

A Review of Eligibility is required at least every 12 months. Use Review of Eligibility Form 2426-EE. Information received between reviews, which may affect eligibility, must be evaluated and acted on when applicable. A Review of Eligibility must be completed no later than the month it is due except when future actions are necessary. Clients are the primary source of information regarding their eligibility. If a client is unable to obtain information, the case manager will assist. Office interviews and home visits are optional and can be done at the discretion of the unit supervisor, or office manager.

The Review of Eligibility Form 2426-EE informs the client about their choices concerning an authorized representative (A/R). If any change in the A/R is indicated on Form 2426-EE, send the client Form 2525-EE to complete and return. If the A/R area on Form 2426-EE is blank, assume there is **NO** change in the status of the A/R for the client.

Form 2426-EE requests recipients to identify any changes in household circumstances. If there are no changes in the circumstances, no further verifications will be required. If changes are reported, send the client a 2429 requesting verification of the reported changes only.

INDEX
SECTION 370
KATIE BECKETT

370 CHILDREN ELIGIBLE UNDER 1902(e)(3) OF THE SOCIAL SECURITY ACT (KATIE BECKETT)

A. OVERVIEW

Section 1902(e)(3) of the Social Security Act authorizes Medicaid coverage to disabled children who require a level of care provided in a medical facility but can appropriately be cared for at home for less cost.

1. ELIGIBILITY REQUIREMENTS

Children in this category must meet each of the following:

a. Disability criteria (determined by SSA or NMO);

NOTE: Do not delay sending for NMO disability decision while waiting for SSI decision. NMO decision can be pursued at same time as SSI for Katie Beckett.

b. Be age 18 or under;

c. Be living at home;

d. Require a level of care provided in a nursing facility (determined by NMO);

e. Have medical costs for home care which are less than if the client were institutionalized (determined by NMO);

f. Meet all eligibility criteria of an institutional case except for residing in an institution.

If these children would be eligible for Medicaid while residing in an institution, they may be eligible for Medicaid while living at home.

Send Form NMO-3004 to DHCFP district office requesting a Katie Beckett determination, and if necessary, a disability determination.

The child must also be evaluated for QMB eligibility.

2. NEVADA MEDICAID OFFICE (NMO) DETERMINATION

After all other eligibility requirements are met, NMO, Central Office, will determine disability, level of care, medical costs, and if home care is appropriate, NMO determinations are made per Medicaid Operations Manual. The FSS or, if appropriate, the Title XIX Social Worker will send Form NMO-3004 to NMO.

NMO will notify the district office of the review board's decision of disability and/or final eligibility under 1902(e)(3) on Form NMO-3004.

B. AGED, BLIND, DISABLED

Children in this category must be disabled as determined by Social Security Administration criteria.

C. TIME FRAMES

An eligibility decision must be made within 90 days from the Medicaid application date unless extenuating circumstances exist.

D. SOCIAL SECURITY NUMBER (SSN)

Social Security numbers must be provided by every applicant and recipient. See Manual Section 204.

E. IDENTIFICATION

All applicants for Medicaid must be identified.

F. NEVADA RESIDENCY

1. NON-INSTITUTIONAL PERSONS (INCLUDES SSI RECIPIENTS NOT RECEIVING SSP)

Clients must be living in Nevada with the intention of making Nevada their home permanently or for an indefinite period (no expected end date) OR must be living in Nevada with a job commitment or seeking employment. Clients do not have to have a fixed place of residence to meet this requirement.

The ability to indicate intent to reside in Nevada is not to be taken lightly or stand by itself. A statement or indication of intent to reside in Nevada must be supported by additional verification or collateral material to substantiate the intent if residency is questionable. Manual Section 205,D,5 is not all inclusive. See manual section 205,A for more detail.

Nevada residency continues when a client is temporarily absent IF he/she intends to return to Nevada when the purpose of the absence has been accomplished. Document in the casefile the temporary absence situation and obtain the client/representative's statement concerning the intent of residency and the purpose of the absence.

2. SSI RECIPIENTS RECEIVING A STATE SUPPLEMENTARY PAYMENT (SSP) FROM ANOTHER STATE

State Supplementary Payments are funds paid in addition to the federal SSI payment. SSP entitlements and amounts differ from state to state.

When the client is receiving SSI/SSP through another state, the state paying the State Supplementary Payment is the state of residence UNLESS SSA acknowledges Nevada residency. In this instance only, use SSA's effective date of residency.

3. SSI RECIPIENTS NOT RECEIVING A STATE SUPPLEMENT FROM ANOTHER STATE

If a client is receiving SSI from another state but that state is <u>not</u> paying a supplementary payment (SSP), establish residency per "1" above.

G. CITIZENSHIP

To qualify for assistance, applicants must be a U.S. citizen or a non-citizen in an eligible category. See manual section 206 for citizenship requirements.

H. PRIOR MEDICAL

Clients may apply for prior medical coverage for up to 3 months prior to the month of Medicaid application.

1. Prior Medicaid coverage must be requested; AND

2. There must be evidence that medical care or services were provided in the month(s) for which Medicaid is requested.

When clients request prior medical, first determine if they are eligible for prior medical as an SSI recipient or State Institutional case.

If they are not eligible in either of those categories determine if they would have been eligible for SSI had SSA made a determination. See "Prior Medical Determinations Only - Would Have Been Eligible for SSI."

Do not make an independent SSI determination IF there is a pending SSI application covering the month(s) Medicaid is requested. Wait for the SSI decision.

Use SSI/SSA's disability decision (the disability on–set date) for any month of requested prior medical assistance. All other factors of eligibility, e.g., residency, citizenship, income, resources, etc., must be evaluated by the case manager.

I. THIRD PARTY LIABILITY (TPL)

Medicaid is always payor of last resort whenever any other resource may be responsible for payment.

When insurance coverage is available at no cost to the client (e.g., through employment or Tricare), request the client to enroll. See manual section 208 regarding Medicare.

Notify the fiscal intermediary of third party liability and any changes to such by recording all known information on the NOMADS MINS and MEDI screens.

J. RESERVED

This program is no longer available.

K. CHILD SUPPORT ENFORCEMENT (CSE)

All dependent children (including automatic Medicaid eligible newborns) who have absent parent(s) require referrals to CSE for support enforcement services. Support Enforcement services include establishing paternity, securing child and medical support. See manual section 209.

L. INCOME

Income means the receipt of money in the month for which an eligibility determination is being made. All income or changes in income must be reported. All income must be evaluated for financial eligibility.

1. OWNERSHIP/AVAILABILITY

a. Sole Ownership

All income which a payor designates as the clients, will be considered in determining eligibility.

When a benefit or income is received for more than one person or family member, only the client's portion of the income is considered.

b. Shared Ownership

1)	Deeming:	Does not apply.
2)	Dividing:	Does not apply.
3)	Court Orders:	Does not apply.
4)	Exceptions:	Monies received by the client in his/her capacity as an agent are not income to him/her. An "agent" is a person acting on behalf of someone, i.e., representative payee, guardian, conservator, etc.

2. TREATMENT OF INCOME

When determining financial eligibility, budget income for the month it is received.

Regular unearned income deposited directly into a financial institution is considered received in the month for which it is intended to be received.

a. Intake Cases

Individually determine financial eligibility for each month of requested coverage.

b. Ongoing Cases

Financial eligibility is always determined prospectively (future month). When information becomes known which causes ineligibility, prospectively terminate benefits allowing adverse action time.

3. INCOME LIMITS

See MAABD income chart in Appendix C.

4. BUDGETING PROCEDURES FOR FINANCIAL ELIGIBILITY - FORM 2203-EM

a. Gross Countable Income Test

1) Enter the countable amount of all unearned income.

2) Enter the gross earned income.

3) Determine TOTAL GROSS COUNTABLE INCOME by adding items I-A and I-B.

4) Compare the total gross countable income to the income limit.

If gross countable income is less than or equal to the income limit, the client is eligible under the Katie Beckett category.

If gross countable income exceeds the income limit, the client is ineligible under the Katie Beckett category.

M. RESOURCES

Resources are defined as those assets, both real and personnel, which an individual owns and can apply, either directly or by sale, to meet basic needs of food, clothing, and shelter and medical costs.

Real property is land, including buildings or immovable objects attached permanently to the land.

Personal property is any property that is not real property. The term encompasses such things as cash, tools, life insurance policies, mobile homes, automobiles, etc.

Any income which is retained the month following the month of receipt and later, is subject to resource evaluation.

Resources are evaluated at market value less encumbrances. When the combined value of all countable resources does not exceed the resource limit, verification of encumbrances is not necessary.

When the value of countable resources is under the resource limit on any day of the month, the client is eligible for that month.

All resources must be reported.

1. OWNERSHIP/AVAILABILITY

a. Sole Ownership

Sole ownership of real or personal property means only one person may sell, transfer or otherwise dispose of the property. All of the resource evaluated at market value less encumbrances is available to the client.

b. Shared Ownership

Shared ownership of real or personal property means two or more people own it simultaneously. The following are common types of shared ownership:

1) Tenancy-In-Common

Two or more persons each have an undivided fractional interest in the whole property for the duration of the tenancy. These interests are not necessarily equal. One owner may sell, transfer or otherwise dispose of his/her share of the property without permission of the other owner(s); but cannot take these actions with the entire property. If a tenant-in-common dies, the deceased's interest passes to his/her estate or heirs. Count the fair market value less encumbrances of the client's property share.

2) Joint Tenancy

Each of two or more persons have one and the same undivided ownership interest and possession of the whole property for the duration of the tenancy. This means each owner owns ALL the property. If a joint tenant dies, the survivor becomes the sole owner. If more than one joint tenant survives, the survivors become joint tenants of the entire property interest. Count the total fair market value less encumbrances of the entire property.

3) Tenancy By The Entirety (Married Couples Only)

This type of ownership can only exist between married couples. The wife and husband as a unit own the entire property and can be sold only with the consent of both parties. However, if a legal divorce occurs, the former spouses become tenants-in-common and one can sell his/her share without the consent of the other. If one spouse dies, the survivor becomes the sole owner. Verify whether the client's spouse will give permission to sell the property. If permission cannot be obtained, DO NOT count the client's one-half share of the property.

4) Exceptions

When a resource is owned jointly by more than one TANF/Medicaid applicant/recipient (other than a community spouse), divide the resource equally among those applicants/recipients to whom available.

When a client is representative payee or legal guardian managing someone else's funds, these funds are not considered the client's resource when they are kept in an account separate and apart from the client's monies AND can be identified as being received and designated for someone other than the client.

c. Treatment of Resources

1) Deeming: Does not apply
2) Dividing: Does not apply
3) Court Order: Does not apply
4) Inaccessible Resources

The cash value of resources which are not legally available to the household are exempt. If the Medicaid applicant/recipient or authorized representative is able to verify a resource is unavailable due to the client’s inability to access the resource due to incapacity and no one else has the ability to access the resource on their behalf, exempt the value of the resource as long as reasonable and timely steps are being taken to access the account on the client’s behalf, (i.e., referral to the public guardian’s office). Once the resource becomes accessible, the resource becomes countable and eligibility must be reevaluated for future months.

2. TRANSFER OF ASSETS (Refer to Section 240)

3. TREATMENT OF TRUSTS (Refer to Section 250)

4. RESOURCE LIMITS

The value of all countable resources of the client cannot be more than $2,000. When the resource limit is exceeded, the case is ineligible.

N. PATIENT LIABILITY

Does not apply in Katie Beckett cases unless the child has a temporary hospital stay. See Manual Section 340,N to determine patient liability.

O. REVIEW OF ELIGIBILITY

Review of eligibility is required at least every 12 months. Use Review of Eligibility, Form 2426-EE. Information received between reviews which may affect eligibility must be evaluated and acted on when applicable. Reviews must be completed no later than the month it is due except when future actions are necessary. Clients are the primary source of information regarding their eligibility. If a client is unable to obtain information, the case manager will assist. Office interviews and home visits are optional and can be done at the discretion of the unit supervisor or office manager.

The Review of Eligibility Form 2426-EE informs the client about their choices concerning an authorized representative (A/R). If any change in the A/R is indicated on Form 2426-EE, send the client Form 2525-EE to complete and return. If the A/R area on Form 2426-EE is blank, assume there is **NO** change in the status of the A/R for the client.

Verification used to reestablish Medicaid eligibility must be current (within the last 45 days).

MEDICAID CASES:

The child's income, resources and eligibility factors must be reevaluated and necessary action taken. Allow at least 60 days in advance of the RD due date when sending another Form NMO-3004 to NMO, Central Office advising an RD is due. NMO will inform the district office of its redetermination decision on the case via Form NMO-3004.

Hospital stays for children in this category will be common. When a child's stay in a hospital exceeds two months or if a child enters a nursing home, reevaluate eligibility as a State Institutional case. Notify the child/authorized representative they must apply for SSI. There will be no break in Medicaid eligibility pending a decision from SSI.

MEDICAID-QMB (SLMB) CASES:

When re-evaluating factors of eligibility, follow the specific review instructions above.

Verify Medicare Part A and evaluate for QMB (SLMB) income/resource limitations.

Should the client not cooperate with a Medicaid Review, close the case, do not continue QMB-only (SLMB-only) coverage.

INDEX
SECTION 380
PRIOR MEDICAL

380 PRIOR MEDICAL DETERMINATIONS

This category of eligibility is used only after all other eligibility categories have been considered.

If the client is not eligible in another Medicaid category, determine if they would have been eligible for SSI had SSA made a determination.

A. OVERVIEW

Clients may apply for prior medical coverage for up to 3 months prior to the month of Medicaid application.

1. Prior Medicaid coverage must be requested; AND

2. There must be evidence that medical care or services were provided in the month(s) for which Medicaid is requested; AND

3. The client would have been eligible for SSI had the client applied, regardless of whether the individual is alive when application for Medicaid is made.

Do not make an independent SSI determination IF there is a pending SSI application covering the month(s) Medicaid is requested. Wait for the SSI decision.

B. AGED, BLIND, DISABLED

Persons must be aged (65 years of age or older), blind or disabled as determined by Social Security Administration criteria.

C. TIME FRAMES

An eligibility decision must be made within Forty-five days from the Medicaid application date for the aged and blind and 90 days for the disabled, unless extenuating circumstances exist.

D. SOCIAL SECURITY NUMBER (SSN)

Social Security Numbers must be provided by every applicant and recipient. See manual section 204.

E. IDENTIFICATION

All applicants for Medicaid must be identified.

F. NEVADA RESIDENCY

Clients must be living in Nevada with the intention of making Nevada their home permanently or for an indefinite period (no expected end date) OR must be living in Nevada with a job commitment or seeking employment. Clients do not have to have a fixed place of residence to meet this requirement.

The ability to indicate intent to reside in Nevada is not to be taken lightly or stand by itself. A statement or indication of intent to reside in Nevada must be supported by additional verification or collateral material to substantiate the intent if residency is questionable. Manual section 205,D,5 is not all inclusive. See Manual Section 205 for more detail.

G. CITIZENSHIP

To qualify for assistance, applicants must be a U.S. citizen, or a non-citizen in an eligible category. See manual section 206 for citizenship requirements.

All persons applying for assistance must, as a condition of eligibility, sign the application form or an addendum to the application form, or a copy of the applicable page of the application, certifying that they are United States citizens or a non-citizen in an eligible category. Persons not certified in this manner are not considered to have met citizenship requirements. If the person for which the application is being submitted is unable to sign, the authorized representative may sign for him/her.

H. RESERVED

I. THIRD PARTY LIABILITY (TPL)

Medicaid is always payor of last resort whenever any other resource may be responsible for payment.

When insurance coverage is available at no cost to the client (e.g., through employment or Tricare), request the client to enroll. See manual section 208 regarding Medicare.

Notify the fiscal intermediary of third party liability and any changes to such by recording all known information on the NOMADS MINS and MEDI screens.

J. RESERVED

This program no longer available.

K. CHILD SUPPORT ENFORCEMENT (CSE)

Does not apply to prior medical only coverage.

L. INCOME

Income means the receipt of money in the month for which an eligibility determination is being made. All income or changes in income must be reported. All income must be evaluated for financial eligibility.

1. OWNERSHIP/AVAILABILITY

a. Sole Ownership

All income which a payor designates as the clients, will be considered in determining eligibility.

When a benefit or income is received for more than one person or family member, only the client's portion of the income is considered.

Determine financial eligibility using the "Individual" column of "SSI Budget" Form 2646-EE. Only the client's income is budgeted.

b. Shared Ownership

1) Deeming:

If the client is married and was living with his/her spouse, deem the spouse's income to the client using "SSI Budget" Form 2646-EE.

If the client is a child (under age 18) and was living with his/her parent(s), deem the parent(s)' income using "Parent to Child Deeming Budget" Form 2646-EE/A.

2) Dividing: Does not apply.

3) Court Orders: Does not Apply.

4) Exceptions: Monies received by the client in his/her capacity as an agent are not income to him/her. An "agent" is a person acting on behalf of someone, i.e., representative payee, guardian, conservator, etc.

2. TREATMENT OF INCOME

When determining financial eligibility, budget income for the month it is received.

Regular unearned income deposited directly into a financial institution is considered received in the month for which it is intended to be received.

Individually determine financial eligibility for each month of requested coverage.

3. INCOME LIMITS

Countable net income must be equal to or less than the applicable SSI payment amounts (SPA).

4. BUDGETING PROCEDURES FOR SSI FINANCIAL ELIGIBILITY - SSI BUDGET FORM 2646-EE (Spouse to Spouse Deeming)

a. Income Consideration

Determine whether the client is considered an individual or a member of a couple with an SSI eligible spouse by applying the definitions in this section.

When the client is considered an individual only the client's income is counted. Additionally, when the client is considered a member of a couple the spouse's income is counted for a specified time period.

Spouses **separated temporarily** for economic (employment) or emergency reasons (hospitalization), vacations or visits are NOT considered "separated" (e.g. ceased living together) for purposes of income consideration. The separation must be expected to continue. A temporary absence is one where the individual leaves and returns to the household in the same month or the following month.

When income of the spouse must be considered, the income will be verified. If impossible to verify the spouse's income, document the circumstances and accept the client's statement.

b. Definitions

1) SSI Eligible Spouse

The client's spouse who meets the requirements in both a. and b. below:

a) Is pending SSI, received SSI or would have been eligible for SSI;

To determine if the spouse would have been eligible for SSI, the spouse:

(1) must have been aged, blind or disabled. Blindness and disability is established when the spouse has been determined eligible for any type of permanent disability/blind benefits (e.g., SSA, VA, or Retirement Disability Benefits), and
(2) must be determined financially eligible.

b) Is living with the client or has not been separated longer than the specified time frames:

Consider the client a MEMBER OF A COUPLE WITH AN ELIGIBLE SPOUSE only for the month they ceased living together.

2) SSI Ineligible Spouse

The client's spouse who is not pending SSI, not receiving SSI and would not have been eligible for SSI.

When the spouse is not aged or has not been determined eligible for some type of permanent disability/blindness benefits consider the spouse an SSI ineligible spouse.

The ineligible spouse's income must always be considered when the client is living with the spouse. When the client and ineligible spouse are separated, the ineligible spouse's income is only considered the month of separation.

3) Individual

Consider clients as individuals when they are:

a) NOT married;

b) Married but have been separated from their SSI ELIGIBLE spouse for a specified time frame:

The client will be considered an individual beginning the month after the month they cease living together;

c) Married but have been separated from their SSI INELIGIBLE spouse for a specified time frame:

Consider the client an individual the month FOLLOWING the month they ceased living together;

d) Had an SSI INELIGIBLE spouse who received TANF, VA pension or other assistance based on need for the month Medicaid is requested.

c. SSI Budget Form 2646-EE - General Instructions

1) Member of Couple with Eligible Spouse

Any time the spouse appears potentially SSI eligible, treat as an eligible spouse until determined ineligible.

Use the MEMBER OF A COUPLE, WITH ELIGIBLE SPOUSE column. If ineligibility results, consider the spouse ineligible and go through the deeming computation (using the MEMBER OF A COUPLE WITH INELIGIBLE SPOUSE column) to determine if deeming applies.

If deeming doesn't apply, proceed to Part B using the INDIVIDUAL column. If deeming does apply, proceed with the budget under the MEMBER OF A COUPLE WITH INELIGIBLE SPOUSE COLUMN. If this process also results in ineligibility, the client is ineligible for Medicaid.

2) Member of Couple, with Ineligible Spouse

Use the MEMBER OF A COUPLE, WITH INELIGIBLE SPOUSE column, items A-1 through 3 to determine if deeming applies.

If deeming doesn't apply, proceed to the INDIVIDUAL column of the budget. Deeming never applies when the SSI ineligible spouse received TANF, VA pension or other federal or state assistance based on need.

3) Individual

Use the INDIVIDUAL column, when the person meets the definition of an individual.

d. SSI Budget Specific Instructions

1) Deeming Computation

Deeming never applies when the SSI ineligible spouse received TANF, VA pension or other federal or state assistance based on need.

a) Determine the ineligible spouse's total unearned income.

b) Determine if an SSI ineligible child(ren) allocation is applicable. The allocation is applicable if there are any dependent children who are:

(1) Under age 18 OR under age 22 and are students regularly attending a school, college or university or a course of vocational or technical training to prepare for gainful employment; AND

(2) The child(ren) are not receiving TANF, VA pension or other federal or state assistance based on need.

c) If the allocation deduction is applicable, for each ineligible child, subtract the child's unearned income from the Child Allocation Amount. Subtract the remainder from the ineligible spouse's unearned income.

d) Determine the ineligible spouse's gross earned income.

e) Subtract the balance of any allocation for ineligible children not offset by unearned income.

f) Add the remaining unearned income to the remaining earned income, after the allocation deductions.

g) Compare the total income after allocations to the Deeming Indicator Amount.

If less than the Deeming Indicator Amount, deeming does not apply, proceed to Part B, INDIVIDUAL column of the SSI budget using only the client's income.

If equal to or more than the Deeming Indicator Amount, deeming DOES APPLY. Proceed to Part B MEMBER OF A COUPLE WITH AN INELIGIBLE SPOUSE column adding the unearned income after allocations to the client's unearned income and the remaining earned income to the client's earned income.

2) SSI Eligibility Determination

In this section of the budget, use only the client's income when using the INDIVIDUAL column. Use combined incomes of the client and eligible or ineligible spouse when using the MEMBER OF A COUPLE WITH AN ELIGIBLE OR INELIGIBLE SPOUSE column.

a) Determine unearned income.

b) Subtract the general income exclusion of $20 to arrive at the remaining unearned income.

c) Determine total gross earned income.

d) Subtract any balance of the general exclusion not offset by unearned income.

e) Subtract the work expense exclusion of $65.

f) Impairment–Related Work Expenses (IRWE). This exclusion is applied to earned income of disabled (but not blind) individuals under age 65.

The expense must be reasonable; for items/ services which are directly related to enabling an impaired individual to work, and which are necessarily incurred by the individual because of a physical or mental impairment.

IRWEs are excludable when the cost is paid by the disabled individual and is not reimbursable from another source.

g) Subtract 1/2 of the remaining earned income after the above deductions.

h) Determine the total countable income by adding Items B-1-b and B-2-e.

i) Compare the total countable income (Item B-3) to the appropriate SSI payment amount (SPA).

If the amount is equal to or greater than the SPA in the MEMBER OF A COUPLE WITH INELIGIBLE SPOUSE or INDIVIDUAL columns, the client is ineligible for Medicaid.

If ineligible in the MEMBER OF A COUPLE WITH ELIGIBLE SPOUSE column, proceed to the MEMBER OF A COUPLE WITH INELIGIBLE SPOUSE column to complete the eligibility determination.

5. BUDGETING PROCEDURES FOR SSI FINANCIAL ELIGIBILITY OF CHILDREN - PARENT TO CHILD DEEMING BUDGET – FORM 2646–EE/A

a. General Deeming Provisions

If the child is under age 18 OR under age 21 and regularly attending school, college, university or technical training designed to prepare him/her for gainful employment AND living in the same household with the natural/adoptive parent(s) or a natural/adoptive parent and a stepparent; all income of the ineligible parent(s) will be considered in determining eligibility for the child.

Deeming applies from a parent to a child when they live together in the same household. Deeming stops the month following the month of institutionalization in a medical facility. Deeming begins the month following the month the child returns home from a medical facility.

Deeming applies even when the child is temporarily absent from the home. A temporary absence exists when:

1) The child leaves the household but intends to, and does, return in the same month or the following month; OR

2) The child is away at school but returns home on some weekends, holidays, or vacations AND is subject to parental control.

Consider the parent(s) or stepparent an ineligible parent when they are not pending SSI, receiving SSI or would not have been eligible for SSI.

To determine if the parent would have been eligible for SSI, the parent must be aged, blind or disabled. Blindness and disability is established when the parent has been determined eligible for any type of permanent disability/blind benefits (e.g., SSA, VA, or Retirement Disability Benefits), and is determined financially eligible.

When the parent is not aged or has not been determined eligible for some type of permanent disability/blindness benefits, consider the parent an SSI ineligible parent.

If the child is only living with a stepparent (natural/adoptive parent is not in the home) deeming does not apply. If the child is living with a natural/adoptive parent and a stepparent, deeming will apply.

b. Parent to Child Deeming Budget - General Instructions

Section 220 applies when evaluating countable and excluded income. In addition, the following types of parental income is excluded when determining the amount of deemed income:

1) Any portion of a grant, scholarship or fellowship used to pay tuition or fees;

2) Money received for providing foster care to an ineligible child;

3) Any income used to comply with the terms of court-ordered support or support payments enforced under Title IV-D;

4) Disaster Assistance.

Deeming never applies when the parent(s) or stepparent receives TANF, VA pension or other federal or state assistance based on need.

c. Deeming Computation

1) Determine the ineligible parent/stepparent's total unearned income.

2) Determine if a SSI ineligible child(ren) allocation is applicable. The allocation is applicable if there are dependent (natural or adoptive) child(ren) who are:

a) Under age 18 OR under age 21 and are students regularly attending a school, college or university or a course of vocational or technical training to prepare for gainful employment; AND
b) The child(ren) are <u>not</u> receiving TANF, VA pension or other federal or state assistance based on need.

3) If the allocation deduction is applicable, for each ineligible child, subtract the ineligible child's unearned income **(includes the total child support for the ineligible child)** from the Child Allocation Amount. Subtract the remainder from the ineligible parent/ stepparent's unearned income.

4) Determine the ineligible parent/stepparent's gross earned income.

5) Subtract the balance of any allocation for ineligible children not offset by unearned income.

6) Subtract $20 (general income exclusion) from the remaining unearned income.

7) Subtract any balance of the general income exclusion not offset by unearned income from earned income.

8) Subtract the work expense exclusion of $65.

9) Impairment–Related Work Expenses (IRWE). This exclusion is applied to earned income of disabled (but not blind) individuals under age 65.

The expense must be reasonable; for items/services which are directly related to enabling an impaired individual to work, and which are necessarily incurred by the individual because of a physical or mental impairment.

IRWEs are excludable when the cost is paid by the disabled individual and is not reimbursable from another source.

10) Subtract 1/2 of the remaining earned income after the above deductions.

11) Add the countable unearned and earned income to arrive at total countable income.

12) Then subtract the Parent Allocation Amount.

13) The net amount (if any) is the deemed income to the child.

d. Eligibility Determination

1) Add the child's own unearned income to the deemed income from the ineligible parent/stepparent.

2) Subtract $20 (general income exclusion).

3) If the child has earnings subtract any balance of the general income exclusion not offset by the child's unearned income from the child's earned income.

4) Subtract the work expense exclusion of $65.

5) Impairment–Related Work Expenses (IRWE). This exclusion is applied to earned income of disabled (but not blind) individuals under age 65.

The expense must be reasonable; for items/services which are directly related to enabling an impaired individual to work, and which are necessarily incurred by the individual because of a physical or mental impairment.

IRWEs are excludable when the cost is paid by the disabled individual and is not reimbursable from another source.

6) Subtract 1/2 of the remaining earned income after the above deductions.

7) Add countable unearned and earned income to arrive at total countable income.

8) Compare the total countable income to the individual SSI Payment Amount (SPA). If the amount is equal to or greater than the SPA, the child is ineligible for Medicaid.

M. RESOURCES

Resources are defined as those assets, both real and personal, which an individual owns and can apply, either directly or by sale, to meet basic needs of food, clothing, shelter and medical costs.

Real property is land, including buildings or immovable objects attached permanently to the land.

Personal property is any property that is not real property. The term encompasses such things as cash, tool, life insurance policies, mobile homes, automobiles, etc.

Any income which is retained the month following the month of receipt and later, is subject to resource evaluation.

Resources are evaluated at market value less encumbrances. When the combined value of all countable resources does not exceed the resource limit, verification of encumbrances is not necessary.

When the value of countable resources is under the resource limit on any day of the month, the client is eligible for that month.

All resources must be reported.

1. OWNERSHIP/AVAILABILITY

a. Sole Ownership

Sole ownership of real or personal property means only one person may sell, transfer or otherwise dispose of the property. All of the resource evaluated at market value less encumbrances is available to the client.

b. Shared Ownership

Shared ownership of real or personal property means two or more people own it simultaneously. The following are common types of shared ownership:

1) Tenancy-In-Common

Two or more persons each have an undivided fractional interest in the whole property for the duration of the tenancy. These interests are not necessarily equal. One owner may sell, transfer or otherwise dispose of his/her share of the property without permission of the other owner(s); but cannot take these actions with the entire property. If a tenant-in-common dies, the deceased's interest passes to his/her estate or heirs. Count the fair market value less encumbrances of the client's property share.

2) Joint Tenancy

Each of two or more persons have one and the same undivided ownership interest and possession of the whole property for the duration of the tenancy. This means each owner owns ALL the property. If a joint tenant dies, the survivor becomes the sole owner. If more than one joint tenant survives, the survivors become joint tenants of the entire property interest. Count the total fair market value less encumbrances of the entire property.

3) Tenancy By The Entirety (Married Couples only)

This type of ownership can only exist between married couples. The wife and husband as a unit own the entire property and can be sold only with the consent of both parties. However, if a legal divorce occurs, the former spouses become tenants-in-common and one can sell his/her share without the consent of the other. If one spouse dies, the survivor becomes the sole owner. Verify whether the client's spouse will give permission to sell the property. If permission cannot be obtained, DO NOT count the client's one-half share of the property.

4) Exceptions:

When a resource is owned jointly by more than one TANF/Medicaid applicant/recipient (other than a community spouse), divide the resource equally among those applicants/ recipients to whom available.

When a client is representative payee or legal guardian managing someone else's funds, these funds are not considered the client's resource when they are kept in an account separate and apart from the client's monies AND can be identified as being received and designated for someone other than the client.

c. Treatment of Resources

1) Spouse to Spouse Deeming

If the applicant/recipient is married and living with his/her spouse, spouse to spouse deeming rules apply. Use the resource limit for a couple for all months eligibility is being determined.

The value of the client's and spouse's countable resources (whether owned separately by each or jointly by both) are counted. Only one automobile and home may be excluded per couple.

Deeming applies from spouse to spouse when they live together in the same household. Deeming stops the month following the month of institutionalization in a medical facility. Deeming begins the month following the month the spouse returns home from a medical facility.

2) Parent to Child Deeming

Deeming applies from a parent to a child when they live together in the same household. Deeming stops the month following the month of institutionalization in a medical facility. Deeming begins the month following the month the child returns home from a medical facility.

Deeming does not apply:

a) if the child lives with a stepparent only;

b) The month following the month the child turns 18;

c) If the spouse or parent(s) are recipients of SSI, TANF, Medicaid, Refugee Assistance, General Assistance (GA) or VA Pension, VA Compensation as a surviving parent of a veteran, VA Aid and Attendance and VA Payment for Unusual Medical Expenses. This is because these benefits are paid based on need, not entitlement.

Determine the value of countable resources of the child's natural/adoptive parent(s) or spouse of a parent.

Subtract from the value of the parent(s)' or spouse of a parent's countable resources from the resource limit of:

– an individual, if one natural/adoptive parent lives in the home; or
– a couple, if two parents (or one natural/ adoptive parent and a spouse of that parent) live in the home.

The remaining value of resources is considered the child's own countable resources. Apply the individual resource limit to the child's countable resources to determine eligibility.

3) Dividing: Does not apply.

4) Court Order: Does not apply.

5) Inaccessible Resources

The cash value of resources which are not legally available to the household are exempt. If the Medicaid applicant/recipient or authorized representative is able to verify a resource is unavailable due to the client's inability to access the resource due to incapacity and no one else has the ability to access the resource on their behalf, exempt the value of the resource as long as reasonable and timely steps are being taken to access the account on the client's behalf, (i.e., referral to the public guardian's office). Once the resource becomes accessible, the resource becomes countable and eligibility must be reevaluated for future months.

2. TRANSFER OF ASSETS: Does not apply.

3. TREATMENT OF TRUSTS (Refer to Section 250)

4. RESOURCE LIMITS

Resource limits are $2,000 for an individual and $3,000 for a couple. When countable resources exceed the limit, the client is ineligible.

N. PATIENT LIABILITY

Does not apply.

O. REDETERMINATIONS

Does not apply.

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SECTION 390
SPECIALIZED MEDICAID
ELIGIBILITY GROUPS

390 SPECIALIZED MEDICAID ELIGIBILITY GROUPS

1. EMERGENCY MEDICAL FOR INELIGIBLE NON-CITIZENS

Section 9406 of Public Law 99-509 authorizes Medicaid coverage for emergency medical situations to ineligible non-citizens who would otherwise meet Medicaid eligibility criteria.

Any individual who does not meet the criteria of a qualified non-citizen (described in Manual Section 206), but who otherwise meets Medicaid eligibility criteria, may receive emergency medical services. Some non-citizens may be lawfully admitted, but only for a temporary or specified time period. They are:

- foreign government representatives on official business and their families and servants;
- visitors for business or pleasure, including exchange visitors;
- aliens in travel status while traveling directly through the U.S.;
- crewman on shore leave;
- treaty traders and investors and their families;
- foreign students;
- international organization representation and personnel and their families and servants;
- temporary workers including agricultural contract workers; and
- members of foreign press, radio, film, or other information media and their families.

Individuals who request assistance under this category must meet the following:

a. Are aged, blind, or disabled **AND** would qualify for Medicaid as a state institutional case, or would be eligible for SSI, except for the fact they are ineligible non-citizens; and

b. Meet all eligibility criteria except the citizenship requirements. Residency requirements must be met (see manual section 205).

In determining whether an applicant is eligible as a state institutional case, eligibility is determined the same as a state institutional case except for meeting the citizenship requirements.

If the client does not qualify as a state institutional case, the case manager must make a determination of whether the applicant would be eligible for SSI except for meeting the citizenship requirements.

NOTE: If the client is or becomes pregnant, evaluate her eligibility using CHAP criteria rather than institutional or SSI criteria.

The case can remain ongoing provided the individual continues to meet all the requirements for a state institutional or SSI case and the individual has a chronic emergency medical condition.

These cases are only entitled to coverage for emergency services. If, after receiving all documents for a billing from a provider, the service(s) does not meet the guidelines given First Health for emergency medical payment, payment of the service(s) will be denied.

NOTE: If the client is under age 65, a disability determination is needed; follow procedures in Manual Section 202.

2. CONTINUATION OF PREGNANCY RELATED MEDICAL COVERAGE

Once initial Medicaid eligibility has been established, a pregnant woman, who would lose Medicaid eligibility solely due to countable income, will be considered continuously eligible for "pregnancy related" medical coverage throughout the pregnancy and into the postpartum eligibility period.

Pregnant women in this category will remain eligible for pregnancy related coverage provided other non–income related eligibility factors are met.

At the same time advance notice is given to terminate full Medicaid coverage, notify the client of the continuation in pregnancy related medical coverage.

When the child is born, he/she will be OBRA eligible for one (1) year from the date of birth. Ensure a notice is sent to the client informing her of the newborn's Medicaid eligibility and when the postpartum coverage ends. See “C” below for OBRA requirements.

The postpartum coverage ends the last day of the second month immediately following the month the pregnancy ended. Example: The pregnancy ends on June 22nd. Postpartum period ends the last day of August.

3. MEDICAID ELIGIBILITY FOR NEWBORNS

a. General

A child born to a woman eligible for Medicaid the date of the child’s birth is deemed to have applied and been found eligible for Medicaid effective the birth month and remains eligible for one year. Changes in income, household composition, cooperation with other program requirements, including redetermination and citizenship, will not affect the child’s eligibility during the first year. The newborn is eligible under the same conditions when born in a prior medical month in which the mother was determined eligible.

Newborns taken into protective custody, being adopted, pending adoption or pending relinquishment are deemed eligible for the birth month if born to an eligible Medicaid mother whether or not they go home with the birth mother. The newborn is deemed to have filed a Medicaid application through the birth mother.

Coverage of newborns does not transfer from one state to another. If the newborn moves to another state, Medicaid eligibility as a "newborn" ceases.

b. Determining Eligibility For Newborns

Use the most readily available verification to add the child to the medical case.

Example: Client statement, hospital discharge forms, Managed Care alert, birth confirmation. Do not request verification of household composition unless the circumstances are unclear or Nevada residency is questionable.

Newborns are eligible for one year from the month of birth. Income is not a factor in determining OBRA eligibility. Newborns are exempt from the requirement to apply for a SSN during the one year of newborn eligibility.

Children who become eligible for Medicaid based on their mother's Nevada Medicaid eligibility are considered to have provided satisfactory evidence of citizenship and shall not be required to provide further documentary evidence, even after the automatic coverage period ends.

The child's eligibility must not be delayed while awaiting documentation to be submitted.

c. Termination of Eligibility

1. Terminate Medicaid coverage before the year ends if the child fails to meet residency requirements.

2. Terminate Medicaid coverage if the eligibility period is ending and no application for continued assistance is received.

No redetermination (RD) is required on an OBRA only case. To continue Medicaid past the first OBRA year, a new Medicaid application must be filed.

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SECTION 400
HEALTH INSURANCE FOR WORK ADVANCEMENT (HIWA)

410 HEALTH INSURANCE FOR WORK ADVANCEMENT (HIWA)

A. OVERVIEW

This optional category of Medicaid allows employed people with disabilities the opportunity to obtain/maintain healthcare coverage.

Clients are required to pay an insurance premium to be eligible under this category.

The applicant must be employed to be eligible under this category.

An individual receiving assistance under the HIWA program who is no longer employed due to hospitalization, an inability to work that is directly related to the individual's disability, a worksite closure, or a loss of current transportation with no other alternative means of transportation available, will continue eligibility for an additional three (3) months after the month in which eligibility ended as long as premiums are paid by the due date.

ELIGIBILITY EXCEPTIONS

1. Individuals eligible for the HIWA program must not be eligible for any other Medicaid category, with the exception of QMB and SLMB.

2. Individuals under 65, residing in an Institution for Mental Disease (IMD) i.e., free standing psychiatric hospital, **are not** eligible for Medicaid. EXCEPTION: Children under 22 when SSI eligible. (See chapter Addendum listing IMD facilities.)

B. AGED, BLIND, DISABLED

Individuals must be at least 16 and less than 65 years of age, and be disabled or blind. The Nevada State Division of Welfare and Supportive Services (DWSS) accepts the blindness/disability criteria as established by the Social Security Administration.

Prior SSI recipients and/or current or prior Social Security Disability Insurance recipients, whose benefits ended for a reason other than loss of disability do not need a new disability determination unless SSA's decision was based on a disability different from what is presented to the Division. If the disability is different or their SSI or RSDI benefits ended for loss of disability, a new disability decision is needed. If a person has never received SSI or RSDI benefits, they must provide a determination or other verification of their disability.

C. TIME FRAMES

An eligibility decision must be made within 45 days from the date the agency receives the application , unless extenuating circumstances exist.

D. SOCIAL SECURITY NUMBER (SSN)

Social Security numbers must be provided, or applied for, by every applicant and recipient. (See manual section 204.)

E. IDENTIFICATION

All applicants for Medicaid must provide proof of identification.

F. RESIDENCY

Applicants must be living in Nevada with the intention of making Nevada their home permanently or for an indefinite period (no expected end date) OR living in Nevada with a job commitment or seeking employment. Clients do not have to have a fixed place of residence to meet this requirement.

Nevada residency continues when a client is temporarily absent IF they intend to return to Nevada when the purpose of the absence has been accomplished. Document in the case file the temporary absence situation and obtain the client/representative's statement concerning the intent of residency and the purpose of the absence.

VERIFICATION (not all inclusive)

1. Rent/Mortgage receipt
2. Landlord statement
3. Statement from the nursing facility in which the client resides
4. Nevada driver's license
5. Nevada vehicle registration
6. Utility bills/receipts
7. Employer's statement
8. Statement from a friend, relative or other person who is knowledgeable about the client's residency

G. CITIZENSHIP

To qualify for assistance, applicants must be a U.S. citizen or a non-citizen in an eligible category. See manual section 206 for citizenship requirements.

All persons applying for assistance must, as a condition of eligibility, sign the application form or an addendum to the application form, or a copy of the applicable page of the application, certifying they are United States citizens or a non-citizen in an eligible category. Persons not certified in this manner have not met citizenship requirements. If the person for whom the application is being submitted is unable to sign, the authorized representative may sign for them.

H. PRIOR MEDICAL

Individuals may request prior medical coverage for up to three (3) months prior to the month of Medicaid application.

1. Prior medical coverage must be requested; AND
2. There must be evidence medical care or services were provided in the month(s) for which Medicaid is requested.

When prior medical assistance is requested, first determine if they are eligible for prior medical under any other category. Prior Medical under the HIWA program CANNOT exist prior to July 1, 2004.

If the applicant is not an SSI recipient, determine if they would have been eligible for SSI had Social Security Administration made a determination (See PRIOR MEDICAL DETERMINATIONS ONLY - WOULD HAVE BEEN ELIGIBLE FOR SSI). This category of eligibility is used 2nd to last after all other eligibility categories have been considered.

Do not make an independent SSI determination IF there is a pending SSI application covering the month(s) Medicaid is requested. The SSI decision is used, when received.

Use SSI/SSA's disability decision (the disability onset date) for any month of requested prior medical assistance. All other factors of eligibility (e.g., residency, citizenship, income, resources, etc.) must be met.

I. THIRD PARTY LIABILITY

Medicaid is always payor of last resort whenever any other resource may be responsible for payment.

When insurance coverage is available **at no cost** (e.g., through employment or Tricare), request the applicant to enroll for coverage.

Nevada will pay the HIWA recipient's Medicare Premium Part B when:

- The client is also eligible for the QMB or SLMB program; or
- The client is eligible for Medicaid, the buy-in begin date for the Medicare part B premium is effective the month of approval.

Assistance will be denied or terminated if the individual refuses to apply for, pursue, or provide information necessary to establish insurance coverage/claims and/or fails to cooperate in the collection process from a third party.

J. RESERVED

K. SUPPORT ENFORCEMENT PROGRAM (SEP)

All dependent children (including automatic Medicaid eligible newborns) who have absent parent(s) may be referred to Child Support Enforcement Program (CSEP) for support enforcement services. If the child's parent is also a Medicaid recipient they must be referred for support enforcement services. If the parent refuses to cooperate their Medicaid may be affected.

L. INCOME

Income is the receipt of money in the month for which an eligibility determination is being made. All income or changes in income must be reported.

The client must be employed and receiving earned income to be eligible for HIWA.

All income is evaluated for financial eligibility.

1. OWNERSHIP/AVAILABILITY

a. Sole Ownership

All income which a payor designates as the clients, will be considered in determining eligibility.

When a benefit or income is received for more than one person or family member, only the client's portion of the income is considered.

b. Shared Ownership

1. Deeming: Does not apply.
2. Dividing: Does not apply.
3. Court Order: Does not apply.
4. Exceptions: Monies received by the client in their capacity as agent are not income to them. An agent is a person acting on behalf of someone, (i.e., representative payee, guardian, conservator, etc.).

2. TREATMENT OF INCOME

When determining financial eligibility, budget income for the month received.

Regular unearned income deposited directly into a financial institution is considered received in the month for which it is intended to be received.

a. Intake Cases

Individually determine financial eligibly for the month of requested coverage.

b. Ongoing Cases

Financial eligibility is always determined prospectively (future month). When information becomes known which causes ineligibility prospectively, terminate benefits allowing time for adverse action.

3. INCOME

There are **three** income tests for the HIWA program. If any income test fails, the system will deny assistance and not progress to the next level of testing. The income tests run in order as follows:

a. $699 Unearned Income Limit

b. Maximum Gross Earned Income Test

The maximum gross earned income *prior to* income disregards is 450% of the Federal Poverty Level (see Appendix C); and

c. Net Income Test

The individual's **net earned** income plus **net unearned** income must be at or below 250% of the Federal Poverty Level (see Appendix C).

4. EMPLOYMENT RELATED WORK DISREGARDS

In addition to the $20 General Income Exclusion and $65 Earnings Exclusion, participants in the HIWA program are allowed Employment Related Work Disregards (ERWD) to be subtracted from their countable earned income. The disregard must be directly related to enabling the individual with a disability to work.

Expenses paid for by the employer or another party are not an allowable deduction.

a. Employment Related Transportation Expense

- **To and from work in personal vehicle**

  Allow a mileage allowance based on the current state mileage rate. (See State Administrative Manual)

- **To and from work in a modified vehicle**

  In addition to the mileage allowance, allow the cost of modifications to a vehicle necessary for the individual to get to and from work. The modification must be directly related to the individual's impairment.

  Note: Only the cost of the modifications is allowable, not the cost of the vehicle.

- **Other transportation**

  When the individual does not have a vehicle, allow the cost of:

  - Bus fare
  - Cab fare
  - Amount paid to another individual to transport the client to and from work.

b. Employment Related Personal Care Aid (PCA) Services Expense

- **Services at work or to and from work**

  Allow the cost for services needed in the work setting, or traveling to and from work.

  The cost must be incurred by the individual and not provided by the employer.

- **Services at home**

  All the cost of services needed for preparation for going to work, or needed upon the individual's return home from work.

  Examples of In-Home Services (not all inclusive)

  - Bathing and dressing
  - Cooking and eating
  - Administering medications
  - Adjusting or arranging medical devices or equipment
  - Transportation to and from work

  The deduction is limited to services provided on normal work days, and does not include services for shopping or general homemaking.

c. Service Animal Expense

Allow the cost if the animal enables the individual to overcome functional limitations in order to work.

Allowable expenses include:

- Cost of purchasing the animal
- Food and maintenance costs
- Veterinary services

d. Educational Expenses to Enhance Employability

Allow the costs for education directly related to enabling the individual to work.

Allowable expenses include but are not limited to:

- Tuition and fees
- Books and supplies
- Parking permits
- Tutoring expenses

e. Medical Equipment/Supplies and Services

Allow the cost of medical equipment, supplies or services necessary to enable the individual to work. This includes the cost of the item and any costs related to maintenance and repair.

The cost for certain medications and services is allowable if they are necessary to control a condition and enable the individual to function in their work activity. Routine medical and dental services not directly related to the client's impairment and ability to work are not allowable.

Allowable expenses include: (not all inclusive)

- Braces
- Inhalers
- Pacemakers
- Respirators
- Wheelchairs
- Prostheses (not cosmetic)
- Physical therapy
- Blood level monitorings
- Radiation treatments
- Catheters and Irrigating Kits
- Bandages and incontinence pads

f. Work-Related Equipment/Services

Allow the cost of equipment/services essential for the individual to function in their work activity. This includes any cost for maintenance or repair.

Allowable expenses include: (not all inclusive)

- Vision and sensory aids
- One-handed keyboards
- Typing aids
- Telecommunication devices
- Tools designed to accommodate the workplace
- Translation into Braille
- Child care costs (work hours only)
- Safety equipment/apparel

g. Training on Work-Related Equipment

Allow the cost of training needed to use impairment-related equipment and services.

Examples of allowable training costs include: (not all inclusive)

- Braille
- Computer program courses
- Stenotype instruction
- Use of impairment-related equipment

Note: Training does not include general education courses.

h. Interpreting Services

Allow the cost of services essential for the individual to function on the job.

i. Residential Modifications

Costs associated with modifications made to an individual's home may be an allowable expense depending on the location of their place of work.

- **Work Outside the Home**

  Allow the cost of modifications made to the outside of the residence necessary for the individual to access transportation to and from work.

- **Employed at Home**

  Allow the cost of modifications essential to create a working space that accommodates the individual's impairment to enable them to perform their job.

5. COMPUTING MONTHLY EMPLOYMENT-RELATED WORK DISREGARDS

The frequency in which an individual incurs an expense will determine the method used for computing the deduction.

a. Recurring Monthly Expenses

Use the amount the client pays each month. If an individual incurs a one-time cost, but is making payments, allow the monthly payment amount.

b. Recurring Non-Monthly Expenses

Some expenses are incurred less often than monthly. Allow the entire amount in the month paid, or allocate the amount over the months in the payment period, whichever the client chooses.

Example: A client is billed every three months for a contained oxygen supply. Allow the billed amount in the month the client pays it, or divide the amount over the three months.

c. Nonrecurring Expenses

Part of an individual's expenses may not be recurring, but involve a one-time payment. Allow the entire amount in the month paid, or allocate the amount over a 12-consecutive month period, whichever the individual chooses.

Obtain verification of each Employment-Related Work Expense claimed, including the frequency of the payments.

6. HIWA INCOME DETERMINATION

a. Determine countable unearned income (MS 220).
b. Subtract the general income exclusion of $20 to arrive at the net countable unearned income amount.
c. Determine the gross earned income.
d. Subtract any balance of the general income exclusion not offset by unearned income.
e. Subtract the work expense exclusion of $65.
f. Divide the remaining income by two and the remainder is considered the countable earned income.
g. Subtract allowable Employment Related Work Disregards (ERWD) from the countable earned income. The remainder is considered the **net countable earned income**.

h. Determine the total countable income by adding the net countable unearned income and the net countable earned income.
i. Compare the total countable income to 250% FPL (see Appendix C).

M. RESOURCES

Resources are defined as those assets, both real and personal, which an individual owns and can apply, either directly or by sale, to meet their basic needs of food, clothing, shelter and medical costs.

All resources must be reported.

1. TRANSFER OF RESOURCES

Resources cannot be transferred by an individual in order to become eligible for Medicaid or to retain Medicaid eligibility.

2. RESOURCE LIMITS

Resource limit is $15,000. When countable resources exceed the limit, the client is ineligible.

Use MS 230 to determine countable or exempt resources with the following exceptions:

Under the HIWA program the following resources are excluded:

- One vehicle
- Approved accounts of $15,000 or less
- Special needs trusts
- IRS recognized retirement accounts
- SSA death benefit payment
- Medical savings account
- Tax refunds
- Life insurance policies with cash surrender values of less than $50,000.
- Funeral/burial policies

3. Inaccessible Resource

The cash value of resources which are not legally available to the household are exempt. If the Medicaid applicant/recipient or authorized representative is able to verify a resource is unavailable due to the client's inability to access the resource due to incapacity and no one else has the ability to access the resource on their behalf, exempt the value of the resource as long as reasonable and timely steps are being taken to access the account on the client's behalf, (i.e., referral to the public guardian's office). Once the resource becomes accessible, the resource becomes countable and eligibility must be reevaluated for future months.

N. PATIENT LIABILITY

See manual section 320 for procedures on calculating patient liability.

O. REDETERMINATION

Redeterminations of eligibility are required at least every 12 months. Information received between redeterminations which may affect eligibility must be evaluated and acted on when applicable. Redeterminations must be completed no later than the month it is due except when future actions are necessary. Clients are the primary source of information regarding their eligibility. If a client is unable to obtain information, the case manager may assist. Office interviews and home visits are optional and can be done at the discretion of the Unit Supervisor or Social Welfare Manager.

The MAABD Redetermination form (2930-EM) informs the client about their choices concerning an authorized representative (A/R). If any change in the A/R is indicated on Form 2930-EM, send the client Form 2525-EE to complete and return. If the A/R area on Form 2930-EM is blank, assume there is **NO** change in the status of the A/R for the client.

Verification used to re-establish Medicaid eligibility must be current (within the last 45 days).

Upon receipt of the requested information, take the appropriate action and document this in the case narrative.

If the client does not return the requested information, send a termination notice allowing an additional ten (10) days to provide the information. Assistance will continue if the information is received within the ten-day period provided all eligibility requirements are met. Close the case for non-cooperation and document this in the case narrative if the information is not returned within the ten-day extension period

P. MEDICAID BUY-IN

Individual applying for or receiving assistance under the HIWA program are required to pay a premium based on their monthly combined net income as a percentage of the Federal Poverty Level (FPL).

At initial approval, the client is *"conditionally eligible,"* awaiting verification from the Division of Health Care, Financing and Policy the client has paid their premium. Once verification is received, the client is either approved for full Medicaid, or denied for failing to pay the premium.

1. PREMIUM AMOUNTS

a. Individuals whose combined net income is less than 200% FPL will pay a monthly premium of 5% of their combined net income.
b. Individuals whose combined net income is between 200% and 250% FPL will pay a monthly premium of 7.5% of their combined net income.

Prior medical month premiums are based on the combined net income for the months requested.

The individual's Medicaid Buy-In premiums are recalculated any time a change in income is reported, but not less than once a year at the time of the annual eligibility redetermination.

The Medicaid Buy-In premiums are due on the first day of each month. If an individual fails to submit a premium payment, Nevada Medicaid will notify the Division around the 11th of the month, to terminate Medicaid effective the end of the month. If the client subsequently pays their premium, they must submit an application to have the program reinstated.

Individuals who are terminated from the HIWA program for failure to pay premiums will not be eligible for the HIWA program for two (2) years from the date of the past due premium(s) unless the past due premiums are paid in full.

NEVADA MEDICAID RESIDENTIAL TREATMENT CENTER (RTC) SERVICE PROVIDERS

Benchmark Hospital
592 West 1350 South
Woods Cross, Utah 84087
(801) 299-5300

Brown Schools, Inc.-Cedar Springs Ctr
22135 Southgate Road
Colorado Springs, Colorado 80906
(719) 633-4114

Brown Schools, Inc.-Laurel Ridge Trtmt Ctr
17720 Corporate Woods Drive
San Antonio, Texas 78259-3509
(210) 491-9400

Brown Schools, Inc.-San Marcos Trtmt Ctr
One Bert Brown Road
San Marcos, Texas 78667
(512) 396-8500

Brown Schools, Inc.-The Oaks Trtmt Ctr
1407 Stassney Lane
Austin, Texas 78745
(512) 444-9561

Cathedral Home for Children
P.O. Box 520
Laramie, Wyoming 82073-0520
(307) 745-8997

Cleo Wallace Center
430 Gold Pass Heights
Colorado Springs, Colorado 80906
(719) 527-1600
(Denver Campus - (303) 466-7391

Copper Hills at St. George
115 West 1470 South, Suite B
St. George, Utah 84770
(435) 634-1730

Copper Hills Youth Center
5899 West Rivendell Dr
West Jordan, Utah 84080
(801) 561-3377

Desert Willow Treatment Center (RTC)
6171 West Charleston Boulevard
Las Vegas, Nevada 89146
(702) 486-8900

Primary Childrens Medical Center RTC
497 South Colorow Way
Salt Lake City, Utah 84108
(801) 588-4980

Provo Canyon School
P.O. Box 1441
Provo, Utah 84603
(801) 227-2000

San Diego Center for Children
3002 Armstrong Street
San Diego, California 92111
(619) 277-9550

Spring Mountain Treatment Center
7000 West Spring Mountain Road
Las Vegas, Nevada 89117
(702) 873-2400

Vista Care RTC
4120 East Ramsey Road
Hereford, Arizona 85615
(520) 378-6466

Willow Springs Center
P.O. Box 30012
Reno, Nevada 89520
(702) 323-3303

NEVADA MEDICAID PSYCHIATRIC HOSPITAL SERVICE PROVIDERS

Charter Hospital
7000 West Spring Mountain Road
Las Vegas, Nevada 89117
(702) 876-4356

Desert Willow Treatment Center (RTC)
6171 West Charleston Boulevard
Las Vegas, Nevada 89146
(702) 486-8900

Montevista Hospital
5900 West Rochelle Avenue
Las Vegas, Nevada 89103
(702) 364-1111

Nevada Mental Health Institute
480 Galletti Way
Sparks, Nevada 89431
(702) 688-2001

Southern NV Adult Mental Health
6161 West Charleston Blvd.
Las Vegas, Nevada 89102
(702) 486-6000

West Hills Hospital
1240 East Ninth Street
Reno, Nevada 89520
(702) 323-0478

501 PARENTAL FINANCIAL RESPONSIBILITY FOR SERVICES PROVIDED TO DISABLED CHILDREN

Parents are financially responsible for their children's medical expenses paid by Medicaid. Financially able parents will be assessed a monthly payment amount to reimburse the Division of Health Care Financing and Policy for incurred medical costs.

This section applies to disabled children under age 18 eligible for Medicaid in categories in which there is no deeming of parental income/resources in determining eligibility for public assistance programs. These categories include, without limitation:

- Katie Beckett Program;
- State Institutional Category (including SSI recipients residing in medical facilities);
- Physically Disabled Waiver Program;
- Mental Health Developmental Services (MHDS) Waiver Program (including SSI recipients residing in ICF/MR facilities); and
- SSI recipient, age 0-18, residing in appropriate settings as determined by Medicaid.

Under no circumstances will the policy in this section affect the child's Medicaid eligibility.

A. DEFINITIONS

1. Parent – natural/adoptive parents and stepparents.

2. Income – all earned and unearned income to include but not limited to the sources described in MAABD Program Policy Section 220 without regard to any exclusions.

B. CALCULATING MONTHLY PARENTAL REIMBURSEMENTS

Based on the parents' gross monthly income and considering court ordered child support/alimony, home care credit, medical expenses, and health insurance covering the disabled child, the amount of monthly reimbursement is determined as follows:

1. Family Size

Determine family size, choosing one of the following methods, whichever is greater (most benefits the parent(s) in allowing the family deduction):

a. Count the disabled child(ren), his/her blood-related siblings, and natural/adoptive parent(s) living in the home; or
b. Allow the total number of exemptions claimed on last year’s federal income tax form 1040 of 1040A, line 6d.

2. Countable Income

Determine the amount of the natural/adoptive parents' annual gross income using Federal Income Tax Form 1040, line 34; 1040A, line 16 or Form W-2. Parents who are self-employed must provide copies of their last two (2) income tax returns.

Parents claiming their current income is substantially different than the income reported on their tax forms must provide proof of their actual income.

If the natural/adoptive parent is married and living with an individual who is not the natural/adoptive parent of the disabled child (stepparent to the disabled child), total the natural/adoptive parent's and stepparent's gross annual income and divide it equally. This one-half share will be considered the natural/adoptive parent's annual gross income to determine the reimbursement amount.

3. Court Ordered Child Support or Alimony

Court ordered child support obligations paid by the natural/adoptive parent will be deducted as an annual cost from the gross annual income.

When the custodial parent and NCP live separate and apart, consider their income separately. Alimony paid by the NCP is deducted from the NCP income and counted in the ex-spouse's income when determining amount of reimbursement.

4. Annual Family Deduction

Subtract the following Family Deduction amount (200% of Federal Poverty Guidelines) from the adjusted annual gross income (total annual gross income less child support deduction) to arrive at the net annual gross income amount:

Family Size	Amount	Family Size	Amount
1	$21,780	5	$52,340
2	29,420	6	59,980
3	37,060	7	67,620
4	44,700	8	75,260

Add $7,640 for each additional family member.

5. Net Annual Gross Income

Multiply the net annual gross income which is:

a. Up to $50,000 by 10%
b. Between $50,000 - $60,000 by 13%
c. Between $60,000 - $75,000 by 16%
d. Over $75,000 by 19%

Add the percentage increase amounts in a, b, c and d, then divide by 12 to reach the Monthly Reimbursement Amount.

6. Home Care Credit

Natural/adoptive parents who care for their disabled child(ren) in their home will receive a $300 deduction from the Monthly Reimbursement Amount.

7. Medical Expenses

Allow medical deductions claimed on last year's federal income tax form 1040, line 4 (Medical and Dental Expenses) of Schedule A – Itemized Deductions.

8. Health Insurance

If a parent carries private or group comprehensive health insurance **which covers the disabled child**, the entire amount of the monthly insurance premium is deducted from the Monthly Reimbursement Amount.

A health insurance penalty of 5% is imposed IF the natural/adoptive parent has health insurance available and does not elect to secure coverage for the disabled child.

DO NOT apply the insurance penalty IF the health insurance coverage would cost more than 5% of their gross annual income.

9. Court Orders

If a parent alleges a court order which specifies the noncustodial parent is responsible for all medical costs, obtain a copy of the court order and forward to the local Support Enforcement Unit AND the Chief of Eligibility and Payments.

In this instance, DO NOT assess a monthly reimbursement until directed by the Chief of Eligibility and Payments.

10. Noncooperation

If a parent fails to provide income information, provides false or misleading statements; misrepresents, conceals or withholds facts to avoid financial responsibility, a monthly reimbursement of $1,900 is assessed.

If a parent provides only partial information/verification, request the remaining information/verification giving 10 days. If all the information/verification is not received by the deadline given, assess $1,900.

If after receiving notification of $1,900 obligation the parent later provides needed verifications. Determine monthly reimbursement amount and notify I&R of change in monthly obligation effective the month after the month of cooperation.

C. REVIEW OF ELIGIBILITY

At each scheduled review of eligibility (at least once per year), the monthly reimbursement is recalculated for the upcoming year. Adjustments to the previous year's assessment will be reported to the Investigations and Recovery Unit via Form 6009-AG.

D. UNDUE HARDSHIP

Responsible parents may apply for a "hardship waiver" if they are unable to pay their assessed monthly reimbursement amount due to:

1. a change in families monthly income (25% or more); or
2. payment of the monthly reimbursement amount would severely compromise the health, shelter or subsistence needs of their family.

Individuals seeking a hardship waiver should fully document their circumstances in writing and submit their request to the Chief of Investigations and Recovery in Central Office. No adjustment of the monthly parental reimbursement amount will be made (other than annual redetermination, see subsection C) without the prior approval of the Chief of Investigations and Recovery.

E. RESPONSIBILITIES OF ELIGIBILITY STAFF

The Case Manager:

1. Requests completion of Form 2069–EM "Parent Income and Household Information" and verification of income, court-ordered child support/alimony, medical expenses and health insurance coverage at application and redetermination.

2. Determines the monthly reimbursement amount based on the family size, annual income, child support/alimony, home care credit, medical expenses and medical insurance using Form 2028-EE, "Parental Reimbursement Worksheet." Notify the parents of their monthly reimbursement amount using Form 2849-EM.

EXAMPLE: A family of 4 has an annual gross income of $150,000, the monthly reimbursement will be $1,280.75 or with insurance penalty, $1,739.50.

COMPUTATION:

$150,000	
- 1,200	Child Support
$148,800	
-44,700	Family Deduction
$104,100	Net Annual Gross Income

a. $50,000 of Net Annual Gross Income is multiplied by 10% or 15% (5% Insurance Penalty)

$50,000 X 10% = $5,000 or 15% = $7,500

b. The Net Annual Gross Income is also between $50,000 - $60,000, multiply $10,000 by 13% or 18% (5% Insurance Penalty)

$10,000 X 13% = $1,300 or 18% = $1,800

c. The Net Annual Gross Income is also between $60,000 - $75,000, multiply $15,000 by 16% or 21% (5% Insurance Penalty)

$15,000 X 16% = $2,400 or 21% = $3,150

d. The Net Annual Gross Income is also OVER $75,000, multiply the amount which is over $75,000 by 19% or 24% (5% Insurance Penalty)

$29,100 X 19% = $5,529 or 24% = $6,984

Add the results of a, b, c and d, then divide by 12 for the monthly reimbursement amount.

No Insurance Penalty	Insurance Penalty 5%
$ 5,000	$ 7,500
1,300	1,800
2,400	3,150
+ 5,529	+ 6,984
$14,229/12	$19,434/12
= $1,185.75	= $1,619.50

From either of these two Monthly Reimbursement Amounts, the home care credit, medical expenses and/or health insurance premium would be deducted to reach the net Monthly Reimbursement Amount.

3. If the monthly reimbursement is greater than zero, send copies of the parent questionnaire and copy of Form 2849-EM form with the recovery referral form to the Investigations and Recovery Unit in their service area.

If a parent's whereabouts is unknown, the case manager will refer eligibility information to Investigations and Recovery for parent locate services using Form 2683–EE "Investigation Referral Form."

If eligibility for the child terminates, the case manager will notify Investigation and Recovery Unit on Form 6009-AG.

F. RESPONSIBILITIES OF RECOVERY STAFF

Investigations and Recovery staff are responsible for:

1. Setting up a case file on referred cases.
2. Sending the initial notice of monthly reimbursement letter along with a copy of the worksheet, Form 2028-EE. A monthly reimbursement will be calculated for each month the disabled child is Medicaid eligible.
3. Controlling and receiving the monthly reimbursement funds.
4. Sending delinquent letters, filing small claims court actions and making referrals to the Deputy Attorney General as appropriate.
5. Evaluating and negotiating undue hardship requests.
6. On an annual basis, reviewing the child's medical costs in comparison to paid reimbursement amounts and providing a credit against future month reimbursement amounts for any funds in excess of the child's medical costs. Medicaid-paid Provider 60 amounts are not included in the "child's medical costs" for these purposes.

502 RESERVED

503 RESERVED

504 RESERVED

505 MEDICAID PROGRAM CLAIMS

A. DEFINITION OF A CLAIM

A Medicaid claim is the calculated value of any service, good or other item of value paid by the Medicaid Program which exceeds the amount of benefits the individual(s) was eligible for.

B. WHEN INFORMATION IS RECEIVED INDICATING A CLAIM MAY EXIST

The appropriate case manager will:

- Ensure the household's current budget reflects correct, up-to-date information to avoid further incorrect payment of benefits.

- Obtain written verification of the questionable issue.
- Refer the claim to I&R via the Investigations and Recovery Information System (IRIS) for review, calculation and claim establishment.

C. CLAIM PACKET

Immediately at claim referral, case manager shall compile a "claim packet." The claim packet must include:

- a copy or original of all pertinent documents (applications, picture ID, etc.) contained within the case file;
- a copy or original of substantiating documentation relative to the claim;
- a case narrative containing at a minimum how the claim occurred; and
- a copy of the claim referral.

The claim packet must be sent to the I&R Unit responsible for their program office as soon as possible to begin the collection process.

NOTE: Claims are addressed in detail in the I&R Manual, section 300–500, respectively. Reference should be made to these manual sections for issues/events not addressed in this chapter.

506 MEDICAID ESTATE RECOVERY PROGRAM

506.1 LEGAL AUTHORITY

Authority for operating the Medicaid Estate Recovery (MER) Program is published in Section 1917 of the Social Security Act and Nevada Revised Statute 422.2935.

506.2 PROGRAM OVERVIEW

Federal and state law mandates state operation of a MER program whereby correctly paid Medicaid benefits are recoverable from the estate of a deceased Medicaid recipient. Recovery is accomplished only after the death of a recipient and at a time when there is no surviving spouse, children under the age of 21 or disabled children.

Regulations of the MER program affect individuals who received Medicaid benefits on or after October 1, 1993. Collections will be pursued against the estate of the recipient up to the amount of Medicaid benefits correctly paid or up to the determined value of the recipient's estate whichever is less.

MER staff is currently housed at the Division of Health Care Financing and Policy (DHCFP).

506.3 DEFINITION OF "ESTATE"

For the purposes of Medicaid Estate Recovery "Estate" means assets included in the estate of a deceased recipient of assistance to the medically indigent and any other assets in or to which he had an interest or legal title immediately before or at the time of his death, to the extent of that interest or title. The term includes assets passing by reason of joint tenance, reserved life estate, survivorship, trust, annuity, homestead or other arrangement.

506.4 AFFECTED INDIVIDUALS

MER actions are imposed against Medicaid recipients who are:

- 55 years of age or older when they receive Medicaid assistance; or
- an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, where they are required to spend for costs of medical care all but a minimal amount of income which is permitted for the recipient's personal needs.

506.5 NOTIFICATION TO AFFECTED INDIVIDUALS

Full disclosure of MER program operation is made during the application process. Statements regarding MER are included on the eligibility application and applicants (or their representatives) are given Form 6160-AF, "Medicaid Estate Recovery Notification of Program Operation." Staff MUST attempt to secure the acknowledgment (via signature) of information provided on Form 6160-AF. However, the applicant's (or their representative's) failure to sign the form does NOT preclude Division pursuit of correctly paid benefits.

Form 6160-AF, Medicaid Estate Recovery Notification of Program Operation, must be given to all applicants for Medicaid assistance at the time of application for services and redetermination. Be sure the applicant receives the form in English or Spanish, whichever is appropriate.

One copy of the form will be given to the applicant and one copy will be filed in the Medicaid eligibility casefile.

506.6 REFERRAL OF CASES TO MER UNIT

When a MER affected recipient is no longer Medicaid eligible due to death, the eligibility worker MUST forward their casefile to DHCFP, Attention: MER, within three (3) working days after the closure of the Medicaid casefile resulting from the death of the Medicaid recipient.

Eligibility staff will request in writing the return of the casefile, if necessary. The written request must include the name and Social Security Number of the client; the date of the request; the eligibility staff member requesting the file and the district office where the file should be sent. This request may be faxed or forwarded to DHCFP, Attention: MER, utilizing interoffice mail. MER staff will provide the casefile within three (3) working days.

Casefiles for Medicaid applicants who have been denied Medicaid eligibility and who do not have a history of prior approval should not be forwarded to the MER unit at DHCFP.

506.7 INITIATION OF MER ACTIVITIES

Upon receipt of the closed Medicaid eligibility casefile, DHCFP MER personnel will establish a MER recovery case. MER staff will validate the recipient's reported resource information.

506.8 NOTIFICATION TO RECIPIENT OR THEIR HEIRS

When MER staff receives notification of an affected Medicaid recipient's death, they will provide their known heirs with a written notice which:

- advises of the state's intent to recover the value of Medicaid benefits paid on the recipient's behalf from the recipient's estate; and
- provides information addressing Medicaid payments made on behalf of the recipient; and
- includes a statement advising the amount the MER claim may increase if there are additional Medicaid claims which have not yet been processed.

All MER notices will include a statement advising the recipient and/or their heirs of the MER hardship waiver provisions.

506.9 IDENTIFICATION OF MER COLLECTIBLES

After the reported death of an affected recipient, MER personnel will review the recipient's estate to determine an estimated dollar value. Asset information will be recorded in the recipient's MER file and will serve as the maximum value collectable under the MER program. In addition, MER personnel will prepare a detailed listing of all Medicaid services provided to the recipient and the amount of Medicaid expenditures paid on behalf of the recipient. This amount will be the maximum amount recoverable under the MER program.

MER actions will be pursued against the estate of the recipient up to the amount of Medicaid benefits correctly paid or up to the determined value of the recipient's estate whichever is less.

506.10 INITIATING MER COLLECTIONS

After the recipient's death, MER personnel will immediately pursue adjustments or recovery of any Medicaid assistance correctly paid on behalf of the recipient from the recipient's estate or upon sale of the recipient's real property.

Any adjustment or recovery against a recipient may be made only after the death of the recipient's surviving spouse, if any, and only at a time when:

- the recipient has no surviving child who is under 21 years of age; or
- the recipient has no surviving child who is blind or disabled.

506.11 RECOVERY AGAINST AN ESTATE

After the death of an affected recipient, and in accordance with Nevada Revised Statutes, MER personnel will immediately file a claim against the estate of the recipient for the full value of Medicaid benefits paid on behalf of the recipient. Once MER staff have requested the deceased recipient's casefile, eligibility staff WILL FORWARD the casefile to DHCFP, Attention: MER within three (3) working days.

Claims will be filed with:

- the court having jurisdiction over the recipient's estate pursuant to NRS 147.040; or
- any individual or entity empowered with the legal ability to control, liquidate or transfer any part of the recipient's estate.

506.12 IMPOSITION OF LIENS

Liens may be imposed to protect recovery of estate assets for correctly paid Medicaid benefits when permitted by federal and state law. However, the use of lien authority requires prior notification to the recipient or their known heirs and district court review. Liens may only be imposed with district court approval. The equity interest of the surviving spouse shall be considered in determining the value of the deceased recipient's interest in the property.

Foreclosure action may occur only after the death of the recipient and after the death of the recipient's surviving spouse, if any, and only at a time when the recipient has no surviving child who is under 21 years of age, and the recipient has no surviving child who is blind or disabled.

In the event of incorrectly paid benefits, a lien may be imposed on both real and personal property with authority of a court judgment without regard to circumstances.

NRS 155.020 requires notice be given to the Department of Health and Human Services of all probate proceedings filed with the court. Any probate notices received in the district office MUST be faxed IMMEDIATELY to DHCFP, Attention: MER.

506.13 POSTPONING/TERMINATING MER ACTIONS

If, after the reported death of the recipient, immediate MER action is prohibited because of exception conditions, MER personnel postpone MER action until all exception conditions are no longer present. Termination of MER action will occur when all real and personal property included as part of the recipient's estate is no longer accessible.

506.14 RECEIPTING/POSTING MER COLLECTIONS

All MER collections will be received by MER personnel located at DHCFP or the DHCFP Accounting Unit.

In the event a MER payment is received in the district office, district office staff must photocopy the negotiable instrument and document on the copy:

- the name and address of the person making the payment;
- the name and Social Security Number of the deceased recipient;
- the amount and method of payment; and
- the date and signature of the person receiving the payment.

A copy will be provided to the person making the payment and another copy along with the negotiable instrument MUST be forwarded to DHCFP, Attention: MER, immediately utilizing interoffice mail.

If payment is made by cash, the office MUST follow the procedure outlined above. CASH MUST BE DEPOSITED BY THE DISTRICT OFFICE AND CANNOT BE TRANSMITTED THROUGH THE MAIL. If assistance is needed, please contact DHCFP, MER.

DO NOT STATE VERBALLY OR IN WRITING THIS PAYMENT RELEASES THE HEIR FROM MEDICAID ESTATE RECOVERY ACTION.

506.15 EXCLUSION FROM RECOVERY

The following income, resources and property are exempt from Medicaid estate recovery;

1. Certain income and resources of American Indians and Alaska Natives. Income and resources (such as interests in and income derived from tribal land and other resources currently held in trust status and judgment funds from the Indian Claims Commission and the U.S. Claims Court) that are exempt from Medicaid estate recovery by other laws and regulations;

2. Ownership interest in trust or non-trust property, including real property and improvements:

   a. Located on a reservation (any federally recognized Indian tribe's reservation, Pueblo or Colony, including former reservations in Oklahoma, Alaska Native regions established by Alaska Native Claims Settlement Act and Indian allotment) or near a reservation as designated and approved by the Bureau of Indian Affairs of the U.S. Department of the Interior, or
   b. For any federally-recognized tribe not described in a., located within the most recent boundaries of a prior federal reservation.
   c. Protection of non-trust property described above is limited to circumstances when it passes from an Indian (as defined in section 4 of the Indian Health Care Improvement Act) to one or more relatives (by blood, adoption or marriage), including Indians not enrolled as members of a tribe and non-Indians, such as spouses and stepchildren, that their culture would nevertheless protect as family members; to a tribe or tribal organization; and/or to one or more Indians.

3. Income left as a remainder in an estate derived from property protected in 2. above that was either collected by an Indian, or by a tribe or tribal organization and distributed to Indian(s), as long as the individual can clearly trace it as coming from the protected property.

4. Ownership interests left as a remainder in an estate in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish and shellfish) resulting from the exercise of federally-protected rights, and income either collected by an Indian, or by a tribe or tribal organization and distributed to Indian(s) derived from these sources as long as the individual can clearly trace it as coming from protected sources; and

5. Ownership interest in or usage rights to items not covered by 1.-4. above that have unique religious, spiritual, traditional and/or cultural significance, or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom.

6. Government reparation payments to special populations.

Income, resources and property of American Indians and Alaska Natives, which are not exempt from Medicaid estate recovery:

1. Ownership interests in assets and property, both real and personal, that are not described in the above items.

2. Any income and assets left as a remainder in an estate that do not derive from protected property or sources listed above.

506.16 HARDSHIP WAIVER

At the time recovery is initiated, the MER recovery specialist will discuss hardship waivers, compromises or adjustments to the state's claim. Hardship requests will be submitted to the administrator (or their appointed representative) for review. The denial of a hardship waiver or compromise may be appealed through the appropriate court system.

There is no hardship waiver provided at the time of lien placement against the real property of a deceased Medicaid recipient. The equity interest of the heir will be considered to determine the percentage of the deceased recipient's interest in the property. Lien placement is utilized to delay recovery until such time an exemption to recovery does not exist, or in the case of a hardship, until such time as the hardship no longer exist. The state's lien would be the Medicaid benefits paid on behalf of the recipient or the percentage of interest of the deceased recipient at the time of sale, whichever is less.

506.17 HARDSHIP WAIVER CRITERIA

Recovery will be waived of any estate recovery claim when the requesting party is able to show, through convincing evidence, the state's pursuit of estate recovery subjects them to undue and substantial hardship. In determining whether an undue hardship exists, the following criteria will be used:

1. The asset to be recovered is the sole income-producing asset of the applicant, or,

2. The recovery of the assets would result in the applicant becoming eligible for governmental public assistance based on need and/or medical assistance programs; or

3. Medical condition which compromises the applicant's ability to repay the Medicaid claim. A claim for emotional hardship is not considered sufficient to warrant waiver approval.

In response to any hardship request, recovery may be temporarily waived, recovery amounts could be compromised or recovery techniques modified. The administrator (or designated representative) may consider the following circumstances, including but not limited to:

1. The gross annual income, property and other assets of the applicant and their immediate family;

2. The relationship of the applicant to the decedent;

3. The type and level of care provided by the applicant to the decedent and the extent to which the care delayed or prevented the institutionalization of the decedent;

4. Whether the applicant continuously resided with the decedent for two years or more immediately prior to the decedent's death and continues to reside in the decedent's residence, and the prior occupancy permitted the decedent to reside at home rather than in an institution;

5. The estimated value of the real or personal property at issue, and/or;

6. The financial impact of recovery against other affected parties.

The following collection methods may be utilized when recovery is temporarily waived, compromised or modified.

1. Reduction of the recovery amount;

2. Reasonable payment schedule based on the asset to be recovered; and/or

3. Where not prohibited by law, imposition of a lien against the assets of the Medicaid recipient. If a lien is placed on an individual's home, adjustment or recovery will only be made when: 1) there is no sibling of the individual residing in the home who has resided there for at least one year immediately before the date of the individual's death, and has resided there on a continuous basis since that time; and 2) there is no son or daughter of the individual residing in the home who has resided there for at least two years immediately before the date of the individual's death, has resided there on a continuous basis since that time, and can establish to the agency's satisfaction that he/she had been providing care which permitted the individual to reside at home rather than in an institution.

506.18 PROCEDURES FOR APPLYING FOR HARDSHIP WAIVER

FEDERAL LAW PROHIBITS RECOVERY DURING THE LIFETIME OF A SPOUSE WHEN THERE ARE CHILDREN UNDER THE AGE OF 21, AND/OR WHEN THERE ARE CHILDREN WHO ARE BLIND AND/OR DISABLED.

Nevada defines hardship as undue and substantial hardship resulting in severe financial duress or a significant compromise to an individual's health care or shelter needs.

1. Any beneficiary, heir or family member claiming entitlement to receive the assets of the deceased client may apply for a hardship waiver by submitting a written request for a waiver, within thirty (30) days of being notified of an intent to recover, to the Medicaid Estate Recovery (MER) unit.

2. The division may request additional information or documentation from the waiver applicant. If some or all of the additional information or documentation is not provided within thirty (30) days of the request, the hardship waiver request will be considered solely on the basis of the information and documentation provided.

3. Within ninety (90) days of receipt of the hardship waiver request, the division administrator (or appointed representative) will issue a written decision granting or denying the applicant's request for an undue hardship waiver.

4. If the hardship waiver is denied, the decision may be appealed through the appropriate court system.

5. Receipt of a timely request for a hardship waiver shall not prevent or delay the division's pursuit of the estate recovery claim pending the final decision. The Division shall return any funds collected if the waiver is granted. No waiver will be granted if the division finds the undue hardship was created by estate planning methods by which the waiver applicant or deceased client divested, transferred or otherwise encumbered assets in whole or part to avoid estate recovery.

506.19 APPLICATION (REQUEST) FOR HARDSHIP WAIVER FOR CORRECTLY PAID MEDICAID BENEFITS

Name of Medicaid Recipient: _____

Name of Applicant: _____

Address of Applicant: _____

_____
City State Zip Code

1. Relationship to person who received Medicaid assistance: _____

2. Are the assets to be recovered your sole income-producing asset in your trade, profession or occupation? □ Yes □ No

   Please explain: _____

3. Please explain how denial of the hardship will affect you. Please provide any documentation and/or receipts which would support your statements.

   Financially: _____

   Medically: _____

   Shelter Needs: _____

   Other: _____

4. I am applying for a hardship waiver because of disability. Please explain this disability and provide any medical evidence supporting this disability.

   _____

5. Are you currently receiving public assistance of any type? □ Yes □ No

   If Yes, please explain: _____

   _____

6. Did you reside in the home and provide care for the Medicaid recipient on a continuous basis for a minimum 2-year period before death? □ Yes □ No

7. Provide documentation of the type of care you provided for the Medicaid recipient. Please detail the type of care you provided and the approximate number of hours per day you provided this care.

   _____

   _____

8. Provide a copy of your federal income tax return for the most current year.

9. If Aging Services provided at-home care for the Medicaid recipient, please provide the name of the Aging Services' representative.

   _____

An application for hardship will be considered on a case-by-case basis. The decision may be to waive recovery, delay recovery, compromise the recovery amount, or modify the collection method. You will be notified by letter within ninety (90) days of the decision. If the request for hardship is denied, you may appeal the decision in the appropriate court system.

A return envelope is provided for your convenience.

Distribution: WHITE – Central Office E&P/MER (Page 3 of 3) 6135-AFC (7/02)

NEVADA STATE DIVISION OF WELFARE

AND

SUPPORTIVE SERVICES

MAABD PROGRAM MANUAL

APPENDIX A

GLOSSARY OF TERMS

AND

ACRONYMS

GLOSSARY OF TERMS AND ACRONYMS

AGCF	Adult Group Care Facility. Aid codes GC & HG
APPL	A signed application for benefits.
COBRA	Consolidated Budget Reconciliation Act of 1985
COLA	Cost-of-living-adjustment. Yearly increases in Social Security, VA, pension benefits
CONT.	Continuance. Ongoing terminology used when a term-pend is lifted to continue benefits
CONVERSION	An application or redetermination used to change a client's eligibility from one category to another, e.g., SSI to State Institutional case
DAG	Deputy Attorney General. The attorney representing the Division in legal matters
DENIAL	Intake terminology for denying an application
DWSS	Division of Welfare and Supportive Services
DROP-OFF	Applications which are left at the district office front desk station. No in-person interview held
E&P	Eligibility and Payments
FA	Future Action. A form used to control when an action is needed on a case at a later date
FCH	Obsolete
HBW	Home Based Waiver. A Medicaid program which provides medical services in the client's home
ICF	Intermediate Care Facility
ICF/MR	Intermediate Care Facility for the Mentally Retarded
IMD	Institution for Mental Disease
INTAKE	The eligibility determination process for an application for medical assistance
INQUIRY	An application form which is not signed by the applicant or their authorized representative/legal guardian

KATIE BECKETT	A Medicaid eligible category for at-home medical care of disabled children
MAABD	Medical Assistance to the Aged, Blind and Disabled
MAF	Obsolete - MAABD Action Form. (Computer Document)
MAPNET	Obsolete
MEDICAID	Medical "assistance" program administered by the Division of Healthcare, Financing and Policy (DHCFP)
MEDICARE	Medical "insurance" program administered by the Social Security Administration
MRT	Medical Review Team. Medicaid staff involved in making a disability determination
NF	Nursing Facility
NMO	Nevada Medicaid Office. Location: DHCFP
NSWD	Obsolete acronym for the formerly named Nevada State Welfare Division
OBRA	Omnibus Budget Reconciliation Act of '86; '87; '89; and '90
ONGOING	The continued process of determining eligibility after case approval
OV	Office Visit or Opportunity Village
PA	Public Administrator. A county official named guardian to handle an incompetent affairs
PCN	Primary Care Network. A Medicaid enrolled health plan
P/L	Patient Liability. A recipient's share of medical costs while residing in a medical facility or receiving at-home care
PENDING SLIP	A form given to clients after an application is submitted to show/verify case status
PICKLE	A Medicaid coverage group-Public Law 94-566, Pickle Amendment
PRIOR MED	Medical assistance available 3 months prior to Medicaid application
QDWI	Qualified Disabled Working Individuals

QMB	Qualified Medicare Beneficiaries.
RD	Redetermination of Medicaid eligibility. Occurs annually.
REINSTATEMENT	Terminology used when a case is reopened from closed status. (Intake or Ongoing)
RSDI	Retirement, Survivor, Disability Insurance (Title II) funds administered by the Social Security Administration.
SAMI	Obsolete word used to describe Medicaid benefits.
SDX	State Data Exchange. A computer print-out of SSI information received from Social Security.
SEL	Service Eligibility Listing. Also known as TR or Treasury Report. Contains same information as SDX on SSI recipients.
SLMB	Special Low-Income Medicare Beneficiaries.
SNF	Skilled Nursing Facility.
SSA	Social Security Administration.
SSI CARD	A computer card (imprinted with SSI) used to ask for specific information on a client.
SSI	Supplemental Security Income. (Based on Need)
STATE CASES	Eligibility determined by the State not Social Security. Also used for State Institutional cases.
TERMINATED	Ongoing terminology for stopping benefits.
TERM-PEND	A computer action to hold benefits for the future month while waiting for information previously requested. A Notice of Decision is always sent.
TITLE XIX	A.K.A. Medicaid.
TR	Treasury Report. Contains SSI data.
UME	Unusual Medical Expense. (VA related)
VA	Veteran's Administration or Veteran's benefits.
ZEBLEY	Ninth Circuit Court decision requiring SSA determine disability of children using children criteria not adult criteria.

NEVADA STATE DIVISION OF WELFARE

AND

SUPPORTIVE SERVICES

MAABD PROGRAM MANUAL

APPENDIX B

POSSIBLE BENEFITS AVAILABLE TO DIVISION OF WELFARE AND SUPPORTIVE SERVICES CLIENTS

APPENDIX B

TABLE OF CONTENTS

I. SOCIAL SECURITY - RETIREMENT, SURVIVORS AND DISABILITY INSURANCE (RSDI) BENEFITS.

RSDI benefits are paid to beneficiaries based on the Social Security earnings of the retired or deceased worker.

A. RETIREMENT BENEFITS

Retirement is earned on a quarter or "credit" basis. Currently, $500 annually must be earned for each credit toward Social Security, with a maximum of 4 credits earned annually. If a claimant is fully credited when retirement age (62 or older) is reached, both the claimant and certain family members may be eligible for benefits.

If the claimant is receiving Social Security retirement benefits, benefits are also available to:

1. Unmarried children under age 18, or under age 19 if enrolled full-time in elementary or high school. (Includes stepchildren if parent and stepparent are married one (1) year or more. Benefits may also be available if putative father dies prior to paternity verification or if child(ren) are illegitimate and paternity is established.)

2. Unmarried children age 18 or over who became severely disabled prior to age 22 and who continue to be disabled.

3. Spouse* who is age 62 or over.

4. Spouse who is under age 62 and is a caretaker for a disabled child or child under age 16 who is receiving Social Security benefits.

* Benefits can be paid to divorced spouses who are age 62 or over if the marriage lasted 10 years or more. The divorced spouse may remarry after age 60 (50 if disabled) and continue to receive spousal benefits.

Grandchildren and great grandchildren may be eligible for Social Security benefits under certain conditions.

Social Security retirement benefits may continue even if the claimant returns to work. After age 70, there is no reduction of Social Security benefits if the claimant also works.

If you feel there are unusual circumstances involved with a Social Security claimant, contact the local Social Security Office directly.

B. SURVIVOR'S BENEFITS

Survivor's benefits are "earned" on a quarter or "credit" basis, (credits are earned as described in A. above). Only if the deceased worker had sufficient credits in Social Security are benefits payable. The exact amount of credits required to receive benefits depend on the worker's age at death. Generally, the older the worker at death, the more credits required for survivors payments.

Benefits are available to a survivor who:

1. is a widow(er) at any age who is caring for the deceased workers child (under age 16 or disabled).

2. is a widow(er) who is age 60 (50 if disabled) who is not caring for a child. Remarriage after age 60 (50 if disabled) will not prevent payment if the worker died prior to remarriage.

3. is a divorced widow(er) caring for an entitled child (under age 16 or disabled). Length of marriage does not apply.

4. is an unmarried child age 18, or age 19 if still attending elementary or high school full-time. If the child is disabled before age 22, he/she can receive benefits as long as he/she remains disabled. (Includes stepchildren if parent and stepparent are married one (1) year or more. Benefits may also be available if the putative father dies prior to paternity verification or if child(ren) are illegitimate and paternity is established.)

C. DISABILITY BENEFITS

Disability is earned on a quarter or "credit" basis as are retirement and survivor's benefits. The required amount of credit required to receive benefits depends on the age of the applicant at time of disability.

If the applicant is younger than age 50 at the time of disability, credits needed vary between 6 - 20.

Benefits are available to disabled applicants and their families for:

1. Unmarried children under age 18, or age 19 if attending elementary or high school full-time. If the child is disabled before age 22, he/she can receive benefits as long as the child remains disabled. (Step-children may also be eligible if the parent and stepparent have been married one (1) year or more. Benefits may also be available if the putative father dies prior to paternity verification or if child(ren) are illegitimate and paternity is established.)

2. Spouse who is:

   a. Caring for disabled person's child (or step-child if parent and stepparent were married one (1) year or more) under 16 or disabled and received checks.

   b. Age 62 or older.

   c. Disabled widow(er) at age 50.

   d. Disabled divorced spouse if married 10 years or longer. Benefits are payable at age 50.

   Disability of an applicant is determined by Social Security based on the following criteria:

a. Medical evidence showing that the applicant's condition is severe enough to prevent the applicant from working.

b. The medical condition is expected to last (or has lasted) for at least one year or is expected to result in death.

Blindness is considered a disability. Blindness is defined by Social Security as vision that cannot be corrected to better than 20/200 in the better eye or if the vision field is less than 20 degrees with corrective lenses.

II. SUPPLEMENTAL SECURITY INCOME (SSI) BENEFITS

SSI is a different facet of Social Security payment. It is, in effect, a federal welfare program for those people who are aged (65 or older) or disabled and have resources and INCOME below allowable maximums.

SSI has several rules that must be met for eligibility. These rules are:

1. The applicant must be a U.S. citizen, a lawful permanent resident (foreign born), or a foreign born person the INS (Immigration and Naturalization Service) plans to allow to stay in the United States.

2. The applicant must reside within the United States or Northern Mariana Islands.

3. If the applicant is eligible for other benefits, he/she must apply for those benefits.

4. The applicant must be accepted and comply with vocational rehabilitation services if the services are offered.

5. Resources/property are evaluated to determine if they are countable or excluded. Countable resources cannot currently exceed $2,000 for an individual or $3,000 for a couple.

6. Applicants/recipients must not have countable income in a month of more than the Federal Benefit Rate (FBR) for an individual or for a couple. Certain types of income are excluded in determining eligibility and benefit amount.

Countable income of an eligible spouse, parent of an eligible child, an essential person or sponsor of an alien is considered (deemed) to be the applicant/recipient's income.

III. VETERAN'S ADMINISTRATION (VA) BENEFITS

The VA has several different types of assistance available to veterans and their families. The first type of benefit is a monetary payment for a service-connected disability or non-service connected disability.

A. SERVICE CONNECTED DISABILITY - VA COMPENSATION

Veterans who became disabled while enlisted may receive VA Compensation payments. These payments are not based on need. Payment is determined by length of service and percent of determined disability.

Under certain circumstances, these payments can be increased if the recipient can prove hardship to the VA. If the recipient is 30% or more disabled, both the spouse and children (under age 18 or full-time students to age 22) can be included in the payment amount.

B. NON-SERVICE CONNECTED DISABILITY - VA PENSION

Veterans who became disabled after separation from active duty or become disabled after 90 days or more of wartime service may receive a VA pension. Payment is based on need. Both the spouse and children (under age 18 or a full-time student under age 22) can be included in the payment amount.

Surviving spouses and unmarried children under age 18 (or until 23 if attending a VA-approved school) of deceased veterans with wartime service may be eligible for pension based on need. This is called nonservice-connected death pension.

C. AID AND ATTENDANCE - ADDITIONAL PAYMENT

Veterans who are disabled or spouses of veterans who are disabled to the extent of being unable to care for their basic daily needs (i.e., shopping, housekeeping, personal hygiene, etc.) may be eligible for a disability payment. Eligibility is based both on need and a disability determination made by the discharging medical facility. This payment type is not currently counted in determining MAABD financial eligibility.

D. EDUCATIONAL ASSISTANCE

Clients, who are veterans or are surviving spouses and children, may also be eligible for student/educational assistance.

This assistance can be in the form of either:

1. Noncontributory GI Bill - (education)

    a. Educational loans through the VA.

    b. Grants and reduced tuition through VA.

    c. Work-study and on-the-job training funds.

2. Contributory GI Bill - (education)

a. VEAP - Veterans Education Assistance Program

This is a program under which educational benefits are paid to veterans who entered active service between January 1, 1977 and June 30, 1985.

The maximum benefit from this program is $8,100 payable over a 36-month timeframe.

b. "NEW" GI Bill - Active Duty Educational Assistance Program.

Benefits are payable, on a sliding scale determined by the active duty pay, for 36 months with an additional 36 months available for veteran's with 5+ years of service. This is a program under which educational benefits are paid to veterans who entered active service on or after July 1, 1985.

E. VOCATIONAL TRAINING - DISABLED VETERANS

While a veteran is attending vocational training, he/she may receive a "subsistence allowance" in addition to the regular monthly VA disability payment. The allowance may continue for two (2) months after training has been completed.

If the client obtains a job within four (4) years after training, disability payments from VA will continue for 12 months.

F. VA MEDICAL ASSISTANCE

There are two types of medical assistance available for spouses and dependent children of active, retired and disabled veterans. These medical programs are CHAMPUS and CHAMP VA. Both insurance programs are cost sharing (i.e., deductible + percentage of cost of care). For specific information regarding eligibility and medical expense determination, contact the local VA office.

G. VA LIFE INSURANCE

There are 5 types of life insurance available to veterans. Each category corresponds to a different time frame of duty (i.e., WWI, WWII, etc.). These policies are all term policies. They are as follows:

1. *USGL1 - WWI veterans through 10/7/40

2. *NSL1 - 10/8/40 - 4/24/51 (Includes WWII veterans)

3. VSL1 - 4/25/51 - 12/31/56 (Includes Korean War Veterans)

4. SDV1 - after 4/25/51 - 10% + disability

5. VR1 - 5/1/65 - 5/2/66 - WWII and Korean War Veterans only

6. SGL1 - All other veterans, or

7. VGL1 - All other veterans.

* will pay yearly dividends on yearly anniversary.

Life insurance through the VA does have a surrender value.

H. VA SURVIVORS BENEFITS

Survivor's benefits are authorized for surviving spouses, unmarried children under age 18 (under age 23 if attending VA approved schools), severely disabled children and certain parents. The veteran must have:

1. Died from a disease or injury incurred or aggravated in the line of duty or while training for active duty; or

2. Died from an injury incurred or aggravated in the line of active duty or inactive duty training; or

3. Been rated totally disabled for 10 or more years; or

4. Been rated totally disabled for at least 5 years and the rating was continuous from date of discharge.

Eligibility for benefits is not based on need.

To qualify, a surviving spouse generally must have been married one year or more OR for any time if a child was born of or before the marriage. If the surviving spouse remarries, the remarriage usually makes the spouse ineligible for benefits unless the remarriage was void, annulled or terminated due to death or divorce. Contact the VA for specific case or eligibility information.

IV. RAILROAD RETIREMENT AND DISABILITY BENEFITS

A. RETIREMENT

In general, the employee earns his retirement through the number of "creditable" months worked in railroad service. There are three stages of eligibility for retirement benefits:

1. With 360 months or over of creditable service at age 60 (20% penalty if drawn prior to age 62).

2. With 120 - 359 months of creditable service at age 62 (1/180 reduction for each month the employee is under age 65 at the beginning of annuity payment).

3. With 120 months of creditable service at age 65 (no age reduction).

There is a potential for "vested dual benefits," i.e., benefits paid both through Social Security and the railroad board. The employee must have been eligible for both benefits prior to 1975.

Spousal annuity benefit requirements are different than Social Security benefit requirements. The spouse must be:

1. Married to the employee for one year, or

2. Is the natural parent of an employee's child, or

3. Previously eligible for an annuity prior to marrying the employee, or

4. Is living in the same household and defacto spouse is a person who would otherwise be a spouse if not for some legal impediment unknown at the time of the marriage ceremony.

Spousal annuity payments are usually payable when the spouse reaches age 60 to 62 depending on individual circumstances. The one exception to the age restriction on spousal annuity payments is if the employee is age 65 and the spouse is caring for the employee's child who is under 18 (age 16 if the spouse is male) or a child who became disabled before age 22. A divorced spouse must meet all of the following criteria to become eligible for payment:

1. The employee must be at least age 62 and drawing retirement benefits, and

2. The divorced spouse must be at least age 62, and

3. The marriage ended in a final decree of divorce, and

4. The marriage between the employee and the divorced spouse must have lasted a minimum of 10 years before the decree date, and

5. The divorced spouse is not currently married, and

6. The Social Security benefits the divorced spouse may be eligible for are less than the railroad annuity, and

7. The divorced spouse is not working for an employer covered by the Railroad Retirement Act.

B. DISABILITY PAYMENTS

An employee can be eligible to receive disability payments if he/she is determined to be permanently disabled for all work. There are two types of disability payments and corresponding eligibility criteria:

1. Non-work related - The employee must:

   a. have a minimum of 120 creditable months of railroad service, or

b. be permanently disabled (expected to last at least 12 months or result in death).

2. Occupational related - The employee must:

a. have worked more for the railroad than any other occupation in the last 5 years, or

b. have worked at least one half of the months in the last 15 years (for any industry).

V. EMPLOYERS INSURANCE COMPANY OF NEVADA (EICON)

A. DISABILITY BENEFITS

In general most employed Nevada residents are covered by EICON. Employers are required to pay "premiums" to cover employees injured or disabled while at work or performing work-related or assigned duties. Even if employers do not pay the mandated premiums, employees may still receive SIIS benefits by filing suit or applying directly to the Department of Industrial Relations.

1. Eligibility - Eligibility for benefits is determined on a "no-fault" basis. This means that no matter how the injury or accident occurred, if the injury was within the scope of employment, benefits may be paid. (If the accident was self-inflicted or was caused due to the employee being under the influence of a controlled substance, benefits would not be available.) Injury and disability claims are reviewed and processed through medical evidence presented at the local EICON office.

2. Benefits - Once eligibility for benefits has been established, medical expenses related to the accident are covered. Payment will also be made while the employee is unable to return to work.

Payments for "temporary total disability" are made until the injured employee is recovered and able to return to work (24 month maximum) OR reaches age 70, whichever occurs first. If disability is so great as to prevent the employee from ever returning to work, payments can continue until the employee's death.

Payments may also be made as a "lump sum settlement." If a settlement is made, future injury-related medical and monetary benefits are usually forfeited. A copy of the settlement document should be requested to verify third party liability.

VI. COUNTY GENERAL ASSISTANCE

A. PAYMENT OF BENEFITS

In general, county general assistance is a cash payment program designed to be temporary. The recipient is required to repay assistance when financially able. There are four categories of eligibility for general assistance benefits:

1. Single Unemployables - the individual must be determined unemployable by a doctor's statement and meet financial eligibility criteria. The period of disability does not have to be permanent in nature to qualify for assistance. This category of client is usually pending Social Security or another type of disability program determination. Payment is usually issued monthly.

2. Single Parents - The family must meet financial eligibility criteria to receive assistance. This category of client is usually pending an TANF decision. Payment is usually issued monthly.

3. Incapacitated Head of Household - The head of household must be determined incapacitated, thus causing financial hardship to the family. Financial eligibility criteria must be met and disability does have to be verified by doctor's statement and does not need to be permanent in nature. Payment is usually issued monthly.

4. Intact Family - The family must meet financial eligibility criteria to receive this type of assistance. Payment is normally issued on a weekly basis and a job-search type of activity is routinely required.

   To qualify, applicants must meet income and asset guidelines. Both income and asset limits are set on a graduated scale depending on the number of household members. Actual income and asset breakdowns vary between counties and specific eligibility questions should be directed to the corresponding county office.

VII. INDIAN GENERAL ASSISTANCE (IGA)

A. PAYMENT OF BENEFITS

In general, Indian General Assistance is a federal cash payment program administered by the tribal councils. Eligibility is based on two eligibility criteria:

1. Tribal Affiliation - the tribe must be officially recognized by the federal government and the applicant must be an identifiable member of that tribe.

2. Need - the Indian applicant(s) must prove need to be considered eligible for an IGA grant. The amount of grant varies both between tribes and number of household members in the assistance unit.

Indian General Assistance is considered a temporary grant program while the recipient is pending approval for another type of assistance program or become financially ineligible for assistance. IGA grants are normally paid on a monthly or semi-monthly basis. Specific eligibility questions should be directed to the corresponding tribal assistance office.

VIII. REFUGEE RESETTLEMENT GRANTS (LANDING GRANT)

A. PAYMENT OF BENEFITS

In general, refugees are sponsored either by private parties or through volunteer "helping" agencies. The sponsors assume responsibility for placing the refugee(s) in a suitable community and ensure that the refugee(s) will become self-sufficient. The federal government currently administers a federal resettlement grant to volunteer sponsoring agencies to assist them in their relocation efforts. The agency can administer the funds as it decides best meets the needs of the refugee(s). Most agencies do not give the grant directly to the client in the form of cash, but rather as clothing or shelter.

To determine if a refugee applicant has received countable assistance, the volunteer agency must be contacted directly. For information on how to contact the appropriate agency, contact:

U.S. Catholic Conference (202) 541-32
INTERACTION (Umbrella Agency) (212) 777-8210

Either of these agencies should be able to direct inquiries, or give specific grant distribution information.

NEVADA STATE DIVISION OF WELFARE

AND

SUPPORTIVE SERVICES

MAABD PROGRAM MANUAL

APPENDIX C

MAABD INCOME STANDARD

CHART

2012 MAABD INCOME STANDARD CHART

SSI BUDGETING		
Child Allocation Amount		$350.00
Parent Allocation Amount		
- One Parent		$698.00
- Two Parents		$1,048.00
Deeming Indicator Amount		$350.00
HIWA BUDGETING		
Gross Unearned Income		$699.00
Gross Earned Income		$4,189.00
Combined Net Income		$2,327.00
PATIENT LIABILITY		
Home and Community Based Waivers Personal Needs Allowance		
- DMH – MR Waiver Allowance		$2,094.00
- Aged – Independent Living		$2,094.00
- Aged – Group Care		$2,094.00
- Disabled Waiver		$2,094.00
HBW Spouse Allowance		$524.00
Institutional Spouse Allowance		$698.00
- Dependent Need Standard		$740.00
- Each Additional Child		$190.00
SPOUSAL IMPOVERISHMENT		
State Medicaid Maximum Resource Share		$22,728.00
Federal Maximum Spousal Resource Share		$113,640.00
Federal Maximum Maintenance Need Standard		$2,841.00
Federal Minimum Maintenance Need Standard		$1,891.50
Federal Excess Shelter Deduction		$567.45
LONG TERM CARE/HOME BASED WAIVER CASES		
Gross Income Limit		$2,094.00
Average Cost Private Nursing Care		$7,200.00

MEDICARE BENEFICIARY INCOME LIMITS	**INDIVIDUAL**	**COUPLE**
QMB	$931.00	$1,261.00
SLMB	$931.01 - $1,117.00	$1,261.01 - $1,513.00
QI1	$1,117.01 - $1,257.00	$1,513.01 - $1,703.00
QDWI	$1,862.00	$2,522.00

MEDICARE MONTHLY PREMIUMS	
Part A Hospital	$451.00
Part B Medical	$99.90

NEVADA: January 1, 2012 to December 31, 2012

	INDEPENDENT LIVING			LIVING IN HOUSEHOLD OF ANOTHER			DOMICILIARY CARE		
	TOTAL	SSP	SSI	TOTAL	SSP	SSI	TOTAL	SSP	SSI
INDIVIDUAL									
AGED	$734.40	$36.40	$698.00	$489.61	$24.27	$465.34	$1,089.00	$391.00	$698.00
BLIND	$807.30	$109.30	$698.00	$679.30	$213.96	$465.34	$1,089.00	$391.00	$698.00
DISABLED	$698.00	$0.00	$698.00	$465.34	$0.00	$465.34	$698.00	$0.00	$698.00
COUPLES									
AGED	$1,122.46	$74.46	$1,048.00	$748.31	$49.64	$698.67	$1,929.00	$881.00	$1,048.00
BLIND	$1,422.60	$374.60	$1,048.00	$1,230.61	$531.94	$698.67	$1,929.00	$881.00	$1,048.00
DISABLED	$1,048.00	$0.00	$1,048.00	$698.67	$0.00	$698.67	$1,048.00	$0.00	$1,048.00
MEM OF COUPLE									
AGED	$561.23	$37.23	$524.00	$374.16	$24.82	$349.34	$964.50	$440.50	$524.00
BLIND	$711.30	$187.30	$524.00	$615.31	$265.97	$349.34	$964.50	$440.50	$524.00
DISABLED	$524.00	$0.00	$524.00	$349.34	$0.00	$349.34	$524.00	$0.00	$524.00

NEVADA STATE DIVISION OF WELFARE AND SUPPORTIVE SERVICES

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APPENDIX D

BENEFIT LEVEL CHART
SSI
VA
QMB
SLMB
QI1
QI2
QDWI
COUNTY MATCH
SPOUSAL IMPOVERISHMENT

	SSI INDIVIDUAL				VA BENEFITS				300% OF SSI COUNTY MATCH
	Aged	Blind	Disabled	Medicare Premium	Vet	A&A	Widow	A&A	
1995	$494.40	$567.30	$458.00	$46.10	$669.00	$402.00	$448.00	$269.00	$1,374.00
1996	$506.40	$579.30	$470.00	$42.50	$687.00	$412.00	$460.00	$276.00	$1,410.00
1997	$520.40	$593.30	$484.00	$43.80	$707.00	$424.00	$474.00	$284.00	$775.01 - *(7/1/97)* $1,452.00
1998	$530.40	$603.30	$494.00	$43.80	$722.00	$433.00	$483.00	$290.00	$775.01 - $1,482.00
1999	$536.40	$609.30	$500.00	$45.50	$731.00	$489.00	$490.00	$294.00	$780.01 - $1,500.00
2000	$548.40	$621.30	$512.00	$45.50	$749.00	$500.00	$502.00	$300.00	$799.01 - $1,536.00
2001	$567.40	$640.30	$531.00	$50.00	$775.00	$518.00	$519.00	$312.00	$829.01 - $1,593.00
2002	$581.40	$654.30	$545.00	$54.00	$796.00	$532.00	$533.00	$320.00	$851.01 - $1,635.00
2003	$588.40	$661.30	$552.00	$58.70	$807.00	$540.00	$541.00	$324.00	$862.01 – $1,656.00
2004	$600.40	$673.30	$564.00	$66.60	$824.00	$551.00	$552.00	$331.00	$880.00 – $1,692.00
2005	$615.40	$688.30	$579.00	$78.20	$846.00	$566.00	$567.00	$340.00	$904.01 $1,737.00
2006	$639.40	$712.30	$603.00	$88.50	$881.00	$589.00	$590.00	$354.00	$941.01 $1,809.00
2007	$659.40	$732.30	$623.00	$93.50	$910.00	$608.00	$609.00	$366.00	$972.01 $1,869.00
2008	$673.40	$746.30	$637.00	$96.40	$951.00	$628.00	$637.00	$382.00	$994.01 $1,911.00
2009	$710.40	$783.30	$674.00	$96.40	$985.00	$651.00	$661.00	$395.00	$1,051.01 $2,022.00
2010	$710.40	$783.30	$674.00	$96.40	$985.00	$651.00	$661.00	$395.00	$1,051.01 $2,022.00
2011	$710.40	$783.30	$674.00	$96.40	$985.00	$651.00	$661.00	$395.00	$957.01 $2,022.00
2012	$734.40	$807.30	$698.00	$99.90	$1,021.00	$682.00	$684.00	$410.00	$991.01 $2,094.00

SPOUSAL IMPOVERISHMENT DETERMINATION *(Effective 9/30/89)*			Transfer of Assets	MAINTENANCE ALLOWANCE *(Effective 10/89)*			
	Medicaid Maximum	Spousal Share	Private Nursing Costs	Standard Allowance (SUA)	30% of Poverty	122% of Poverty	Maximum Monthly Maintenance Allowance
					30% of 150% Poverty **2 Person**	**150% of Poverty 2 Person**	
1994	**$14,532.00**	**$72,660.00**	**$3,575.00**	**$177.00** *(Effective 10/94)* **$17.00** *Telephone Only*	**$369.00** *(2/94)*	**$1,230.00** *(2/94)*	**$1,817**
1995	**$14,964.00**	**$74,820.00**	**$4,281.00**	**$175.00** *(Effective 10/95)* **$17.00** *Telephone Only*	**$376.00** *(2/95)*	**$1,253.75** *(2/95)*	**$1,871**
1996	**$15,348.00**	**$76,740.00**	**$3,984.00**	**$175.00** *(10/96)*	**$388.50** *(3/96)*	**$1,295.00** *(3/96)*	**$1,919**
1997	**$15,804.00**	**$79,020.00**	**$3,991.00**	**$163.00** *(10/97)* **$12.00** *Telephone Only*	**$398.00**	**$1,326.00**	**$1,975**
1998	**$16,152.00**	**$80,760.00**	**$4,441.00**		**$407.00**	**$1,356.00**	**$2,019**
1999	**$16,392.00**	**$81,960.00**	**$4,583.00**	**$174.00** *(10/98)* **$12.00** *Telephone Only*	**$415.00**	**$1,383.00**	**$2,049**
2000	**$16,824.00**	**$84,120.00**	**$4,583.00**	**$179.00** *(10/99)* **$13.00** *Telephone Only*	**$422.00**	**$1,407.00**	**$2,103**
2001	**$17,400.00**	**$87,000.00**	**$4,583.00**	**$211.00** *(10/01)* **$13.00** *Telephone Only*	**$435.60**	**$1,452.00**	**$2,175**
2002	**$17,856.00**	**$89,280.00**	**$4,583.00**	**$211.00** *(10/01)* **$13.00** *Telephone Only*	**$447.75**	**$1,492.50**	**$2,232.00**
2003	**$18,132.00**	**$90,660.00**	**$4,583.00**	**$288.00** *(10/02)* **$17.00** *Telephone Only*	**$454.50**	**$1,515.00**	**$2,266.50**
2004	**$18,552.00**	**$92,760.00**	**$4,583.00**	**$219.00** *(10/03)* **$17.00**	**$468.37**	**$1,561.25**	**$2,319.00**
2005	**$19,020.00**	**$95,100.00**	**$4,583.00**	**$226.00** *(10/04)* **$17.00**	**$481.12**	**$1,603.75**	**$2,377.50**
2006	**$19,908.00**	**$99,540.00**	**$4,583.00**	**$230.00** *(10/05)* **$16.00**	**$495.00**	**$1,650.00**	**$2,488.50**
2007	**$20,328.00**	**$101,640.00**	**$4,583.00**	**$258.00** *(8/06)* **$17.00**	**$513.00**	**$1,711.00**	**$2,541.00**
2008	**$20,880.00**	**$104,400.00**	**$5.714.00** *(5/07)*	**$264.00** *(10/07)* **$11.00**	**$525.00**	**$1,750.00**	**$2,610.00**
2009	**$21,912.00**	**$109,560.00**	**$5,714.00** *(5/07)*	**$274.00** *(10/08)* **$11.00**	**$546.38**	**$1,821.25**	**$2,739.00**
2010	**$21,912.00**	**$109,560.00**	**$6,345.00** *(4/10)*	**$289.00** **(10/09)** **$28.00**	**$546.38**	**$1,821.25**	**$2,739.00**
2011	**$21,912.00**	**$109,560.00**	**$6,858.00** *(4/11)*	**$292.00** **(10/10)** **$26.00**	**$551.63**	**$1,838.75**	**$2,739.00**
2012	**$22,728.00**	**$113,640.00**	**$6,858.00** *(4/11)*	**$292.00** **(10/10)** **$26.00**	**$551.63**	**$1,838.75**	**$2,841.00**

	MEDICARE BENEFICIARIES				
	0% - 100% FPL QMB	100% - 120% FPL SLMB	120% - 135% FPL QI1	135% - 175% FPL QI2	200% FPL QDWI
1992	$567.50				
1993	$580.83	$638.92			$1,278.00
1994	$613.33	$674.67			$1,349.00
1995	$622.50	$747.00			$1,245.00
1996	$645.00	$774.00			$1,290.00
1997	$658.00	$789.00			$1,316.00
1998 1-3/98	$658.00	$789.00 *(Effective 1/1/98)*	$888.00	$1,151.00	$1,316.06
4/98 ongoing	$671.00	$671.01 - $805.00	$805.01 - $906.00	$906.01 - $1,174.00	$1,342.00
4/99	$687.00	$687.01 - $824.00	$824.01 - $927.00	$927.01 - $1,202.00	$1,374.00
4/00	$696.00	$696.01 - $835.00	$835.01 - $940.00	$940.01 - $1,218.00	$1,392.00
4/01	$716.00	$716.01 - $859.00	$859.01 - $967.00	$967.01 - $1,253.00	$1,432.00
4/02	$738.00	$738.01 - $886.00	$886.01 - $997.00	$997.01 - $1,292.00	$1,477.00
4/03	$748.00	$748.01 - $898.00	$898.01 - $1,010.00	- Ended 12/31/02 -	$1,497.00
4/04	$776.00	$776.01 - $931.00	$931.01 - $1,047.00		$1,552.00
7/04	Individual $776.00 Couple $1,041.00	Individual $776.01 - $931.00 Couple $1,041.01 - $1,249.00	Individual $931.01 - $1,047.00 Couple $1,249.01 - $4,405.00		Individual $1,552.00 Couple $2,082.00
4/05	Individual $798.00 Couple $1,069.00	Individual $798.01 - $958.00 Couple $1,069.01 - $1,283.00	Individual $958.01 - $1,077.00 Couple $1,283.01 - $1,443.00		Individual $1,595.00 Couple $2,138.00
4/06	Individual $817.00 Couple $1,100.00	Individual $817.01 - $980.00 Couple $1,100.01 - $1,320.00	Individual $980.01 - $1,103.00 Couple $1,320.01 - $1,485.00		Individual $1,633.00 Couple $2,200.00
4/07	Individual $851.00 Couple $1,141.00	Individual $851.01 - $1,021.00 Couple $1,141.01 - $1,369.00	Individual $1,021.01 - $1,149.00 Couple $1,369.01 - $1,540.00		Individual $1,702.00 Couple $2,282.00
4/08	Individual $867.00 Couple $1,167.00	Individual $ 867.01 – 1,040.00 Couple $1,167.01 - $1,400.00	Individual $1,040.01 – $1,170.00 Couple $1,400.01 - $1,575.00		Individual $1,733.00 Couple $2,333.00
4/09	Individual $903.00 Couple $1,214.00	Individual $903.01 – 1,083.00 Couple $1,214.01 – $1,457.00	Individual $1,083.01 – $1,218.00 Couple $1,457.01 – $1,639.00		Individual $1,805.00 Couple $2,428.00
4/11	Individual $908.00 Couple $1,226.00	Individual $908.01 – $1,089.00 Couple $1,226.01 – $1,471.00	Individual $1,089.01 – $1,225.00 Couple $1,471.01 – $1,655.00		Individual $1,815.00 Couple $2,452.00

***FPL = Federal Poverty Level**

NEVADA STATE DIVISION OF WELFARE

AND

SUPPORTIVE SERVICES

MAABD PROGRAM MANUAL

APPENDIX E

BIC CODE VALUES

BIC CODE VALUES

NOTE: BIC Codes are listed in POMS SM 00550.010

&	Combined A and B beneficiary in the same payment
A	Primary claimant
B	Aged wife, age 62 or over (1st claimant)
B1	Aged husband, age 62 or over (1st claimant)
B2	Young wife, with a child in her care (1st claimant)
B3	Aged wife (2nd claimant)
B4	Aged husband (2nd claimant)
B5	Young wife (2nd claimant)
B6	Divorced wife, age 62 or over (1st claimant)
B7	Young wife (3rd claimant)
B8	Aged wife (3rd claimant)
B9	Divorced wife (2nd claimant)
BA	Aged wife (4th claimant)
BD	Aged wife (5th claimant)
BG	Aged husband (3rd claimant)
BH	Aged husband (4th claimant)
BJ	Aged husband (5th claimant)
BK	Young wife (4th claimant)
BL	Young wife (5th claimant)
BN	Divorced wife (3rd claimant)
BP	Divorced wife (4th claimant)
BQ	Divorced wife (5th claimant)
BR	Divorced husband, age 62 or older (1st claimant)
BT	Divorced husband (2nd claimant)
BW	Young husband (2nd claimant)
BY	Young husband, with a child in his care (1st claimant)
C1-C9	Child (includes minor, student or disabled child)
CA-CK	Child (includes minor, student or disabled child)
D	Aged widow, age 60 or over (1st claimant)
D1	Aged widower, age 60 or over (1st claimant)
D2	Aged widow (2nd claimant)
D3	Aged widower (2nd claimant)
D4	Widow (remarried after attainment of age 60) (1st claimant)
D5	Widower (remarried after attainment of age 60) (1st claimant)
D6	Surviving divorced wife, age 60 or over (1st claimant)
D7	Surviving divorced wife (2nd claimant)
D8	Aged widow (3rd claimant)
D9	Remarried widow (2nd claimant)
DA	Remarried widow (3rd claimant)
DC	Surviving divorced husband, age 60 or over (1st claimant)
DD	Aged widow (4th claimant)
DG	Aged widow (5th claimant)
DH	Aged widower (3rd claimant)
DJ	Aged widower (4th claimant)
DK	Aged widower (5th claimant)
DL	Remarried widow (4th claimant)
DM	Surviving divorced husband (2nd claimant)

DN	Remarried widow (5th claimant)
DP	Remarried widower (2nd claimant)
DQ	Remarried widower (3rd claimant)
DR	Remarried widower (4th claimant)
DS	Surviving divorced husband (3rd claimant)
DT	Remarried widower (5th claimant)
DV	Surviving divorced wife (3rd claimant)
DW	Surviving divorced wife (4th claimant)
DX	Surviving divorced husband (4th claimant)
DY	Survived divorced wife (5th claimant)
DZ	Surviving divorced husband (5th claimant)
E	Mother (widow) (1st claimant)
E1	Surviving divorced mother (1st claimant)
E2	Mother (widow) (2nd claimant)
E3	Surviving divorced mother (2nd claimant)
E4	Father (widower) (1st claimant)
E5	Surviving divorced father (widower) (1st claimant)
E6	Father (widower) (2nd claimant)
E7	Mother (widow) (3rd claimant)
E8	Mother (widow) (4th claimant)
E9	Surviving divorced father (widower) (1st claimant)
EA	Mother (widow) (5th claimant)
EB	Surviving divorced mother (3rd claimant)
EC	Surviving divorced mother (4th claimant)
ED	Surviving divorced mother (5th claimant)
EF	Father (widower) (3rd claimant)
EG	Father (widower) (4th claimant)
EH	Father (widower) (5th claimant)
EJ	Surviving divorced father (3rd claimant)
EK	Surviving divorced father (4th claimant)
EM	Surviving divorced father (5th claimant)
F1	Parent (father)
F2	Parent (mother)
F3	Parent (stepfather)
F4	Parent (stepmother)
F5	Parent (adopting father)
F6	Parent (adopting mother)
F7	Parent (2nd alleged father)
F8	Parent (2nd alleged mother)
J1	Primary Prouty entitled to HIB (less than 3 qualifying quarters (QQs) (General Fund)
J2	Primary Prouty entitled to HIB (over 2 QQs) (Retirement and Survivors Insurance (RSI) Trust Fund)
J3	Primary Prouty not entitled to HIB (less than 3 QQs) (General Fund)
J4	Primary Prouty not entitled to HIB (over 2 QQs) (RSI Trust Fund)
K1	Prouty wife entitled to HIB (less than 3 QQs) (General Fund) (1st claimant)
K2	Prouty wife entitled to HIB (over 2 QQs) (RSI Trust Fund) (1st claimant)
K3	Prouty wife not entitled to HIB (less than 3 QQs) (General Fund) (1st claimant)
K4	Prouty wife not entitled to HIB (over 2 QQs) (RSI Trust Fund) (1st claimant)
K5	Prouty wife entitled to HIB (less than 3 QQs) (General Fund) (2nd claimant)
K6	Prouty wife entitled to HIB (over 2 QQs) (RSI Trust Fund) (2nd claimant)
K7	Prouty wife not entitled to HIB (less than 3 QQs) (General Fund) (2nd claimant)

K8	Prouty wife not entitled to HIB (less than 3 QQs) (RSI Trust Fund) (2nd claimant)
K9	Prouty wife entitled to HIB (less than 3 QQs) (General Fund) (3rd claimant)
KA	Prouty wife entitled to HIB (over 2 QQs) (RSI Trust Fund) (3rd claimant)
KB	Prouty wife not entitled to HIB (less than 3 QQs) (General Fund) (3rd claimant)
KC	Prouty wife not entitled to HIB (over 2 QQs) (RSI Trust Fund) (3rd claimant)
KD	Prouty wife not entitled to HIB (less than 3 QQs) (General Fund) (4th claimant)
KE	Prouty wife entitled to HIB (over 2 QQs) (RSI Trust Fund) (4th claimant)
KF	Prouty wife not entitled to HIB (less than 3 QQs) (General Fund) (4th claimant)
KG	Prouty wife not entitled to HIB (over 2 QQs) (RSI Trust Fund) (4th claimant)
KH	Prouty wife entitled to HIB (less than 3 QQs) (General Fund) (5th claimant)
KJ	Prouty wife entitled to HIB (over 2 QQs) (RSI Trust Fund) (5th claimant)
KL	Prouty wife not entitled to HIB (less than 3 QQs) (General Fund) (5th claimant)
KM	Prouty wife not entitled to HIB (over 2 QQs) (RSI Trust Fund) (5th claimant)
M	Uninsured beneficiary (not qualified for automatic HIB)
M1	Uninsured beneficiary (qualified for automatic HIB but requests only SMIB)
O	Combined A and B beneficiary in the same payment
T	*Fully insured beneficiaries who have elected entitlement only to HIB (usually but not always along with SMIB) *Uninsured beneficiary or renal disease beneficiary only *Deemed insured (hospital insurance only)
TA	Medicare Qualified Government Employment (MQGE) primary beneficiary
TB	MQGE aged spouse (1st claimant)
TC	MQGE childhood disability benefits (CDB) (1st claimant)
TD	MQGE aged widow(er) (1st claimant)
TE	MQGE young widow(er) (1st claimant)
TF	MQGE parent (male)
TG	MQGE aged spouse (2nd claimant)
TH	MQGE aged spouse (3rd claimant)
TJ	MQGE aged spouse (4th claimant)
TK	MQGE aged spouse (5th claimant)
TL	MQGE aged widow(er) (2nd claimant)
TM	MQGE aged widow(er) (3rd claimant)
TN	MQGE aged widow(er) (4th claimant)
TP	MQGE aged widow(er) (5th claimant)
TQ	MQGE parent (female)
TR	MQGE young widow(er) (2nd claimant)
TS	MQGE young widow(er) (3rd claimant)
TT	MQGE young widow(er) (4th claimant)
TU	MQGE young widow(er) (5th claimant)
TV	MQGE disabled widow(er) (1st claimant)
TW	MQGE disabled widow(er) (1st claimant)
TX	MQGE disabled widow(er) (2nd claimant)
TY	MQGE disabled widow(er) (3rd claimant)
TZ	MQGE disabled widow(er) (4th claimant)
T2	MQGE (CDB) (2nd claimant)
T3	MQGE (CDB) (3rd claimant)
T4	MQGE (CDB) (4th claimant)
T5	MQGE (CDB) (5th claimant)
T6	MQGE (CDB) (6th claimant)
T7	MQGE (CDB) (7th claimant)
T8	MQGE (CDB) (8th claimant)
T9	MQGE (CDB) (9th claimant)

W	Disabled widow, age 50 or over (1st claimant)
W1	Disabled widower, age 50 or over (1st claimant)
W2	Disabled widow (2nd claimant)
W3	Disabled widower (2nd claimant)
W4	Disabled widow (3rd claimant)
W5	Disabled widower (3rd claimant)
W6	Disabled surviving divorced wife (1st claimant)
W7	Disabled surviving divorced wife (2nd claimant)
W8	Disabled surviving divorced wife (3rd claimant)
W9	Disabled widow (4th claimant)
WB	Disabled widower (4th claimant)
WC	Disabled surviving divorced wife (4th claimant)
WF	Disabled widow (5th claimant)
WG	Disabled widower (5th claimant)
WJ	Disabled surviving divorced wife (5th claimant)
WR	Disabled surviving divorced husband (1st claimant)
WT	Disabled surviving divorced husband (2nd claimant)

NOTE: Some BICs may be displayed as a three-position code (e.g., B01, C03, etc.). The "0" is a filler and should **not** be entered on the NOMADS screen.

NEVADA STATE DIVISION OF WELFARE

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MAABD PROGRAM MANUAL

APPENDIX F

MAABD BUDGETS

NEVADA STATE DIVISION OF WELFARE AND SUPPORTIVE SERVICES

VETERAN UNUSUAL MEDICAL EXPENSE (UME) BUDGET — 2012

A. $ _____ Maximum VA Annual Rate (from award letter)
(–)
B. $ _____ Gross Annual Income (use reported income from VA award letter)

C. $ _____ Countable Annual VA Benefits

If the amount in "C" is zero or a negative figure, stop here: the entire VA "payment" to the client is UME and must be excluded in both financial eligibility and patient liability.

If the amount in "C" is greater than zero, a portion of the VA payment is countable income. Divide amount in "C" by 12 to reach the monthly countable VA benefit.

D. $ _____ Countable Monthly VA Payment

If the amount in "D" is less than the maximum Aid and Attendance (A&A) or House Bound (HB) benefit rate, stop here: this figure must be excluded in both financial eligibility and patient liability.

If the amount in "D" is greater than the maximum A&A or HB benefit rate, this figure includes a Base Pension which must be counted in both financial eligibility and patient liability. Proceed as follows:

E. $ _____ Monthly Countable VA Income (amount in "D" above)
(–)
F. $ _____ Maximum A&A if HB Rate (excluded in financial eligibility and PL)

G. $ _____ Base Pension (counted in financial & PL)

VA AMOUNTS FOR 2012:

Maximum VA Annual Rate for A&A Veteran with a spouse = $24,228
($1,337 Base + $682 A&A x 12)

Maximum VA Annual Rate for A&A Veteran = $20,436
($1,021 Base + $682 A&A x 12)

Maximum VA Annual Rate for HB Veteran with a spouse = $18,768
($1,337 Base + $227 HB x 12)

Maximum VA Annual Rate for HB Veteran = $14,976
($1,021 Base + $227 HB x 12)

Maximum VA Annual Rate for A&A Widow = $13,128
($684 Base + $410 A&A x 12)

Maximum VA Annual Rate for HB Widow = $10,044
($684 Base + $153 HB x 12)

INSTRUCTIONS FOR FORM 2039-EE (02/12)
"VA UME (UNUSUAL MEDICAL EXPENSE) BUDGET"

PURPOSE — To assist the case manager in determining the portion of a veteran's pension which is an Unusual Medical Expense (UME) reimbursement. UME is excluded income for financial eligibility and patient liability.

INSTRUCTIONS

1. Enter maximum VA annual rate in field "A".
2. Enter the client/spouse's gross annual income as reported on VA award letter in field "B". CAUTION: Don't use VA's indication of COUNTABLE ANNUAL INCOME as this amount is the result of "net countable income" less medical expenses.
3. Subtract the client's income from the VA rate. Enter the difference in field "C".

If the answer is zero or a negative figure, the entire VA "payment" to the client is UME.

If the answer is greater than zero, a portion of the VA "payment" may be countable income. Divide this figure by twelve (12) to reach the monthly countable VA benefit.

If the monthly countable VA income is less than the rate for A&A or HB payment, exclude this income in financial eligibility and patient liability.

If the monthly countable VA income is greater than the A&A or HB rate:

1. Enter the monthly countable VA income in field "E".
2. Enter the maximum A&A or HB rate in field "F".
3. Subtract the A&A or HB rate from the monthly countable VA income. Enter the difference in field "G".

NOTE: USE THE VA AWARD LETTER TO OBTAIN VA ANNUAL RATES AND THE CLIENT/ SPOUSE'S INCOME.

EXAMPLE #1

Y . . .WE INCLUDED THE FOLLOWING SOURCES OF INCOME YOU REPORTED:

SELF: EARNED $00000; SOCIAL SECURITY $06061; RETIREMENT $00000; INTEREST $00000: INSURANCE $00000; AND OTHER INCOME $00000.

EXAMPLE #2

Y . . .OUR DETERMINATION THAT YOUR NET COUNTABLE INCOME IS $10367.

WE ARE CONSIDERING YOUR OWN INCOME OF $0 FROM EARNINGS, $10297 FROM SOCIAL SECURITY BASED UPON A MONTHLY PAYMENT OF $858.10, $0 FROM ANNUITY/RETIREMENT AND $70 FROM OTHER SOURCES.

Distribution: WHITE - Eligibility Casefile

NEVADA STATE DIVISION OF WELFARE AND SUPPORTIVE SERVICES

MAABD BUDGET

Case Name	Case Number	Date	Case Manager

FINANCIAL ELIGIBILITY

I. GROSS COUNTABLE INCOME TEST

INCOME MONTH: _____

A. UNEARNED INCOME

	*GROSS –	EXCLUSIONS	= COUNTABLE
RSDI	_____	_____	_____
Railroad Retirement	_____	_____	_____
Veteran Benefits	_____	_____	_____
Pension/ Retirement	_____	_____	_____
Contributions	_____	_____	_____
Other	_____	_____	_____

Total Countable Unearned Income .....$_____

B. EARNED INCOME

Gross Earnings .....$_____

TOTAL GROSS COUNTABLE INCOME $_____

GROSS Income Limit.....$_____

ELIGIBLE ..... ☐ YES ☐ NO

C. DIVISION OF INCOME

Client's Gross Income .....$_____

Spouse's Gross Income .....$_____

Total GROSS Community Income .....$_____

Divide Community Income by 2.....$_____

Total Countable Income.....$_____

GROSS Income Limit.....$_____

ELIGIBLE ..... ☐ YES ☐ NO

II. NET INCOME DETERMINATION

A. UNEARNED INCOME

1. Total .....$_____ (COUNTABLE)

LESS:
(a) General Income Exclusion..... – 20.00

2. Countable Unearned Income ..... $_____

B. EARNED INCOME

1. Earnings..... _____
LESS:
(a) Remaining General Exclusion..... –_____
(b) Earnings Exclusions ..... – 65.00
(c) IRWE..... –_____
Remaining Earned Income ..... =_____
(d) Less 1/2 of 1(c) ..... -_____
2. Countable Earned Income .... _____

TOTAL COUNTABLE NET INCOME .....$_____
(Sum of A-2 and B-2)

III. AID CODE DETERMINATION

☐ Receiving $30 SSI institutional payment (SS)

☐ Countable Net income greater than $30 and less than SSI Payment level. (WB)

☐ Countable Net income greater than SSI Payment level up to 142% of payment level. (SI)

☐ Countable Net is greater than 142% and less than 300% SSI payment level, County Match. (CM)

REMARKS/DOCUMENTATION

(Medicare Beneficiary Budget Side 2)

NEVADA STATE DIVISION OF WELFARE AND SUPPORTIVE SERVICES

MEDICARE BENEFICIARY BUDGET

Case Name	Case Number	Date	Worker Name/Number

CHECK WHICH APPLIES

	☐ Member of a Couple, With Ineligible Spouse	☐ Individual	☐ Member of a Couple, With Eligible Spouse
A. DEEMING COMPUTATION			
1. Ineligible spouse's unearned income……. Subtract allocation for ineligible children (children not applying for/receiving any type of public assistance)			
No. 1 / No. 2 / No. 3			
Allocation: $350.00 / $350.00 / $350.00			
Subtract child's (under 18) income: – / – / –			
+ / + =			
a. Total Allocation……	–		
b. Remaining unearned income……			
2. Ineligible spouse's gross earned income……			
a. Subtract balance of allocation for ineligible child(ren) not offset by unearned income……	–		
b. Remaining earned income ……..			
c. Add remaining unearned income from 1.b. …….	+		
3. Total income after allocations……..			
☐ LESS THAN $350, Deeming does NOT apply. Proceed to Part B, second column, using only the client's income			
☐ $350 OR MORE, Deeming DOES apply. Proceed to Part B, first column, adding the figure in 1.b. to the client's unearned income in B.1. and using the figure in 2.b. to the client's earned income in B.2.		*START HERE*	*START HERE*
B. ELIGIBILITY DETERMINATION Use combined income (client and ineligible spouse after ineligible child allocations when deeming applies OR client and eligible spouse) OR client's income if using INDIVIDUAL column.	**Client and ineligible spouse's deemed**	**Client**	**Client and eligible spouse**
1. Unearned income……..			
a. Subtract general income exclusion …….	– 20.00	– 20.00	– 20.00
b. Remaining unearned income……..			
2. Gross earned income…….			
a. Subtract balance of general exclusion not offset by unearned income……	–	–	–
b. Remaining earned income ……..			
c. Subtract work expense exclusion……	– 65.00	– 65.00	– 65.00
d. Remaining earned income ……..			
e. Subtract 1/2 of 2.d. amount ……	÷ 2 =	÷ 2 =	÷ 2 =
3. Total countable income (sum of 1.b. and 2.e.) …….			
4. Compare 3. to the appropriate income limit from Appendix C. If the amount is greater than the limit for a couple in the first or third columns, or greater than the limit for an individual in the second column, the client is ineligible for Medicaid. (If ineligible in the third column, proceed to the first column.)……..	**Compare to Couple Income Limit**	**Compare to INDIVIDUAL Income Limit**	**Compare to Couple Income Limit**
	☐ ELIGIBLE ☐ INELIGIBLE	☐ ELIGIBLE ☐ INELIGIBLE	☐ ELIGIBLE ☐ INELIGIBLE

Income Month(s) _____ Benefit Month(s) _____

NEVADA STATE DIVISION OF WELFARE AND SUPPORTIVE SERVICES

PATIENT LIABILITY BUDGET – SPOUSAL IMPOVERISHMENT

Case Name	Case Number	Date	Worker

MAINTENANCE ALLOWANCE

COMMUNITY SPOUSE MONTHLY INCOME ALLOWANCE

1. Housing Costs ..... $_____
2. Standard Utility Allowance (SUA)..... +_____
3. Shelter Costs..... _____
4. Maximum Shelter (30% of 150% of 2-Person Poverty)..... –_____
5. Excess Shelter Allowance..... _____
6. 150% of 2-Person Poverty .....$_____
   Excess Shelter Allowance.....+_____
7. Monthly Maintenance Allowance ..... _____

▲ *COMPARE* ▼

8. Federal Maximum Monthly Maintenance Allowance..... $_____
9. Lessor of #7 or #8 $_____ _____
10. Community Spouse Gross Income…… – _____
11. Community Spouse Monthly .....Income Allowance..... $_____

FAMILY ALLOWANCE

Repeat this calculation for each family member:

	-1-	-2-
1. 150% of 2-Person Poverty.....	$_____	$_____
2. Family Member Total.....	–_____	–_____
3. Net Difference	$_____	$_____
	÷ 3	÷ 3
4. Family Member Allowance	$_____	$_____

5. Total All Family Member Allowances (1+2) ..... $_____

PATIENT LIABILITY

INCOME MONTH: _____ *FOR:* _____ (MONTH)

TOTAL GROSS MONTHLY INCOME..... $ _____
Less Involuntary Mandatory Deductions..... $–_____
Less Income Excluded from P/L..... $–_____
TOTAL PATIENT LIABILITY INCOME ..... $ _____

LESS:

1. Personal Needs Allowance..... –_____

$ _____ (SUBTOTAL)

2. Community Spouse Income Allowance..... –_____
3. Family Allowance..... –_____
4. Payments for Health Insurance..... –_____
5. Incurred Medical Expense..... –_____

TOTAL DEDUCTIONS (Nos. 2-5)..... $ _____
PATIENT LIABILITY (Full Month)..... $ _____

PARTIAL MONTH PRORATION

Full Month Patient Liability..... $ _____
Number of Days in the Month..... + _____
Daily Rate…. = _____
Number of Days Institutionalized..... x _____
Patient Liability for _____ ..... = $ _____

REMARKS/DOCUMENTATION

NEVADA STATE DIVISION OF WELFARE AND SUPPORTIVE SERVICES

PATIENT LIABILITY BUDGET – NON-SPOUSAL IMPOVERISHMENT

Case Name	Case Number	Date	Worker

MAINTENANCE ALLOWANCE	**REMARKS/DOCUMENTATION**

EARNED INCOME

SPOUSE/DEPENDENT'S GROSS EARNINGS ..... _____
LESS:
1. Tax and Social Security ..... _____
2. Other ..... _____
3. Other ..... _____
TOTAL EXPENSES ..... _____
NET EARNINGS ..... _____

UNEARNED INCOME

RSDI ..... _____
SSI ..... _____
UIB ..... _____
Pensions ..... _____
Other ..... _____
TOTAL UNEARNED INCOME ..... _____

ALLOWANCE

SPOUSE/DEPENDENTS' TOTAL NEEDS ..... _____
TOTAL NET INCOME (Earned and Unearned) ..... _____
MAINTENANCE ALLOWANCE ..... _____

PATIENT LIABILITY

INCOME MONTH: _____ *FOR:* _____ (MONTH)

TOTAL GROSS MONTHLY INCOME ..... $ _____
Less Involuntary Mandatory Deductions ..... $– _____
Less Income Excluded from P/L ..... $– _____
TOTAL PATIENT LIABILITY INCOME ..... $ _____
LESS:
1. Personal Needs Allowance ..... _____
2. Home Based Maintenance ..... _____
3. Spouse/Dependents' Maintenance ..... _____
4. Payments for Health Insurance ..... _____
5. Incurred Medical Expenses ..... _____
TOTAL DEDUCTIONS ..... $ _____
PATIENT LIABILITY (Full Month) ..... $ _____

PARTIAL MONTH PRORATION

Full Month Patient Liability ..... $ _____
Number of Days in the Month ..... ÷ _____
Daily Rate ..... = _____
Number of Days Institutionalized ..... x _____
Patient Liability for _____ (MONTH) = $ _____

NEVADA STATE DIVISION OF WELFARE AND SUPPORTIVE SERVICES
SSI BUDGET

Case Name: _____
Case No.: _____

CHECK WHICH APPLIES

	☐ Member of a Couple, With Ineligible Spouse	☐ Individual	☐ Member of a Couple, With Eligible Spouse
A. DEEMING COMPUTATION			
1. Ineligible spouse's unearned income……. Subtract allocation for ineligible children (children not applying for/receiving any type of public assistance)			

	No. 1	No. 2	No. 3
Allocation	$350.00	$350.00	$350.00
Subtract child's (under 18) income	–	–	–
		+	+ =

a. Total Allocation……	–		
b. Remaining unearned income……			
2. Ineligible spouse's gross earned income……			
a. Subtract balance of allocation for ineligible child(ren) not offset by unearned income…….	–		
b. Remaining earned income ……..……..			
c. Add remaining unearned income from 1.b. …….	+		
3. Total income after allocations……...			
☐ LESS THAN $350, Deeming does NOT apply. Proceed to Part B, second column, using only the client's income			
☐ $350 OR MORE, Deeming DOES apply. Proceed to Part B, first column, adding the figure in 1.b. to the client's unearned income in B.1. and using the figure in 2.b. to the client's earned income in B.2.		*START HERE*	*START HERE*
B. SSI ELIGIBILITY DETERMINATION Use combined income (client and ineligible spouse after ineligible child allocations when deeming applies OR client and eligible spouse) OR client's income if using INDIVIDUAL column.	**Client and ineligible spouse's deemed**	**Client**	**Client and eligible spouse**
1. Unearned income……..			
a. Subtract general income exclusion …….	– 20.00	– 20.00	– 20.00
b. Remaining unearned income……...			
2. Gross earned income…….			
a. Subtract balance of general exclusion not offset by unearned income……	–	–	–
b. Remaining earned income ……..			
c. Subtract work expense exclusion……	– 65.00	– 65.00	– 65.00
d. Remaining earned income ……..			
e. Subtract 1/2 of 2.d. amount ……	÷ 2 =	÷ 2 =	÷ 2 =
3. Total countable income (sum of 1.b. and 2.e.) …….			
4. Compare 3. to the appropriate SPA. If amount is equal or greater than the SPA in the first and second columns, the client is ineligible for Medicaid. If ineligible in the third column, proceed to the first column ……	**Compare to Couple (SPA)**	**Compare to INDIVIDUAL (SPA)**	**Compare to Couple (SPA)**
	☐ ELIGIBLE ☐ INELIGIBLE	☐ ELIGIBLE ☐ INELIGIBLE	☐ ELIGIBLE ☐ INELIGIBLE

Income Month(s) _____ Benefit Month(s) _____

Worker: _____

Date: _____

SSI PAYMENT AMOUNTS (SPA)
Effective 1/1/12 through 12/31/12

Aged	$734.40	$1,085.46
Blind	$807.30	$1,385.60
Disabled	$698.00	$1,011.00
Aged and Blind		$1,235.53
Aged and Disabled		$1,048.23
Blind and Disabled		$1,198.30

Nevada State Division of Welfare and Supportive Services

PARENT TO CHILD DEEMING BUDGET

Case Name: _____ Case No.: _____

DEEMING COMPUTATION

1. Ineligible parent's unearned income …… $ _____
   Subtract allocation for ineligible children (children not applying for/receiving any type of public assistance)

	No. 1	**No. 2**	**No. 3**	
Allocation ……	$350.00	$350.00	$350.00	
Subtract child's income ……	– _____	– _____	– _____	
	+ _____	+ _____	+ _____	= _____

   (a) Subtract total allocation for ineligible children …… – _____
   (b) Remaining unearned income …… $ _____

2. Ineligible parent's earned income …… _____
   (a) Subtract balance of allocation for ineligible child(ren) not offset by unearned income …… – _____
   (b) Remaining earned income …… $ _____

3. PARENT DEDUCTION & ALLOCATION

(a)	Enter remaining unearned income ……	_____
(b)	Subtract general income exclusion ……	– 20.00
(c)	Countable unearned income ……	_____
(d)	Enter remaining earned income ……	_____
(e)	Subtract balance of general income exclusion ……	– 20.00
(f)	Remainder ……	_____
(g)	Subtract work expense exclusion ……	– 65.00
(h)	Remainder ……	_____
(i)	Subtract 1/2 remainder ……	– _____
(j)	Countable earned income ……	_____
(k)	Add countable unearned income ……	+ _____
(l)	Total countable income ……	_____
(m)	Subtract parent allocation ……	– _____
(n)	Deemed income ……	_____

4. ELIGIBILITY DETERMINATION **ELIGIBILITY**

Deemed income ……	_____
Add individual's own unearned income ……	+ _____
Total unearned income ……	_____
Subtract general income exclusion ……	– 20.00
Total countable unearned income……	_____
Total earned income ……	_____
Subtract balance of general income exclusion……	– _____
Remainder……	_____
Subtract work expense exclusions ……	– 65.00
Subtract 1/2 remainder ……	– _____
Countable earned income……	_____
Add countable unearned income ……	+ _____
Total countable income ……	_____

Benefit month(s) _____
Income month(s) _____
Worker _____
Date _____

INSTITUTIONAL LIMIT
$2,094.00

SSI PAYMENT AMOUNT (SPA)
Effective 1/1/12 through 12/31/12

Blind …… $807.30
Disabled …… $698.00

COMPARE TO INSTITUTIONAL LIMIT OR SPA
☐ Eligible ☐ Ineligible

PARENT ALLOCATION
$698 if only one parent lives in the household;
$1,048 if both parents live in the household.

NEVADA STATE DIVISION OF WELFARE AND SUPPORTIVE SERVICES

RSDI COMPUTATION WORKSHEET

Case Name _____ Case Number _____ Worker _____ Date _____

1. Enter the current RSDI amount on the top line of Column A.
2. Divide the Column A amount by the Column B figure (percentage amount of the previous cost of living increase). Round to the nearest dime and enter that amount in Column C.
3. Transfer the Column C figure to the next line in Column A.
4. Continue steps 2. and 3. for each year until you reach the last RSDI amount received before client became ineligible for SSI.
5. Transfer the final amount in Column C. to SSI Budget as the countable RSDI amount.

A. RSDI Amount		B. Percentage of Prior Cost of Living Increase	Effective Date of Increase		C. Previous Year RSDI Amount
$ _____	÷	1.036%	(1/12)	=	$ _____
$ _____	÷	0.00	(1/11)	=	$ _____
$ _____	÷	0.00	(1/10)	=	$ _____
$ _____	÷	1.058	(1/09)	=	$ _____
$ _____	÷	1.023	(1/08)	=	$ _____
$ _____	÷	1.033	(1/07)	=	$ _____
$ _____	÷	1.041	(1/06)	=	$ _____
$ _____	÷	1.027	(1/05)	=	$ _____
$ _____	÷	1.021	(1/04)	=	$ _____
$ _____	÷	1.014	(1/03)	=	$ _____
$ _____	÷	1.026	(1/02)	=	$ _____
$ _____	÷	1.035	(1/01)	=	$ _____
$ _____	÷	1.024	(1/00)	=	$ _____
$ _____	÷	1.013	(1/99)	=	$ _____
$ _____	÷	1.021	(1/98)	=	$ _____
$ _____	÷	1.029	(1/97)	=	$ _____
$ _____	÷	1.026	(1/96)	=	$ _____
$ _____	÷	1.028	(1/95)	=	$ _____
$ _____	÷	1.026	(1/94)	=	$ _____
$ _____	÷	1.030	(1/93)	=	$ _____
$ _____	÷	1.037	(1/92)	=	$ _____
$ _____	÷	1.054	(1/91)	=	$ _____
$ _____	÷	1.047	(1/90)	=	$ _____
$ _____	÷	1.040	(1/89)	=	$ _____
$ _____	÷	1.042	(1/88)	=	$ _____
$ _____	÷	1.013	(1/87)	=	$ _____
$ _____	÷	1.031	(1/86)	=	$ _____
$ _____	÷	1.035	(1/85)	=	$ _____
$ _____	÷	1.035	(7/84)	=	$ _____
$ _____	÷	1.074	(7/82)	=	$ _____
$ _____	÷	1.112	(7/81)	=	$ _____
$ _____	÷	1.143	(7/80)	=	$ _____
$ _____	÷	1.099	(7/79)	=	$ _____
$ _____	÷	1.065	(7/78)	=	$ _____

NEVADA STATE DIVISION OF WELFARE AND SUPPORTIVE SERVICES

SPOUSAL IMPOVERISHMENT RESOURCE DETERMINATION

Case Name	Case Number	Date	Worker

I. SPOUSAL SHARE OF RESOURCES AT TIME OF INSTITUTIONALIZATION/HOME BASED WAIVER SERVICES

a.	Community spouse's separate resources	$_____	(Client's Spouse)	
b.	Client's separate resources	+_____		
c.	Joint resources between spouses	+_____		_____ Month/Year
d.	Total Resources		**$**_____	
e.	Total resources divided equally		÷2	
f.	A spousal share		**$**_____	

II. COMMUNITY SPOUSE RESOURCE ALLOWANCE

a.	Enter State Medicaid Maximum Resource Share from Appendix C	$_____	
b.	Enter the spousal share up to the Federal Maximum from Appendix C	$_____	
c.	Enter the amount established based on a hearing decision	$_____	
d.	Enter the amount established in a court order	$_____	
e.	Enter the greatest of a, b, c or d above		$_____
f.	The amount "considered" available to the community spouse (M.S. 350.M.2)		−_____
g.	Community Spouse Resource Allowance		**$**_____

III. ASSIGNMENT OF RESOURCES AT TIME OF APPLICATION

a.	Community spouse's separate resources	$_____	(Client's Spouse)	
b.	Client's separate resources	+_____		_____ Month/Year
c.	Joint resources between spouses	+_____		
d.	Total Resources		**$**_____	
e.	Total amount from Section II, item e above		−_____	
*f.	Countable resources for client's eligibility		**$**_____	

**If the amount in item III.f is within Medicaid resource limits, then resources up to the amount in item II.g must be transferred to the community spouse within 30 days from the date of the approval notice.*

NEVADA STATE DIVISION OF WELFARE AND SUPPORTIVE SERVICES

SPOUSAL IMPOVERISHMENT RESOURCE DETERMINATION

Case Name	Case Number	Date	Worker

I. SPOUSAL SHARE OF RESOURCES AT TIME OF INSTITUTIONALIZATION/HOME BASED WAIVER SERVICES

Liquid/non-liquid in spouse's name and/or joint with others - not the client.

a. Community spouse's separate resources $_____ (Client's Spouse)

Liquid/non-liquid in client's name and/or joint with others - not the spouse.

b. Client's separate resources +_____

Liquid/non-liquid joint between spouses.

c. Joint resources between spouses +_____

Day of Admit
_____
Month/Year

d. Total Resources **$**_____

e. Total resources divided equally ÷2

f. A spousal share **$**_____

II. COMMUNITY SPOUSE RESOURCE ALLOWANCE

a. Enter the State Medicaid Maximum Resource Share from Appendix C $_____

b. Enter the spousal share up to the Federal Maximum from Appendix C $_____

c. Enter the amount established based on a hearing decision $_____

d. Enter the amount established in a court order $_____

e. Enter the greatest of a, b, c or d above $_____

Total of I.a. and 1/2 of non-liquid in I.c.

f. The amount "considered" available to the community spouse (M.S. 350.M.2) –_____

g. Community Spouse Resource Allowance **$**_____

III ASSIGNMENT OF RESOURCES AT TIME OF APPLICATION

Liquid/non-liquid in spouse's name and/or joint with others - not the client.

a. Community spouse's separate resources $_____ (Client's Spouse)

Liquid/non-liquid in client's name and/or joint with others - not the spouse.

b. Client's separate resources +_____

Day of Application
_____
Month/Year

Liquid/non-liquid joint between spouses.

c. Joint resources between spouses +_____

Second and ongoing month(s) use low resource balance.

d. Total Resources **$**_____

e. Total amount from Section II, item e above –_____

*f. Countable resources for client's eligibility **$**_____

**If the amount in item III.f is within Medicaid resource limits, then resources up to the amount in item II.g must be transferred to the community spouse within 30 days from the date of the approval notice.*

Case Name	Case Number	Date	Worker

NEVADA STATE DIVISION OF WELFARE AND SUPPORTIVE SERVICES

HEALTH INSURANCE WORK ADVANCEMENT (HIWA) BUDGET

FINANCIAL ELIGIBILITY *INCOME MONTH:*

I. GROSS COUNTABLE INCOME TEST

A. UNEARNED INCOME

	***GROSS –**
RSDI	
Railroad Retirement	
Veteran Benefits	
Pension / Retirement	
Contributions	
Other	
Total Countable Unearned Income	$
GROSS UNEARNED INCOME LIMIT	$

ELIGIBLE ☐ YES ☐ NO

B. EARNED INCOME

Gross Earnings	
GROSS EARNED INCOME LIMIT	$

ELIGIBLE ☐ YES ☐ NO

II. NET INCOME TEST

A. UNEARNED INCOME

1. Total	$ (COUNTABLE)
LESS (a) General Income Exclusion	– 20.00
2. Net Countable Unearned Income	$

B. EARNED INCOME

1. Gross Earnings	$
LESS (a) Remaining General Exclusion	–
(b) Earnings Exclusions	– 65.00
(c) Remaining Earned Income	
(d) Less 1/2 of 1(c)	
2. Countable Net Earned Income	
LESS	
Total Employment Related Disregards	–
3. Net Countable Earned Income	
TOTAL COUNTABLE NET INCOME (Sum of A-2 and B-3)	
COMBINED NET INCOME LIMIT	

ELIGIBLE ☐ YES ☐ NO

INSTRUCTIONS FOR FORM 2046-EM (6/04), "HEALTH INSURANCE WORK ADVANCEMENT (HIWA) BUDGET"

PURPOSE

The budget is used to calculate income for determining eligibility for the HIWA program.

INSTRUCTIONS

Complete section I.A., entering all gross unearned income received by the applicant. Compare the total unearned income to the Gross Unearned Income Limit. If the income exceeds the limit, the budget stops here, and the applicant is ineligible. If the income does not exceed the limit, proceed to I.B.

Complete section I.B., entering the total gross earned income received by the applicant. Compare the total to the Gross Earned Income Limit. If the total gross earned income exceeds the limit, the budget stops here, and the applicant is ineligible. If the income does not exceed the limit, proceed to section II.

Complete section II.A., entering the total unearned income minus the $20 General Income Exclusion to determine the net unearned income.

Complete section II.B., entering the total gross earned income minus a) any General Income Exclusion not offset by the unearned income, and b) minus the $65 Earnings Exclusion.

Divide the remaining earned income by 2 to determine the Countable Net Earned Income. Subtract any Employment Related Expenses to determine the final net earned income.

Combine the net unearned income and the net earned income. Compare the total to the Net Income Limit. If the income exceeds the limit, the applicant is ineligible. If the income is below the limit, the applicant is eligible for the HIWA program.

NEVADA STATE DIVISION OF WELFARE

AND

SUPPORTIVE SERVICES

MAABD PROGRAM MANUAL

APPENDIX G

PRUCOL

VERIFICATION

SSN'S ISSUED PRIOR TO JANUARY 1, 1972 FOR PRUCOL VERIFICATION

First Three Digits	Second Two Digits		First Three Digits	Second Two Digits		First Three Digits	Second Two Digits	
001	Odd Even	01-09 10-48	151-158	Odd Even	01-09 10-50	261-266	Odd Even	01-35 02-98
002-003	Odd Even	01-09 10-46	159-176	Odd Even	01-09 10-48	267	Odd Even	01-33 02-98
004-006	Odd Even	01-09 10-60	177	Odd Even	01-09 10-46	268-290	Odd Even	01-09 10-58
007	Odd Even	01-09 10-58	178	Odd Even	01-09 10-48	291	Odd Even	01-09 10-56
008-009	Odd Even	01-09 10-46	179	Odd Even	01-09 10-46	292	Odd Even	01-09 10-58
010-025	Odd Even	01-09 10-48	180	Odd Even	01-09 10-48	293	Odd Even	01-09 10-56
026-028	Odd Even	01-09 10-46	181-211	Odd Even	01-09 10-46	294	Odd Even	01-09 10-58
029	Odd Even	01-09 10-48	212-218	Odd Even	01-09 10-70	295-302	Odd Even	01-09 10-56
030-034	Odd Even	01-09 10-46	219-220	Odd Even	01-09 10-68	303-314	Odd Even	01-09 10-66
035-039	Odd Even	01-09 10-38	221-222	Odd Even	01-09 10-44	315-316	Odd Even	01-09 10-64
040-044	Odd Even	01-09 10-54	223-227	Odd Even	01-09 10-88	317	Odd Even	01-09 10-66
045-049	Odd Even	01-09 10-52	228-231	Odd Even	01-09 10-86	318	Odd Even	01-09 10-54
050-100	Odd Even	01-09 10-50	232-236	Odd Even	01-09 10-92	319-320	Odd Even	01-09 10-52
101-125	Odd Even	01-09 10-48	237-246	Odd Even	01-09 02;10-98	321-323	Odd Even	01-09 10-54
126-133	Odd Even	01-09 10-50	247-248	Odd Even	01-11 02-98	324-325	Odd Even	01-09 10-52
134	Odd Even	01-09 10-48	249-251	Odd Even	01-09 02-98	326-327	Odd Even	01-09 10-54
135-150	Odd Even	01-09 10-52	252-260	Odd Even	01-09 02;10-98	328-361	Odd Even	01-09 10-52

362-384	Odd Even	01-09 10-64	442-447	Odd Even	01-09 10-60	505	Odd Even	01-09 10-82
385	Odd Even	01-09 10-62	448	Odd Even	01-09 10-58	506-508	Odd Even	01-09 10-80
386-396	Odd Even	01-09 10-64	449-451	Odd Even	01-13 02-98	509-514	Odd Even	01-09 10-64
397-398	Odd Even	01-09 10-62	452	Odd Even	01-11 02-98	515	Odd Even	01-09 10-62
399	Odd Even	01-09 10-64	453-457	Odd Even	01-13 02-98	516	Odd Even	01-09 10-74
400-405	Odd Even	01-09 10-86	458-465	Odd Even	01-11 02-98	517	Odd Even	01-09 10-72
406-407	Odd Even	01-09 10-84	466	Odd Even	01-09 02-98	518-519	Odd Even	01-09 10-74
408	Odd Even	01-09 02;10-98	467	Odd Even	01-11 02-98	520	Odd Even	01-09 10-70
409	Odd Even	01-09 02-04; 10-98	468-470	Odd Even	01-09 10-72	521-524	Odd Even	01-09 10-90
410-415	Odd Even	01-09 02;10-98	471-477	Odd Even	01-09 10-70	525	Odd Even	01-09 10-98
416-420	Odd Even	01-09 10-82	478-479	Odd Even	01-09 10-78	526-527	Odd Even	01-21 02-98
421-424	Odd Even	01-09 10-80	480-485	Odd Even	01-09 10-76	528-529	Odd Even	01-09 10-92
425	Odd Even	01-09 02-98	486-489	Odd Even	01-09 10-66	530	Odd Even	01-09 10-56
426-428	Odd Even	01-09 2-06;10-98	490-500	Odd Even	01-09 10-64	531-534	Odd Even	01-09 10-64
429	Odd Even	01-15 02-98	501	Odd Even	01-09 10-74	535-539	Odd Even	01-09 10-62
430-432	Odd Even	01-13 02-98	502	Odd Even	01-09 10-72	540-544	Odd Even	01-09 10-74
433-439	Odd Even	01-09 02;10-98	503	Odd Even	01-09 10-76	545-546	Odd Even	01-11 02-98
440-441	Odd Even	01-09 10-62	504	Odd Even	01-09 10-74	547	Odd Even	01-09 02-98

548	Odd Even	01-11 02-98	574	Odd Even	01-09 10-30	587	Odd Even	01-19 02-98
549	Odd Even	01-09 02-98	575	Odd Even	01-09 10-76	700-723	Odd Even	01-09 10-18
550-551	Odd Even	01-11 02-98	576	Odd Even	01-09 10-74	724	Odd Even	01-09 10-28
552	Odd Even	01-09 02-98	577-579	Odd Even	01-09 10-78	725-726	Odd Even	01-09 10-18
553-558	Odd Even	01-11 02-98	580-582	Odd Even	01-09 10-98	727	Odd Even	01-09 10
559-560	Odd Even	01-09 02-98	583-584	Odd Even	01-09 10-84	728	Odd Even	01-09 10-14
561	Odd Even	01-11 02-98	585	Odd Even	01-09 10-88	729	Odd Even	01-09 (No Even)
562-573	Odd Even	01-09 02-98	586	Odd Even	01-09 10-60			

MAABD PROGRAM MANUAL
TRANSMITTAL LETTER 1/01

APRIL 6, 2001

TO: CUSTODIANS OF MAABD PROGRAM MANUALS

FROM: MICHAEL J. WILLDEN, ADMINISTRATOR

SUBJECT: MAABD PROGRAM MANUAL CHANGES

Material Transmitted	Material Superseded
FURNISHING SOCIAL SECURITY NUMBERS Section 204,A - 205,D,3,d MTL 1/01 - 2 Pages	**FURNISHING SOCIAL SECURITY NUMBERS** Section 204,A - 205,D,3,d MTL 8/99 - 2 Pages
MEDICARE BENEFICIARIES Section 310,B - 310,H MTL 1/01 - 1 Page	**MEDICARE BENEFICIARIES** Section 310,B - 310,H MTL 12/99 - 1 Page
SUPPLEMENTAL SECURITY INCOME Section 320,F - 320,F,4,c,1) MTL 1/01 - 1 Page	**SUPPLEMENTAL SECURITY INCOME** Section 320,F - 320,F,4,c,1) MTL 8/99 - 1 Page
PUBLIC LAW CASES Section 330,F - 330,J MTL 1/01 1 Page	**PUBLIC LAW CASES** Section 330,F - 330,J MTL 8/99 1 Page
PERSONS INSTITUTIONALIZED AT LEAST 30 CONSECUTIVE DAYS Section 350,F,3 - 350,F,3,c,2),c) MTL 1/01 - 1 Page	**PERSONS INSTITUTIONALIZED AT LEAST 30 CONSECUTIVE DAYS** Section 350,F,3 - 350,F,3,c,2),c) MTL 8/99 - 1 Page
HOME AND COMMUNITY BASED SERVICES Section 360,B - 360,H MTL 1/01 - 1 Page	**HOME AND COMMUNITY BASED SERVICES** Section 360,B - 360,H MTL 8/99 - 1 Page
CHILDREN ELIGIBLE UNDER 1902(E)(3) OF THE SOCIAL SECURITY ACT Section 370,F- 370,J MTL 1/01 - 1 Page	**CHILDREN ELIGIBLE UNDER 1902(E)(3) OF THE SOCIAL SECURITY ACT** Section 370,F- 370,J MTL 8/99 - 1 Page
PRIOR MEDICAL DETERMINATION ONLY – WOULD HAVE BEEN ELIGIBLE FOR SSI Section 380 - 380,K MTL 1/01 - 1 Page	**PRIOR MEDICAL DETERMINATION ONLY – WOULD HAVE BEEN ELIGIBLE FOR SSI** Section 380 - 380,K MTL 8/99 - 1 Page
PARENTAL FINANCIAL RESPONSIBILITY FOR SERVICES PROVIDED TO DISABLED CHILDREN Section 501 - 505,B MTL 1/01 - 3 Pages	**PARENTAL FINANCIAL RESPONSIBILITY FOR SERVICES PROVIDED TO DISABLED CHILDREN** Section 501 - 505,B MTL 8/00, 5/00 - 3 Pages

Background and Explanation

Section 205 Nevada Residency Section 310 Section 320 Section 330 Section 350 Section 360 Section 370 Section 380	These sections are updated to further clarify when a person living in Nevada is considered to be a resident for the purposes of Medicaid eligibility. A person temporarily living in Nevada possessing a return ticket (expected end date of their stay in Nevada) to their original state/country of origin are not residents of Nevada. Even if their expected return date is altered due to unforseen circumstances (emergency hospitalization, etc.), they are not residents of Nevada.
Section 501 Annual Family Deduction	Tables and examples are updated to reflect 2001 Federal Poverty Guidelines.

Effective Date

April 1, 2001.

Instructions for Manual Maintenance

Replaced superseded page(s) (12) with transmitted page(s) (12).

(MTL\MAABD1_01)

MAABD PROGRAM MANUAL
TRANSMITTAL LETTER 2/01

APRIL 13, 2001

TO: CUSTODIANS OF MAABD PROGRAM MANUALS

FROM: MICHAEL J. WILLDEN, ADMINISTRATOR

SUBJECT: MAABD PROGRAM MANUAL CHANGES

Material Transmitted	Material Superseded
INDEX (Types of Earned and Unearned Income) Section 220 MTL 2/01 - 1 Page	**INDEX (Types of Earned and Unearned Income)** Section 220 MTL 4/97 - 1 Page
TYPES OF EARNED AND UNEARNED INCOME Section 220 (Austrian Social Insurance Payments – Bank Accounts) MTL 2/01 - 1 Page	**TYPES OF EARNED AND UNEARNED INCOME** Section 220 (Austrian Social Insurance Payments – Bank Accounts) MTL 1/96 - 1 Page
Section 220 (Housing and Urban Development [HUD] – Job Corp) MTL 2/01 - 2 Pages	Section 220 (Housing and Urban Development [HUD] – Job Corp) MTL 2/94 - 1 Page
INDEX (Types of Resources) Section 230 MTL 2/01 - 1 Page	**INDEX (Types of Resources)** Section 230 MTL 1/96 - 1 Page
TYPES OF RESOURCES Section 230 (Annuities – Bank Accounts) MTL 2/01 - 1 Page	**TYPES OF RESOURCES** Section 230 (Annuities – Bank Accounts) MTL 1/96 - 1 Page
Section (Earned Income Tax Credit [EIC] – Life Estates) MTL 2/01 - 1 Page	Section (Earned Income Tax Credit [EIC] – Life Estates) MTL 1/96 - 1 Page

Background and Explanation

Section 220 & 230

The use of Individual Development Accounts (IDAs) are intended to improve the economic independence and stability of individuals and families and to promote and support the transition to economic self-sufficiency. Federal funds match the amount of earnings of low-income working individuals and families. IDA savings are to be used for a first home purchase, post secondary educational expenses, or business capitalization.

The Social Security Act provides for the use of State Family Assistance Grant funds, such as Temporary Assistance for Needy Families (TANF) and Welfare-to-Work (WtW) funds to be used to establish IDAs for low-income working individuals and families. The Assets for Independence Act (AFIA) provides for IDAs under Head Start, Low Income Home Energy Assistance (LIHEA) and Community Services. IDAs have been established under WtW and Community Services. NSWD is currently evaluating the use of TANF funds for IDAs.

Federal matching funds (including interest accruing on the matching funds) deposited into IDAs are disregarded in determining eligibility for, or the amount of assistance furnished under any federal or federally assisted program based on need, e.g., TANF, Medicaid and Food Stamps. However, the AFIA statute permits states to count any participant funds deposited and interest earned on the funds.

The U.S.D.A. Food and Nutrition Service (FNS), the Office of Family Assistance Division of the Department of Health and Human Services (HHS), and the Health Care Financing and Policy (HCFA) Division of HHS is encouraging states to disregard funds deposited and interest earned by an IDA participant. In addition to disregarding funds deposited and interest earned, HHS is encouraging states to disregard the amount of earned income deposited by a participant into an IDA. FNS policies do not allow for disregarding income deposited from earned income.

Nevada has chosen to disregard IDA accounts as follows:

> **FOOD STAMP PROGRAM**: FNS approved Nevada's request to participate in an IDA food stamp demonstration project. An IDA participant can only deposit earned income into the IDA. The participant's earned income is budgeted in determining eligibility and allotment amounts. IDA funds (earned income and matching) are excluded resources.
>
> **TANF AND MEDICAID PROGRAMS**: Nevada is exercising the state's authority to disregard all participant and matching contributions to IDA accounts. An IDA participant can only deposit earned income into the IDA. The amount of earned income deposited into an IDA will be considered an earned income disregard in determining eligibility and benefit amounts. IDA funds (earned income and matching) are excluded resources.

Effective Date

April 1, 2001.

Instructions for Manual Maintenance

Replaced superseded page(s) (6) with transmitted page(s) (7).

MAABD PROGRAM MANUAL
TRANSMITTAL LETTER 3/01

OCTOBER 17, 2001

TO: CUSTODIANS OF MAABD PROGRAM MANUALS

FROM: NANCY K. FORD, ADMINISTRATOR

SUBJECT: MAABD PROGRAM MANUAL CHANGES

Material Transmitted	Material Superseded
CITIZENSHIP REQUIREMENT Section 206 – 206,D,2 MTL 3/01 – 2 Pages	**CITIZENSHIP REQUIREMENT** Section 206 – 206,D,2 MTL 4/00 – 1 Page

Background and Explanation

Under the Trafficking Victims Protection Act, adult victims of trafficking who are certified by the Office of Refugee Resettlement (ORR) at the Department of Health and Human Services (HHS) are eligible for benefits to the same extent as refugees. Children who have been subjected to trafficking are also eligible for refugees but do not need to be certified.

Trafficking Victims section added to Citizenship policy section 206.

Effective Date

Upon receipt.

Instructions for Manual Maintenance

Replaced superseded page(s) (1) with transmitted page(s) (2).

(MTL\MAABD3_01)

MAABD PROGRAM MANUAL
TRANSMITTAL LETTER 4/01

NOVEMBER 5, 2001

TO: CUSTODIANS OF MAABD PROGRAM MANUALS

FROM: NANCY K. FORD, ADMINISTRATOR

SUBJECT: MAABD PROGRAM MANUAL CHANGES

Material Transmitted	Material Superseded
APPENDIX C **MAABD Income Standard Chart** MTL 4/01 – 1 Page	**APPENDIX C** **MAABD Income Standard Chart** MTL 10/00 – 1 Page
APPENDIX D **Benefit Level Chart** MTL 4/01 – 2 Pages	**APPENDIX D** **Benefit Level Chart** MTL 10/00 – 2 Pages

Background and Explanation

Original MTL was drafted to release the 2001 poverty levels and sent to Publications in 2/01, than SSI adjusted the payment level by $1 which affected several limits. MTL was pulled out of Publications to finish all updates at the same time. Now corrected and published are these 2001 limits. Year 2002 should be out soon.

The year 2001 mandated Federal Poverty Levels.

Effective Date

Upon receipt.

Instructions for Manual Maintenance

Replaced superseded page(s) (3) with transmitted page(s) (3).

(MTL\MAABD4_01)

MAABD PROGRAM MANUAL
TRANSMITTAL LETTER 5/01

NOVEMBER 9, 2001

TO: CUSTODIANS OF MAABD PROGRAM MANUALS

FROM: NANCY K. FORD, ADMINISTRATOR

SUBJECT: MAABD PROGRAM MANUAL CHANGES

Material Transmitted	Material Superseded
HOME AND COMMUNITY BASED SERVICES Section 360 – 360,A,1,a,3),d) MTL 5/01 – 1 Page	**HOME AND COMMUNITY BASED SERVICES** Section 360 – 360,A,1,a,3),d) MTL 2/99 – 1 Page

Background and Explanation

Section 360	Effective January 1, 2001, the Elderly in Group Care Homes waiver was amended to allow for any person in an Elderly Group Care Home, who lost SSI as a result of the cost-of-living increase of their RSDI, to have continued Medicaid evaluated under the Public Law "Pickle Amendment" (using Group care SSI levels). Effective July 1, 2001, the Elderly in Group Care Homes waiver was further amended to remove the SSI requirement. Income eligibility for this category is now determined using Institutional income limits (300% of SSI).

Effective Date

July 1, 2001

Instructions for Manual Maintenance

Replaced superseded page(s) (1) with transmitted page(s) (1).

(MTL\MAABD5_01)

MAABD PROGRAM MANUAL
TRANSMITTAL LETTER 1/02

JANUARY 7, 2002

TO: CUSTODIANS OF MAABD PROGRAM MANUALS

FROM: NANCY K. FORD, ADMINISTRATOR

SUBJECT: MAABD PROGRAM MANUAL CHANGES

Material Transmitted	Material Superseded
APPENDIX C **MAABD INCOME STANDARD CHART** MTL 1/02 – 1 Page	**APPENDIX C** **MAABD INCOME STANDARD CHART** MTL 4/01 – 1 Page
APPENDIX D **BENEFIT LEVEL CHART** MTL 1/02 – 1 Page	**APPENDIX D** **BENEFIT LEVEL CHART** MTL 4/01 – 1 Page
APPENDIX F **VETERAN UNUSUAL MEDICAL EXPENSE (UME) BUDGET – 2002** FORM 2039-EE (Page 1-2) MTL 1/02 - 1 Page	**APPENDIX F** **VETERAN UNUSUAL MEDICAL EXPENSE (UME) BUDGET** FORM 2039-EE (Page 1-2) MTL 10/00 - 1 Page
APPENDIX F **SSI BUDGET - RSDI COMPUTATION WORKSHEET** FORMS 2646-EE (Page 1-2) – 2654-EE MTL 1/02 – 2 Pages	**APPENDIX F** **SSI BUDGET - RSDI COMPUTATION WORKSHEET** FORMS 2646-EE (Page 1-2) – 2654-EE MTL 10/00 – 2 Pages

Background and Explanation

Appendix C	Updated with 2002 cost-of-living adjustment, including new Medicare premiums and new QI2 reimbursement rate.
Appendix D	Updated with 2002 cost-of-living adjustment in Supplemental Security Income amounts, 2002 VA amounts, and the 2002 institutional and county match limits. Also corrected 2001 VA Aide and Attendance amount.
Appendix F	Adds 2002 cost-of-living increases adjusted on forms: SSI Budget, Parent to Child Deeming budget, VA UME budget, and the RSDI computation worksheet. Also corrected the VA UME budget for 2001. Due to a typo on the computation worksheet, an incorrect amount for the Aide and Attendance was published for 2001.

Effective Date -- January 1, 2002

Instructions for Manual Maintenance -- Replaced superseded pages (5) with transmitted pages (5).

(MTL\Maabd01_02)

MAABD PROGRAM MANUAL
TRANSMITTAL LETTER 2/02

MARCH 18, 2002

TO: CUSTODIANS OF MAABD PROGRAM MANUALS

FROM: NANCY K. FORD, ADMINISTRATOR

SUBJECT: MAABD PROGRAM MANUAL CHANGES

Material Transmitted	Material Superseded
CHAPTER 500 – PARENTAL FINANCIAL RESPONSIBILITY FOR SERVICES PROVIDED TO DISABLED CHILDREN Section 501 – 505,B MTL 2/02 – 3 Pages	**CHAPTER 500 – PARENTAL FINANCIAL RESPONSIBILITY FOR SERVICES PROVIDED TO DISABLED CHILDREN** Section 501 – 505,B MTL 1/01 – 3 Pages
APPENDIX C **MAABD INCOME STANDARD CHART** MTL 2/02 - 1 Page	**APPENDIX C** **MAABD INCOME STANDARD CHART** MTL 4/01 - 1 Page
APPENDIX D **BENEFIT LEVEL CHART** MTL 2/02 - 2 Pages	**APPENDIX D** **BENEFIT LEVEL CHART** MTL 1/02, 4/01 - 2 Pages

Background and Explanation

Section 501,B,4	**PARENTAL FINANCIAL RESPONSIBILITY** 2002 Federal Poverty Level increases require change in annual family deduction allowance permitted by Parental Financial Responsibility program.
Section 501,E,2 **Section 501,E,2,d**	Update example computation in the manual based on new poverty levels.
Appendix C **Appendix D**	**MAABD INCOME STANDARD CHART & BENEFIT LEVEL CHART** 2002 Federal Poverty Level increases updated.

Effective Date

April 1, 2002.

Instructions for Manual Maintenance

Replaced superseded pages (6) with transmitted pages (6).

(MTL\Maabd2_02)

MAABD PROGRAM MANUAL
TRANSMITTAL LETTER 3/02

JULY 26, 2002

TO: CUSTODIANS OF MAABD PROGRAM MANUALS

FROM: NANCY K. FORD, ADMINISTRATOR

SUBJECT: MAABD PROGRAM MANUAL CHANGES

Material Transmitted	Material Superseded
INSURANCE COVERAGE Section 208,A,3 – 208,C,3 MTL 3/02 – 1 Page	**INSURANCE COVERAGE** Section 208,A,3 – 208,C,3 MTL 1/00 – 1 Page
TYPES OF RESOURCES Section 230(Patient Trust Accounts – Radiation Exposure Payments) MTL 3/02 – 1 Page	**TYPES OF RESOURCES** Section 230(Patient Trust Accounts – Radiation Exposure Payments) MTL 1/96 – 1 Page
TRANSFER OF ASSETS Section 240 – 240,B,7 MTL 3/02 – 1 Page	**TRANSFER OF ASSETS** Section 240 – 240,B,7 MTL 2/97 – 1 Page

Background and Explanation

208	At the request of the Division of Health Care Financing & Policy DHCFP), the manual is updated to clarify that Anthem Blue Cross Blue Shield (BC/BS) of Nevada now makes the determination of cost effectiveness of health care insurance. Once completed, the questionnaire is to be sent to BC/BS instead of Medicaid (NMO-DHCFP).
230	Pension Funds – Conditional exclusion is updated to clarify the IRA of an ineligible spouse is not counted in determining resources unless spousal impoverishment rules apply.
240	Correction to cross-referenced manual section.

Effective Date

July 1, 2002

Instructions for Manual Maintenance

Replaced superseded pages (3) with transmitted pages (3).

(MTL\Maabd3_02)

When the client has an accident or job related injury, was injured while in the custody of a law enforcement agency, or received insurance reimbursements for Medicaid-paid bills, notify the fiscal intermediary on form 2511. The fiscal intermediary will request completion of form 2511 whenever a trauma incident (accident) is reported to the fiscal intermediary through an outside source. However, the fiscal intermediary is not to request "additional investigations" through district office staff. If this should occur, notify the Chief of Eligibility and Payments in Central Office.

Clients are required to report and surrender all monies received for reimbursement of medical care and treatment being billed to or previously paid for by the Medicaid program. When monies are received by district offices, a Payment Receipt, Form 1070-MF, is completed and all available information and accompanying documentation (e.g., insurance explanation of benefits) should be obtained. All monies must be deposited into the State's account in accordance with deposit procedures. A copy of the receipt is sent to Accounting in Central Office. DO NOT APPLY THESE MONIES TO PATIENT LIABILITY. When monies are received by a medical provider other than the one who provided the medical services, all monies must be deposited into the State's account in accordance with deposit procedures. A copy of the receipt is sent to Accounting in Central Office. If the client refuses to surrender the money, the case must be referred to the Deputy Attorney General for action.

B. MANDATORY PREMIUM PAYMENTS FOR COST EFFECTIVE EMPLOYER GROUP HEALTH INSURANCE

Section 4402 of OBRA 1990 requires states pay for premiums, deductibles, co-insurance and other cost sharing obligations for Medicaid recipients entitled to employer group health insurance.

The health insurance coverage must be cost effective and the enrollee must be Medicaid eligible. An individual's enrollment in a group health plan is considered cost effective if Medicaid payments for services are likely to be greater than the cost of paying the insurance premiums and other cost sharing obligations for the same set of services.

Enrollment in the group health plan is a condition of eligibility except when the individual is unable to enroll on their own behalf. A child will not be penalized if their parent fails to cooperate with this requirement for the child's benefit.

Anthem Blue Cross/Blue Shield (BC/BS) will determine if the group health insurance is cost effective. The ECS is responsible for obtaining available insurance information. Clients must complete Form 2230 and provide a copy of their insurance policy or benefits letter in the intake or ongoing eligibility process when the client is or will be entitled to group health insurance. Failure to comply will cause denial or termination of assistance.

Send the completed insurance questionnaire and a copy of the policy or benefits letter to Anthem Blue Cross/Blue Shield of Nevada, Attention: TPL Coordinator. If the health insurance is determined to be cost effective, BC/BS will notify the ECS. Premiums will be paid to the employer or insurance carrier through our fiscal agent, Blue Cross/Blue Shield of Nevada. Premiums which can only be paid through a payroll deduction will be reimbursed directly to the client. These reimbursements are exempt income to the client.

C. MEDICARE AND BUY-IN/BENDEX

1. MEDICARE

Medicare is Social Security's health insurance program. Medicare has two types of coverage Part A - Hospital Insurance: and Part B- Medical Insurance.

2. PERSONS ELIGIBLE FOR MEDICARE

a. All persons OVER AGE 65 who are either a U.S. citizen; or an alien lawfully admitted for permanent residency who has resided in the U.S. continuously 5 years immediately preceding the month the alien applies for Medicare.

b. Persons UNDER AGE 65 who have received monthly Social Security/Railroad Retirement disability benefits for 24 months.

c. Most people with CHRONIC KIDNEY DISEASE.

3. BUY-IN

Medicare is a prior resource to Medicaid. This helps cut Medicaid costs and it is to our advantage to insure a recipient remain eligible for this coverage.

Welfare does not normally pay for Medicare Part A. In most instances, this premium is free to those who are entitled. Those who must pay for this premium have a suffix "M", "J" or "K" on their Medicare claim number.

EXCEPTION: The Medicare Catastrophic Coverage Act of 1988 mandates all recipients who qualify under the QMB category of assistance will have their Part A premium covered by Medicaid. QMBs will be accreted effective the date eligibility begins. (The month immediately following the month the decision is made.)

Due to cost savings realized, NSWD has elected to pay the Part B Medicare premium for all Medicaid recipients enrolled in Medicare.

RESOURCE TYPE	DESCRIPTION
PATIENT TRUST ACCOUNTS (Cont'd)	**c. It must be clear the encumbered portion would not be released to the client if a request were made by the client.** **If a statement is provided with all of the above, the portion the facility states is unavailable will not be counted as a resource in determining eligibility.** **Verification: (not all inclusive)** **- Patient Trust Account Ledgers** **- Medical Facility Information Form 2547-EE**
PENSION FUNDS **1. Person Property** **2. Conditional Exclusion**	**Pension funds are funds held in individual retirement accounts (IRA) (as described by the IRS), or in workBrelated pension plans (including Keogh plans).** **Pension funds of the client's ineligible spouse are excluded, unless spousal impoverishment rules apply.** **Verification: (not all inclusive)** **B Financial statements** **B Tax return documents**
PROMISSORY NOTES, FORMAL WRITTEN LOAN AGREEMENTS AND PROPERTY AGREEMENTS **1. Personal Property** **2. Conditional Exclusion**	**Generally, promissory notes, property agreements and loan agreements may be sold or discounted. If the client's statement of value, either alone or combined with other resources, exceeds the resource limit, there is no need to verify current market value. Presume the value is its outstanding principal balance unless reliable evidence shows current market value (CMV) is less.** **If the individual alleges the item is for sale, promissory notes, formal written loan agreements and property agreements are excluded when the client verifies the item is for sale at market value and no offers to purchase have been received. The item must remain for sale while the client receives assistance.**

RESOURCE TYPE	DESCRIPTION
PROMISSORY NOTES, FORMAL WRITTEN LOAN AGREEMENTS AND PROPERTY AGREEMENTS (Cont'd)	**"Good Faith" efforts must be made by or on behalf of the client to qualify under this exclusion. These efforts must continue for the exclusion to remain in effect.** **Federal regulations state "good faith efforts" to sell resources consist of taking all necessary and reasonable steps to sell it in the geographic area covered by media (radio, television, and newspaper, etc.) serving the area where the property is located.** **"Necessary and reasonable" steps to sell this resource will be to utilize a licensed realtor to list the resource for sale OR advertise the resource is for sale through at least one media source covering the area where the resource is located and posting a 'for sale' sign on the property if applicable. The frequency in advertising property for sale will be at least twice a month.** **Example: Newspaper advertisements should appear twice in a month with each length of time the decision of the client/representative.** **A bonafide negotiable agreement is a resource. The portion of any payment received representing payment on the principal is also a resource. The portion of any payment which represents interest on the principal is unearned income.** **An agreement which is not bonafide or negotiable is not a resource. The total payments received, whether principal and/or interest, are unearned income.** **Verification: (not all inclusive)** **B Bank or other financial institution** **B Title company** **B Private investor** **B Real estate broker**
RADIATION EXPOSURE PAYMENTS **1. Personal Property** **2. Excluded**	**Payments made under the Radiation Exposure Compensation Act.** **Verification: (not all inclusive)** **B Documents from Source of Payment** **B Verify how the resources are held**

240 TRANSFER OF ASSETS (Not applicable to QMB-Section 310, SSI-Section 320, Public Law-Section 330 and Prior Medical-Section 380)

A. INTRODUCTION

For purposes of this section, assets include all income and resources of the individual and of the individual's spouse. This includes income or resources which the individual or the individual's spouse is entitled to but does not receive because of any action by:

- **The individual or the individual's spouse;**
- **A person, including 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**
- **Any person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.**

For purposes of this section, the term "assets an individual or spouse is entitled to" includes assets to which the individual is entitled or would be entitled if action had not been taken to avoid receiving the assets.

The following are examples of actions which would cause income or resources not to be received:

- **Irrevocably waiving pension income;**
- **Waiving the right to receive an inheritance;**
- **Not accepting or accessing injury settlements;**
- **Tort settlements which are diverted by the defendant into a trust or similar device to be held for the benefit of an individual who is a plaintiff; and**
- **Refusal to take legal action to obtain a court ordered payment that is not being paid, such as child support or alimony.**

Failure to cause assets to be received does not entail a transfer of assets for less than fair market value in all instances. For example, the individual may not be able to afford to take the necessary action to obtain the assets. Or the cost of obtaining the assets may be greater than the assets are worth, thus effectively rendering the assets worthless to the individual. Examine the specific circumstances of each case before making a decision whether an uncompensated asset transfer occurred.

B. DEFINITIONS

1. **TRANSFER OF ASSETS – Assets (income/resources) which are given away, sold or disposed of for less than fair market value to obtain or retain Medicaid eligibility. This includes all income and resources to which the client or spouse is entitled or would be entitled if action had not been taken to avoid receiving the assets.**

   The home of an applicant/recipient (principal place of residence) can only be transferred in the specific instances outlined in section 240.L.5 whether the home is excludable or not.

2. **INSTITUTIONALIZED INDIVIDUAL - Any person who is residing in a medical facility, including SSI recipients, or persons who fall into any category considered institutionalized recipients, such as Home and Community Based Waiver clients.**

3. **FAIR MARKET VALUE - The current market value of the asset AT THE TIME OF TRANSFER.**

4. **COMPENSATION - All money, real or personal property, food, shelter, or services received by the applicant/recipient at or after the time of transfer in exchange for the asset. Items received prior to the transfer will be considered compensation only if they were provided pursuant to a binding contract (verbal or written) to provide such items in exchange for payment.**

5. **UNCOMPENSATED VALUE - The Fair Market Value of the asset AT THE TIME OF TRANSFER, minus the amount of compensation received by the applicant/recipient or spouse in exchange for the asset.**

6. **LEGAL REPRESENTATIVE - Parent of a minor child, power of attorney, legal guardian, or anyone legally authorized to execute a contract for the client/spouse.**

   Assets transferred by anyone acting in place of or on behalf of or at the request or direction of the client or spouse, are considered to be transferred by the client or spouse.

7. **UNDUE HARDSHIP - Undue hardship is when there is no means, legal or otherwise, by which the applicant/recipient is able to have the asset transferred back to his/her ownership or receive further compensation.**

MAABD PROGRAM MANUAL
TRANSMITTAL LETTER 4/02

SEPTEMBER 12, 2002

TO: CUSTODIANS OF MAABD PROGRAM MANUALS

FROM: NANCY K. FORD, ADMINISTRATOR

SUBJECT: MAABD PROGRAM MANUAL CHANGES

Material Transmitted	Material Superseded
MAABD OVERVIEW Section 100 – 101,A,8 MTL 4/02 – 2 Pages	**MAABD OVERVIEW** Section 100 – 101,A,8 MTL 1/00 – 1 Page

Background and Explanation

PART A - ELIGIBILITY	
Section 101,A	**DISTINCTION BETWEEN APPLICATION AND INQUIRY** – This section is being clarified as a result of Policy and Procedure #20-00 requesting clarification of what an application is. The first page of the application, as long as it is signed, must be accepted as an application.
Section 101,A,3	**FAXED APPLICATIONS** – This section is being clarified at the field's request. The current policy conflicts with policy in the E&P Manual for Medicaid under the TANF/CHAP programs. Faxed applications with a signature will be registered into the computer system.

Effective Date

Upon receipt.

Instructions for Manual Maintenance

Replaced superseded pages (1) with transmitted pages (2).

(MTL\Maabd4_02)

100 MAABD OVERVIEW

The MAABD Program is medical assistance for persons who are aged, blind or disabled AND meet the requirements of one of the eligible categories.

101 APPLICATION PROCESS

Upon request, every person will be mailed or given an application and a pamphlet explaining the Medicaid program.

Applicants will be provided assistance in completing the application if such help is requested.

A. DEFINITIONS

1. DISTINCTION BETWEEN APPLICATION AND INQUIRY

Any application not signed by the client or authorized representative is an inquiry only and must be returned for signature. Do not date stamp the unsigned application and do not register it in the computer system. An application must contain the applicant's name, address and appropriate signature. Although we encourage the applicant to submit all pages of the application, the first page of Form 2905-EG must be accepted to preserve the actual application date and begin the application process.

Applicants who cannot sign their name must have their mark witnessed by at least one other person. Applicants with no ability to understand what they are signing must have a competent adult family member sign for them. Example: [client name] by [family member name].

If there are no family members or the existing family members do not wish to assist the applicant, the hospital, nursing home or county agency social service staff may sign on behalf of the applicant. Example: [client name] by [the hospital, nursing home or county agency social service worker name]. In this case, a public guardian referral is required.

NOTE: When a request for institutional Medicaid assistance is received on a regular application versus the "institutional application," send Home Care Questionnaire (Form 2915-EG) with Insufficient Information (Form 2429-EE or EEB) to request the information which is not addressed on the regular application from the individual or agency submitting the application.

2. INITIAL APPLICATIONS

Initial requests for an application for assistance may be made verbally, in writing, in person, or through a representative. Every person has the right to apply for assistance. The date a signed application form is received in the district office is the DATE OF APPLICATION.

3. FAXED APPLICATIONS

A faxed application is acceptable and must be date-stamped the day it is received to protect the applicant's filing date. Enter the faxed application into the computer system the date received or no later than the close of business the next work day. An original signature is required before approval of benefits. Notify the client and their authorized representative their faxed application has been received and request the client'' original application and signature allowing at least 20 days to respond. This request may be made with other information required to process the case on an Insufficient Information Form 2429-EE. If the applicant fails to provide the original signed application, deny the case for non-cooperation.

4. REAPPLICATIONS

Reapplications for assistance are made in the same manner as initial applications. Previous records and eligibility factors must be thoroughly reviewed/verified. All information used to verify eligibility factors which are subject to change, may be pulled forward from previous application if the information is less than thirty (30) days old.

Terminated cases must reapply for assistance.

5. REINSTATEMENTS

Reinstatements are made at the discretion of the District Office Manager (DOM) or Supervisor.

6. TRANSFERS

When the client has previously applied for/received assistance in another Nevada State Welfare office, request the casefile from that office using Form 2609.

7. DUPLICATE ASSISTANCE

Assistance can only be provided from one Nevada program at a time.

Nevada Medicaid programs include:

TANF Temporary Assistance for Needy Families
CHAP Child Health Assurance Program
CWS Child Welfare Services
(*Division of Child & Family Services*)
MAABD Medical Assistance to the Aged, Blind & Disabled

When an applicant indicates he/she received benefits from another state within 3 months prior to the month of application, the ECS must verify status and amount of benefits. Any income or resources revealed by the other state which were not claimed on the current application must be evaluated. Use Form 2258 and 2531.

8. CLIENT REPRESENTATION

Clients may designate anyone they choose to act on their behalf by using an authorized representative Form 2525 OR they may sign a "Release of Information" allowing the Division to release case information to individuals or agencies/organizations. With each subsequent reapplication and redetermination a new Form 2525 and/or Release of Information is required.

There are two types of authorized representatives called primary and secondary representatives. Legal guardians are considered primary representatives.

Power of Attorney status varies with each client. Therefore, obtain Form 2525 designating either primary or secondary representation.

DECEMBER QUARTERLY RELEASE

MAABD PROGRAM MANUAL
TRANSMITTAL LETTER 5/02

DECEMBER 31, 2002

TO: CUSTODIANS OF MAABD PROGRAM MANUALS

FROM: NANCY K. FORD, ADMINISTRATOR

SUBJECT: MAABD PROGRAM MANUAL CHANGES

Material Transmitted	Material Superseded
MAABD OVERVIEW Section 100 – 103 MTL 5/02 – 4 Pages	**MAABD OVERVIEW** Section 100 – 103 MTL 4/02, 4/98, 2/99 – 4 Pages
INTERDISTRICT TRANSFERS Section 213 – 214,B,5 MTL 5/02 – 1 Page	**INTERDISTRICT TRANSFERS** Section 213 – 214,B,5 MTL 1/98 – 1 Page
TYPES OF EARNED AND UNEARNED INCOME Section 220 (Refund on Taxes – Retirement Pay) MTL 5/02 – 2 Pages	**TYPES OF EARNED AND UNEARNED INCOME** Section 220 (Refund on Taxes – Retirement Pay) MTL 4/94 – 1 Page
NEVADA MEDICAID RESIDENTIAL TREATMENT CENTER (RTC) SERVICE PROVIDER Addendum to Section 320 MTL 5/02 – 1 Page	**NEVADA MEDICAID RESIDENTIAL TREATMENT CENTER (RTC) SERVICE PROVIDER** Addendum to Section 320 MTL 5/99 – 1 Page
PERSONS INSTITUTIONALIZED LESS THAN 30 CONSECUTIVE DAYS Section 340 – 340,G MTL 5/02 – 1 Page	**PERSONS INSTITUTIONALIZED LESS THAN 30 CONSECUTIVE DAYS** Section 340 – 340,G MTL 8/99 – 1 Page
NEVADA MEDICAID RESIDENTIAL TREATMENT CENTER (RTC) SERVICE PROVIDER Addendum to Section 340 MTL 5/02 – 1 Page	**NEVADA MEDICAID RESIDENTIAL TREATMENT CENTER (RTC) SERVICE PROVIDER** Addendum to Section 340 MTL 5/99 – 1 Page
PERSONS INSTITUTIONALIZED AT LEAST 30 CONSECUTIVE DAYS Section 350 – 350,F,2 MTL 5/02 – 1 Page	**PERSONS INSTITUTIONALIZED AT LEAST 30 CONSECUTIVE DAYS** Section 350 – 350,F,2 MTL 2/99 – 1 Page
Section 350, L,1,b – 350,L,4,a,4) MTL 5/02 – 1 Page	Section 350, L,1,b – 350,L,4,a,5) MTL 6/00 – 1 Page

NEVADA MEDICAID RESIDENTIAL TREATMENT CENTER (RTC) SERVICE PROVIDER Addendum to Section 350 MTL 5/02 – 1 Page	**NEVADA MEDICAID RESIDENTIAL TREATMENT CENTER (RTC) SERVICE PROVIDER** Addendum to Section 350 MTL 5/99 – 1 Page
HOME AND COMMUNITY BASED SERVICES Section 360,L,2,b – 360,M,1,b,2) MTL 5/02 – 1 Page	**HOME AND COMMUNITY BASED SERVICES** Section 360,L,2,b – 360,M,1,b,2) MTL 6/00 – 1 Page
CHILDREN ELIGIBLE UNDER 1902(E)(3) OF THE SOCIAL SECURITY ACT Section 370,L,1,a – 370,M,1,a MTL 5/02 – 1 Page	**CHILDREN ELIGIBLE UNDER 1902(E)(3) OF THE SOCIAL SECURITY ACT** Section 370,L,1,a – 370,M,1,a MTL 6/00 – 1 Page
N/A	**SSI BUDGET – VETERAN UNUSUAL MEDICAL EXPENSE (UME) BUDGET** Section 380 MTL 2/97 – 2 Pages
APPENDIX C MAABD Income Standard Chart MTL 5/02 – 1 Page	**APPENDIX C** MAABD Income Standard Chart MTL 2/02 – 1 Page
APPENDIX D Benefit Level Chart MTL 5/02 – 1 Page	**APPENDIX D** Benefit Level Chart MTL 2/02 – 1 Page
APPENDIX F – MAABD BUDGETS Veteran Unusual Medical Expense (UME) Budget Form 2039-Ee (Pages 1-2) MTL 5/02 – 1 Page	**APPENDIX F – MAABD BUDGETS** Veteran Unusual Medical Expense (UME) Budget Form 2039-Ee (Pages 1-2) MTL 5/02 – 1 Page
MAABD Budget – Medicare Beneficiary Budget Form 2203-EM (Sides 1-2) MTL 5/02 – 1 Page	MAABD Budget – Medicare Beneficiary Budget Form 2203-EM (Sides 1-2) MTL 9/00 – 1 Page
SSI Budget – RSDI Computation Worksheet Forms 2646-EE (Pages 1-2) – 2654-EE MTL 5/02 – 2 Pages	SSI Budget – RSDI Computation Worksheet Forms 2646-EE (Pages 1-2) – 2654-EE MTL 1/02 – 2 Pages

Background and Explanation

101,A,1 & 101,A,3	Correct grammatical errors.
101,A,5	Updated to change the reference from District Office Manager to Social Welfare Manager.
101,A,6	Updated to remove reference to form number.
101,A,8	Updated to remove requirement to obtain new Authorized Representative form at redetermination. Redetermination sections in 310 through 370 were previously updated.
101,B,8	Incorporates new "Discrimination Complaint Form "2174-EG" and provides guidance on actions that must be taken when a discrimination complaint has been filed

101,D	Updated to remove instructions to complete MAF.
103	Updated to note the procedures for enrollment in Hospice.
214,A,3	**CLOSURES** – QC error cited due to unclear manual section regarding loss of contact.
220	**INCOME** – The definition of rental income is clarified, per field request. Rental income is a product of renting out rooms of a property **OWNED** by the recipient. Shared expenses between renters is not rental income. However, any amount received by the applicant in excess of the household's expenses would be considered income.
Addendum to 320	Updated list of Residential Treatment Centers.
340,A	**OVERVIEW** – Instructions added, per field request, on how to determine the number of days in a medical facility. The day of admission is counted. The day of discharge/death is not.
Addendum to 340	Updated list of Residential Treatment Centers.
350,A	**OVERVIEW** – Clarifications added, per field request, on how to determine the number of days in a medical facility. Also added clarification that an institutional case may be worked prior to meeting the 30 days institutional requirement, provided a licensed physician indicates the client is likely to be in the institution at least 30 days.
350,L,4,a **360,L,4,a** **370,L,4,a**	Remove #2 which allowed a $20 general income exclusion in determining financial eligibility. Per clarification, Federal Financial Participation is available for services provided to individuals only if their income before deductions does not exceed 300% of the SSI benefit amount. The financial eligibility limit in Nevada is 300% of the SSI benefit rate. FFP would not be received for any clients who receive Medicaid over the 300% level. Cases should be corrected on a flow basis, at next update, or redetermination of eligibility
Addendum to 350	Updated list of Residential Treatment Centers.
380	Remove examples of forms 2646-EE/A, 2646-EE and 2039-EE. The examples for these forms were moved to Appendix F.
Appendix C	Updated MAABD Income Standard Chart with 2003 limits as a result of SSI cost-of-living adjustment. Remove income limit for QI2 program which sunsets 12/31/02.
Appendix D	Updated 2003 Benefit Level Chart with new 2003 income limits.
Appendix F	Updated forms with new 2003 amounts. MAABD budget, Form 2203-EM (Side 2) updated to remove $20 and $65 income exclusions. Per above, there are no exclusions/deductions allowed when determining financial eligibility for MAABD programs with a 300% income limit.

Effective Date

January 1, 2003.

Instructions for Manual Maintenance

Replaced superseded pages (22) with transmitted pages (21).

(MTL\Maabd5_02/DecQrtly)

YOU CAN ACCESS THE INDIVIDUAL CHAPTERS ON THE "I' DRIVE UNDER MANUALS/MAABD

MAABD PROGRAM MANUAL
TRANSMITTAL LETTER 6/02

DECEMBER 16, 2002

TO: CUSTODIANS OF MAABD PROGRAM MANUALS

FROM: NANCY K. FORD, ADMINISTRATOR

SUBJECT: MAABD PROGRAM MANUAL CHANGES

Material Transmitted	Material Superseded
TABLE OF CONTENTS Section 505.1 – Appendix G MTL 6/02 – 1 Page	**TABLE OF CONTENTS** Section 505.1 – Appendix G MTL 3/99 – 1 Page
MEDICAID ESTATE RECOVERY PROGRAM Section 506 – 506.19 MTL 6/02 – 5 Pages	**MEDICAID ESTATE RECOVERY PROGRAM** Section 506 – 506.15 MTL 3/97 – 3 Pages

Background and Explanation

506	Updates section to define hardship criteria, exclusions to recovery; deletes references to TEFRA liens and clarifies program operation.

Effective Date

Upon approval.

Instructions for Manual Maintenance

Replaced superseded pages (4) with transmitted pages (6).

(MTL\Maabd06_02Webb)

506 MEDICAID ESTATE RECOVERY PROGRAM

506.1 LEGAL AUTHORITY

Authority for operating the Medicaid Estate Recovery (MER) Program is published in Section 1917 of the Social Security Act and Nevada Revised Statute 422.2935.

506.2 PROGRAM OVERVIEW

Federal and state law mandates state operation of a MER program whereby correctly paid Medicaid benefits are recoverable from the estate of a deceased Medicaid recipient. Recovery is accomplished only after the death of a recipient and at a time when there is no surviving spouse, children under the age of 21 or disabled children.

Regulations of the MER program affect individuals who received Medicaid benefits on or after October 1, 1993. Collections will be pursued against the estate of the recipient up to the amount of Medicaid benefits correctly paid or up to the determined value of the recipient's estate whichever is less.

MER staff are currently housed at the Welfare Division, Central Office.

506.3 DEFINITION OF "ESTATE"

For the purposes of Medicaid Estate Recovery "Estate" means assets included in the estate of a deceased recipient of assistance to the medically indigent and any other assets in or to which he had an interest or legal title immediately before or at the time of his death, to the extent of that interest or title. The term includes assets passing by reason of joint tenance, reserved life estate, survivorship, trust, annuity, homestead or other arrangement.

506.4 AFFECTED INDIVIDUALS

MER actions are imposed against Medicaid recipients who are:

- 55 years of age or older when they receive Medicaid assistance; or
- an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, where they are required to spend for costs of medical care all but a minimal amount of income which is permitted for the recipient's personal needs.

506.5 NOTIFICATION TO AFFECTED INDIVIDUALS

Full disclosure of MER program operation is made during the application process. Statements regarding MER are included on the eligibility application and applicants (or their representatives) are given Form 6160-AF, "Medicaid Estate Recovery Notification of Program Operation." Staff MUST attempt to secure the acknowledgment (via signature) of information provided on Form 6160-AF. However, the applicant's (or their representative's) failure to sign the form does NOT preclude Welfare Division pursuit of correctly paid benefits.

Form 6160-AF, Medicaid Estate Recovery Notification of Program Operation, must be given to all applicants for Medicaid assistance at the time of application for services and redetermination. Be sure the applicant receives the form in English or Spanish, whichever is appropriate.

One copy of the form will be given to the applicant and one copy will be filed in the Medicaid eligibility casefile.

506.6 REFERRAL OF CASES TO MER UNIT

When a MER affected recipient is no longer Medicaid eligible due to death, the eligibility worker MUST forward their casefile to Central Office, Attention: MER, within three (3) working days after the closure of the Medicaid casefile resulting from the death of the Medicaid recipient.

Eligibility staff will request in writing the return of the casefile, if necessary. The written request must include the name and Social Security Number of the client; the date of the request; the eligibility staff member requesting the file and the district office where the file should be sent. This request may be faxed or forwarded to Central Office, Attention: MER, utilizing interoffice mail. MER staff will provide the casefile within three (3) working days.

Casefiles for Medicaid applicants who have been denied Medicaid eligibility and who do not have a history of prior approval should not be forwarded to the MER unit in Central Office.

506.7 INITIATION OF MER ACTIVITIES

Upon receipt of the closed Medicaid eligibility casefile, Central Office MER personnel will establish a MER recovery case. MER staff will validate the recipient's reported resource information.

506.8 NOTIFICATION TO RECIPIENT OR THEIR HEIRS

When MER staff receives notification of an affected Medicaid recipient's death, they will provide their known heirs with a written notice which:

- advises of the state's intent to recover the value of Medicaid benefits paid on the recipient's behalf from the recipient's estate; and
- provides information addressing Medicaid payments made on behalf of the recipient; and
- includes a statement advising the amount the MER claim may increase if there are additional Medicaid claims which have not yet been processed.

All MER notices will include a statement advising the recipient and/or their heirs of the MER hardship waiver provisions.

506.9 IDENTIFICATION OF MER COLLECTIBLES

After the reported death of an affected recipient, MER personnel will review the recipient's estate to determine an estimated dollar value. Asset information will be recorded in the recipient's MER file and will serve as the maximum value collectable under the MER program. In addition, MER personnel will prepare a detailed listing of all Medicaid services provided to the recipient and the amount of Medicaid expenditures paid on behalf of the recipient. This amount will be the maximum amount recoverable under the MER program.

MER actions will be pursued against the estate of the recipient up to the amount of Medicaid benefits correctly paid or up to the determined value of the recipient's estate whichever is less.

506.10 INITIATING MER COLLECTIONS

After the recipient's death, MER personnel will immediately pursue adjustments or recovery of any Medicaid assistance correctly paid on behalf of the recipient from the recipient's estate or upon sale of the recipient's real property.

Any adjustment or recovery against a recipient may be made only after the death of the recipient's surviving spouse, if any, and only at a time when:

- the recipient has no surviving child who is under 21 years of age; or
- the recipient has no surviving child who is blind or disabled.

506.11 RECOVERY AGAINST AN ESTATE

After the death of an affected recipient, and in accordance with Nevada Revised Statutes, MER personnel will immediately file a claim against the estate of the recipient for the full value of Medicaid benefits paid on behalf of the recipient. Once MER staff have requested the deceased recipient's casefile, eligibility staff WILL FORWARD the casefile to Central Office, Attention: MER within three (3) working days.

Claims will be filed with:

- the court having jurisdiction over the recipient's estate pursuant to NRS 147.040; or
- any individual or entity empowered with the legal ability to control, liquidate or transfer any part of the recipient's estate.

506.12 IMPOSITION OF LIENS

Liens may be imposed to protect recovery of estate assets for correctly paid Medicaid benefits when permitted by federal and state law. However, the use of lien authority requires prior notification to the recipient or their known heirs and district court review. Liens may only be imposed with district court approval. The equity interest of the surviving spouse shall be considered in determining the value of the deceased recipient's interest in the property.

Foreclosure action may occur only after the death of the recipient and after the death of the recipient's surviving spouse, if any, and only at a time when the recipient has no surviving child who is under 21 years of age, and the recipient has no surviving child who is blind or disabled.

In the event of incorrectly paid benefits, a lien may be imposed on both real and personal property with authority of a court judgement without regard to circumstances.

NRS 155.020 requires notice be given to the Department of Human Resources of all probate proceedings filed with the court. Any probate notices received in the district office MUST be faxed IMMEDIATELY to Central Office, Attention: MER.

506.13 POSTPONING/TERMINATING MER ACTIONS

If, after the reported death of the recipient, immediate MER action is prohibited because of exception conditions, MER personnel postpone MER action until all exception conditions are no longer present. Termination of MER action will occur when all real and personal property included as part of the recipient's estate is no longer accessible.

506.14 RECEIPTING/POSTING MER COLLECTIONS

All MER collections will be received by MER personnel located in Central Office or the Central Office Accounting Unit.

In the event a MER payment is received in the district office, district office staff must photocopy the negotiable instrument and document on the copy:

- the name and address of the person making the payment;
- the name and Social Security Number of the deceased recipient;
- the amount and method of payment; and
- the date and signature of the person receiving the payment.

A copy will be provided to the person making the payment and another copy along with the negotiable instrument MUST be forwarded to Central Office, Attention: MER, immediately utilizing interoffice mail.

If payment is made by cash, the office MUST follow the procedure outlined above. CASH MUST BE DEPOSITED BY THE DISTRICT OFFICE AND CANNOT BE TRANSMITTED THROUGH THE MAIL. If assistance is needed, please contact Central Office, MER.

DO NOT STATE VERBALLY OR IN WRITING THIS PAYMENT RELEASES THE HEIR FROM MEDICAID ESTATE RECOVERY ACTION.

506.15 EXCLUSION FROM RECOVERY

The following income, resources and property are exempt from Medicaid estate recovery;

1. Certain income and resources of American Indians and Alaska Natives. Income and resources (such as interests in and income derived from tribal land and other resources currently held in trust status and judgment funds from the Indian Claims Commission and the U.S. Claims Court) that are exempt from Medicaid estate recovery by other laws and regulations;

2. Ownership interest in trust or non-trust property, including real property and improvements:

   a. Located on a reservation (any federally recognized Indian tribe's reservation, Pueblo or Colony, including former reservations in Oklahoma, Alaska Native regions established by Alaska Native Claims Settlement Act and Indian allotment) or near a reservation as designated and approved by the Bureau of Indian Affairs of the U.S. Department of the Interior, or
   b. For any federally-recognized tribe not described in a., located within the most recent boundaries of a prior federal reservation.
   c. Protection of non-trust property described above is limited to circumstances when it passes from an Indian (as defined in section 4 of the Indian Health Care Improvement Act) to one or more relatives (by blood, adoption or marriage), including Indians not enrolled as members of a tribe and non-Indians, such as spouses and stepchildren, that their culture would nevertheless protect as family members; to a tribe or tribal organization; and/or to one or more Indians.

3. Income left as a remainder in an estate derived from property protected in 2. above that was either collected by an Indian, or by a tribe or tribal organization and distributed to Indian(s), as long as the individual can clearly trace it as coming from the protected property.

4. Ownership interests left as a remainder in an estate in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish and shellfish) resulting from the exercise of federally-protected rights, and income either collected by an Indian, or by a tribe or tribal organization and distributed to Indian(s) derived from these sources as long as the individual can clearly trace it as coming from protected sources; and

5. Ownership interest in or usage rights to items not covered by 1.-4. above that have unique religious, spiritual, traditional and/or cultural significance, or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom.

6. Government reparation payments to special populations.

Income, resources and property of American Indians and Alaska Natives, which are not exempt from Medicaid estate recovery:

1. Ownership interests in assets and property, both real and personal, that are not described in the above items.

2. Any income and assets left as a remainder in an estate that do not derive from protected property or sources listed above.

506.16 HARDSHIP WAIVER

At the time recovery is initiated, the MER recovery specialist will discuss hardship waivers, compromises or adjustments to the state's claim. Hardship requests will be submitted to the administrator (or their appointed representative) for review. The denial of a hardship waiver or compromise may be appealed through the appropriate court system.

There is no hardship waiver provided at the time of lien placement against the real property of a deceased Medicaid recipient. The equity interest of the heir will be considered to determine the percentage of the deceased recipient's interest in the property. Lien placement is utilized to delay recovery until such time an exemption to recovery does not exist, or in the case of a hardship, until such time as the hardship no longer exist. The state's lien would be the Medicaid benefits paid on behalf of the recipient or the percentage of interest of the deceased recipient at the time of sale, whichever is less.

506.17 HARDSHIP WAIVER CRITERIA

Recovery will be waived of any estate recovery claim when the requesting party is able to show, through convincing evidence, the state's pursuit of estate recovery subjects them to undue and substantial hardship. In determining whether an undue hardship exists, the following criteria will be used:

1. The asset to be recovered is the sole income-producing asset of the applicant, or,

2. The recovery of the assets would result in the applicant becoming eligible for governmental public assistance based on need and/or medical assistance programs; or

3. Medical condition which compromises the applicant's ability to repay the Medicaid claim. A claim for emotional hardship is not considered sufficient to warrant waiver approval.

In response to any hardship request, recovery may be temporarily waived, recovery amounts could be compromised or recovery techniques modified. The administrator (or designated representative) may consider the following circumstances, including but not limited to:

1. The gross annual income, property and other assets of the applicant and their immediate family;

2. The relationship of the applicant to the decedent;

3. The type and level of care provided by the applicant to the decedent and the extent to which the care delayed or prevented the institutionalization of the decedent;

4. Whether the applicant continuously resided with the decedent for two years or more immediately prior to the decedent's death and continues to reside in the decedent's residence, and the prior occupancy permitted the decedent to reside at home rather than in an institution;

5. The estimated value of the real or personal property at issue, and/or;

6. The financial impact of recovery against other affected parties.

The following collection methods may be utilized when recovery is temporarily waived, compromised or modified.

1. Reduction of the recovery amount;

2. Reasonable payment schedule based on the asset to be recovered; and/or

3. Where not prohibited by law, imposition of a lien against the assets of the Medicaid recipient. If a lien is placed on an individual's home, adjustment or recovery will only be made when: 1) there is no sibling of the individual residing in the home who has resided there for at least one year immediately before the date of the individual's death, and has resided there on a continuous basis since that time; and 2) there is no son or daughter of the individual residing in the home who has resided there for at least two years immediately before the date of the individual's death, has resided there on a continuous basis since that time, and can establish to the agency's satisfaction that he/she had been providing care which permitted the individual to reside at home rather than in an institution.

506.18 PROCEDURES FOR APPLYING FOR HARDSHIP WAIVER

FEDERAL LAW PROHIBITS RECOVERY DURING THE LIFETIME OF A SPOUSE WHEN THERE ARE CHILDREN UNDER THE AGE OF 21, AND/OR WHEN THERE ARE CHILDREN WHO ARE BLIND AND/OR DISABLED.

Nevada defines hardship as undue and substantial hardship resulting in severe financial duress or a significant compromise to an individual's health care or shelter needs.

1. Any beneficiary, heir or family member claiming entitlement to receive the assets of the deceased client may apply for a hardship waiver by submitting a written request for a waiver, within thirty (30) days of being notified of an intent to recover, to the Medicaid Estate Recovery (MER) unit.

2. The division may request additional information or documentation from the waiver applicant. If some or all of the additional information or documentation is not provided within thirty (30) days of the request, the hardship waiver request will be considered solely on the basis of the information and documentation provided.

3. Within ninety (90) days of receipt of the hardship waiver request, the division administrator (or appointed representative) will issue a written decision granting or denying the applicant's request for an undue hardship waiver.

4. If the hardship waiver is denied, the decision may be appealed through the appropriate court system.

5. Receipt of a timely request for a hardship waiver shall not prevent or delay the division's pursuit of the estate recovery claim pending the final decision. The division shall return any funds collected if the waiver is granted. No waiver will be granted if the division finds the undue hardship was created by estate planning methods by which the waiver applicant or deceased client divested, transferred or otherwise encumbered assets in whole or part to avoid estate recovery.

506.19 APPLICATION (REQUEST) FOR HARDSHIP WAIVER IF CORRECTLY PAID MEDICAID BENEFITS

Name of Medicaid Recipient: _____

Name of Applicant: _____

Address of Applicant: _____

_____

City State Zip Code

1. Relationship to person who received Medicaid assistance: _____

2. Are the assets to be recovered your sole income-producing asset in your trade, profession or occupation? □ Yes □ No

   Please explain: _____

3. Please explain how denial of the hardship will affect you. Please provide any documentation and/or receipts which would support your statements.

   Financially: _____

   Medically: _____

   Shelter Needs: _____

   Other: _____

4. I am applying for a hardship waiver because of disability. Please explain this disability and provide any medical evidence supporting this disability. _____

   _____

5. Are you currently receiving public assistance of any type? □ Yes □ No

   If Yes, please explain:

   _____

6. Did you reside in the home and provide care for the Medicaid recipient on a continuous basis for a minimum 2-year period before death? □ Yes □ No

7. Provide documentation of the type of care you provided for the Medicaid recipient. Please detail the type of care you provided and the approximate number of hours per day you provided this care.

   _____

   _____

8. Provide a copy of your federal income tax return for the most current year.

9. If Aging Services provided at-home care for the Medicaid recipient, please provide the name of the Aging Services' representative.

   _____

An application for hardship will be considered on a case-by-case basis. The decision may be to waive recovery, delay recovery, compromise the recovery amount, or modify the collection method. You will be notified by letter within ninety (90) days of the decision. If the request for hardship is denied, you may appeal the decision in the appropriate court system.

A return envelope is provided for your convenience.

APRIL QUARTERLY RELEASE
MAABD PROGRAM MANUAL
TRANSMITTAL LETTER 1/03

MARCH 28, 2003

TO: CUSTODIANS OF MAABD PROGRAM MANUALS

FROM: NANCY K. FORD, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
APPLICATION PROCESS Section 101,B,7 – 101,E,3,b MTL 1/03 – 1 Page	**APPLICATION PROCESS** Section 101,B,7 – 101,E,3,b MTL 5/02 – 1 Page
TABLE OF CONTENTS Section 207 – 240,N MTL 1/03 – 1 Page	**TABLE OF CONTENTS** Section 207 – 240,N MTL 1/98 – 1 Page
BLIND/DISABLED INDIVIDUALS Section 202,A,3,a,6) – 206 (Conditional Entrant) MTL 1/03 – 5 Pages	**BLIND/DISABLED INDIVIDUALS** Section 202,A,3,a,6) – 206 (Conditional Entrant) MTL 11/99, 1/01, 8/99, 4/00 – 5 Pages
INSURANCE COVERAGE Section 208,C,4 – 214,B,5 MTL 1/03 – 5 Pages	**INSURANCE COVERAGE** Section 208,C,4 – 214,B,5 MTL 4/93, 4/98, 5/93, 2/99, 5/02 – 5 Pages
TYPES OF EARNED AND UNEARNED INCOME Section 220 (Austrian Social Insurance Payments – Bank Accounts) MTL 1/03 – 1 Page	**TYPES OF EARNED AND UNEARNED INCOME** Section 220 (Austrian Social Insurance Payments – Bank Accounts) MTL 2/01 – 1 Page
Section 220 (Earned Income Tax Credit – Holiday Pay) MTL 1/03 – 1 Page	Section 220 (Earned Income Tax Credit – Holiday Pay) MTL 2/94 – 1 Page
Section 220 (Judgements – Older Americans Act) MTL 1/03 – 2 Pages	Section 220 (Judgements – Older Americans Act) MTL 1/96, 3/95 – 2 Pages
Section 220 (Retirement, Survivors, Disability Insurance – Supplemental Security Insurance) MTL 1/03 – 1 Page	Section 220 (Retirement, Survivors, Disability Insurance – Supplemental Security Insurance) MTL 2/99 – 1 Page
TYPES OF RESOURCES Section 230 (Patient Trust Accounts – Radiation Exposure Payments) MTL 1/03 – 2 Pages	**TYPES OF RESOURCES** Section 230 (Patient Trust Accounts – Radiation Exposure Payments) MTL 3/02 – 1 Page
MEDICARE Section 310 – 310,P,4 MTL 1/03 - 7 Pages	**MEDICARE** Section 310 – 310,P,4 MTL 12/99, 1/01, 2/99, 4/98, 2/97 - 8 Pages

SUPPLEMENTAL SECURITY INCOME
Section 320 – 320,E
MTL 1/03 – 1 Page

Section 320,O,2 – 320,P,8
MTL 1/03 – 2 Page**s**

PUBLIC LAW CASES
Section 330,C – 330,E
MTL 1/03 – 1 Page

PERSONS INSTITUTIONALIZED LESS THAN 30 CONSECUTIVE DAYS
Section 340 – 340,G
MTL 1/03 – 1 Page

PERSONS INSTITUTIONALIZED AT LEAST 30 CONSECUTIVE
Section 350 – 350,F,2
MTL 1/03 – 1 Page

HOME AND COMMUNITY BASED SERVICES
Section 360,A,1,c – 360,A,1,c,3)
MTL 1/03 – 1 Page

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CHILDREN ELIGIBLE UNDER 1902(E)(3) OF THE SOCIAL SECURITY ACT
Section 370 – 370,E
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MTL 1/03 – 1 Page

PRIOR MEDICAL DETERMINATIONS ONLY – WOULD HAVE BEEN ELIGIBLE FOR SSI
Section 380 – 380,K
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SPECIALIZED MEDICAID ELIGIBILITY GROUPS
Section 390 – 390,C,3
MTL 1/03 - 2 Pages

SUPPLEMENTAL SECURITY INCOME
Section 320 – 320,E
MTL 1/98 – 1 Page

Section 320,O,2 – 320,P,8
MTL 2/99 – 1 Page

PUBLIC LAW CASES
Section 330,C – 330,E
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PERSONS INSTITUTIONALIZED LESS THAN 30 CONSECUTIVE DAYS
Section 340 – 340,G
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PERSONS INSTITUTIONALIZED AT LEAST 30 CONSECUTIVE
Section 350 – 350,F,2
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CHILDREN ELIGIBLE UNDER 1902(E)(3) OF THE SOCIAL SECURITY ACT
Section 370 – 370,E
MTL 4/97 – 1 Page

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PRIOR MEDICAL DETERMINATIONS ONLY – WOULD HAVE BEEN ELIGIBLE FOR SSI
Section 380 – 380,K
MTL 1/01 – 1 Page

SPECIALIZED MEDICAID ELIGIBILITY GROUPS
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PARENTAL FINANCIAL RESPONSIBILITY FOR SERVICES PROVIDED TO DISABLED CHILDREN Section 501 – 505,B MTL 1/03 – 3 Pages	**PARENTAL FINANCIAL RESPONSIBILITY FOR SERVICES PROVIDED TO DISABLED CHILDREN** Section 501 – 505,B MTL 2/02 – 3 Pages
APPENDIX C **MAABD Income Standard Chart** MTL 1/03 – 1 Page	**APPENDIX C** **MAABD Income Standard Chart** MTL 5/02 – 1 Page
APPENDIX D **Benefit Level Chart** MTL 1/03 – 2 Pages	**APPENDIX D** **Benefit Level Chart** MTL 5/02, 1/02 – 2 Pages
APPENDIX F – MAABD BUDGETS Patient Liability Budget-Spousal Impoverishment – Patient Liability Budget - Non-Spousal Impoverishment (Form 2230-EM) MTL 1/03 – 1 Page (Sides 1 & 2)	**APPENDIX F – MAABD BUDGETS** Patient Liability Budget-Spousal Impoverishment – Patient Liability Budget - Non-Spousal Impoverishment (Form 2230-EM) MTL 4/97 – 1 Page (Sides 1 & 2)

Background and Explanation

101,E,1	Remove reference to MAABD Action Form (MAF).
101,E,2	Remove reference to MAF.
204	Since the agency is no longer contracted to process SS-5 forms to obtain SSN or replacement cards on behalf of our applicants, policy updated to reflect we must still offer to send in the paperwork for the client. Per federal regulations added exception to requirement for applicant to provide SSNs due to religious objections.
204,A	Updated policy on how to clear up SSN discrepancy.
205,D,4	Updated to change reference to old hand written Notice of Decision form 2400 to NOMADS Notice of Decision.
205,D,5,j	Updated reference from TPQY to WPTY.
208,C,4	Changed from MAF to MEDI screen. Changed "on the action form" to "in NOMADS."
208,C,4,c	Removed reference to Computer Systems Handbook, added INFC Buy-In.
208,C,5	Corrected reference to NOMADS and removed reference to the "Action Form." Also updated reference from TPQY to WTPY.
209,B	Removes the reference of how to affect a pregnant woman in the WELF system.
212,A	Changed instructions to remove reference to the Action Form. Benefits are authorized in NOMADS when a worker views and posts a version.
212,E,1	Removed the instructions to "Term Pend" a MAABD case.
212,E,2	Renumbered to manual section 212,E,1.
213	Removed "Action Form" and replaced with "in NOMADS."
214	Changed reference from "[manually] complete and mail" a Notice of Decision. Due to the NOMADS notices being printed and mailed from a centralized location, updated adverse from 13 days to 14 days prior to the end of the month.
214,A	Changed from 13 days to 14 days Advance Notice Period
220	**Bank Accounts** - Changed reference from AFDC to TANF.
220	**Family Preservation Program** – New income type added to refer workers to the income type "Assistance Based on Need" in cases where the applicant is receiving FPP payments.

220	**Lump Sum Payment** – Moved bullet over to align with other bullets.
220	**Older Americans Act** – Added the payments must be made under chapter 35 of title 42 of the US Code. Most of the programs under the Older Americans Act were moved to chapter 66 of title 42 of the US Code under other program administration. Payments under chapter 35 are budgetale while payments under chapter 66 are not. See income types Action/ RSVP/VISTA/ and Foster Grandparent.
220	Added new section for Senior Companion Program, referring to the Action Programs Income Type.
220	**Supplemental Security Income (SSI)** – Changed TPQY to WTPY.
230	**Pension Funds** – Policy updated to reflect SSI rules for exempting the client's retirement fund if he/she must terminate employment to obtain or access the resource.
310,A,2	Removed reference to "MAABD application" since any Medicaid application can be used to determine MAABD eligibility. Removed reference to using the Legacy Med form to update eligibility.
310,A,3,b	Section removed since the QI2 program ended 12/31/02.
310,A,4	Removed instructions to type of MAABD application used.
310,D	Added instructions to refer to MS 204 for SSN policy.
310,L,4 **310,L,4,e** **310,M,2**	Removed "QI2".
310,O	Removed reference to the Legacy MAF and the MED form. Numbered section to clarify policy for Medicare Beneficiary only cases not DUALLY eligible under another category.
310,O,2	Added section to clarify if the client is dually eligible under any other category, i.e., SSI/QMB or HBW/SLMB, to refer to see the manual section for the other category for RD instructions.
310,P	Removed reference to Legacy MAF and MED form and removed reference to a specific type of Medicaid application. Added general reference to updating information in NOMADS. For specific instructions, workers must see the appropriate task guide. On last page for "case examples," removed the references to Legacy system MAF, MED Form, and Computer Documents Handbook.
320,D	Added instructions to refer to MS 204 for SSN policy.
320,P,1-8	Removed the references to Legacy system MAF, MED form, and Computer documents Handbook. Removed various references to the QI2 program.
330,D **340,D** **350,D**	Added instructions to refer to MS 204 for SSN policy.
360,A,1,c	Effective 1/1/03, "blind/disabled individuals" (DWIP) waiver program is no longer limited to persons under 65, therefore, removed the original "a)" requirement and re-lettered the remaining criteria.
360,D **370,D**	Added instructions to refer to MS 204 for SSN policy.
370,O **370,P, 1-5**	Removed the references to Legacy System MAF, MED form, and Computer Documents Handbook.
370,P,5	Added clarification, a SSI eligible child cannot be eligible under the Katie Becket Program, therefore, if a child is subsequently approved for SSI action must be taken to change the case to the SSI eligible category.
380,D	Added instructions to refer to MS 204 for SSN policy.

390,A **390,B** **390,C**	Removed the references to Legacy System MAF, MED form, and Computer Documents Handbook.
501,B,4	Updated Family Size Income Chart to reflect the 2003 increased Federal Poverty Level.
501,E,2 **501,E,d**	Updated computation example due to increased Federal Poverty Level.
Appendix C	Rearranged Patient Liability area of chart for clarity. Allowance amounts vary depending on Home and Community Based Waiver Programs. Updated the Federal Minimum Need Income Allowance based on changes in the Federal Poverty Levels (150% of a 2-person household). Updated the Federal Excess Shelter Allowance based on changes in the Federal Poverty Limits (30% of 150% of a 2-person household). Updated QMB/SLMB/QI1/DEWI limits.
Appendix D	Updated Maintenance Allowance Amounts based on changes in the Federal Poverty Level. **Minimum Monthly Maintenance Allowance** equals 150% of poverty tor a 2-person household **plus** allowable excess shelter costs in excess of 30% of 150% of poverty for 2-person household, not to exceed the Maximum Monthly Maintenance Allowance (a.k.a. Cap on the Minimum Monthly Maintenance Allowance). Added April 2003 QMB/SLMB/QI1/QDWI amounts to chart.
Appendix F	Updated instructions on form for clarity.

Effective Date

Upon receipt.

Instructions for Manual Maintenance

Replace superseded page(s) [45] with transmitted page(s) [46].

(WP/MTL/MAABD01_03)

JULY QUARTERLY RELEASE
MAABD MANUAL
TRANSMITTAL LETTER 2/03

JUNE 30, 2003

TO: CUSTODIANS OF MAABD MANUALS

FROM: NANCY KATHRYN FORD, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
APPLICATION PROCESS Section 101,E,3,c – 103 MTL 2/03 – 1 Page	**APPLICATION PROCESS** Section 101,E,3,c – 103 MTL 5/02 – 1 Page
SUPPLEMENTAL SECURITY INCOME (SSI) Section 320,O,2 – 320,P,4 MTL 2/03 – 1 Page	**SUPPLEMENTAL SECURITY INCOME (SSI)** Section 320,O,2 – 320,P,4 MTL 1/03 – 1 Page
PUBLIC LAW CASES Section 330,O – 330,P,6 MTL 2/03 – 1 Page	**PUBLIC LAW CASES** Section 330,O – 330,P,6 MTL 2.99 – 1 Page
PERSONS INSTITUTIONALIZED LESS THAN 30 CONSECUTIVE DAYS Section 340,P – 340,P,4 MTL 2/03 – 1 Page	**PERSONS INSTITUTIONALIZED LESS THAN 30 CONSECUTIVE DAYS** Section 340,P – 340,P,4 MTL 2/9 – 1 Page
PERSONS INSTITUTIONALIZED AT LEAST 30 CONSECUTIVE DAYS Section 350,N,6,b,3) – 350,P,5 MTL 2/03 – 2 Pages	**PERSONS INSTITUTIONALIZED AT LEAST 30 CONSECUTIVE DAYS** Section 350,N,6,b,3) – 350,P,5 MTL 2/99, 1/96 – 2 Pages
HOME & COMMUNITY BASED SERVICES Section 360,N,5,b,1),c),(2),(c) - 360,P,5 MTL 2/03 2 Pages	**HOME & COMMUNITY BASED SERVICES** Section 360,N,5,b,1),c),(2),(c) - 360,P,5 MTL 2/99 2 Pages
APPENDIX C – MAABD INCOME STANDARD CHART 2003 MAABD Income Standard Chart MTL 2/03 – 1 Page	**APPENDIX C – MAABD INCOME STANDARD CHART** 2003 MAABD Income Standard Chart MTL 1/03 – 1 Page
APPENDIX F – MAABD BUDGETS MAABD Budget – Medicare Beneficiary Budget Form 2203-EM (sides 1-2) MTL 2/03 – 1 Page	**APPENDIX F – MAABD BUDGETS** MAABD Budget – Medicare Beneficiary Budget Form 2203-EM (sides 1-2) MTL 5/02 – 1 Page

Manual Section	BACKGROUND & EXPLANATION of policy changes/clarifications/updates for MAABD MTL 2/03	Obsolete PT, P&P, PUT or IM
101.E.3	Remove reference to WELF system action forms.	
320.P	Remove WELF system instructions.	
330.P	Add Case update reminders for Nomads system.	
330.P.1	Remove WELF system instructions. Update reference from Notice (2400) cut off to "Adverse."	
330.P.2	Remove WELF system instructions.	
330.P.3	Remove WELF system instructions.	
330.P.4	Remove WELF system instructions.	
330.P.5	Removed reference to QI2 program and removed WELF system instructions.	IM 47/02 IM 54/02
330.P.6	Remove WELF system instructions.	
340.P	Add Case update reminders for Nomads system.	
340.P.1	Remove WELF system instructions.	
340.P.2	Removed reference to QI2 program and removed WELF system instructions.	IM 47/02 IM 54/02
340.P.3	Remove WELF system instructions.	
340.P.4	Remove WELF system instructions.	
350.O	Remove WELF system instructions.	
350.P	Add Case update reminders for Nomads system.	
350.P.1	Removed reference to QI2 program and removed WELF system instructions.	IM 47/02 IM 54/02
350.P.2	Remove WELF system instructions.	
350.P.3	Remove WELF system instructions.	
350.P.4	Remove WELF system instructions.	
350.P.5	Remove WELF system instructions.	
360.O	Remove WELF system instructions.	
360.P	Add Case update reminders for Nomads system.	
360.P.1	Remove WELF system instructions.	
360.P.2	Removed reference to QI2 program and removed WELF system instructions.	IM 47/02 IM 54/02
360.P.3	Remove WELF system instructions.	
360.P.4	Remove WELF system instructions.	
360.P.5	Remove WELF system instructions.	
Appendix C	Correction to Spousal Impoverishment – Federal Maximum Need Income Allowance	
Appendix F	Updated to remove QI2 program from side 2 of the 2203 budget form.	IM 47/02 IM 54/02

Effective Date -- 1/1/03

Instructions for Manual Maintenance

Replace superseded page(s) [10] with transmitted page(s) [10].

(WP/Man/Maabd02_03)

OCTOBER QUARTERLY RELEASE
MAABD MANUAL
TRANSMITTAL LETTER 3/03

SEPTEMBER 30, 2003

TO: CUSTODIANS OF MAABD MANUALS

FROM: NANCY KATHRYN FORD, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
INDEX (Types of Earned and Unearned Income) Section 220 MTL 3/03 – 1 Page	**INDEX (Types of Earned and Unearned Income)** Section 220 MTL 2/01 – 1 Page
TYPES OF EARNED AND UNEARNED INCOME Section 220 (Retirement Pay – Supported Living Arrangement) MTL 3/03 – 2 Pages	**TYPES OF EARNED AND UNEARNED INCOME** Section 220 (Retirement Pay – Supported Living Arrangement) MTL 5/02, 1/03, 4/97 – 3 Pages
INDEX (Types of Resources) Section 230 MTL 3/03 – 1 Page	**INDEX (Types of Resources)** Section 230 MTL 2/01 – 1 Page
TYPES OF RESOURCES Section 230 (Real Property – Self-Employment Resources) MTL 3/03 – 1 Page	**TYPES OF RESOURCES** Section 230 (Real Property – Self-Employment Resources) MTL 7/99 – 1 Page
PUBLIC LAW CASES Section 330,L,4,b – 330,L,5,b,2) MTL 3/03 – 1 Page	**PUBLIC LAW CASES** Section 330,L,4,b – 330,L,5,b,2) MTL 2/94 – 1 Page

Manual Section	**BACKGROUND & EXPLANATION of policy changes/clarifications/ updates for MAABD MTL 3/03**	**Obsolete PT, P&P, PUT or IM**
Index - Section 220	Added Reverse Mortgage as an income type.	
Section 220	Added Reverse Mortgage as an income type. Reverse Mortgage payments are loans and are exempt from financial and patient liability.	PUT #17
Index – Section 230	Added Reverse Mortgage as a resource type.	
Section 230	Added Reverse Mortgage as a resource type. Payment from a reverse mortgage is exempt as income, but any portion retained the following month is considered a countable resource.	PUT #17
Section 330	Changed the incorrect word **NOT** to the correct word **NOW**.	

Effective Date -- Upon receipt.

Instructions for Manual Maintenance - Replace superseded page(s) [7] with transmitted page(s) [6].

(WP/MTL/Maabd03_03)

JANUARY QUARTERLY RELEASE
MAABD MANUAL
TRANSMITTAL LETTER 1/04

DECEMBER 31, 2003

TO: CUSTODIANS OF MAABD MANUALS

FROM: NANCY KATHRYN FORD, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
TABLE OF CONTENTS – PART A Section 100 – Appendix G MTL 1/04 – 4 Pages	**TABLE OF CONTENTS - PART A** Section 100 – Appendix G MTL 4/00, 1/03, 1/98, 6/02 – 4 Pages
CHILDREN ELIGIBLE UNDER 1902(e)(3) OF THE SOCIAL SECURITY ACT Section 370 – 370,P,5 MTL 1/04 – 6 Pages	**CHILDREN ELIGIBLE UNDER 1902(E)(3) OF THE SOCIAL SECURITY ACT** Section 370 – 370,P,5 MTL 4/03 – 6 Pages
N/A	**TABLE OF CONTENTS – PART B** Section SA – XC MTL 3/99, 2/99 – Inclusive
N/A	**STANDARD COMPUTER APPROVAL (SA) – CONTINUATION OF PREGNANCY RELATED MEDICAL COVERAGE (XC)** Section SA – XC MTL 3/99, 5/93, 4/93, 3/95, 2/98, 2/94, 1/98, 2/99, 6/93, 4/97 – Inclusive
APPENDIX C MAABD Income Standard Chart MTL 1/04 – 1 Page	**APPENDIX C** MAABD Income Standard Chart MTL 2/03 – 1 Page
APPENDIX D Benefit Level Chart MTL 1/04 – 1 Page	**APPENDIX D** Benefit Level Chart MTL 1/03 – 1 Page
APPENDIX F – MAABD BUDGETS Veteran UME Budget, Form 2039-EE (Pages 1-2) MTL 1/04 – 1 Page	**APPENDIX F – MAABD BUDGETS** Veteran UME Budget, Form 2039-EE (Pages 1-2) MTL 5/02 – 1 Page
SSI Budget – RSDI Computation Worksheet 2646-EE (Pages 1-2) – 2654-EE MTL 1/04 – 2 Pages	SSI Budget – RSDI Computation Worksheet 2646-EE (Pages 1-2) – 2654-EE MTL 5/02 – 2 Pages

Manual Section	BACKGROUND & EXPLANATION of policy changes/clarifications/ updates.	Obsolete PT, P&P, PUT or IM
Section 370	The Division of Health Care Financing and Policy has requested staff to use their updated form when requesting disability determinations. Obsoleting Form 3004-SM and updating manual section to instruct staff to use Form NMO-3004.	
Part B	**Legal & Factuals** – Legacy system legal and factual notices no longer used. Entire section obsolete.	
Appendix C	Update MAABD Income Standard Chart with 2004 limits as a result of SSI cost-of-living adjustment.	
Appendix D	Update 2004 Benefit Level Chart with new 2004 income limits.	
Appendix F	Update forms with new 2004 amounts.	

Effective Date -- January 1, 2004

Instructions for Manual Maintenance - Replace superseded page(s) [63] with transmitted page(s) [15].

(WP/MTL/Maabd01_04)

APRIL QUARTERLY RELEASE
MAABD MANUAL TRANSMITTAL LETTER 2/04

APRIL 1, 2004

TO: CUSTODIANS OF MAABD MANUALS

FROM: NANCY KATHRYN FORD, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superceded
APPLICATION PROCESS Section 101,A,7 – 101,B,6 MTL 2/04 – 1 Page	**APPLICATION PROCESS** Section 101,A,7 – 101,B,6 MTL 5/02 – 1 Page
FACTORS OF ELIGIBILITY Section 200 – 214,B,5 MTL 2/04 – 21 Pages	**FACTORS OF ELIGIBILITY** Section 200 – 214,B,5 MTL 4/97, 1/03, 4/00, 3/01, 3/99, 3/02, 2/99 – 25 Pages
PARENTAL FINANCIAL RESPONSIBILITY FOR SERVICES PROVIDED TO DISABLED CHILDREN Section 501 – 505,B MTL 2/04 – 3 Pages	**PARENTAL FINANCIAL RESPONSIBILITY FOR SERVICES PROVIDED TO DISABLED CHILDREN** Section 501 – 505,B MTL 1/03 – 3 Pages
MAABD INCOME STANDARD CHART Appendix C MTL 2/04 – 1 Page	**MAABD INCOME STANDARD CHART** Appendix C MTL 1/04 – 1 Page
BENEFIT LEVEL CHART Appendix D MTL 2/04 – 2 Pages	**BENEFIT LEVEL CHART** Appendix D MTL 1/04, 1/03 – 2 Pages

Manual Section	BACKGROUND & EXPLANATION of policy changes/clarifications/ updates.	Obsolete PT, P&P, PUT or IM
Section 101	**Application Process** - Added Nevada Check Up to list of Nevada Medicaid programs for duplicate assistance.	N/A
Section 208(B)	**Insurance Coverage** - Revise Anthem Blue Cross/Blue Shield to First Health.	N/A
Section 209 (1) & (2)	**Support Enforcement Program** - Update SEP due to NOMADS interface with MMIS process.	N/A
Section 210(A)	**Cooperation** - Clarification added regarding what happens if a client, at intake, fails to provide necessary information within the time allowed.	Office Request
Section 501,B,4	**Parental Financial Responsibility** – 2004 federal poverty level increases require change in family deduction allowance permitted by Parental Financial Responsibility program.	
Section 501,E,2 & 501,E,2,d	**Parental Financial Responsibility** – Update example computation in the manual based on new poverty levels.	
Appendix C & D	**MAABD Income Standard Chart & Benefit Level Chart** – 2004 federal poverty level increases updated in the manual.	

Effective Date -- April 1, 2004

Instructions for Manual Maintenance -- Replace superseded page(s) [32] with transmitted page(s) [28].

(WP/MTL/Maabd02_04)

JULY QUARTERLY RELEASE

MAABD MANUAL TRANSMITTAL LETTER 3/04

JULY 1, 2004

TO: CUSTODIANS OF MAABD MANUALS

FROM: NANCY KATHRYN FORD, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
TABLE OF CONTENTS Section 250 – 505,B MTL 3/04 – 1 Page	**TABLE OF CONTENTS** Section 250 – 505,B MTL 1/04 – 1 Page
RESIDENCE REQUIREMENTS Section 205,D,4 – 206 MTL 3/04 – 1 Page	**RESIDENCE REQUIREMENTS** Section 205,D,4 – 206 MTL 2/04 – 1 Page
AUTHORIZING MEDICAID BENEFITS Section 212,B – 214,A,6 MTL 3/04 – 1 Page	**AUTHORIZING MEDICAID BENEFITS** Section 212,B – 214,A,6 MTL 2/04 – 1 Page
TYPES OF EARNED AND UNEARNED INCOME Section 220 (Veteran's Benefits-Work Training Programs) MTL 3/04 – 1 Page	**TYPES OF EARNED AND UNEARNED INCOME** Section 220 (Veteran's Benefits-Work Training Programs) MTL 1/96 – 1 Page
INDEX – MEDICARE BENEFICIARIES Section 300 MTL 3/04 – 1 Page	**INDEX – MEDICARE BENEFICIARIES** Section 310 MTL 3/95 – 1 Page
MEDICARE BENEFICIARIES Section 310 (inclusive) MTL 3/04 – 8 Pages	**MEDICARE BENEFICIARIES** Section 310 (inclusive) MTL 1/03 – 7 Pages
SUPPLEMENTAL SECURITY INCOME (SSI) Section 320 – 320,P,8 MTL 3/04 – 9 Pages	**SUPPLEMENTAL SECURITY INCOME (SSI)** Section 320 – 320,P,8 MTL 1/03, 1/01, 4/99, 2/99, 4/98, 3/97, 2/03 – 9 Pages
INDEX – HEALTH INSURANCE FOR WORK ADVANCEMENT (HIWA) Section 400 MTL 3/04 – 1 Page	**N/A**

Material Transmitted	Material Superseded
HEALTH INSURANCE FOR WORK ADVANCEMENT (HIWA) Section 410 – Addendum to Section 400 (side 2) MTL 3/04 – 7 Pages	**N/A**
PARENTAL FINANCIAL RESPONSIBILITY FOR SERVICES PROVIDED TO DISABLED CHILDREN Section 501 – 505,B MTL 3/04 – 3 Pages	**PARENTAL FINANCIAL RESPONSIBILITY FOR SERVICES PROVIDED TO DISABLED CHILDREN** Section 501 – 505,B MTL 2/04 – 3 Pages
MAABD INCOME STANDARD CHART Appendix C MTL 3/04 – 1 Page	**MAABD INCOME STANDARD CHART** Appendix C MTL 2/04 – 1 Page
BENEFIT LEVEL CHART Appendix D – Medicare Beneficiaries MTL 3/04 – 1 Page	**BENEFIT LEVEL CHART** Appendix D – Medicare Beneficiaries MTL 2/04 – 1 Page
MAABD BUDGETS Appendix F – MAABD Budgets MAABD Budget – Medicare Beneficiary Budget [2203-EM (side 1 & 2)] MTL 3/04 – 1 Page	**MAABD BUDGETS** Appendix F – MAABD Budgets MAABD Budget – Medicare Beneficiary Budget [2203-EM (side 1 & 2)] MTL 2/03 – 1 Page
Appendix F – MAABD Budgets Health Insurance Work Advancement (HIWA) Budget [2046-EM (side 1 & 2)] MTL 3/04 – 1 Page	**N/A**

Manual Section	**BACKGROUND & EXPLANATION of policy changes/clarifications/updates.**	**Obsolete PT, P&P, PUT or IM**
Table of Contents	**Health Insurance for Work Advancement** – Add section 400 on policy for the HIWA program.	
205,5	**Residence Requirements** – The "g" is missing from the list of residence requirements. Add missing letter with "Award Letter" as method of verifying residency.	PUT 292
212,B	**Duplicate Assistance** – Updated to include Nevada Check Up as another Medicaid program for duplicate assistance.	P&P 7-04 PUT 309
212,D	**No Medicaid Cards Will Be Mailed To Out-of-State Addresses Unless** – Removed section since Medicaid cards are handled out of the MMIS system through Nevada Medicaid.	
212,E & F	**Release/Cancel and Lost or Stolen Medical Certificate** – Removed section since Medicaid cards are handled by Nevada Medicaid and First Health.	

Manual Section	BACKGROUND & EXPLANATION of policy changes/clarifications/updates.	Obsolete PT, P&P, PUT or IM
212,G	**Erroneous Payment** – Renumbered to keep sections in sequential order.	
220	**Types of Income** – Policy on treatment of veteran's benefits clarified. Veteran's residing in a Veteran's state home do not have their pension used for financial eligibility.	
Index	Titles updated to match chapter.	
310	All references to ECS eliminated.	
310,I	**Third Party Liability** – Reference to Blue Cross/Blue Shield changed to First Health.	
310,L	**Income** – Section updated to reflect federally mandated change to the budgeting methods used for Medicare Beneficiaries. Spousal income must be considered in determining eligibility for the QMB/SLMB/QI/QDWI categories.	
320,A	**Overview** – Removed reference to WTPY and replaced with SOLQ.	
320,H & 320,N,4,a,2	**Prior Medical and Maintenance Allowances** – Removed reference to ECS and replaced with the term 'case manager'.	
320,O	**Redetermination** – Removed reference to ECS and replaced with the term 'case manager'. Removed reference to the WELF system action form and replaced with wording indicating the NOMADS system should be checked instead.	
320,O,1	**Redetermination SSI Cases** – Removed reference to WTPY and replaced with SOLQ. Updated section to clarify termination of Medicaid on SSI recipients occurs when the redetermination cannot be done by phone, and the 2930-EM form is not returned by the client to verify TPL and subrogation information. Added section to clarify SSI cases cannot be terminated for income/resources if still in CO1 status.	P&P 12-04 P&P 11-04 PUT 318
320,O,2	**Redetermination SSI/QMB Cases** – Removed reference to WTPY and replaced with SOLQ. Updated section to clarify termination of QMB occurs for the same reasons as SSI, but can also occur for non-receipt of income/resource verification.	P&P 12-04 PUT 318
Index & 400	**Health Insurance for Work Advancement (HIWA)** – New manual section added with policy for the new Medicaid program for the working disabled.	
501,B,2 & 501,B,3	**Calculating Monthly Parental Reimbursements** – Changed the designated line on Federal Tax Form 1040 from #31 to the correct #34. Also, clarified how NCP alimony is treated in determining parental reimbursement.	PUT 319
Appendix C	**Income Limits** – Medicare Beneficiaries updated to add income limits for couples. Income chart updated adding the income limits for the Health Insurance for Work Advancement (HIWA) program.	
Appendix D	**Benefit Level Chart** – Updated to include levels for couples.	
Appendix F	**MAABD Budgets** – Revised Medicare Beneficiaries budget to include procedures for budgeting spousal income. Added new budget for the Health Insurance for Work Advancement (HIWA) program.	

Effective Date -- July 1, 2004

Instructions for Manual Maintenance -- Replace superseded page(s) [26] with transmitted page(s) [36].

(WP/MTL/Maabd03_04)

OCTOBER QUARTERLY RELEASE

MAABD MANUAL TRANSMITTAL LETTER 4/04

October 1, 2004

TO: CUSTODIANS OF MAABD MANUALS

FROM: NANCY KATHRYN FORD, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
TABLE OF CONTENTS Section 208 – 240,N MTL 4/04 – 1 Page	**TABLE OF CONTENTS** Section 208 – 240,N MTL 1/04 – 1 Page
SSI APPLICATION AND DETERMINATION Section 207 – 210,5 MTL 4/04 – 5 Pages	**SSI APPLICATION AND DETERMINATION** Section 207 – 210,5 MTL 2/04 – 5 Pages
SUPPLEMENTARY SECURITY INCOME (SSI) Section 320 - Index (A-P) MTL 4/04 – 1 Page	**SUPPLEMENTARY SECURITY INCOME (SSI)** Section 320 - Index (A-P) MTL 3/95 – 1 Page
Section 320,G – 320,M,2 MTL 4/04 – 1 Page	Section 320,G – 320,M,2 MTL 3/04 – 1 Page
PUBLIC LAW CASES Section 330 – Index (A-P) MTL 4/04 – 1 Page	**PUBLIC LAW CASES** Section 330 – Index (A-P) MTL 3/95 – 1 Page
Section 330,F – 330,L,4,b MTL 4/04 – 2 Pages	Section 330,F – 330,L,4,b MTL 1/01, 2/94 – 2 Pages
PERSONS INSTITUTIONALIZED LESS THAN 30 CONSECUTIVE DAYS Section 340 – Index (A-P) MTL 4/04 – 1 Page	**PERSONS INSTITUTIONALIZED LESS THAN 30 CONSECUTIVE DAYS** Section 340 – Index (A-P) MTL 3/95 – 1 Page
Section 340, H – 340,L,1,b,4) MTL 4/04 – 1 Page	Section 340, H – 340,L,1,b,4) MTL 2/99 – 1 Page
PERSONS INSTITUTIONALIZED AT LEAST 30 CONSECUTIVE DAYS Section 350 – Index (A-P) MTL 4/04 – 1 Page	**PERSONS INSTITUTIONALIZED AT LEAST 30 CONSECUTIVE DAYS** Section 350 – Index (A-P) MTL 3/95 – 1 Page
Section 350,F,3,d,2) – 350,L,1,a MTL 4/04 – 1 Page	Section 350,F,3,d,2) – 350,L,1,a MTL 2/99 – 1 Page

HOME AND COMMUNITY BASED SERVICES
Section 360 – Index (A-P)
MTL 4/04 – 1 Page

Section 360 – 360,P,5
MTL 4/04 – 19 Pages (inclusive)

HOME AND COMMUNITY BASED SERVICES
Section 360 – Index (A-P)
MTL 3/95 – 1 Page

Section 360 – 360,P,5
MTL 3/97, 5/01, 1/03, 2/99, 5/02, 1/96, 1/97, 9/99, 2/97, 4/98, 2/03 – 18 Pages (inclusive)

CHILDREN ELIGIBLE UNDER 1902(e)(3) OF THE SOCIAL SECURITY ACT
Section 370 – Index (A-P)
MTL 4/04 – 1 Page

Section 370,F – 370,M
MTL 4/04 – 2 Pages

CHILDREN ELIGIBLE UNDER 1902(e)(3) OF THE SOCIAL SECURITY ACT
Section 370 – Index (A-P)
MTL 3/95 – 1 Page

Section 370,F – 370,M
MTL 1/04 – 2 Pages

PRIOR MEDICAL DETERMINATIONS ONLY– WOULD HAVE BEEN ELIGIBLE FOR SSI
Section 380 – Index (A-P)
MTL 4/04 – 1 Page

Section 380 – 380,K
MTL 4/04 – 1 Page

PRIOR MEDICAL DETERMINATIONS ONLY– WOULD HAVE BEEN ELIGIBLE FOR SSI
Section 380 – Index (A-P)
MTL 3/95 – 1 Page

Section 380 – 380,K
MTL 1/03 – 1 Page

SPECIALIZED MEDICAID ELIGIBILITY GROUPS
Section 390 – Index (A-C)
MTL 4/04 – 1 Page

SPECIALIZED MEDICAID ELIGIBILITY GROUPS
Section 390 – 390,C,3
MTL 4/04 – 2 Pages

SPECIALIZED MEDICAID ELIGIBILITY GROUPS
Section 390 – Index (A-C)
MTL 4/93 – 1 Page

SPECIALIZED MEDICAID ELIGIBILITY GROUPS
Section 390 – 390,C,3
MTL 1/03 – 2 Pages

Manual Section	**BACKGROUND & EXPLANATION of policy changes/clarifications/updates.**	**Obsolete PT, P&P, PUT or IM**
Section 208	**Insurance Coverage** – Update section to include policy on pursuit of Medicare for ongoing Medicaid recipients.	**PUT 311**
Section 208,C,3	**Buy-In** – Highlight 'recipients' to stress fact a recipient qualifying under QMB could be terminated for failing to pursue Medicare Part A, since it would be available at no cost due to the Buy-In.	
Section 209 (Title)	**Support Enforcement Program** – Add 'Child' to better identify this unit within the Welfare Division.	
Section 209,A	**Referrals to Support Enforcement** – Update section to include the change in form(s) used in making referrals to CSE. 4000-EC forms are obsolete.	
Section 209,B	**Action for Failure to Cooperate** – Update acronym to CSE for 'Child Support Enforcement. Added text addressing procedures for MAABD clients who have been sent a TANF 30-day conciliation notice on failing to cooperate with CSE.	**PUT 197 PUT 120**
Section 209,C,1,a	**Information Exchanged Between MAABD and Child Support Enforcement** – Update section with correct form used to obtain third party insurance information.	

Section 209,C,2	**Information Sent to CSE** – Update section to address changes in the procedures for sending information to CSE.	
Section 320-370,K	**Support Enforcement** – Update each section with correct acronym CSE. Add cross reference to M.S. 209.	
Section 320-380,I	**Third Party Liability** – Add cross reference to M.S. 208 for policy on Medicare as a TPL. Removed references to Blue Cross/Blue Shield, and added text regarding NOMADS documentation for notifying the fiscal intermediary.	
Section 360	**Home Based Community Based Services** – Update newly created NMO MMIS changes with the waiver program when an individual enters, leaves or reenters the program.	**PUT 06-04**
Section 390,C	**Medicaid Eligibility for Newborns** – Section being expanded to include more detail regarding OBRA eligibility pertinent to adding a SSI OBRA who has been placed in child protective services custody (CPS). ***INADVERTENTLY OMITTED FROM MTL 04/04.***	

Effective Date -- October 1, 2004 release or sooner.

Instructions for Manual Maintenance -- Replace superseded page(s) [42] with transmitted page(s) [43].

JANUARY QUARTERLY RELEASE
MAABD MANUAL
TRANSMITTAL LETTER 1/05

DECEMBER 31, 2004

TO: CUSTODIANS OF MAABD MANUALS

FROM: NANCY KATHRYN FORD, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
TYPES OF EARNED AND UNEARNED INCOME Section 220 (Austrian Social Insurance Payments – Bank Accounts) MTL 1/05 – 1 Page	**TYPES OF EARNED AND UNEARNED INCOME** Section 220 (Austrian Social Insurance Payments – Bank Accounts) MTL 4/98 – 1 Page
TYPES OF RESOURCES Section 230 (Annuities – Bank Accounts) MTL 1/05 – 1 Page	**TYPES OF RESOURCES** Section 230 (Annuities – Bank Accounts) MTL 2/01 – 1 Page
TRANSFER OF ASSETS Section 240,H – 240,N,6 MTL 1/05 – 4 Pages	**TRANSFER OF ASSETS** Section 240,H – 240,N,6 MTL 2/97, 2/99 – 4 Pages
MEDICARE BENEFICIARIES Section 310,G – 310,L,4,c,1) MTL 1/05 – 2 Pages	**MEDICARE BENEFICIARIES** Section 310,G – 310,L,4,c,1) MTL 3/04 – 2 Pages
INDEX (Specialized Medicaid Eligibility Groups) Section 390 MTL 1/05, 1 Page	**INDEX (Specialized Medicaid Eligibility Groups)** Section 390 MTL 4/04, 1 Page
SPECIALIZED MEDICAID ELIGIBILITY GROUPS Section 390 – 390,C,3,c MTL 1/05 – 2 Pages	**SPECIALIZED MEDICAID ELIGIBILITY GROUPS** Section 390 – 390,C,3,c MTL 4/04 – 2 Pages
HEALTH INSURANCE FOR WORK ADVANCEMENT (HIWA) Section 410 – 410,P,1 MTL 1/05 – 6 Pages	**HEALTH INSURANCE FOR WORK ADVANCEMENT (HIWA)** Section 410 – 410,P,1 MTL 3/04 – 6 Pages
PARENTAL FINANCIAL RESPONSIBILITY FOR SERVICES PROVIDED TO DISABLED CHILDREN Section 501 – Section 505,B MTL 1/05 – 3 Pages	**PARENTAL FINANCIAL RESPONSIBILITY FOR SERVICES PROVIDED TO DISABLED CHILDREN** Section 501 – Section 505,B MTL 4/04 – 3 Pages
APPENDIX C MAABD Income Standard Chart MTL 1/05 – 1 Page	**APPENDIX C** MAABD Income Standard Chart MTL 3/04 – 1 Page

Material Transmitted	Material Superseded
APPENDIX D Benefit Level Chart MTL 1/05 – 1 Page	**APPENDIX D** Benefit Level Chart MTL 2/04 – 1 Page
APPENDIX F – MAABD Budgets Veteran Unusual Medical Expense Budget (2039 –EE) MTL 1/05 – 1 Page (Sides 1 & 2)	**APPENDIX F – MAABD Budgets** Veteran Unusual Medical Expense Budget (2039 –EE) MTL 1/04 – 1 Page (Sides 1 & 2)
SSI Budget (2646-EE) – Parent to Child Deeming Budget (2646-EE/A) MTL 1/05 – 1 Page (Sides 1 & 2)	SSI Budget (2646-EE) – Parent to Child Deeming Budget (2646-EE/A) MTL 1/04 – 1 Page (Sides 1 & 2)
RSDI Computation Worksheet (2654-EE) MTL 1/05 – 1 Page	RSDI Computation Worksheet (2654-EE) MTL 1/04 – 1 Page

Manual Section	**BACKGROUND & EXPLANATION of policy changes/clarifications/ updates.**	**Obsolete PT, P&P, PUT or IM**
220	**Income** – Revised section on bank accounts to clarify monies deposited on behalf of another individual (when client is acting as an agent) and disbursed for that individual are not income.	P&P 41-04 PUT 352
230	**Resources** – Revised section on bank accounts to clarify monies in an account deposited on behalf of another individual, for disbursement for that individual, is excluded. This occurs when the client is acting as an agent for another individual.	P&P 41-04 PUT 352
240	Update transfer of asset/application of penalty(ies) language with State Plan.	
310,L,1,b,2	**Income Availability** – Added exception to identify spouses receiving Medicaid under a Waiver are not considered to be residing in the home for purposes of spousal deeming.	P&P 61-04
310,L,1,b,5	**Income Availability** – Removed word "exception" as this is another example of availability rather than an exception.	
310,L,4,a	**Budget Method** – Added exception to identify spousal income as not countable when the spouse is receiving Medicaid under a Waiver.	P&P 61-04
310,L,4,b,1&2	**Budget Method/Ineligible Spouse** – Added wording to clarify the spouse must be residing in the home.	P&P 61-04
390	**Index** – Correct wording from 'illegal' to 'ineligible non citizen'.	
390,A	**Emergency Medical for Ineligible Non-Citizens** – Removed references to requiring proof of service. Client is eligible to receive Medicaid for coverage of emergency services. The fiscal intermediary will determine whether services billed fit the criteria.	PUT 251
410,A – 4104 – 410,L,3,c – 410,M,1 & 410,P	**Overview** – Changed wording from 'participant' to 'individual' to avoid confusion on applying disregards for new applicants as well as existing recipients.	
410,B	**Aged, Blind, disabled** – Reworded for clarity, and removed reference to Nevada Medicaid determinations. Disability determinations will need to be done through another source.	

410,H	**Prior Medical** – Reworded to clarify requests for Prior Med do not have to be in writing, and apply to applicants and recipients.	
410,L,3	**Income** – Update Unearned Income Limit to $699.	
410,L,4	**Employment Related Work Disregards** – Section rewritten to meet State Plan requirements of using SSI methodology in budgeting disregards. All disregards allow the full expense with no standard deductions. Additional disregards added, and several removed based on SSI criteria and the State Plan.	
410,L,5	**Computing Monthly Employment Related Work Disregards** – New section added providing methods for budgeting disregards based on the frequency in which the client pays the expense.	
410,L,6	**HIWA Eligibility Determination** – Changed heading to "Income Determination" since it is specific to budgeting. Section changed from '5' to '6', and wording changed for d. to correctly identify deduction.	
410,P	**Medicaid Buy-In** – Added paragraph clarifying actions done at initial approval for Conditional Eligibility vs. actual eligibility.	
501,B	**Calculating Monthly Parental Reimbursement** – Added wording to include medical expenses.	
501,B,1	**Family Size** – Revised policy to allow two methods of determining family size. The method providing the most benefit to the parent(s) in the assessed obligation is to be used. One method uses the actual family members in the home, while the other method allows for family members residing outside the home, but who are dependents.	
501,B,6	**Home Care Credit** – The credit amount is increased to $300.	
501,B,7	**Health Insurance** – Changed heading to 'Medical Expenses', and added text for allowing medical and dental expenses a deduction on the parental reimbursement calculations. Changed 'payment' to 'premium' to distinguish this from medical expenses.	
501,B,8	**Court Orders** – Reassigned to 'Health Insurance'.	
501,B,9	**Noncooperation** – Reassigned to 'Court Orders'.	
501,B,10	New section created for 'Noncooperation'.	
501,E	**Responsibilities of Eligibility Staff** – Revised section to include additional deductions and increased Home Care Credit.	
501,F	**Responsibilities of Recovery Staff** – Added new procedure to include the worksheet, Form 2028-EE, as part of documents sent to parent(s). Changed the effective month for parental obligation to the approval month, with no retroactive assessment.	
Appendix C	Updated MAABD Income Standard Chart with 2005 limits as a result of SSI Cost-of-Living Adjustment notice .	IM 39-04
Appendix D	Updated 2005 Benefit Level Chart with new 2005 income limits.	IM 39-04
Appendix F	Updated forms with new 2005 amounts.	IM 39-04

Effective Date -- January 1, 2005

Instructions for Manual Maintenance - Replace superseded page(s) [25] with transmitted page(s) [25].

(WP/MTL/Maabd01_05)

MAABD MANUAL
TRANSMITTAL LETTER 2/05

MAY 7, 2005

TO: CUSTODIANS OF MAABD MANUALS

FROM: NANCY KATHRYN FORD, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
MAABD OVERVIEW Section 100 – 103 MTL 2/05 – 4 Pages	**MAABD OVERVIEW** Section 100 – 103 MTL 5/02, 4/04, 1/03, 2/03 – 4 Pages
BLIND/DISABLED INDIVIDUALS Section 202,A,3,b – 206 MTL 2/05 – 4 Pages	**BLIND/DISABLED INDIVIDUALS** Section 202,A,3,b – 206 MTL 2/04, 3/04 – 4 Pages
Section 206,A – 206,D,2,c MTL 2/05 – 1 Page	Section 206,A – 206,D,2,c MTL 2/04 – 1 Page
Section 207 – 208,A MTL 2/05 – 1 Page	Section 207 – 208,A MTL 4/04 – 1 Page
Section 212,B – 214,B,5 MTL 2/05 – 1 Page	Section 212,B – 214,B,5 MTL 3/04, 2/04 – 2 Pages
TYPES OF RESOURCES Section 230 (Life Estates – Life Insurance Policies) MTL 2/05 – 1 Page	**TYPES OF RESOURCES** Section 230 (Life Estates – Life Insurance Policies) MTL 1/96 – 1 Page
Section 230 (SSI/RSDI Retro Payments – Uniform Gifts to Minors) MTL 2/05 – 1 Page	Section 230 (SSI/RSDI Retro Payments – Uniform Gifts to Minors) MTL 4/98 – 1 Page
TREATMENT OF TRUSTS Section 250 – 250,E,6 MTL 2/05 – 3 Pages	**TREATMENT OF TRUSTS** Section 250 – 250,E,6 MTL 2/97 – 3 Pages
SUPPLEMENTAL SECURITY INCOME (SSI) Section 320 – 320,E MTL 2/05 – 1 Page	**SUPPLEMENTAL SECURITY INCOME (SSI)** Section 320 – 320,E MTL 3/04 – 1 Page
HEALTH INSURANCE FOR WORK ADVANCEMENT (HIWA) Section 410,L3 – 410,L,4,c MTL 2/05 – 1 Page	**HEALTH INSURANCE FOR WORK ADVANCEMENT (HIWA)** Section 410,L3 – 410,L,4,c MTL 1/05 – 1 Page

Material Transmitted	Material Superseded
PARENTAL FINANCIAL RESPONSIBILITY FOR SERVICES PROVIDED TO DISABLED CHILDREN Section 501 – 505,B MTL 2/05 – 3 Pages	**PARENTAL FINANCIAL RESPONSIBILITY FOR SERVICES PROVIDED TO DISABLED CHILDREN** Section 501 – 505,B MTL 1/05 – 3 Pages
APPENDIX C **MAABD INCOME STANDARD CHART** MTL 2/05 – 1 Page	**APPENDIX C** **MAABD INCOME STANDARD CHART** MTL 1/05 – 1 Page
APPENDIX D **BENEFIT LEVEL CHART** MTL 2/05 – 2 Pages	**APPENDIX D** **BENEFIT LEVEL CHART** MTL 1/05, 3/04 – 2 Pages

Manual Section	BACKGROUND & EXPLANATION of policy changes/ clarifications/ updates.	Obsolete PT, P&P, PUT or IM
102	**Medicaid Eligibility Prior to Application** – Corrected wording to indicate prior medical requests do not need to be in writing.	**P&P 09-05** **PUT 374**
103	**Medicaid Hospice Care Program** – Clean up on terms used – case manager in place of ECS.	
204	**Furnishing Social Security Numbers** – Clean up on terms used – ineligible non-citizen in place of illegal alien. Removed numbering in '**Exception**' as not needed.	
204,A & 205,A	**Verification** – Removed references to WTPY.	
206,A	**Verification** – Revised to show the new process and website for verifying citizenship status through S.A.V.E., and added information regarding secondary verifications.	**P&P 10-05**
208	**Insurance Coverage** – Added reference to Veterans Administration insurance coverage as a potential TPL. Reworded to add in exceptions to TPL to match the E&P Manual	**P&P 08-05** **P&P 17-05** **PUT 373** **PUT 379**
214	**Closures** – Revised to include non cooperation as a reason for termination. Added wording for provision of reinstating eligibility if the client complies prior to the effective date of termination. Added reference to WAM 3100.	**P&P 56-04**
230	**Life Insurance Policies** – Revised the wording to clarify the total amount evaluated for VF encompasses all policies, owned by the client, which have a CSV.	**P&P 78-04** **PUT 366**
230	**Trust Funds** – Clean up – removed reference to ECS since not needed in text.	
250,A,7	**Definitions** – Clarified who is a beneficiary.	
250,C	**Application of Trust Provisions** – Clarified status of principal home in trust.	
250,D,6	**Types of Trusts** – Clarified Mill Trusts.	
320,A	**Supplemental Security Income (SSI)** – Revised to add 'Note' indicating Medicaid must be terminated when SSI is suspended and no payment made. Added reference back to manual section 214.	**P&P 56-04** **PUT 360**

410,L,4,a	**Employment Related Transportation Expense** – Removed reference to specific amount since it changes annually. Staff can access the correct amount in the Administrative Manual.	**P&P 20-05**
501,B,4	**Parental Financial Responsibility** – 2005 Federal Poverty Level increases require change to Annual Family Deduction section.	
501,E	**Responsibilities of Eligibility Staff** – Updated computations to new Federal Poverty guidelines.	
Appendix C&D	**MAABD Income Standard Chart & Benefit Level Chart** – Updated using 2005 Federal Poverty Level increases.	

Effective Date -- May 7, 2005

Instructions for Manual Maintenance - Replace superseded page(s) [25] with transmitted page(s) [24].

(WP/MTL/Maabd02_05)

MAABD MANUAL
TRANSMITTAL LETTER 3/05

JULY 1, 2005

TO: CUSTODIANS OF MAABD MANUALS

FROM: NANCY KATHRYN FORD, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
RESIDENCE REQUIREMENTS Section 205,D,4 – 206,E,a MTL 3/05 – 4 Pages	**RESIDENCE REQUIREMENTS** Section 205,D,4 – 206,F,a MTL 2/05, 2/04 – 8 Pages
TREATMENT OF TRUSTS Section 250, D,6 – 250, E,6 MTL 3/05 – 1 Page	**TREATMENT OF TRUSTS** Section 250, D,6 – 250, E,6 MTL 2/05 – 1 Page
NEVADA MEDICAID RESIDENTIAL TREATMENT CENTER (RTC) SERVICE PROVIDERS Addendum to Section 350 (Side 1 & 2) MTL 3/05 – 1 Page	**NEVADA MEDICAID RESIDENTIAL TREATMENT CENTER (RTC) SERVICE PROVIDERS** Addendum to Section 350 (Side 1 & 2) MTL 5/02 – 1 Page
SPECIALIZED MEDICAID ELIGIBILITY GROUPS Section 390 – 390,C,1 MTL 3/05 – 1 Page	**SPECIALIZED MEDICAID ELIGIBILITY GROUPS** Section 390 – 390,C,1 MTL 1/05 – 1 Page

Manual Section	BACKGROUND & EXPLANATION of policy changes/ clarifications/ updates.	Obsolete PT, P&P, PUT or IM
206	**Citizenship Requirement** – Removed existing table and replaced with table simplifying evaluation of non-citizens for program eligibility.	P&P 24-05 P&P 29-05 PUT 383
206,E	**Social Security Earnings – Quarters** – Removed this section as not applicable. LPR status meets requirements for Medicaid.	
206,F	**Definition of Battered Non-citizen** – Renumbered to 206,E.	
250,D,6	**Income** – Clarified Income-added reference to use of NOMADS UNIN screen(s) to determine financial eligibility.	
Addendum to 350	**Nevada Medicaid Residential Treatment Center (RTC) Service Providers** – Updated MRTCS providers per NMO.	
390,A	**Emergency Medical for Ineligible Non-citizens** – Corrected wording from ECS to case manager.	

Effective Date -- July 1, 2005

Instructions for Manual Maintenance - Replace superseded page(s) [11] with transmitted page(s) [7].

(WP/MTL/Maabd03_05)

MAABD MANUAL
TRANSMITTAL LETTER 4/05

NOVEMBER 1, 2005

TO: CUSTODIANS OF MAABD MANUALS

FROM: NANCY KATHRYN FORD, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
MAABD PROGRAM MANUAL Title Page N/A – 1 Page	**MAABD PROGRAM MANUAL** Title Page N/A – 1 Page
TABLE OF CONTENTS Section 100 – Appendix G MTL 4/05 – 4 Pages	**TABLE OF CONTENTS** Section 100 – Appendix G MTL 1/04, 4/04, 3/04 – 4 Pages
HOME AND COMMUNITY BASED SERVICES Section Index – 369,P,5 MTL 4/05 – 20 Pages (inclusive)	**HOME AND COMMUNITY BASED SERVICES** Section Index – 369,P,5 MTL 4/04 – 20 Pages (inclusive)
APPENDIX C – MAABD INCOME STANDARD CHART Section Title Page – Appendix C MTL 4/05 – 2 Pages	**APPENDIX C – MAABD INCOME STANDARD CHART** Section Title Page – Appendix C MTL 2/05 – 2 Pages

Manual Section	BACKGROUND & EXPLANATION of policy changes/ clarifications/ updates.	Obsolete PT, P&P, PUT or IM
The Division's name has been changed throughout chapters as they are revised.		
360,N,4	**Notification of Patient Liability/Case Status** – Remove reference to the Medicaid Eligibility Status Form (2214) and provider participation in the EVE system. Obsolete with introduction of MMIS system. All providers are required to participate in the EVE system.	
360,N,5,1,a	**Home Base Maintenance Allowance** – Added reference to Appendix C which reflects the dollar amounts for the Home Base Maintenance Allowance.	
Appendix C	**MAABD Income Standard Chart** – Corrected Unearned Income Limit in HIWA. Updated Home Base Maintenance Allowance for Aged – Independent Living to $1,737.00 to match other waivers.	

Effective Date -- Upon receipt.

Instructions for Manual Maintenance - Replace superseded page(s) [27] with transmitted page(s) [27].

(WP/MTL/Maabd04_05)

JANUARY RELEASE
MAABD MANUAL
TRANSMITTAL LETTER 1/06

JANUARY 1, 2006

TO: CUSTODIANS OF MAABD MANUALS

FROM: NANCY KATHRYN FORD, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

The Division's name has been changed throughout the chapters.

Material Transmitted	Material Superseded
MEDICAL ASSISTANCE FOR THE AGED, BLIND AND DISABLED PROGRAM MANUAL Title Page & Table of Contents (100-Appendix G) MTL 1/06 – 6 Pages (inclusive)	**MEDICAL ASSISTANCE FOR THE AGED, BLIND AND DISABLED PROGRAM MANUAL** Title Page & Table of Contents (100-Appendix G) MTL 4/05 – 5 Pages (inclusive)
CHAPTER 100 – MAABD OVERVIEW Section 100 - 103 MTL 1/06 – 3 Pages (inclusive)	**CHAPTER 100 – MAABD OVERVIEW** Section 100 - 103 MTL 2/05 – 4 Pages (inclusive)
CHAPTER 200 – FACTORS OF ELIGIBILITY Section 200 - 214,B,5 MTL 1/06 – 16 Pages (inclusive)	**CHAPTER 200 – FACTORS OF ELIGIBILITY** Section 200 - 214,B,5 MTL 2/04, 2/05, 3/05, 4/04 – 16 Pages (inclusive)
Section 220 – Types of Earned and Unearned Income MTL 1/06 – 15 Pages (inclusive)	Section 220 – Types of Earned and Unearned Income MTL 3/03, 4/98, 1/05, 1/96, 4/94, 5/00, 1/03, 2/01, 2/99, 5/02, 3/95, 3/04 – 16 Pages (inclusive)
Section 230 – Types of Resources MTL 1/06 – 12 Pages (inclusive)	Section 230 – Types of Resources MTL 3/03, 1/05, 1/96, 4/97, 3/95, 2/01, 2/05, 3/97, 1/03, 7/99 – 15 Pages (inclusive)
Section 240 – 240,N,6 MTL 1/06 – 6 Pages (inclusive)	Section 240 – 240,N,6 MTL 3/02, 8/00, 1/05 – 7 Pages (inclusive)
Section 250 – 250,E,6 MTL 1/06 – 3 Pages (inclusive)	Section 250 – 250,E,6 MTL 2/05, 3/05 – 3 Pages (inclusive)
CHAPTER 300 – ELIGIBLE CATEGORIES Section 300 MTL 1/06 – 1 Page (inclusive)	**CHAPTER 300 – ELIGIBLE CATEGORIES** Section 300 MTL 3/97 – 1 Page (inclusive)
Section 310 – Medicare Beneficiaries MTL 1/06 – 9 Pages (inclusive)	Section 310 – Medicare Beneficiaries MTL 3/04, 1/05 – 9 Pages (inclusive)
Section 320 – Supplemental Security Income (SSI) MTL 1/06 – 11 Pages (inclusive)	Section 320 – Supplemental Security Income (SSI) MTL 4/04, 2/05, 3/04, 2/03, 5/02 – 11 Pages (inclusive)
Section 330 – Public Laws MTL 1/06 – 14 Pages (Inclusive)	Section 330 – Public Laws MTL 4/04, 2/99, 1/98, 7/00, 1/03, 3/03, 1/96, 2/97, 3/97, 2/03 – 16 Pages (Inclusive)

Material Transmitted	Material Superseded
Section 340 – Persons Institutionalized Less Than 30 Consecutive Days MTL 1/06 – 14 Pages (inclusive)	Section 340 – Persons Institutionalized Less Than 30 Consecutive Days MTL 4/04, 1/03, 8/99, 1/96, 4/98, 2/99 – 16 Pages (inclusive)
Section 350 – Persons Institutionalized at Least 30 Consecutive Days MTL 1/06 – 20 Pages (inclusive)	Section 350 – Persons Institutionalized at Least 30 Consecutive Days MTL 4/04, 1/03, 1/01, 8/99, 5/02, 1/96, 2/99, 2/97, 9/99, 4/98, 3/97, 1/98, 2/03, 3/05 – 20 Pages (inclusive)
Section 360 – Home and Community Based Services MTL 1/06 – 20 Pages (inclusive)	Section 360 – Home and Community Based Services MTL 4/05 – 20 Pages (inclusive)
Section 370 – Katie Beckett MTL 1/06 – 7 Pages (inclusive)	Section 370 – Katie Beckett MTL 4/04, 1/04 – 7 Pages (inclusive)
Section 380 – Prior Medical MTL 1/06 – 9 Pages (inclusive)	Section 380 – Prior Medical MTL 4/04, , 1/96, 2/99, 2/97 – 9 Pages (inclusive)
Section 390 – Specialized Medicaid Eligibility Groups MTL 1/06 – 3 Pages (inclusive)	Section 390 – Specialized Medicaid Eligibility Groups MTL 1/05, 3/05 – 3 Pages (inclusive)
CHAPTER 400 – HEALTH INSURANCE FOR WORK ADVANCEMENT (HIWA) Index – RTC Service Providers (Page 2 of 2) MTL 1/06 – 8 Pages (inclusive)	**CHAPTER 400 – HEALTH INSURANCE FOR WORK ADVANCEMENT (HIWA)** Index – RTC Service Providers (Page 2 of 2) MTL 3/04,, 1/05, 2/05 – 8 Pages (inclusive)
CHAPTER 500 – PARENTAL FINANCIAL RESPONSIBILITY FOR SERVICES PROVIDED TO DISABLED CHILDREN Section 501 – 506.19 MTL 1/06 – 13 Pages (inclusive)	**CHAPTER 500 – PARENTAL FINANCIAL RESPONSIBILITY FOR SERVICES PROVIDED TO DISABLED CHILDREN** Section 501 – 506.19 MTL 2/05, 1/94, 6/00, 5/93, 6/02 – 14 Pages (inclusive)
APPENDIX A – GLOSSARY OF TERMS AND ACRONYMS MTL 1/06 – 3 Pages (inclusive)	**APPENDIX A – GLOSSARY OF TERMS AND ACRONYMS** MTL 4/93 – 3 Pages (inclusive)
APPENDIX B – POSSIBLE BENEFITS AVAILABLE TO DIVISION OF WELFARE AND SUPPORTIVE SERVICES CLIENTS MTL 1/06 – 7 Pages (inclusive)	**APPENDIX B – POSSIBLE BENEFITS AVAILABLE TO DIVISION OF WELFARE AND SUPPORTIVE SERVICES CLIENTS** MTL 4/93, 3/93 – 7 Pages (inclusive)
APPENDIX C – MAABD INCOME STANDARD CHART MTL 1/06 – 2 Pages (inclusive)	**APPENDIX C – MAABD INCOME STANDARD CHART** MTL 4/05 – 2 Pages (inclusive)
APPENDIX D – BENEFIT LEVEL CHART MTL 1/06 – 3 Pages (inclusive)	**APPENDIX D – BENEFIT LEVEL CHART** MTL 2/05 – 3 Pages (inclusive)

Material Transmitted	Material Superseded
APPENDIX E – CASE FORMAT MTL 1/06 – 2 Pages (inclusive)	**APPENDIX E – CASE FORMAT** MTL 2/99 – 2 Pages (inclusive)
APPENDIX F – MAABD BUDGETS MTL 1/06 – 8 Pages (inclusive)	**APPENDIX F – MAABD BUDGETS** MTL 1/05, 3/04, 1/03, 9/00 – 8 Pages (inclusive)
APPENDIX G – PRUCOL VERIFICATION MTL 1/06 – 3 Page (inclusive)	**APPENDIX G – PRUCOL VERIFICATION** MTL 3/99 – 3 Page (inclusive)

Manual Section	BACKGROUND & EXPLANATION of policy changes/ clarifications/ updates.	Obsolete PT, P&P, PUT or IM
The Division's name has been changed throughout the chapters.		
101,A,9	**Spousal Authorization** – New section added covering the requirement to obtain the Interface Consent, Form 2179-EE, from spouses whose income is used for financial eligibility.	
210,6,b	**Spouse/Dependent Relative's Income** – Added wording to indicate spousal income is used in financial eligibility for QMB/SLMB/QI. Added 'NOTE' addressing need for Interface Consent, Form 2179-EE, allowing us to request information through our interfaces.	
210-214	**Page Headings** – Re-numbered section heading to match revisions.	
310,A,1	**Qualified Medicare Beneficiaries (QMB)** – Added NOTE to address resource verification on SSI recipients applying for QMB. No verification should be required since SSI requirements provide for resource eligibility on QMB.	
360,N,4	**Notification of Patient Liability/Case Status** – Removed reference to the Medicaid Eligibility States Form (2214) and provider participation in the E.V.E. system. Obsoleted with introduction of MMIS system. All providers are required to participate in the E.V.E. system.	
360,N,5,b,1,a	**Home Base Maintenance Allowance** – Added reference to Appendix C which reflects the dollar amounts for the Home Base Maintenance Allowance.	
Appendix C	**MAABD Income Standard Chart** – Corrected Unearned Income limit for HIWA. Updated Home Base Maintenance Allowance for Aged – Independent Living to $1,737 to match other waivers. Updated MAABD Income Standard Chart with 2006 limits as a result of SSI Cost-of-Living Adjustment notice.	**E&P IM39-04 dated November 1, 2004**
Appendix D	**Benefit Level Chart** – Updated 2006 chart with new 2006 income limits .	**E&P IM39-04 dated November 1, 2004**
Appendix F	**MAABD Budgets** – Updated forms with new 2006 amounts. Corrected 'ECS' with 'Case Manager'.	

Effective Date -- January 1, 2006

Instructions for Manual Maintenance - Replace superseded page(s) [228] with transmitted page(s) [218].

(WP/MTL/Maabd01_06)

MARCH RELEASE
MAABD MANUAL TRANSMITTAL LETTER 2/06

MARCH 1, 2006

TO: CUSTODIANS OF MAABD MANUALS

FROM: NANCY KATHRYN FORD, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
BLIND/DISABLED INDIVIDUALS Section 202,A,3,b – 204,A MTL 2/06 – 1 Page	**BLIND/DISABLED INDIVIDUALS** Section 202,A,3,b – 204,A MTL 1/06 – 1 Page
CITIZENSHIP REQUIREMENT Section 206,E,2,I – 208,C,3,a MTL 2/06 – 2 Pages	**CITIZENSHIP REQUIREMENT** Section 206,E,2,I – 208,C,3,a MTL 1/06 – 2 Pages
Section 208,C,4 – 214,A,6 MTL 2/06 – 4 Pages	Section 208,C,4 – 214,A,6 MTL 1/06 – 4 Pages
TYPES OF EARNED AND UNEARNED INCOME Section 220 (Bonus - Death Benefits) MTL 2/06 – 1 Page	**TYPES OF EARNED AND UNEARNED INCOME** Section 220 (Bonus - Death Benefits) MTL 1/06 – 1 Page
Section 220 (Replacement/Repair Destroyed or Damaged Property – Trust Funds) MTL 2/06 – 2 Pages	Section 220 (Replacement/Repair Destroyed or Damaged Property – Trust Funds) MTL 1/06 – 2 Pages
TRANSFER OF ASSETS Section 240,G,2,b,2) – 240,I,2,d MTL 2/06 – 1 Page	**TRANSFER OF ASSETS** Section 240,G,2,b,2) – 240,I,2,d MTL 1/06 – 1 Page
PARENTAL FINANCIAL RESPONSIBILITY FOR SERVICES PROVIDED TO DISABLED CHILDREN Section 501 – 505,B MTL 2/06 – 3 Pages	**PARENTAL FINANCIAL RESPONSIBILITY FOR SERVICES PROVIDED TO DISABLED CHILDREN** Section 501 – 505,B MTL 1/06 – 3 Pages
APPENDIX C – 2006 MAABD INCOME STANDARD CHART MTL 2/06 – 1 Page	**APPENDIX C – 2006 MAABD INCOME STANDARD CHART** MTL 1/06 – 1 Page
APPENDIX D – BENEFIT LEVEL CHART MTL 2/06 – 2 Pages	**APPENDIX D – BENEFIT LEVEL CHART** MTL 1/06 – 2 Pages

Manual Section	BACKGROUND & EXPLANATION of policy changes/ clarifications/ updates.	Obsolete PT, P&P, PUT or IM
203	**Identification** – Removed reference to WTPY and replaced with SOLQ.	
208	**Insurance Coverage** – Removed reference to 'CHAMPUS' and replaced with 'TRICARE'.	
208,A	**Insurance Coverage** – Added address used to send Medical Subrogation form 2511.	
208,C,2,c	**Medicare and Buy-In/Bendex** – Reworded for clarity. The term 'renal' is ore widely used.	
208,C,4	**How the Buy-In Process Works** – Reworded to reflect correct process under remodeled system.	
208,C,5	**Case Manager Responsibilities in the Buy-In Process** – Reworded to allow flexibility in staff requests for assistance on Buy-In. Allows for Form 1056 or e-mail. Changed reference of WTPY to SOLQ.	
209,B	**Support Enforcement Program (SEP)** – Reworded section on pregnant women to eliminate confusion over ELIG codes under MAABD. Removed reference to 'MAABD' as ineligibility for the adult is not limited to MAABD. Removed references to 30-day conciliation period.	**P&P 04-06**
210,6,b	**Cooperation** – Added wording to clarify Form 2179 not needed if the spouse has signed the application.	
214	**Closures** – Added wording to clarify pregnant women who lose eligibility under MAABD for *excess income* are to be evaluated for coverage as a Qualified Pregnant Woman under the Child Health Assurance Program (CHAP).	
220	**Types of Earned and Unearned Income** – Replaced any reference to WTPY to SOLQ.	
220	**Cost of Living Adjustments (COLAs)** – Added wording to include disregarding increases to a spouse's benefit for the period from January through March.	**P&P 70-05**
240,G,2,B,7)	**Treatment of Certain Kinds of Asset Transfers**—Clarified Medicaid is the beneficiary for an *unmarried* applicant/client with an annuity.	
501,B,4	**Parental Financial Responsibility** – 2006 federal poverty level increase require update of Annual Family Deductions section.	
501,E	**Responsibilities of Eligibility Staff** – Update computations to 2006 federal poverty guideline.	
Appendix C and D	**MAABD Income Standard Chart & Benefit Level Chart** – Update using 2006 federal poverty level increases.	

Effective Date -- March 1, 2006

Instructions for Manual Maintenance - Replace superseded page(s) [17] with transmitted page(s) [17].

(WP/MTL/Maabd02_06)

MAY RELEASE
MAABD MANUAL
TRANSMITTAL LETTER 3/06

MAY 1, 2006

TO: CUSTODIANS OF MAABD MANUALS

FROM: NANCY KATHRYN FORD, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
CITIZENSHIP REQUIREMENT Section 206 – 206,D,2 MTL 3/06 – 1 Page	**CITIZENSHIP REQUIREMENT** Section 206 – 206,D,2 MTL 1/06 – 1 Page
MEDICARE BENEFICIARIES Section 310 – 310,L,1,b,5) MTL 3/06 – 3 Pages	**MEDICARE BENEFICIARIES** Section 310 – 310,L,1,b,5) MTL 1/06 – 3 Pages
SPECIALIZED MEDICAID ELIGIBILITY GROUPS Section 390 – 390,C,1 MTL 3/06 – 1 Page	**SPECIALIZED MEDICAID ELIGIBILITY GROUPS** Section 390 – 390,C,1 MTL 1/06 – 1 Page

Manual Section	BACKGROUND & EXPLANATION of policy changes/ clarifications/ updates.	Obsolete PT, P&P, PUT or IM
206,A	**Verification** – Corrected form name and number used for secondary verification to G 845S, SAVE Documentation Verification Request.	IM 13-06
310	**Medicare Beneficiaries** – Changed verbiage to clarify individuals eligible under MIB category are not on *Medicaid* unless they are found eligible under a category for full Medicaid.	
390	**Index** – Removed reference to *continuation* of pregnancy-related coverage.	
390,A	**Emergency Medical for Ineligible Non-citizens** – Reworded for clarity. Removed bullet requiring an emergency situation for eligibility, and added income and resources as criteria. Added wording to indicate availability of ongoing eligibility.	
390,C	**Medicaid Eligibility for Newborns** – Reworded for clarity. Added additional criteria for mother to continue to meet income and resource limits, and clarified OBRA termination if mother no longer meets the requirements.	

Effective Date -- May 1, 2006

Instructions for Manual Maintenance - Replace superseded page(s) [5] with transmitted page(s) [5].

(WP/MTL/Maabd03_06)

JULY RELEASE
MAABD MANUAL
TRANSMITTAL LETTER 4/06

JULY 1, 2006

TO: CUSTODIANS OF MAABD MANUALS

FROM: NANCY KATHRYN FORD, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
INSURANCE COVERAGE Section 208,A – 208,C,3,a MTL 4/06 – 1 Page	**INSURANCE COVERAGE** Section 208,A – 208,C,3,a MTL 2/06 – 1 Page
COOPERATION Section 210 – 210,B MTL 4/06 – 1 Page	**COOPERATION** Section 210 – 210,B MTL 2/06 – 1 Page
PRIOR MEDICAL DETERMINATION ONLY – WOULD HAVE BEEN ELIGIBLE FOR SSI Section 380 – 380,L MTL 4/06 – 1 Page	**PRIOR MEDICAL DETERMINATION ONLY – WOULD HAVE BEEN ELIGIBLE FOR SSI** Section 380 – 380,L MTL 1/06 – 1 Page

Manual Section	BACKGROUND & EXPLANATION of policy changes/ clarifications / updates.	Obsolete PT, P&P, PUT or IM
208,B	**Mandatory Premium Payments for Cost Effective Employer Group Health Insurance** – Reworded to clarify the need to obtain a 2230-EM to identify potential third party coverage.	
210,B	**Ongoing Eligibility Case Processing** – Reworded for allowance of client turning in information before the end of the month on terminations. Reduces the number of reapplications on clients who are late in complying with requests. Now, matches with E&P manual.	
380,A	**Overview** – Removed reference to requirement that Prior Med be requested in writing.	

Effective Date -- July 1, 2006

Instructions for Manual Maintenance - Replace superseded page(s) [3] with transmitted page(s) [3].

(WP/MTL/Maabd04_06)

SEPTEMBER RELEASE
MAABD MANUAL
TRANSMITTAL LETTER 5/06

SEPTEMBER 1, 2006

TO: CUSTODIANS OF MAABD MANUALS

FROM: NANCY KATHRYN FORD, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
FACTORS OF ELIGIBILITY Section 200 – 202,A,3,a.,9) MTL 5/06 – 1 Page	**FACTORS OF ELIGIBILITY** Section 200 – 202,A,3,a.,9) MTL 1/06 – 1 Page
RESIDENCE REQUIREMENTS Section 205,D,4,b. – 206,D,2 MTL 5/06 – 4 Pages	**RESIDENCE REQUIREMENTS** Section 205,D,4,b – 206,3 MTL 1/06, 3/06 – 2 Pages
HOME AND COMMUNITY BASED SERVICES Section 360,A,b,3),g) – 360,F.1 MTL 5/06 – 6 Pages	**HOME AND COMMUNITY BASED SERVICES** Section 360,B,g – 360,F MTL 4/5 – 4 Pages

Manual Section	BACKGROUND & EXPLANATION of policy changes/ clarifications / updates.	Obsolete PT, P&P, PUT or IM
201,A,6	**Verification** – Removed wording regarding copying Certificates of Naturalization. CMS confirmed states may do so if done to satisfy a federal regulation.	
206	**Citizenship Requirement** – Section revised to add regulations from Deficit Reduction Act of 2005 on citizenship verification.	**E&PPT 04-06** **E&PPT 06-06**
360,A,1,c	**Aged Individuals – Living in Assisted Living Facility:** New section added to address new waiver for individuals living in an assisted living facility.	**PT #05-06**
360,A,1,d	**Blind/Disabled Individuals:** Renumbered from 350A.1.c to accommodate new waiver.	

Effective Date -- September 1, 2006

Instructions for Manual Maintenance - Replace superseded page(s) [7] with transmitted page(s) [11].

(WP/MTL/Maabd05_06)

JANUARY RELEASE
MAABD MANUAL
TRANSMITTAL LETTER 1/07

January 1, 2007

TO: CUSTODIANS OF MAABD MANUALS

FROM: NANCY KATHRYN FORD, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
CITIZENSHIP REQUIREMENT Section 206 – 206,2,a MTL 1/07 – 1 Page	**CITIZENSHIP REQUIREMENT** Section 206 – 206,2,a MTL 5/06 – 1 Page
INDEX – TYPES OF EARNED AND UNEARNED INCOME Section 220 MTL 1/07 – 1 Page	**INDEX – TYPES OF EARNED AND UNEARNED INCOME** Section 220 MTL 1/06 – 1 Page
Section 220 (Infrequent and Irregular Income – Lease Income) MTL 1/07 – 2 Pages	Section 220 (Infrequent and Irregular Income – Lease Income) MTL 1/06 – 1 Page
Section 220 (Sick Pay – Tribal Gaming Income) MTL 1/07 – 3 Pages	Section 220 (Sick Pay – Veteran's Benefits) MTL 1/06 – 2 Pages
INDEX – TYPES OF RESOURCES Section 230 MTL 1/07 – 1 Page	**INDEX – TYPES OF RESOURCES** Section 230 MTL 1/06 – 1 Page
Section 230 (Cash on Hand – Individual Development Account (IDA)) MTL 1/07 – 2 Pages	Section 230 (Cash on Hand – Individual Development Account (IDA)) MTL 1/06 – 1 Page
TRANSFER OF ASSETS Section 240, B – 240,N,6 MTL 1/07 – 9 Pages	**TRANSFER OF ASSETS** Section 240, B – 240,N,6 MTL 1/06 – 6 Pages
TREATMENT OF TRUSTS Section 250,D,4 – 250,E,6 MTL 1/07 – 2 Pages	**TREATMENT OF TRUSTS** Section 250,D,4 – 250,E,6 MTL 1/06 – 2 Pages
PERSONS INSTITUTIONALIZED AT LEAST 30 CONSECUTIVE DAYS Section 350,M,2,a,3 – 350,N,6,b,2,b,1,b MTL 1/07 – 10 Pages	**PERSONS INSTITUTIONALIZED AT LEAST 30 CONSECUTIVE DAYS** Section 350,M,2,a,3 – 350,N, 6,b,2,b,1,b MTL 1/06 – 8 Pages
HOME AND COMMUNITY BASED SERVICES Section 360,A,1,b,1,a – 360,A,1,b,1,f MTL 1/07 – 1 Page	**HOME AND COMMUNITY BASED SERVICES** Section 360,A,1,b,1,a – 360,A,1,b,1,f ML 1/06 – 1 Page

Material Transmitted	Material Superseded
APPENDIX C **2007 MAABD INCOME STANDARD CHART SCHEDULE OF PAYMENTS** MTL 1/07 – 1 Page	**APPENDIX C** **2007 MAAABD INCOME STANDARD CHART SCHEDULE OF PAYMENTS** MTL 2/06 – 1 Page
APPENDIX D **BENEFIT LEVEL CHART** MTL 1/07 – 1 Page	**APPENDIX D** **BENEFIT LEVEL CHART** MTL 2/06 – 1 Page
APPENDIX F **VETERAN UNUSUAL MEDICAL EXPENSE (UME) BUDGET – 2007 — RSDI COMPUTATION WORKSHEET** FORMS 2039-EE (Pages 1 & 2), 2203-EM (Sides 1 & 2), 2220-EM (Sides 1 & 2), 2646-EE (Sides 1 & 2), 2654-EE MTL 1/07 – 5 Pages	**APPENDIX F** **VETERAN UNUSUAL MEDICAL EXPENSE (UME) BUDGET – 2007 – RSDI COMPUTATION WORKSHEET** FORMS 2039-EE (Page 1 & 2), 2203-EM (Sides 1 & 2), 2220-EM (Sides 1 & 2), 2646-EE (Sides 1 & 2), 2654-EE MTL 1/06 – 5 Pages

Manual Section	BACKGROUND & EXPLANATION of policy changes/ clarifications / updates.	Obsolete PT, P&P, PUT or IM
206	**CITIZENSHIP REQUIREMENT** – Sentence left out in previous update – put back in.	
220	**INDEX – TYPES OF EARNED & UNDEARNED INCOME** – Add new income type – Tribal Gaming Income	P&P 33-05
220	**INCOME TYPE – INFREQUENT AND IRREGULAR INCOME** – Update exclusion provision.	
220	**INCOME TYPE – TRIBAL GAMING INCOME** – Clarify exclusion provision of Tribal Gaming Income Received	P&P 33-05
230	**INDEX - TYPES OF RESOURCES** – Add new resources pursuant to DRA rule.	PT 08-06
230	**ENTRANCE FEES** – Add new resource pursuant to DRA rules.	PT 08-06
230	**HOME EQUITY** – Add new resource pursuant to DRA rules.	PT 08-06
240,B	**DEFINITIONS** – Define Spouse and Community Spouse. Add Definition of Deficit Reduction Act of 2005.	 PT 03-06
240,C	**GENERAL RULE** – Change to *Case Manager*	
240,D	**LOOK-BACK PERIOD** – Add reference to Long Term Care (LTC) and Home and Community Based Waiver Services (HCBW) Update *look-back* pursuant to DRA rule.	 PT 03-06
240,G,1 and 2,c	**TREATMENT OF CERTAIN KINDS OF ASSET TRANSFERS** – Update Life Estates Add new provisions regarding treatment of Annuities, Notes, Loans, or Mortgages pursuant to DRA rules.	PT 03-06 PT 03-06
240,H	**ESTABLISHING THE PROPOSED PENALTY PERIOD** – Section removed.	
240, H,1,2,3	**PURSUING A POSSIBLE TRANSFER** – Adjust alphabetical order of Section Clarify process of completion of Form 2601, Rebuttal, Undue Hardship	 Transfer of Asset Form 2601-EE
240,J	**PENALTY PERIOD – SPOUSE INVOLVEMENT** – Adjust alphabetical order.	
240,K	**SITUATIONS UNDER WHICH TRANSFER OF ASSET PROVISIONS DO NOT APPLY** – Adjust alphabetical order.	
240,L,3	**DECISION** – Adjust alphabetical order Remove language describing when a penalty period begins. Add reference to DRA rules regarding effective dates of transfers and begin month of penalty.	 PTs 03-06 and 08-06
240,N	**UNDERSTANDING HOW A DECISION IS MADE –** Remove section as the decision to indicate an asset was transferred exclusively for a purpose other than the establish or retain eligibility rests with the Chief of Eligibility and Payments.	
250,D,4	**TYPES OF TRUSTS** – Clarify Special Needs Trust	

Manual Section	BACKGROUND & EXPLANATION of policy changes/ clarifications / updates.	Obsolete PT, P&P, PUT or IM
350,M,2,a	**RESOURCE PROVISIONS FOR SPOUSAL IMPOVERISHMENT CASES - DEFINITIONS –** Define Spouse and Undue Hardship pursuant to DRA rules and Policy and Procedure	P&P 46-06
350,2,c,7	**UNDUE HARDSHIP** – Clarify when Undue Hardship can be requested pursuant to the DRA rules and Policy and Procedure	P&P 46-06
350,M,5	**RESOURCE LIMITS** – Add reference of Home Equity Limits	PT 08-06
350,N,3,b,	**EFFECTIVE DATE OF PATIENT LIABILITY** – Add reference of Fiscal Intermediary	
350,N,4	**NOTIFICATION OF PATIENT LIABILITY/CASE STATUS** – Add reference of Fiscal Intermediary.	
350,N,5,a	**BUDGETINIG PROCEDURES** – Delete inappropriate reference to deductions from countable income.	
350,N,5,b,2,b	**PATIENT LIABILITY** – Clarify Spousal Monthly Maintenance Allowance	
350,N,6,a	**BUDGETING PROCEDURES** – Remove inappropriate reference to deductions from countable income.	
360,A,1,b,1,a	**AGED INDIVIDUALS – LIVING IN AN ADULT GROUP CARE FACILITY** – Amendment pursuant to the Chief of Eligibility and Payments through the DHCSP.	E-mail dated November 22, 2006
360,A,1,b,2,b	**AGED INDIVIDUALS – LIVING IN AN ADULT GROUP CARE FACILITY** – Update pursuant to the Chief of Eligibility and Payments through the DHCSP.	
Appendix C	**MAABD INCOME STANDARD CHART** – Update MAABD Income Standard Chart with 2007 limits pursuant to SSI Cost-of-Living Adjustment notice.	
Appendix C	Add *Schedule of Payments* as new addition to the Appendix Section and Update with new 2007 Cost of Living Information.	
Appendix D	**BENEFIT LEVEL CHART** – Update 2007 Benefit Level Chart with new 2007 income limits.	IM 27-07 dated August 23, 2006
Appendix F	**MAABD BUDGETS** – Update forms with new 2007 amounts.	

Effective Date -- January 1, 2007

Instructions for Manual Maintenance - Replace superseded page(s) [31] with transmitted page(s) [39].

(WP/MTL/MAABD01_07)

MARCH RELEASE
MAABD MANUAL
TRANSMITTAL LETTER 2/07

March 1, 2007

TO: CUSTODIANS OF MAABD MANUALS

FROM: NANCY KATHRYN FORD, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
TREATMENT OF CERTAIN KINDS OF ASSET TRANSFERS Section 240,G,2,d,3,b MTL 2/07 – 2 Pages	**TREATMENT OF CERTAIN KINDS OF ASSET TRANSFERS** Section 240,G,2,d,3,b MTL 1/07 – 2 Pages
TRANSFER OF ASSETS Section 240,H – 240,H,3 MTL 2/07 – 1 Page	**TRANSFER OF ASSETS** Section 240,H – 240,H,3 MTL 1/07 – 2 Page
CHAPTER 500 – PARENTAL FINANCIAL RESPONSIBILITY FOR SERVICES PROVIDED TO DISABLED CHILDREN Section 501,B,4 – 505,B MTL 2/07 – 3 Pages	**CHAPTER 500 – PARENTAL FINANCIAL RESPONSIBILITY FOR SERVICES PROVIDED TO DISABLED CHILDREN** Section 501,B,4 – 505,B MTL 2/06 – 3 Pages
APPENDIX C **2007 MAABD INCOME STANDARD CHART SCHEDULE OF PAYMENTS** MTL 1/07 – 1 Page	**APPENDIX C** **2007 MAABD INCOME STANDARD CHART SCHEDULE OF PAYMENTS** MTL 2/06 – 1 Page
APPENDIX D **BENEFIT LEVEL CHART** MTL 1/07 – 1 Page	**APPENDIX D** **BENEFIT LEVEL CHART** MTL 2/06 – 1 Page

Manual Section	BACKGROUND & EXPLANATION of policy changes/ clarifications / updates.	Obsolete PT, P&P, PUT or IM
240,G,2,d,3,b	**TREATMENT OF CERTAIN KINDS OF ASSET TRANSFERS** – Clarify section relevant to how an annuity is treated.	
240,H,3	**PURSUING A POSSIBLE TRANSFER** – Remove incorrect reference to *Section 350* and add *Section 240(B)(7).*	
501,B,4	**CALCULATING MONTHLY PARENTAL REIMBURSEMENTS**.– 2007 Federal Poverty level increases require update of Annual Family Deductions section.	
501,E	**RESPONSIBILITIES OF ELIGIBILITY STAFF** – Update computations to 2007 Federal Poverty guideline.	
Appendix C and D	**MAABD INCOME STANDARD CHART & BENEFIT LEVEL CHART** – Update using 2007 Federal Poverty level increases.	

Effective Date -- March 1, 2007

Instructions for Manual Maintenance - Replace superseded page(s) [9] with transmitted page(s) [8].

(WP/MTL/MAABD02_07)

JULY RELEASE
MAABD MANUAL
TRANSMITTAL LETTER 4/07

July 1, 2007

TO: CUSTODIANS OF MAABD MANUALS

FROM: NANCY KATHRYN FORD, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
TRANSFER OF ASSETS Section 240,H – 240,L,3 MTL 4/07 – 9 Pages	**TRANSFER OF ASSETS** Section 240,H – 240,L,3 MTL 1/07, 2/07, 3/07 – 9 Pages
PERSONS INSTITUTIONALIZED AT LEAST 30 CONSECUTIVE DAYS Section 350,M,2,c,8 – 350,O MTL 4/07 – 8 Pages	**PERSONS INSTITUTIONALIZED AT LEAST 30 CONSECUTIVE DAYS** Section 350,M,2,c,8 – 350,O MTL 1/06, 1/07 – 7 Pages
APPENDIX C **2007 MAABD INCOME STANDARD CHART** MTL 4/07 – 1 Page	**APPENDIX C** **2007 MAABD INCOME STANDARD CHART** MTL 2/07 – 1 Page

Manual Section	BACKGROUND & EXPLANATION of policy changes/ clarifications / updates.	Obsolete PT, P&P, PUT or IM
240,B,1	**DEFINITIONS** – Corrected reference to manual section K	
240,F	**TREATMENT OF JOINTLY OWNED ASSETS** – Clarify Joint Account Owners	
240,G,2,d,1,a,2	**TREATMENT OF CERTAIN KINDS OF ASSET TRANSFERS** – Corrected typo	
240,G,2,d,3,b,2,	Corrected typo in reference to IRAs	
240,I,1,b	Update average cost of private care and examples with new amounts	
240,I,2,c & d	Update average cost of private care and examples with new amounts	
240,L,3	**DECISION** –¨Added penalty calculation information for consistency.	
350,M,2,c,8	**RESOURCES –** Update Resource sections with new Long-Term Care resource exemption policy.	
Appendix C	**2007 MAABD INCOME STANDARD CHART** – Update with average cost of private nursing care.	

Effective Date -- July 1, 2007

Instructions for Manual Maintenance - Replace superseded page(s) [17] with transmitted page(s) [18].

(WP/MTL/MAABD04_07)

JULY RELEASE
MAABD MANUAL
TRANSMITTAL LETTER 4/07

July 1, 2007

TO: CUSTODIANS OF MAABD MANUALS

FROM: NANCY KATHRYN FORD, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
TRANSFER OF ASSETS Section 240,H – 240,L,3 MTL 4/07 – 9 Pages	**TRANSFER OF ASSETS** Section 240,H – 240,L,3 MTL 1/07, 2/07, 3/07 – 9 Pages
PERSONS INSTITUTIONALIZED AT LEAST 30 CONSECUTIVE DAYS Section 350,M,2,c,8 – 350,O MTL 4/07 – 8 Pages	**PERSONS INSTITUTIONALIZED AT LEAST 30 CONSECUTIVE DAYS** Section 350,M,2,c,8 – 350,O MTL 1/06, 1/07 – 7 Pages
APPENDIX C **2007 MAABD INCOME STANDARD CHART** MTL 4/07 – 1 Page	**APPENDIX C** **2007 MAABD INCOME STANDARD CHART** MTL 2/07 – 1 Page

Manual Section	BACKGROUND & EXPLANATION of policy changes/ clarifications / updates.	Obsolete PT, P&P, PUT or IM
240,B,1	**DEFINITIONS** – Corrected reference to manual section K	
240,F	**TREATMENT OF JOINTLY OWNED ASSETS** – Clarify Joint Account Owners	
240,G,2,d,1,a,2	**TREATMENT OF CERTAIN KINDS OF ASSET TRANSFERS** – Corrected typo	
240,G,2,d,3,b,2,	Corrected typo in reference to IRAs	
240,I,1,b	Update average cost of private care and examples with new amounts	
240,I,2,c & d	Update average cost of private care and examples with new amounts	
240,L,3	**DECISION** –¨Added penalty calculation information for consistency.	
350,M,2,c,8	**RESOURCES –** Update Resource sections with new Long-Term Care resource exemption policy.	
Appendix C	**2007 MAABD INCOME STANDARD CHART** – Update with average cost of private nursing care.	

Effective Date -- July 1, 2007

Instructions for Manual Maintenance - Replace superseded page(s) [17] with transmitted page(s) [18].

(WP/MTL/MAABD04_07)

NOVEMBER RELEASE
MAABD MANUAL
TRANSMITTAL LETTER 5/07

November 1, 2007

TO: CUSTODIANS OF MAABD MANUALS

FROM: NANCY KATHRYN FORD, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
TABLE OF CONTENTS Section 100 – 206,E MTL 5/07 – 1 Page	**TABLE OF CONTENTS** Section 100 – 206,E MTL 1/06 – 1 Page
MAABD OVERVIEW Section 101,C – 103 MTL 5/07 – 1 Page	**MAABD OVERVIEW** Section 101,C – 103 MTL 1/06 – 1 Page
FACTORS OF ELIGIBILITY Section 205,D,2 – 206,D,2 MTL 5/07 – 5 Pages	**FACTORS OF ELIGIBILITY** Section 205,D,2 – 206,D,2 MTL 1/06, 5/06, 3/07 – 5 Pages
Section 240,G,2,c – 240,K,1 MTL 5/07 – 5 Pages	Section 240,G,2,c – 240,K,1 MTL 4/07 – 5 Pages
SUPPLEMENTAL SECURITY INCOME (SSI) Section 320,G – 320,N MTL 5/07 – 1 Page	**SUPPLEMENTAL SECURITY INCOME (SSI)** Section 320,G – 320,N MTL 3/07 – 1 Page
PUBLIC LAWS Section 330,F – 330,L,1,a MTL 5/07 – 1 Page	**PUBLIC LAWS** Section 330,F – 330,L,1,a MTL 3/07 – 1 Page
PERSONS INSTITUTIONALIZED LESS THAN 30 CONSECUTIVE DAYS Section 340,H – 340,L,1,b,2 MTL 5/07 – 1 Page	**PERSONS INSTITUTIONALIZED LESS THAN 30 CONSECUTIVE DAYS** Section 340,H – 340,L,1,b,2 MTL 1/06 – 1 Page
PERSONS INSTITUTIONALIZED AT LEAST 30 CONSECUTIVE DAYS Section 350,F,3,c,3 – 350,I MTL 5/07 – 1 Page	**PERSONS INSTITUTIONALIZED AT LEAST 30 CONSECUTIVE DAYS** Section 350,F,3,c,3 – 350,I MTL 3/07 – 1 Page

Material Transmitted	Material Superseded
HOME AND COMMUNITY BASED SERVICES Section 360,A,1,e,3,m – 360,H,1 MTL 5/07 – 1 Page	**HOME AND COMMUNITY BASED SERVICES** Section 360,A,1,e,3,m – 360,H,1 MTL 3/07 – 1 Page
KATIE BECKETT Section 370,F,1 – 370,L MTL 5/07 – 1 Page	**KATIE BECKETT** Section 370,F,1 – 370,L MTL 3/07 – 1 Page
PRIOR MEDICAL Section 380 – 380,L MTL 5/07 – 1 Page	**PRIOR MEDICAL** Section 380 – 380,L MTL 3/07 – 1 Page
SPECIALIZED MEDICAID ELIGIBILITY GROUPS Index Section 390 MTL 5/07 – 1 Page	**SPECIALIZED MEDICAID ELIGIBILITY GROUPS** Index Section 390 MTL 1/06 – 1 Page
Section 390 – 390,3,c,3 MTL 5/07 – 2 Pages	Section 390 – 390,C,3,c MTL 3/06, 1/06 – 2 Pages
PRIOR MEDICAL Section 410,H – 410, L,2,a MTL 5/07 – 1 Page	**PRIOR MEDICAL** Section 410,H – 410, L,2,a MTL 1/06 – 1 Page
APPENDIX A **Glossary Of Terms and Acronyms** MTL 5/07 – 3 Pages	**APPENDIX A** **Glossary Of Terms and Acronyms** MTL 1/06 – 3 Pages
APPENDIX C **MAABD Income Standard Chart** MTL 5/07 – 1 Page	**APPENDIX C** **MAABD Income Standard Chart** MTL 4/07 – 1 Page
APPENDIX D **Benefit Level Chart** MTL 5/07 – 1 Page	**APPENDIX D** **Benefit Level Chart** MTL 1/07 – 1 Page
APPENDIX F **MAABD Budgets** MTL 5/07 – 8 Pages (inclusive)	**APPENDIX F** **MAABD Budgets** MTL 1/07 – 8 Pages (inclusive)

Manual Section	BACKGROUND & EXPLANATION of policy changes / clarifications / updates.	Obsolete PT, P&P, PUT or IM
102	**MEDICAID ELIGIBILITY PRIOR TO APPLICATION** – Update all references to prior medical to remove any known application. Federal clarification received, prior medical must be requested at the time of application.	**E&P PT 03 / 07**
205	**RESIDENCE REQUIREMENTS** – Corrected formatting for clarification.	
205,4	**DISPUTED RESIDENCY** – Corrected formatting for clarification.	
206	**CITIZENSHIP REQUIREMENT** – Update citizenship and identity requirements with release of final regulations from CMS.	
240,G,2,c	**TREATMENT OF CERTAIN KINDS OF ASSET TRANSFERS** – Clerical correction of "purchased"	
240,G,2,d,3,b	Renumber section.	
240,G,2,d,3,c	Renumber section.	
240,G,2,d,3,d/e	Renumber section.	
240,G,2,d,3,e Note	Renumber section.	
240,I,2,h	Clerical correction adding "s" to opening statement. Clarify Effective Date for Partial and Multiple Transfers Pursuant to DRA	
320,H	**PRIOR MEDICAL** – Update all references to prior medical to remove any known application. Federal clarification received, prior medical must be requested at the time of application.	
330,H	**PRIOR MEDICAL** – Update all references to prior medical to remove any known application. Federal clarification received, prior medical must be requested at the time of application.	
340,H	**PRIOR MEDICAL** – Update all references to prior medical to remove any known application. Federal clarification received, prior medical must be requested at the time of application.	
350,H	**PRIOR MEDICAL** – Update all references to prior medical to remove any known application. Federal clarification received, prior medical must be requested at the time of application.	
360,H	**PRIOR MEDICAL** – Update all references to prior medical to remove any known application. Federal clarification received, prior medical must be requested at the time of application.	

Manual Section	BACKGROUND & EXPLANATION of policy changes / clarifications / updates.	Obsolete PT, P&P, PUT or IM
370,H	**PRIOR MEDICAL** – Update all references to prior medical to remove any known application. Federal clarification received, prior medical must be requested at the time of application.	
380,H	**PRIOR MEDICAL** – Update all references to prior medical to remove any known application. Federal clarification received, prior medical must be requested at the time of application.	
390	**INDEX** – Changed subsections to numbers to help clarify that each group is a separate category, unrelated to the others.	
390,A	**SPECIALIZED MEDICAID ELIGIBILITY GROUPS** – Changed subsections to numbers to help clarify that each group is a separate category, unrelated to the others.	
410,H	**PRIOR MEDICAL** – Update all references to prior medical to remove any known application. Federal clarification received, prior medical must be requested at the time of application.	
410,L	**INCOME** – Remove unearned income limit from HIWA eligibility determination. Medicaid budget enhancement approved the removal of the unearned income limit effective October 1, 2007.	
Appendix A	**GLOSSARY OF TERMS AND ACRONYMS** – Update all references to prior medical to remove any known application. Federal clarification received, prior medical must be requested at the time of application.	
Appendix C	**MAABD INCOME STANDARD CHART** – Remove Gross Unearned Income limit from chart.	
Appendix D	**BENEFIT LEVEL CHART** – Update with new 2008 values.	
Appendix F	**MAABD BUDGETS** – Update forms with new 2008 amounts.	

Effective Date -- November 1, 2007

Instructions for Manual Maintenance - Replace superseded page(s) [36] with transmitted page(s) [36].

(WP/MTL/MAABD05_07)

MARCH RELEASE
MAABD MANUAL
TRANSMITTAL LETTER 1/08

March 1, 2008

TO: CUSTODIANS OF MAABD MANUALS

FROM: NANCY KATHRYN FORD, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
TABLE OF CONTENTS Section 100 – 206,E MTL 1/08 – 1 Page	**TABLE OF CONTENTS** Section 100 – 206,E MTL 5/07 – 1 Page
FACTORS OF ELIGIBILITY Section 200 – 204,A MTL 1/08 – 1 Page	**FACTORS OF ELIGIBILITY** Section 200 – 204,A MTL 1/08 – 1 Page
TREATMENT OF TRUSTS Section 250,C – 250,D,5 MTL 1/08 – 1 Page	**TREATMENT OF TRUSTS** Section 250,C – 250,D,5 MTL 1/07 – 1 Page
SUPPLEMENTAL SECURITY INCOME Section 320,N,4,b,4, – 320,O,1 MTL 1/08 – 1 Page	**SUPPLEMENTAL SECURITY INCOME** Section 320,N,4,b,4, – 320,O,1 MTL 1/06 – 1 Page
Section 330,N,4,3 – 330,O MTL 1/08 – 1 Page	Section 330,N,4,3 – 330,O MTL 3/07 – 1 Page
Section 340, N,5,b,2,b,4 – 340,P,3 MTL 1/08 – 1 Page	Section 340, N,5,b,2,b,4 – 340,P,3 MTL 3/07 – 1 Page
Section 350,N,6,b,3 – 350,P,3 MTL 1/08 – 1 Page	Section 350,N,6,b,3 – 350,P,3 MTL 3/07 – 1 Page
Section 360,N,5,2 – 360,P MTL 1/08 – 1 Page	Section 360,N,5,2 – 360,P MTL 3/07 – 1 Page
Section 370 – 370,F,1 MTL 1/08 – 1 Page	Section 370 – 370,F,3 MTL 1/06 – 1 Page
Section 370,M,3 – 370,P,3 MTL 1/08 – 1 Page	Section 370,M,3 – 370,P,3 MTL 3/07 – 1 Page
PARENTAL FINANCIAL RESPONSIBILITY FOR SERVICES PROVIDED TO DISABLED CHILDREN Section 501 – 501,B,4 MTL 1/08 – 1 Page	**PARENTAL FINANCIAL RESPONSIBILITY FOR SERVICES PROVIDED TO DISABLED CHILDREN** Section 501 – 501,B,4 MTL 2/07 – 1 Page

Material Transmitted	Material Superseded
Section 501,E,2 – 505,B MTL 1/08 – 1 Page	Section 501,E,2 – 505,B MTL 2/06 – 1 Page
APPENDIX C 2008 MAABD Income Standard Chart – Schedule of Payments MTL 1/08 – 1 Page	**APPENDIX C** 2008 MAABD Income Standard Chart – Schedule of Payments MTL 5/07 – 1 Page
APPENDIX D Benefit Level Chart MTL 1/08 – 1 Page	**APPENDIX D** Benefit Level Chart MTL 5/07 – 1 Page

Manual Section	BACKGROUND & EXPLANATION of policy changes / clarifications / updates.	Obsolete PT, P&P, PUT or IM
202,A	Remove references to requesting medical record for NMO disability determinations.	**PT 01-08**
250,D,2	Update section to meet recent DRA rule regarding "look-back."	
320,N,4	Remove reference to medical records.	**PT 01-08**
320,N,5	Removed reference to Blue Shield of Nevada as no longer applicable.	
330,N,4	Remove reference to medical records.	**PT 01-08**
330,O	Remove reference to actions form as they are no longer used. Aid code must be correct in the system.	
340, 350, 360,N	Removed references to medical records.	**PT 01-08**
370, A, 1 and 2	Remove all references to obtaining medical records for disability determinations. Information will be requested by Nevada Medicaid.	**PT 01-08**
370, O	Remove references to obtaining medical records for redetermination of Katie Beckett. Information will be requested by Nevada Medicaid.	**PT 01-08**
501,B,4	2008 Federal Poverty level increases require update of Annual Family Deductions sections.	
501,E	Update computations to 2008 Federal Poverty guideline.	
Appendix C and D	Update using 2008 Federal Poverty level increases.	

Effective Date -- March 1, 2008

Instructions for Manual Maintenance - Replace superseded page(s) [14] with transmitted page(s) [14].

(WP/MTL/MAABD01_08)

MARCH RELEASE
MAABD MANUAL
TRANSMITTAL LETTER 2/08

May 1, 2008

TO: CUSTODIANS OF MAABD MANUALS

FROM: NANCY KATHRYN FORD, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
MAABD OVERVIEW Section 101,C – 103 MTL 2/08 – 1 Page	**MAABD OVERVIEW** Section 101,C – 103 MTL 5/07 – 1 Page
FACTORS OF ELIGIBILITY Section 211 – 214,A,6 MTL 2/08 – 1 Page	**FACTORS OF ELIGIBILITY** Section 211 – 214,A,6 MTL 2/06 – 1 Page
TYPES OF RESOURCES Section 230 (Radiation Exposure Payments) – Real Property (Cont'd) MTL 2/08 – 1 Page	**TYPES OF RESOURCES** Section 230 (Radiation Exposure Payments) – Real Property (Cont'd) MTL 1/06 – 1 Page
Section 240,G,2,d,3,c,3,c – 240,L,3 MTL 2/08 – 4 Pages	Section 240,G,2,d,3,c,3,c – 240,L,3 MTL 4/07, 5/07 – 4 Pages
TREATMENT OF TRUSTS Section 250,C – 250,D,5 MTL 2/08 – 1 Page	**TREATMENT OF TRUSTS** Section 250,C – 250,D,5 MTL 1/08 – 1 Page
ELIGIBLE CATEGORIES Section 300 MTL 2/08 – 1 Page	**ELIGIBLE CATEGORIES** Section 300 MTL 1/06 – 1 Page
SPECIALIZED MEDICAID ELIGIBILITY GROUPS Section 390 – 390,3,a MTL 2/08 – 1 Page	**SPECIALIZED MEDICAID ELIGIBILITY GROUPS** Section 390 – 390,3,a MTL 5/07 – 1 Page
APPENDIX C MAABD Income Standard Chart – Schedule of Payments MTL 2/08 – 1 Page	**APPENDIX C** MAABD Income Standard Chart – Schedule of Payments MTL 1/08 – 1 Page
APPENDIX D Medicare Beneficiaries MTL 2/08 – 1 Page	**APPENDIX D** Medicare Beneficiaries MTL 2/06 – 1 Page

Manual Section	BACKGROUND & EXPLANATION of policy changes / clarifications / updates.	Obsolete PT, P&P, PUT or IM
Section 101,C	**Forms Given To The Client With Application –** Update with current forms.	
Section 214	**Closures –** Add clarification of posting terminations in NOMADS.	
Section 230	**Real Property –** Clarify status of a home when ownership is transferred to a revocable trust	
Section 240,H,1	Clarify Transfer/Disposal of Asset Notification	
Section 240,H,2	**Rebuttal –** Change person reference and clarify information sent to the Chief of E&P and use of Form 2601.	
Section 240,H,3,c	**Undue Hardship –** Clarify what information is sent to the Chief of E&P. Clarify how a decision of the Chief of E&P is considered and processed regarding transfer of asset.	
Section 240,I,1,2,c and d	Update with Average Cost of Private Nursing Care	
Section 250,C	**Application of Trust Provisions –** Clarify status of a home held in a revocable trust.	
Section 300	**Eligible Categories –** Reworded for clarification. Adds pending SSI months.	
Section 390	**Emergency Medical For Ineligible Non-Citizens –** Clarify ongoing emergency medical applies to individuals with chronic medical conditions.	
Appendix C	**MAABD Income Standard Chart –** Update with Average Cost of Private Nursing Care.	
Appendix D	**Medicare Beneficiaries –** Update chart with 2008 Federal Poverty increase.	

Effective Date -- May 1, 2008

Instructions for Manual Maintenance - Replace superseded page(s) [12] with transmitted page(s) [12].

(WP/MTL/MAABD02_08)

JULY RELEASE
MAABD MANUAL
TRANSMITTAL LETTER 3/08

July 1, 2008

TO: CUSTODIANS OF MAABD MANUALS

FROM: NANCY KATHRYN FORD, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
TABLE OF CONTENTS Section Part B – Appendix G MTL 3/08 – 1 Page	**TABLE OF CONTENTS** Section Part B – Appendix G MTL 1/06 – 1 Page
FACTORS OF ELIGIBILITY Section 205,E,b – 206 MTL 3/08 – 1 Page	**FACTORS OF ELIGIBILITY** Section 205,E,b – 206 MTL 5/07 – 1 Page
MEDICARE BENEFICIARIES Section 350,L,4 – 350,M,1 MTL 3/08 – 1 Page	**MEDICARE BENEFICIARIES** Section 350,L,4 – 350,M,1 MTL 1/06 – 1 Page
Section 350,N,1 – 350,N,5 MTL 3/08 – 1 Page	Section 350,N,1 – 350,N,5 MTL 4/07 – 1 Page
HEALTH INSURANCE FOR WORK ADVANCEMENT (HIWA) Section 410,L,2,b – 410,L,4,b MTL 3/08 – 1 Page	**HEALTH INSURANCE FOR WORK ADVANCEMENT (HIWA)** Section 410,L,2,b – 410,L,4,b MTL 1/06 – 1 Page
N/A	**APPENDIX E – CASE FORMAT** Title Page – Seamless Case Format MTL 1/06 – 2 Pages

Manual Section	BACKGROUND & EXPLANATION of policy changes / clarifications / updates.	Obsolete PT, P&P, PUT or IM
Section 205,F	**Verification –** Add SSA State Online Query (SOLQ) as acceptable verification source.	
Section 350,L,4,b,5	**Ownership and Availability –** Correct aid code reference.	
Section 350,N,4	**Notification of Patient Liability/Case Status –** Remove references to form 2214, providers now have access to EVE system.	
Section 410	**Income –** Update HIWA income tests to include reinstatement of $699 unearned income limit.	
Appendix E	**Case Format –** Obsolete section as case format is determined by office procedures.	

Effective Date -- July 1, 2008

Instructions for Manual Maintenance - Replace superseded page(s) [7] with transmitted page(s) [5].

(WP/MTL/MAABD03_08)

SEPTEMBER RELEASE
MAABD MANUAL
TRANSMITTAL LETTER 4/08

September 1, 2008

TO: CUSTODIANS OF MAABD MANUALS

FROM: NANCY KATHRYN FORD, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
MAABD OVERVIEW Section 101,C – 103 MTL 4/08 – 1 Page	**MAABD OVERVIEW** Section 101,C – 103 MTL 2/08 – 1 Page
FACTORS OF ELIGIBILITY Section 206,3 – 206,D,2 MTL 4/08 – 1 Page	**FACTORS OF ELIGIBILITY** Section 206,3 – 206,D,2 MTL 5/07 – 1 Page
INDEX (Types of Earned and Unearned Income) Section 220 MTL 4/08 – 1 Page	**INDEX (Types of Earned and Unearned Income)** Section 220 MTL 1/07 – 1 Page
TYPES OF EARNED AND UNEARNED INCOME Section 220 – Employers Insurance Company of Nevada (EICON) – Individual Development Account (IDA) MTL 4/08 – 1 Page	**TYPES OF EARNED AND UNEARNED INCOME** Section 220 – Employers Insurance Company of Nevada (EICON) – Individual Development Account (IDA) MTL 1/06 – 1 Page
TRANSFER OF ASSETS Section 240,G,2,d,3,c,3,c – 240,L,3 MTL 4/08 – 5 Page	**TRANSFER OF ASSETS** Section 240,G,2,d,3,c,3,c – 240,L,3 MTL 2/08 – 4 Page
TREATMENT OF TRUSTS Section 250,C – 250,E,6 MTL 4/08 – 3 Pages	**TREATMENT OF TRUSTS** Section 250,C – 250,E,6 MTL 1/07, 2/08 – 2 Pages
PERSONS INSTITUTIONALIZED AT LEAST 30 CONSECUTIVE DAYS Section 350,M,1,c,1,2 – 350,M,1,c,4 MTL 4/08 – 1 Page	**PERSONS INSTITUTIONALIZED AT LEAST 30 CONSECUTIVE DAYS** Section 350,M,1,c,1,2 – 350,M,1,c,4 MTL 3/07 – 1 Page
Section 350,M,2,c,5 – 350,M,2,c,8 MTL 4/08 – 1 Page	Section 350,M,2,c,5 – 350,M,2,c,8 MTL 1/07 – 1 Page
HOME AND COMMUNITY BASED SERVICES Section 360,L,2 – 360,M,2,c,4,d MTL 4/08 – 5 Pages	**HOME AND COMMUNITY BASED SERVICES** Section 360,L,2 – 360,M,2,c,4,d MTL 1/06, 3/07 – 5 Pages

Manual Section	BACKGROUND & EXPLANATION of policy changes / clarifications / updates.	Obsolete PT, P&P, PUT or IM
Section 103	**Case Records** – Add case record requirements, renumber 104.	
Section 206.3	**Acceptable Verification of Identity –** Move paragraph regarding verifying non-citizen status to C. Documentation of Non-Citizen Immigration Status	**P&P 21-08**
Index 220	Changed title of Foster Grandparent Program to Foster Care Payments.	
Section 220	**Foster Care Payments –** Changed title of Foster Grandparent program to Foster Care Payments, to include both programs in the income exemption.	**P&P 08-08**
Section 240,G	**Treatment of Certain Kinds of Asset Transfers –** Add new section (4) Home and Community Based Waiver (HCBW) and Miller Trust (QIT)	**PT 05-05 dated July 11, 205; IM 20-05 dated August 17, 2005; and P&P 16-08 dated July 9, 2008**
Section 240,H	**Pursuing a Possible Transfer –** Update policy to allow in individual to request undue hardship after rebuttal to transfer of asset as denied by Chief of E&P or hearing officer.	
250,D,4	**Special Needs Trust –** Clarify how a special needs trust is treated determining eligibility.	
250,D,5	**Pooled Trusts –** Clarify how a pooled trust is treated when determining eligibility.	
250,D,6	**Miller Type or Qualified Income Reduction Trusts –** Clarify Trust Requirements Correct clerical error in Income Clarify how to treat remaining income in a Miller Trust (QIT) after patient liability as Transfer of Assets Clarify Central Office Review of Trust Document and Request for Undue Hardship Waiver	
250,E	**Undue Hardship –** Clarify information needed to complete a request for undue hardship. Describes timeline for undue hardship decision by Chief of E&P and appeal to hearings. Correct clerical error in Undue Hardship "condition #2." Correct "insufficient" to "sufficient" in "condition #3" pursuant to the Nevada State Medicaid Plan. Clarify "condition #4" pursuant to the State Medicaid Manual 3259.8(A).	
350,M,1,c,4	**Inaccessible Resource –** Clarify how to treat resources held in probate when community spouse passes away.	
350,M,2,c,6	**Separate Treatment of Resources After Eligibility is Established –** Clarify what assets are available to the institutionalized spouse when the community spouse passes away.	
360,L,2	**Treatment of Income –** Clarify how to treat a Home and Community Based Waiver (HCBW) individual with a Miller Trust (QIT)	**PT 05-05 dated July 11, 2005; IM 20-05 dated August 17, 2005; and P&P 16-08 dated July 9, 2008**

DECEMBER RELEASE
MAABD MANUAL
TRANSMITTAL LETTER 5/08

December 1, 2008

TO: CUSTODIANS OF MAABD MANUALS

FROM: NANCY KATHRYN FORD, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
MAABD INCOME STANDARD CHART Appendix C MTL 05/08 – 1 Pages	**MAABD INCOME STANDARD CHART** Appendix C MTL 02/08 – 1 Page
BENEFIT LEVEL CHART Appendix D MTL 05/08 – 2 Pages	**BENEFIT LEVEL CHART** Appendix D MTL 01/08 – 2 Pages
MAABD BUDGETS Appendix F MTL 05/08 – 7 Pages	**MAABD BUDGETS** Appendix F MTL 05/07 – 7 Pages

Manual Section	BACKGROUND & EXPLANATION of policy changes / clarifications / updates.	Obsolete PT, P&P, PUT or IM
Appendix C	**MAABD INCOME STANDARD CHART –** Update chart with 2009 limits pursuant to SSI Cost-of-Living Adjustment.	
Appendix D	**BENEFIT LEVEL CHART –** Update chart with new 2009 values.	
Appendix F	**MAABD BUDGETS –** Update forms with new 2009 amounts.	

Effective Date -- December 1, 2008
Instructions for Manual Maintenance - Replace superseded page(s) [10] with transmitted page(s) [10].

(WP/MTL/MAABD05_08)

MARCH RELEASE
MAABD MANUAL
TRANSMITTAL LETTER 1/09

March 1, 2009

TO: CUSTODIANS OF MAABD MANUALS

FROM: ROMAINE GILLILAND, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
SUPPLEMENTAL SECURITY INCOME (SSI) Section 320,N,4,b,4) – O, 1 MTL 01/09 – 1 Page	**SUPPLEMENTAL SECURITY INCOME (SSI)** Section 320,N,4,b,4) – O, 1 MTL 01/08 – 1 Page
PARENTAL FINANCIAL RESPONSIBILITY FOR SEREVICES PROVIDED TO DISABLED CHILDREN Section 501,E,2 – 505,B MTL 01/09 – 1 Page	**PARENTAL FINANCIAL RESPONSIBILITY FOR SEREVICES PROVIDED TO DISABLED CHILDREN** Section 501,E,2 – 505,B MTL 01/08 – 1 Page

Manual Section	BACKGROUND & EXPLANATION of policy changes / clarifications / updates.	Obsolete PT, P&P, PUT or IM
320.O.1.2	**Redetermination –** Delete duplicate sentence.	
501,F,2	**Responsibility of Recovery Staff –** Added clarification of when parental reimbursement is effective.	

Effective Date -- March 1, 2009
Instructions for Manual Maintenance - Replace superseded page(s) [2] with transmitted page(s) [2].

(WP/MTL/MAABD01_09)

MAY RELEASE
MAABD MANUAL
TRANSMITTAL LETTER 2/09

May 1, 2009

TO: CUSTODIANS OF MAABD MANUALS

FROM: ROMAINE GILLILAND, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
TABLE OF CONTENTS Section 100 – 206,F MTL 02/09 – 1 Page	**TABLE OF CONTENTS** Section 100 – 206,E MTL 01/08 – 1 Page
FACTORS OF ELIGIBILITY Section 205,E,b – 206,A,3 MTL 02/09 – 3 Pages	**FACTORS OF ELIGIBILITY** Section 205,E,b – 206,A,3, MTL 05/07, 03/08 – 3 Pages
Section 206,E,2,I – 214,B,5 MTL 02/09 – 8 Pages	Section 206,E,2,I – 214,B,5 MTL 01/06, 02/06, 04/06, 02/08 – 8 Pages
PARENTAL FINANCIAL RESPONSIBILITY Section 501 – 501,B,4 MTL 02/09 – 1 Page	**PARENTAL FINANCIAL RESPONSIBILITY** Section 501 – 501,B,4 MTL 01/08 – 1 Page
Section 501,E,2 – 505,B MTL 02/09 – 1 Page	Section 501,E,2 – 505,B MTL 02/09 – 1 Page
2009 MAABD INCOME STANDARD CHART Appendix C MTL 02/09 – 1 Page	**2008 MAABD INCOME STANDARD CHART** Appendix C MTL 05/08 – 1 Page
BENEFIT LEVEL CHART Appendix D MTL 02/09 – 2 Pages	**BENEFIT LEVEL CHART** Appendix D MTL 05/08 – 2 Pages

Manual Section	BACKGROUND & EXPLANATION of policy changes / clarifications / updates.	Obsolete PT, P&P, PUT or IM
206	**Citizenship Requirement –** Revised chart to match E&P manual changes and added key at bottom of chart for clarification. Changed order of paragraphs in section to read more clearly.	
206,A,1	**Primary Verification –** Added primary source of citizenship verification to include a document issued by a federally recognized Indian tribe.	**CHIPRA 2009 reauthorization**
206,F	**Iraqi and Afghani Special Immigrants –** Added section for Iraqi and Afghani special immigrants.	**Section 1244 of Public Law 101-181 of the National Defense Authorization Act for Fiscal Year 2008**
501,B,4	**Parental Financial Responsibility –** 2009 Federal poverty level increases require update of Annual Family Deductions section.	
501,E	**Responsibilities of Eligibility Staff –** Update computations to 2009 Federal poverty guideline	
Appendix C	**MAABD Income Standard Chart –** Update using 2009 Federal poverty level increases.	
Appendix D	**Benefit Level Chart –** Update using 2009 Federal poverty level increases.	

Effective Date -- May 1, 2009
Instructions for Manual Maintenance - Replace superseded page(s) [17] with transmitted page(s) [17].

(WP/MTL/MAABD 02_09)

JULY RELEASE
MAABD MANUAL
TRANSMITTAL LETTER 3/09

July 1, 2009

TO: CUSTODIANS OF MAABD MANUALS

FROM: ROMAINE GILLILAND, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
MAABD INCOME STANDARD CHART Section Appendix C MTL 03/09 – 1 Page	**MAABD INCOME STANDARD CHART** Section Appendix C MTL 02/09 – 1 Page

Manual Section	BACKGROUND & EXPLANATION of policy changes / clarifications / updates.	Obsolete PT, P&P, PUT or IM
Appendix C	**2009 MAABD Income Standard Chart –** .Update HIWA earned and net income limits with 2009 amounts.	

Effective Date -- July 1, 2009
Instructions for Manual Maintenance - Replace superseded page(s) [1] with transmitted page(s) [1].

(WP/MTL/MAABD03_09)

SEPTEMBER RELEASE
MAABD MANUAL
TRANSMITTAL LETTER 4/09

September 1, 2009

TO: CUSTODIANS OF MAABD MANUALS

FROM: ROMAINE GILLILAND, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
TABLE OF CONTENTS Section Part B – Appendix G MTL 04/09 – 1 Page	**TABLE OF CONTENTS** Section Part B – Appendix G MTL 03/08 – 1 Page
CHAPTER 200 – TYPES OF EARNED AND UNEARNED INCOME Section 220 (Replacement/Repair Destroyed or Damaged Property – Severance Pay) MTL 04/09 – 1 Page	**CHAPTER 200 – TYPES OF EARNED AND UNEARNED INCOME** Section 220 (Replacement/Repair Destroyed or Damaged Property – Severance Pay) MTL 02/06 – 1 Page
Section 230 (Reimbursable Medical Expenses – SSI/RSDI Retro Payments) MTL 04/09 – 1 Page	Section 230 (Reimbursable Medical Expenses – SSI/RSDI Retro Payments) MTL 01/06 – 1 Page
APPENDIX E – BIC CODE VALUES Section Title Page – Note MTL 04/09 – 3 Pages	**APPENDIX E – BIC CODE VALUES** Section Title Page – Note MTL 03/08 – 2 Pages

Manual Section	BACKGROUND & EXPLANATION of policy changes / clarifications / updates.	Obsolete PT, P&P, PUT or IM
Section 220	**Replacement/Repair Destroyed or Damaged Property –** Correct income exclusion for money received for replacement of destroyed or damaged property.	
Section 230	**Replacement/Repair Funds –** Correct resource exclusion for money received for replacement of destroyed or damaged property.	
Appendix E	**BIC Code Values –** To provide field staff with definition of Medicare claim numbers.	

Effective Date -- September 1, 2009
Instructions for Manual Maintenance - Replace superseded page(s) [5] with transmitted page(s) [6].

(WP/MTL/MAABD04_09)

NOVEMBER RELEASE
MAABD MANUAL
TRANSMITTAL LETTER 5/09

November 1, 2009

TO: CUSTODIANS OF MAABD MANUALS

FROM: ROMAINE GILLILAND, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
CHAPTER 500 – PARENTAL FINANCIAL RESPONSIBILITY FOR SERVICES PROVIDED TO DISABLED CHILDREN Section 505,B – 505.1,A,2,a MTL 05/09 – 1 Page	**CHAPTER 500 – PARENTAL FINANCIAL RESPONSIBILITY FOR SERVICES PROVIDED TO DISABLED CHILDREN** Section 505,B – 505.1,A,2,a MTL 01/06 – 1 Page

Manual Section	BACKGROUND & EXPLANATION of policy changes / clarifications / updates.	Obsolete PT, P&P, PUT or IM
Section 505	**Medicaid Program Overpayments –** Add policy paragraph establishing a dollar limit placed on debt establishment, to read "If the calculation determines the debt is equal to or less than $125, the I&R worker may terminate collection action with the approval of the I&R Unit supervisor or their designee. Exception: Program debt subject to pending or current benefit reduction will not be terminated."	

Effective Date -- November 1, 2009
Instructions for Manual Maintenance - Replace superseded page(s) [1] with transmitted page(s) [1].

(WP/MTL/MAABD05_09)

JANUARY RELEASE
MAABD MANUAL
TRANSMITTAL LETTER 1/10

January 1, 2010

TO: CUSTODIANS OF MAABD MANUALS

FROM: ROMAINE GILLILAND, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
FACTORS OF ELIGIBILITY Section 205,E,b – 206,A,2 MTL 01/10 – 2 Pages	**FACTORS OF ELIGIBILITY** Section 205,E,b – 206,A,2 MTL 02/09 – 2 Pages
ELIGIBLE CATEGORIES Section 300 – 305 (3004) MTL 01/10 – 3 Pages	**ELIGIBLE CATEGORIES** Section 300 MTL 02/08 – 1 Page
MEDICARE BENEFICIARIES Section 310 Index MTL 01/10 – 1 Page	**MEDICARE BENEFICIARIES** Section 310 Index MTL 01/06 – 1 Page
Section 310,F – 310,L,1,b,5 MTL 01/10 – 1 Page	Section 310,F – 310,L,1,b,5 MTL 03/07 – 1 Page
Section 310,M,1,c – 310,P,4 MTL 01/10 – 2 Pages	Section 310,M,1,c – 310,P,4 MTL 01/10 – 2 Pages
Section 320 Index MTL 01/10 – 1 Page	Section 320 Index MTL 01/06 – 1 Page
Section 320,O,2 MTL 01/10 – 1 Page	Section 320,O,2 – 320,P,8 MTL 01/06 – 2 Pages
Section 330 Index MTL 01/10 – 1 Page	Section 330 Index MTL 01/06 – 1 Page
Section 330,O,Public Law 103-296 Cases – 330,O,Sponsor Deeming Cases MTL 01/10 – 1 Page	Section 330,O,Public Law 103-296 Cases – 330,P,6 MTL 03/07 – 1 Page
Section 340 Index MTL 01/10 – 1 Page	Section 340 Index MTL 01/06 – 1 Page
Section 340,N,5,b,2,b,4 – 340,O MTL 01/10 – 1 Page	Section 340,N,5,b,2,b,4 – 340,P,4 MTL 3/07, 01/08 – 2 Pages
Section 350 Index MTL 01/10 – 1 Page	Section 350 Index MTL 01/06 – 1 Page
Section 350,N,6,b,3 – 350,O MTL 01/10 – 1 Page	Section 350,N,6,b,3 – 350,P,5 MTL 4/07, 1/08 – 2 Pages

Material Transmitted	Material Superseded
Section 360 Index MTL 01/10 – 1 Page	Section 360 Index MTL 01/06 – 1 Page
Section 360,N,5,b,2) – 360,O MTL 3/07, 1/08 – 1 Page	Section 360,N,5,b,2) – 360,P,5 MTL 3/07, 1/08 – 2 Pages
Section 370 Index MTL 01/10 – 1 Page	Section 370 Index MTL 01/06 – 1 Page
Section 370,M,3 – 370,O MTL 01/10 – 1 Page	Section 370,M,3 – 370,P,5 MTL 1/08 – 2 Pages
Section 380 Index MTL 01/10 – 1 Page	Section 380 Index MTL 01/06 – 1 Page
Section 380,M,1,c,2,c – 380,O MTL 01/10 – 1 Page	Section 380,M,1,c,2,c – 380,P MTL 3/07 – 1 Page
Section 390 Index – 390,3,c,2 MTL 01/10 – 3 Pages	Section 390 Index – 390,3,c,3 MTL 05/07, 02/08 – 3 Pages
APPENDIX C Section 2010 MAABD Income Standard Chart – Nevada : January 1, 2010 to December 31, 2010 MTL 01/10 – 1 Page	**APPENDIX C** Section 2009 MAABD Income Standard Chart – Nevada : January 1, 2009 to December 31, 2009 MTL 01/10 – 1 Page

Manual Section	BACKGROUND & EXPLANATION of policy changes / clarifications / updates.	Obsolete PT, P&P, PUT or IM
MAABD 206	**Citizenship Requirement –** Remove statement regarding citizenship documentation being required prior to approval. Add policy to allow 90 days to provide documentation of citizenship.	**E&P PT 07/09**
MAABD 305	**Conversions –** Add new separate conversion section to manual. Remove conversion from all chapters and combined into one chapter for clarification and simplification.	
MAABD 310	**Index –** Change P from Conversion to Low Income Subsidy Referrals	
MAABD 310, L	**Income –** Changed wording for clarification. Need to determine if deeming is applicable based on deemable income amount.	
MAABD 310,M,4	**Exceptions –** Update Medicare Beneficiary resource limits with new amounts effective January 1, 2010.	**E&P PT 10/09**
MAABD 310,P	**Conversions –** Remove Conversion section as it is being moved to Chapter 100.	
MAABD 310,P	Add Low Income Subsidy Referrals to section P.	**E&P PT 10/09**
MAABD 310,P	Removed conversion section, moved to 305.	
MAABD 320,P	Removed conversion section, moved to 305.	
MAABD 330,P	Removed conversion section, moved to 305.	
MAABD 340,P	Removed conversion section, moved to 305.	
MAABD 350,P	Removed conversion section, moved to 305.	
MAABD 360,P	Removed conversion section, moved to 305.	
MAABD 370,P	Removed conversion section, moved to 305.	
MAABD 380,P	Removed conversion section as was not applicable.	
MAABD 390,3	**Medicaid Eligibility For Newborns –** Update section with changes to OBRA policy and citizenship policy for newborns.	**E&P PT 07/09** **E&P PT 04/09**
Appendix C	**MAABD Income Standard Chart –** Increase Part A Medicare premium amounts. Change year to 2010 on SSI payment chart, no increase in SSI payment amounts.	**E&P IM 26/09**

Effective Date -- January 1, 2010
Instructions for Manual Maintenance - Replace superseded page(s) [31] with transmitted page(s) [28].

(WP/MTL/MAABD 01_10)

MAY RELEASE
MAABD MANUAL
TRANSMITTAL LETTER 2/10

May 1, 2010

TO: CUSTODIANS OF MAABD MANUALS

FROM: ROMAINE GILLILAND, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
MEDICARE BENEFICIARIES Index – Section 310,P MTL 02/10 – 9 Pages	**MEDICARE BENEFICIARIES** Index – Section 310,P MTL 01/06, 03/06, 03/07, 01/10 – 9 Pages

Manual Section	BACKGROUND & EXPLANATION of policy changes / clarifications / updates.	Obsolete PT, P&P, PUT or IM
MAABD 310,A,1,c	**Qualified Medicare Beneficiaries (QMB) –** Update QMB resource limits.	**PT 10/09**
MAABD 310,A,2,c	**Special Low-Income Medicare Beneficiaries (SLMB) –** Update SLMB resource limits.	**PT 10/09**
MAABD 310,A,3,c	**Qualified Individuals (QIs) –** Update QI resource limits.	**PT 10/09**
MAABD 310,L,4,b, 1 & 2 **MAABD 310, L,4,c**	**Budget Method –** Add SSI eligibility to definition of eligible spouse for clarification. If receiving SSI, spouse should be treated as an eligible spouse until determined otherwise. Add SSI eligibility to definition of eligible spouse for clarification.	
MAABD 310,L,4,d	**Budgeting – Specific Instructions –** Change "or" to "and" to clarify when child allocation is applicable. Children must not be receiving benefits from a needs based program. SNAP is not a needs based program for SSI budgeting purposes.	**Field request for clarification. SSA POMS**
MAABD 310,M,4	**Limits –** Update resource limits for Medicare Beneficiary programs and clarify that resource limits for QDWI were not increased and remain at $4,000 for individual and $6,000 for a couple.	
MAABD 310,O	**Review of Eligibility –** Change redetermination policy to review of eligibility.	**PT 01/10**

Effective Date -- May 1, 2010
Instructions for Manual Maintenance - Replace superseded page(s) [9] with transmitted page(s) [9].

(WP/MTL/MAABD 02_10)

JULY RELEASE
MAABD MANUAL
TRANSMITTAL LETTER 3/10

July 1, 2010

TO: CUSTODIANS OF MAABD MANUALS

FROM: ROMAINE GILLILAND, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
MAABD OVERVIEW Section 100 – 104 MTL 3/10 – 4 Pages	**MAABD OVERVIEW** Section 100 – 104 MTL 3/10 – 3 Pages
FACTORS OF ELIGIBILITY Section 200 – 208,C,2,c MTL 3/10 – 13 Pages	**FACTORS OF ELIGIBILITY** Section 200 – 208,C,2,c MTL 05/07, 01/06, 01/08, 04/08, 02/09, 01/10 – 11 Pages
Section 210,A – 214 MTL 3/10 – 1 Page	Section 210,A – 214 MTL 2/09 – 1 Page
TYPES OF EARNED AND UNEARNED INCOME Section 220 Index MTL 3/10 – 1 Page	**TYPES OF EARNED AND UNEARNED INCOME** Section 220 Index MTL 4/08 – 1 Page
Section 220 (Bonus) – (Death Benefits) MTL 3/10 – 1 Page	Section 220 (Bonus) – (Death Benefits) MTL 2/06 – 1 Page
Section 220 (Individual Development Account (IDA) (Cont'd) – (Judgements) MTL 3/10 – 1 Page	Section 220 (Individual Development Account (IDA) (Cont'd) – (Judgements) MTL 1/07 – 1 Page
Section 220 (Life Insurance Payments) – (Tribal Gaming Income) MTL 3/10 – 6 Pages	Section 220 (Life Insurance Payments) – (Tribal Gaming Income) MTL 1/06, 1/07, 4/09 – 5 Pages
Section 220 (Veteran's Benefits)(Cont'd) – (Work Training Programs) MTL 3/10 – 1 Page	Section 220 (Veteran's Benefits)(Cont'd) – (Work Training Programs) MTL 1/06 – 1 Page
TYPES OF RESOURCES Section 230 (Cash on Hand) – (Household Goods and Personal Effects) MTL 3/10 – 1 Page	**TYPES OF RESOURCES** Section 230 (Cash on Hand) – (Household Goods and Personal Effects) MTL 1/07 – 1 Page
Section 230 (Life Estates) – (Life Insurance Policies)(Cont'd) MTL 3/10 – 1 Page	Section 230 (Life Estates) – (Life Insurance Policies)(Cont'd) MTL 1/06 – 1 Page

Material Transmitted	Material Superseded
Section 230 (Patient Trust Accounts)(Cont'd) – (Vehicles) MTL 3/10 – 4 Pages	Section 230 (Patient Trust Accounts)(cont'd) – (Vehicles) MTL 1/06, 2/08, 4/09 – 4 Pages
TRANSFER OF ASSETS Section 240 – 240,L,3 MTL 3/10 – 10 Pages	**TRANSFER OF ASSETS** Section 240 – 240,L,3 MTL 4/07, 5/07, 4/08 – 10 Pages
ELIGIBLE CATEGORIES Section 300 – 305,10 MTL 3/10 – 1 Page	**ELIGIBLE CATEGORIES** Section 300 – 305,10 MTL 1/10 – 1 Page
SUPPLEMENTAL SECURITY INCOME (SSI) Section 320 Index MTL 3/10 – 1 Page	**SUPPLEMENTAL SECURITY INCOME (SSI)** Section 320 Index MTL 1/10 – 1 Page
Section 320,G – 320,O,2 MTL 3/10 – 5 Pages	Section 320,G – 320,O,2 MTL 1/06, 5/07, 1/09, 1/10 – 5 Pages

Manual Section	BACKGROUND & EXPLANATION of policy changes / clarifications / updates.	Obsolete PT, P&P, PUT or IM
Section101,A,1	**Application Process –** Add clarification that signatures are not required for LIS referral applications	
Section101,A,8	**Client Representation –** Add clarification	
Section 101,B,8	**Nondiscrimination –** Corrected address for Office of Civil Rights	
Section 102	**Medicaid Eligibility Prior to Application –** Added clarification of prior medical and added language from E&P manual for consistency.	
Section 104	**Medicaid Hospice Care Program –** Remove DWSS responsibility in enrolling member in hospice. MEMB screens no longer display PCN codes, this function is completed at DHCFP.	
Section 202	**Blind/Disabled Individuals –** Clarified when an NMO disability determination is needed	
Section 202,A	**Nevada Medicaid Office (NMO) Determination –** Add clarification that NMO disability requests, NMO-3004 must include dates and provider name and should be sent to the local DHCFP office rather than Central Office	**Requested by DHCFP**
Section 203	**Identification –** Removed Identification as separate requirement and included it in changes to 206 Citizenship and Identification.	
Section 204,A	**Verification –** Correct SSN Match to NUMIDENT system and add reference to task guide for processing SSN discrepancies.	
Section 205,A, 205,D,3	**Residence Requirements –** Corrected manual reference.	
Section 206,A	**Verification –** Change header to Citizenship and identification and add identification information to section for consistency with E&P manual. Update section with SAVE verification process and Updated Verification of Non-Citizenship status to include secondary procedures. Added clarification per field request that citizenship documentation should not be requested for individuals pending SSI.	
Section 206,B	**Reverification of Immigration Status Due to an INS Document's Extrpiration Date –** Change RD reference to review of eligibility.	**PT 01/10**
Section 206,C	**Documentation of Non-Citizen Immigration Status –** Remove reference to form 2766-EG, SAVE verification printout is acceptable and form does not have to be completed. Add additional information regarding SAVE system to align with E& manual.	
Section 206,E,1,a	**Conditions for a Battered Non-citizen to be Eligible –** Corrected manual reference.	
Section 206,F	**Iraqi and Afghani Special Immigrants –** Removed reference to SNAP and TANF programs.	
Section 206,G	**PRUCOL –** Add paragraph defining PRUCOL and referencing PRUCOL chart in Appendix G.	
Section 206,H	**Victims of Trafficking –** Add Victim of Trafficking policy to the MAABD manual to align with E&P manual.	
Section 208,B	**Mandatory Premium Payments for Cost Effective Employer Group Health Insurance –** Changed form from 2230 to NMO-5000.	**IM 33/09**

Section 220	**Types of Earned Income and Unearned Income –** Add Long Term Care Insurance as an income type.	
	Wages – Remove statement from VISTA and add employer verification form to type of verification of wages per field request for clarification.	
	Add clarification of budgeting child support arrears per field request for clarification.	
	Lump Sum add clarification that patient liability cannot be adjusted above the actual cost of care.	**P&P 01/10**
	Interest – Add dividends to section as they are budgeted the same as an income source.	
	Long Term Care Insurance – Add LTC insurance payment as income type. Clarification of budgeting these payments received from CMS.	
Section 230	**Home Equity –** Add reference to 240 to determine	
	Life Estates – Add reference to 240 to determine potential transfer of asset penalty.	
	Life Insurance – Added note that excluded policies that may affect applicant's burial exclusion. Clarification requested by field.	
	Promissory Notes – Added reference to 240,G,1 to ensure these asset types are evaluated for potential transfer of asset prior to determining resource value.	
	Real Property – Add reference to 240 for potential transfer of assets for the primary residence of an institutionalized individual. Removed reference to redeterminations.	
	Reverse Mortgage – Add reference to 240 to determine potential transfer of asset penalty.	
	Trust Funds – Remove specific reference to the DAG.	
Section 240	**Transfer of Assets –** Remove exemption for SSI recipients when applying transfer of asset policy. Clarification n federal regulations that transfer of assets may apply to Institutionalized SSI recipients only when the transferred asset is the home.	
Section 240,B,11	**Penalty –** Added definition of a penalty to clarify that individuals serving a penalty are not denied or terminated, but certain services are not covered during the penalty period.	
Section 240,C	**General Rule –** Moved paragraphs pertaining to divorce settlement to Section F. Jointly owned assets.	
Section 240,D	**Look Back Period –** Added clarification of look back period and removed reference to penalty period as this information is in Section 240.1 – Penalty Period.	
Section 240,G,4	**Home and Community Based Waiver (HCBW) and Miller Trust (QIT) –** Added clarification that excluded resources are not considered in a transfer of asset determination with the exception of the home of an institutionalized individual.	
Section 240,H	**Pursuing a Possible Transfer –** Added clarification that Form 2601 can be sent at the same time the penalty is imposed in NOMADS.	

Manual Section	BACKGROUND & EXPLANATION of policy changes / clarifications / updates.	Obsolete PT, P&P, PUT or IM
Section 240, I,1	**Application of Penalties Prior to February 8, 2006 –** Added clarification that transfers made prior to February 8, 2006 do not apply to Home Based Waiver recipients. DRA changed the rule and penalties against Home and Community Based Waiver recipients began with transfers made on or after February 8, 2006.	
Section 240,I,1&2	**Application of Penalties Prior to February 8, 2006 & Application of Penalties on or After February 8, 2006 –** Added wording to clarify that penalty period is determined based on the date the transfer occurred.	
Section 240,L	**Decision –** Removed references to penalty period as this is duplicated information. Clarify procedures for referring certain case types to E&P.	
Section 240,L,4	**??????????? –** Added policy for return of assets. Previous policy only included return of assets under transfers prior to February 2006.	
Section 305	**Conversions –** Added clarification that facilities should be added a "4" **–** Facility representative.	
Section 320	**Supplemental Security Income (SSI) –** Update review of eligibility policy and combine process for SSI only and SSI/QMB review to reduce duplication. Correct reinstatement policy to allow reinstatement if client cooperates by the end of the month.	
Section 320,I	**Third Party Liability (TPL) –** Added clarification to Third Party liability section, a child's Medicaid eligibility cannot be terminated for the parent refusing to provide insurance verification.	
Section 320,J	**Pending SSI Determinations –** Added new section. Added clarification of policies that is applicable to applicants still pending SSI determinations.	
Section 320,M,2	**Resource Limits –** Correct resource policy. When SSI recipient has excess resources, they must be reported to SSA to take action.	
Section 320,O	**Review of Eligibility –** Update Redetermination section with Review of Eligibility policy.	**PT 01/10**

Effective Date -- July 1, 2010
Instructions for Manual Maintenance - Replace superseded page(s) [47] with transmitted page(s) [51].

(WP/MTL/MAABD 03_10)

SEPTEMBER RELEASE
MAABD MANUAL
TRANSMITTAL LETTER 4/10

September 1, 2010

TO: CUSTODIANS OF MAABD MANUALS

FROM: ROMAINE GILLILAND, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
APPENDIX C MAABD Income Standard Chart MTL 4/10 – 1 Page	**APPENDIX C** MAABD Income Standard Chart MTL 1/10 – 1 Page

Manual Section	BACKGROUND & EXPLANATION of policy changes / clarifications / updates.	Obsolete PT, P&P, PUT or IM
Appendix C	**MAABD Income Standard Chart –** Update chart with average cost of care effective April 1, 2010.	

Effective Date -- September 1, 2010
Instructions for Manual Maintenance - Replace superseded page(s) [1] with transmitted page(s) [1].

(WP/MTL/MAABD 04_10)

JANUARY RELEASE
MAABD MANUAL
TRANSMITTAL LETTER 1/11

January 1, 2011

TO: CUSTODIANS OF MAABD MANUALS

FROM: ROMAINE GILLILAND, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
TABLE OF CONTENTS Section 100 – Appendix C MTL 5/10 – 5 Pages	**TABLE OF CONTENTS** Section 100 – Appendix C MTL 2/09 – 5 Pages
INDEX – PERSONS INSTITUTIONALIZED AT LEAST 30 CONSECUTIVE DAYS Section 350 MTL 1/11 – 1 Page	**INDEX – PERSONS INSTITUTIONALIZED AT LEAST 30 CONSECUTIVE DAYS** Section 350 MTL 1/10 – 1 Page
Section 350,J – 350,L,3 MTL 1/11 – 1 Page	Section 350,J – 350,L,3 MTL 1/06 – 1 Page
Section 350,M,2 – 350,M,2,b,2),b),1) MTL 1/11 – 1 Page	Section 350,M,2 – 350,M,2,b,2),b),1) MTL 3/07 – 1 Page
Section 350,M, 2,c,8) – 350,O MTL 1/11 – 4 Pages	Section 350,M, 2,c,8) – 350,O MTL 4/07, 3/08, 1/10 – 7 Pages
Section 360, A,1,d,3),g) – 350,A,1,d,3),e),3) MTL 1/11 – 1 Page	Section 360, A,1,d,3),g) – 350,A,1,d,3),e),3) MTL 5/06 – 1 Page
PARENTAL FINANCIAL RESPONSIBILITY Section 501,E,2 – 506.17 MTL 5/10 – 5 Pages	**PARENTAL FINANCIAL RESPONSIBILITY** Section 501,E,2 – 506.17 MTL 1/06, 2/09, 5/09 – 9 Pages
APPENDIX C MAABD Income Standard Chart MTL 1/11 – 1 Page	**APPENDIX C** MAABD Income Standard Chart MTL 4/10 – 1 Page

Manual Section	BACKGROUND & EXPLANATION of policy changes / clarifications / updates.	Obsolete PT, P&P, PUT or IM
Section 350,L,2	**Treatment of Income –** Add clarification that patient liability cannot be adjusted to an amount greater than the actual cost of care for a month.	**P&P 02/10**
Section 350,L,2	Add policy clarification that deeming of community spouses' income is prohibited in institutional budgeting.	**State Medicaid Manual 3261**
Section 350,M,2	**Resource Provisions for Spousal Impoverishment Cases –** Add statement from State Medicaid manual to clarify that spousal resource assessment rules apply regardless of state laws relating to community property or to the division of marital property.	
Section 350,N,1	**Treatment of Income, Deductions and Expenses –** Add clarification that patient liability cannot be adjusted to an amount greater than the actual cost of care for a month.	**P&P 02/10**
Section 350,N,2	**Partial Month Proration –** Add transfer of penalty to reasons for partial month if patient liability.	
Section 350,N,5,2,a,5	Change reference from Food Stamps to SNAP.	
Section, 350,N,5,2,b,5	Add clarification, when a court order is entered for support of community spouse the community spouses gross income is subtracted from the court ordered amount to determine the spousal income allowance.	**Request from field**
Section 350,N	Patient liability calculations for Spousal Impoverishment cases – added clarification to subtract income excluded in PL calculation, clarified the community spouse's income is subtracted from the maintenance needs allowance to determine spousal income allowance. Clarified how the family allowance calculation is determined. Changed court order dividing income to court order granting spousal income, to clarify income is not divided in the patient liability calculation. Clarified Family allowance is calculated and allowed when there are dependents living with the community spouse and Dependent allowance is calculated and allowed when there are dependents living in the home with no community spouse.	
Section 360,A,1,d,3),e),3)	Eligibility Requirements – Combine eligibility requirements a) and c) as individual must meet requirements in a) to meet requirements, in c). Those are not independent requirements.	
Table of Contents 505	Changed "overpayment" to "claim" in title and section (A). Changed title of section (B) to read "When information is Received Indicating a Claim May Exist." Added section (C) "Claim Packet."	
Table of Contents 505.1	Deleted entire section 505.1 (A-1). Moved information to I&R Policy Manual section 300-500.	
Section 505	**Medicaid Program Overpayments –** Changed "overpayment" to "claim" in title and text to standardize verbiage among all manuals.	
Section 505, A	**Definition –** Changed title to read "Definition of a Claim." Changed "overpayment to "claim" in text	

Manual Section	BACKGROUND & EXPLANATION of policy changes / clarifications / updates.	Obsolete PT, P&P, PUT or IM
Section 505,B	Establishing a Medicaid Overpayment – Changed title to read "When Information is received Indicating a Claim May Exist." Deleted existing text in section 505, B Moved to I&R Policy Manual. Added text advising staff of policy/procedures once claim information is received.	
Section 505,C	**Claim Packet –** Created this section advising staff to compile and forward a claim packet to I&R.	
Section 505.1	**Collections –** Deleted section 505.1,A,1. Moved text to I&R Policy Manual.	
Appendix C	**MAABD Income Standard Chart –** Aligned language with update to Patient Liability section. Need standards are used in determining the Maintenance Allowance.	

Effective Date -- January 1, 2011
Instructions for Manual Maintenance - Replace superseded page(s) [26] with transmitted page(s) [18].

(WP/MTL/MAABD 01_11)

MARCH RELEASE
MAABD MANUAL
TRANSMITTAL LETTER 2/11

March 1, 2011

TO: CUSTODIANS OF MAABD MANUALS

FROM: ROMAINE GILLILAND, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
PERSONS INSTITUTIONALIZED LESS 30 CONSECUTIVE DAYS Section 350,L,4 – 350,M,1 MTL 2/11 – 1 Page	**PERSONS INSTITUTIONALIZED LESS 30 CONSECUTIVE DAYS** Section 350,L,4 – 350,M,1 MTL 3/08 – 1 Page
APPENDIX C – MAABD INCOME STANDARD CHART 2011 MAABD Income Standard Chart **MTL 2/11 –** 1 Page	**APPENDIX C** – MAABD INCOME STANDARD CHART 2011 MAABD Income Standard Chart **MTL 1/11 –** 1 Page
APPENDIX D – BENEFIT LEVEL CHART Benefit Level Chart MTL 2/11 – 2 Pages	**APPENDIX D** – BENEFIT LEVEL CHART Benefit Level Chart MTL 2/09 – 2 Pages
APPENDIX F – MAABD BUDGETS Veteran Unusual Medical Expense Budget MTL 2/11 – 1 Page	**APPENDIX F** – MAABD BUDGETS Veteran Unusual Medical Expense Budget MTL 5/08 – 1 Page
SSI Budget – RSDI Computation Worksheet MTL 2/11– 2 Pages	SSI Budget – RSDI Computation Worksheet MTL 5/08– 2 Pages

Section	Explanation	Obsolete or Clarify: PT, P&P, PUT or IM
Section 350(N)(4)b(5)	Clarify County Match Income Determination	
Appendix C	Update MAABD Income Standard Chart with 2011 Effective Date	IM #33/10
Appendix D	Update Benefit Level Chart with 2010 and 2011 Effective Dates	IM #26/09; 11/10
Appendix F	Update forms with 2010 and 2011 Effective Dates	

Effective Date -- March 1, 2011
Instructions for Manual Maintenance - Replace superseded page(s) [7] with transmitted page(s) [7].

(WP/MTL/MAABD 02_11)

MARCH RELEASE
MAABD MANUAL
TRANSMITTAL LETTER 3/11

May 1, 2011

TO: CUSTODIANS OF MAABD MANUALS

FROM: ROMAINE GILLILAND, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
APPLICATION PROCESS Section 100 – 104 MTL 3/11 – 4 Pages	**APPLICATION PROCESS** Section 100 – 104 MTL 3/10 – 4 Pages
FACTORS OF ELIGIBILITY Section 200 – 204,A MTL 3/11 – 1 Page	**FACTORS OF ELIGIBILITY** Section 200 – 204,A MTL 3/10 – 1 Page
Section 206 – 206,A,2 MTL 3/11 – 1 Page	Section 206 – 206,A,2 MTL 3/10 – 1 Page
TYPES OF EARNED AND UNEARNED INCOME Section 220 Index MTL 3/11 – 1 Page	**TYPES OF EARNED AND UNEARNED INCOME** Section 220 Index MTL 3/10 – 1 Page
Section 220 – (Death Benefits (Con't) – Lease Income) MTL 3/11 – 4 Pages	Section 220 – (Death Benefits (Con't) – Lease Income) MTL 1/06, 1/07, 4/08, 3/10 – 4 Pages
TYPES OF RESOURCES Section 230 – (Cash On Hand – Individual Development Account (IDA)) MTL 3/11 – 2 Pages	**TYPES OF RESOURCES** Section 230 – (Cash On Hand – Individual Development Account (IDA)) MTL 1/07, 3/10 – 2 Pages
MEDICARE BENEFICIARIES (QMB'S,SLMB'S AND QDWI'S) Section 310 – 310,3,a. MTL 3/11 – 1 Page	**MEDICARE BENEFICIARIES (QMB'S,SLMB'S AND QDWI'S)** Section 310 – 310,3,a. MTL 2/10 – 1 Page
Section 310,L,4,c,1 – 310,L,4,d,2 MTL 3/11 – 1 Page	Section 310,L,4,c,1 – 310,L,4,d,2 MTL 2/10 – 1 Page
Section 310,M,1,5) – 310,O,2. MTL 3/11 – 1 Page	Section 310,M,1,5) – 310,O,2. MTL 2/10 – 1 Page
PERSONS INSTITUTIONALIZED AT LEAST 30 CONSECUTIVE DAYS Section 350 – 350,F,2 MTL 3/11 – 1 Page	**PERSONS INSTITUTIONALIZED AT LEAST 30 CONSECUTIVE DAYS** Section 350 – 350,F,2 MTL 1/06 – 1 Page

Material Transmitted	Material Superseded
Section 350,L,4 – 350,M,1. MTL 3/11 – 1 Page	Section 350,L,4 – 350,M,1. MTL 2/11 – 1 Page
Section 350,M,2,c,3,d – 350,M,2,c,4 MTL 3/11 – 1 Page	Section 350,M,1,5 – 350,M,2,c,4 MTL 3/07 – 1 Page
Section 350,M,2,c,8 – 350,N MTL 3/11 – 1 Page	Section 350,M,2,c,8 – 350,N MTL 1/11 – 1 Page
HOME and COMMUNITY BASED SERVICES Section 360 Index – 360,O MTL 3/11 – 12 Pages	**HOME and COMMUNITY BASED SERVICES** Section 360 Index – 360,O MTL 1/06, 5/06, 1/07, 3/07, 5/07, 4/08, 1/10, 1/11 – 21 Pages
CHILDREN ELIGIBLE UNDER 1902(e)(3) of the SOCIAL SECURITY ACT (KATIE BECKETT) Section 370 – 370,F,1 MTL 3/11 – 1 Page	**CHILDREN ELIGIBLE UNDER 1902(e)(3) of the SOCIAL SECURITY ACT (KATIE BECKETT)** Section 370 – 370,F,1 MTL 1/08 – 1 Page
Section 370,M,2,3 – 370,O MTL 3/11 – 1 Page	Section 370,M,2,3 – 370,O MTL 1/10 – 1 Page
PRIOR MEDICAL DETERMINATIONS Section 380 – 380,L MTL 3/11 – 1 Page	**PRIOR MEDICAL DETRMINATIONS** Section 380 – 380,L MTL 5/07 – 1 Page
PARENTAL FINANCIAL RESPONSIBILITY FOR SERVICES PROVIDED TO DISABLED CHILDREN Section 501 – 506.14 MTL 3/11 – 5 Pages	**PARENTAL FINANCIAL RESPONSIBILITY FOR SERVICES PROVIDED TO DISABLED CHILDREN** Section 501 – 506.14 MTL 2/06, 2/09, 1/11 – 5 Pages
APPENDIX C Income Standard Chart MTL 3/11 – 1 Page	**APPENDIX C** Income Standard Chart MTL 2/11 – 1 Page
APPENDIX D Benefit Level Chart MTL 3/11 – 2 Pages	**APPENDIX D** Benefit Level Chart MTL 2/09, 2/11 – 2 Pages

Section	Explanation	Obsolete or Clarify: PT, P&P, PUT or IM
Section 101,A,1	**Distinction Between Application and Inquiry** – Add clarification that a signature is needed on the first and last page of application. A signature on the first page can start the application process but client must be pended for a signature on last page for a complete application.	
Section 202	**Blind/Disabled Individuals** – Corrected error in previous release regarding disability onset date and corrected dates in example.	
Section 206	**Citizenship and Identification Requirements** – Remove sentence in Key regarding Cuban/Haitian requirement to update status to continue eligibility.	
Section 220	**Federal Tax Refunds –** Removed Earned Income Tax Credit, replaced with Federal Tax Refunds as income type, and updated with 12-month income exclusion that applies to all federal tax refunds. **Indian Monies –** Added exclusion to patient liability for per capita payments made under public law 108-270 to Western Shoshone Indians.	**IM 04-11** **IM 06-11**
Section 230	**Indian Money –** Added Indian Money as a resource type. Per capita payments made to the Western Shoshone Indians are excluded from resources. **Federal Tax Refunds –** Remove Earned Income Tax Credit and replaced with Federal Tax Refunds. Public Law 111-312 disregards federal tax refunds from resources for a period of 12 months. **Home Equity** – update home equity limit to $506,000 based on increase for 2011.	**IM 06-11** **IM 04-11** **IM 35-10**
Section 310,A,1,c	**Qualified Medicare Beneficiaries** – Update QMB resource limits with 2011 amounts.	**IM 35-10**
Section 310,A,2,c	**Special Low-Income Medicare Beneficiaries (SLMB)** – Update SLMB resource limits with 2011 amounts.	**IM 35-10**
Section 310,A,3	**Qualified Individuals (QIs)** – Update QI resources limits with 2011 amounts.	**IM 35-10**
Section 310,L,4.c.2	**Member of Couple With Ineligible Spouse** – Add clarification that deeming never applied when the ineligible spouse receives assistance based on need, including VA pension benefits.	
Section 310,M,4	**Limits** – Update resource limits with 2011 amounts.	**IM 35-10**
Section 350,A,3	**Eligibility Exceptions** – Remove requirement that RTC treatment be a result of a "Healthy Kids" screening. State plan amended in 2002 to remove EPSDT referral as a stipulation for receiving inpatient psychiatric admission. These admissions only require prior authorization by Medicaid's peer review organization.	

Section 350,L,4	**Budgeting Procedures For Financial Eligibility** – Added clarification to Budgeting procedure to explain aid codes. Added explanation of all institutional aid codes to the net income test rather than just county match.	
Section 350,L,5	**Aid Code Determination** – Update Home Equity resource limit with 2011 amount.	**IM 35-10**
Section 350,M,2,c,3)	**Resource Determination** – Remove definition of resources considered available to community spouse from resource allowance determination for simplification, as the greatest of a,b,c,d in calculation is the total resource allowance.	
Section 360,A,1,a-e	**Home and Community Based Services** – Added Eligible groups to the overview and provide a description and aid code for each waiver.	
Section 360,A,2	**Eligibility Requirements –** Identification of applicants - clarified that potential applicants are those that indicate a need for home based services.	
Section 360,B	**Aged, Blind, Disabled –** Change subsection from Aged, Blind, Disabled to Eligibility Requirements. Included eligibility requirements for each waiver in section in order to condense and simplify the chapter.	
Section 360,B,1	**Eligibility Determination Process –** Combined the process for determining home based waiver eligibility into one section replacing the same process that was previously listed for each waiver. Removed individual waiver processes.	
Section B,1,a-1	Update eligibility determination processes and added clarification at the request of DHCFP and administering agencies regarding proper notification of waiver actions, including email notification to DHCFP, reason for denial on 2734 to be included in notice of decision and holding pending application until 45 days when applicant meets financial eligibility and level of care eligibility but has been placed on waiting list.	
Section 360,L,2	**Treatment of Income –** Removed reference to adjusting patient liability when a lump sum is received by a waiver recipient.	
Section 360,M,2,a	**Definitions** – Corrected typos and corrected definition of continuous period of institutionalization for the home based waiver applicants.	
Section 360,M,2,c	**Change Title** – to Spousal Impoverishment Resource Determination to match form and change order of paragraphs to highlight the importance of completing a resource assessment for all home based waiver applicants at the time of application as part of eligibility determination.	
Section 360,M,2,c,3	Remove sentence to subtract amount of resources considered available to community spouse and definitions of considered available. Sentence caused confusion regarding amount of resources assigned to community spouse. Community Spouse Resource allowance (determination is amount which can be protected for the community spouse.)	
Section 360,N	Removed patient liability budgeting procedures as they do not apply to home based waiver recipients. Added explanation of needs allowance in the home based waiver determination which zeros the patient liability calculation. Added explanation of when to adjust patient liability if recipient is admitted to long-term care.	

Section 360,O	Replace Redetermination with Review of Eligibility	
Section 360	Replaced Aging Division with Aging and Disability Services Division (ADSD) throughout chapter. Aging Division and Office of Disability Services merged in 2009. Replace NMO (Nevada Medicaid Office) with DHCFP (Division of Health Care Financing and Policy) throughout the chapter.	
Section 370,A,1	Remove Form 2451, DHCFP obtains their own form.	
Section 370,O	Replace Redetermination with Review of Eligibility.	
Section 380	**Prior Medical Determinations –** Removed would have been eligible for SSI from title as this is the budgeting methodology not the category. Moved sentence regarding prior medical determinations are made only after determining applicant is not eligible in any other Medicaid category.	
Section 501,B,4	**Parental Financial Responsibility –** 2011 Federal poverty level increases require update of Annual Family Deductions section.	
Section 501.B,10	**Noncooperation –** Add clarification, if parent cooperates after $1,900 monthly assessment, update monthly obligation with effective date of month after month of cooperation and notify I&R.	
Section 501.C	**Replace Redeterminations** with Review of Eligibility. Parental reimbursement needs to be completed each year even when a review of eligibility is used to continue eligibility.	
Section 501,E	**Responsibilities of Eligibility Staff –** Update computations to 2011 Federal poverty guideline. Added requirement to notify parents when there is a parental obligation amount. The change in policy is being implemented in order to allow collection of parental obligation to be effective upon notification. Form 2849-EM is being updated with this release to allow for notification of amounts greater than zero.	
Section 501,E,3	Add a copy of form 2849-EM to information sent to I&R.	
Section 501,F	Remove reference to I&R initial notification.	
Appendix C	Update MAABD Income Standard Chart with updated to Federal Poverty Levels. New income limits are effective April 1, 2011.	
Appendix D	**MAABD Income Standard Chart & Benefit Level Chart –** Update using 2011 Federal Poverty level increases. **MAABD Cost of Care Update effective 4/11**	

Effective Date -- May 1, 2011
Instructions for Manual Maintenance - Replace superseded page(s) [52] with transmitted page(s) [43].

(WP/MTL/MAABD 03_11)

JULY RELEASE
MAABD MANUAL
TRANSMITTAL LETTER 4/11

July 1, 2011

TO: CUSTODIANS OF MAABD MANUALS

FROM: ROMAINE GILLILAND, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
PERSONS INSTITUTIONALIZED AT LEAST 30 CONSECUTIVE DAYS Section 350.L.4.B.5 – 350.M MTL 04/11 – 3 Pages	**PERSONS INSTITUTIONALIZED AT LEAST 30 CONSECUTIVE DAYS** Section 350.L.4.B.5 – 350.M MTL 05/07, 01/11, 03/11 – 3 Pages
Section 350.M.C.2 – 350.M.C.4 MTL 04/11 – 1 Page	Section 350.M.C.2 – 350 M.C.4 MTL 04/08 – 1 Page
Section 350.M.2.B.2 – 350.M.2.C.3.C MTL 04/11 – 1 Page	Section 350.M.2.B.2 – 350.M.2.C.3.C MTL 03/07 – 1 Page
Section 350.N.1 – 350.N.5.4 MTL 04/11 – 2 Pages	Section 350.N.1 – 350.N.5.4 MTL 01/11 – 2 Pages
APPENDIX D Benefit Level Chart MTL 04/11 – 1 Page	**APPENDIX D** Benefit Level Chart MTL 03/11 – 1 Page
APPENDIX F MAABD Budgets MTL 04/11 – 1 Page	**APPENDIX F** MAABD Budgets MTL 05/08 – 1 Page

Section	Explanation	Obsolete or Clarify: PT, P&P, PUT or IM
MAABD 350, H	Remove "would have been eligible for SSI" in the reference as that manual section was renamed to prior medical determinations.	
MAABD 350, I	Added clarification that a MEDI screen must be entered for each month of eligibility when the individual is enrolled in Medicare.	
MAABD 350, L,1,b	Remove paragraph – both spouses do not have to be residing in a medical facility to be considered to be living separate and apart for the purposes of dividing income.	
MAABD 350,L,3	Court order– Added clarification of court orders related to income need to be evaluated by E&P. Previous version stated "designating income," which is different than granting spousal income for patient liability purposes. Change the language to clarify difference between designating income and granting a maintenance allowance and added the establishment of a QIT.	
MAABD 350,L,4,b,5	Update the change in the percentage amount used to determine the income limit for county match effective 7/1/11.	**IM 20-11**
MAABD 350,M,2	Remove paragraph – both spouses do not have to be residing in a medical facility to be considered to be living separate and a part for the purposes of dividing resources.	
MAABD 350,N,1	Add "maintenance allowance" to sentence to clarify the court orders granting maintenance allowance are looked at in the post eligibility determination process.	
MAABD 350,N,3,d	Added retroactive adjustment to patient liability are only made when the change is $25.00 or more.	**PT 03-11**
MAABD 350 N,5,b,2,a,1	Added court ordered amount to the community spouse month income allowance for clarification.	
Appendix D	Update the new income amount for county match effective 7/1/11.	
Appendix F	MAABD Budget Form 2203	

Effective Date -- July 1, 2011
Instructions for Manual Maintenance - Replace superseded page(s) [9] with transmitted page(s) [9].

(WP/MTL/MAABD 04_11)

SEPTEMBER RELEASE
MAABD MANUAL
TRANSMITTAL LETTER 5/11

September 1, 2011

TO: CUSTODIANS OF MAABD MANUALS

FROM: ROMAINE GILLILAND, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
BUDGETING AND PROCEDURES Section 340,5 — Addendum to Section 340 MTL 5/11 — 4 Pages	**BUDGETING AND PROCEDURES** Section 340,5 — Addendum to Section 340 MTL 1/06, 3/07, 1/10 — 3 Pages

Manual Section	Explanation	Obsolete or Clarify: PT, P&P, PUT or IM
340.N.5	This section is being updated to match 350.N.5 (Budgeting Procedures — Form 2220-EM). Patient liability calculations for Spousal Impoverishment cases: added clarification to subtract income excluded in PL calculation, clarified the community spouse's income is subtracted from the maintenance needs allowance to determine spousal income allowance. Clarified how the family allowance calculation is determined. Changed court order dividing income to court order granting spousal income, to clarify income is not divided in the patient liability calculation. Clarified family allowance is calculated and allowed when there are dependants living with the community spouse and Dependent allowance is calculated and allowed when there are dependants living in the home with no community spouse.	
340.N.5.b.2	Changed name from Spousal Impoverishment Maintenance to Community Spouse Monthly Income Allowance to match Patient Liability Budget form 2220-EM.	

Effective Date – Sep. 1, 2011
Instructions for Manual Maintenance - Replace superseded page(s) [4] with transmitted page(s) [3].

(WP/MTL/MAABD 05_11)

NOVEMBER RELEASE
MAABD MANUAL
TRANSMITTAL LETTER 6/11

November 1, 2011

TO: CUSTODIANS OF MAABD MANUALS

FROM: ROMAINE GILLILAND, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
FACTORS OF ELIGIBILITY Section 205, F, k — 214, B.5 MTL 6/11 — 15 Pages	**FACTORS OF ELIGIBILITY** Section 205, F, k — 214, B.5 MTL 2/09, 3/10 — 16 Pages

Manual Section	Explanation	Obsolete or Clarify: PT, P&P, PUT or IM
MAABD 206	Added information to clarify acceptable verifications regarding citizenship and identity to the entire section. Added Medicare information to the chart. Clarified the 90-day time frame to provide verification of citizenship.	

Effective Date – Nov. 1, 2011
Instructions for Manual Maintenance - Replace superseded page(s) [15] with transmitted page(s) [16].

(WP/MTL/MAABD 06_11)

JANUARY RELEASE
MAABD MANUAL
TRANSMITTAL LETTER 01/12

January 1, 2012

TO: CUSTODIANS OF MAABD MANUALS

FROM: ROMAINE GILLILAND, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
MAABD APPENDIX C Section MTL 01/12 — 2 Pages	**MAABD APPENDIX C** Section MTL 01/12 — 2 Pages
MAABD APPENDIX D Section MTL 01/12 — 2 Pages	**MAABD APPENDIX D** Section MTL 01/12 — 2 Pages
MAABD APPENDIX F Section MTL 01/12 — 3 Pages	**MAABD APPENDIX F** Section MTL 01/12 — 3 Pages

Manual Section	Explanation	Obsolete or Clarify: PT, P&P, PUT or IM
MAABD APPENDIX C	Update MAABD Income Standard chart with 2012 Limits pursuant to SSI Cost-of-Living adjustment.	
MAABD APPENDIX D	Update 2012 benefit Level Chart with new 2012 values.	
MAABD APPENDIX F	Update forms with new 2012 amounts.	

Effective Date – Jan. 1, 2012
Instructions for Manual Maintenance - Replace superseded page(s) [7] with transmitted page(s) [7].

(WP/MTL/MAABD 01_12)

MARCH RELEASE
MAABD MANUAL
TRANSMITTAL LETTER 02/12

March 1, 2012

TO: CUSTODIANS OF MAABD MANUALS

FROM: DIANE J. COMEAUX, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
MAABD APPENDIX D Section MTL 02/12 — 1 Page	**MAABD APPENDIX D** Section MTL 01/12 — 1 Page
MAABD APPENDIX F Section MTL 02/12 — 1 Page	**MAABD APPENDIX F** Section MTL 02/11 — 1 Page

Manual Section	Explanation	Obsolete or Clarify: PT, P&P, PUT or IM
MAABD APPENDIX D	Update 2012 VA COLA increase.	
MAABD APPENDIX F	Update 2012 VA COLA increase.	

Effective Date – March 1, 2012
Instructions for Manual Maintenance - Replace superseded page(s) [2] with transmitted page(s) [2].

(WP/MTL/MAABD 02_12)

MAY RELEASE
MAABD MANUAL
TRANSMITTAL LETTER 03/12

May 1, 2012

TO: CUSTODIANS OF MAABD MANUALS

FROM: DIANE J. COMEAUX, ADMINISTRATOR

SUBJECT: MAABD MANUAL CHANGES

Material Transmitted	Material Superseded
MAABD CHAPTER 208 — INSURANCE COVERAGE Section 208 — 208.B MTL 3/12 — 1 Page	**MAABD CHAPTER 208 — INSURANCE COVERAGE** Section 208 — 208.B MTL 6/11 — 1 Page
MAABD APPENDIX C Section APPENDIX C MTL 03/12 — 1 Page	**MAABD APPENDIX C** Section APPENDIX C MTL 01/12 — 1 Page

Manual Section	Explanation	Obsolete or Clarify: PT, P&P, PUT or IM
Chapter 208 — 208.B	Update MAABD with new Subrogation vendor information.	**IM - 10-12**
MAABD APPENDIX C	Update MAABD Income Standard Chart with 2012 Federal Poverty Level increase. New income limits are effective April 1, 2012.	

Effective Date – May 1, 2012
Instructions for Manual Maintenance - Replace superseded page(s) [2] with transmitted page(s) [2].

(WP/MTL/MAABD 03_12)