

# MEDICAL SERVICES – APPENDIX A

## Burial Fund Guide

Life Ins. with No CSV is Not Resource or Burial	Case 1	Case 2	Case 3	Case 4	Case 5	Case 6	Case 7
1a. Ins. Face \$1500 or Less Disregard CSV	\$250 Face (\$200 CSV)	\$1500 Face (\$3000 CSV)				\$1400 Face (\$500 CSV)	
1b. Ins. Face More than \$1500 CSV=Res. \$500 CSV			(\$2000 Face) \$500 CSV	(\$5000 Face) \$3000 CSV	(\$3000 Face) \$3000 CSV		(\$2000 Face)
2. Irrevocable Contracts (Burial Assn., Some Prepaid incl. Those funded with annuities and insurance)	\$500	\$2000 OK to here	\$5000		\$6000		
3. Revocable Contracts A. Prepaid B. Insured Bur. Contracts	A. \$500	B. \$500 CSV (Resource)					A. \$3200
4. Cash—Includes CSV from 1b	\$250	\$2000 (Resource)	\$500 (CSV from above)	\$3000 (CSV from above)	\$3000 (CSV from above)	\$1600	\$500 (CSV from above)
Treatment	\$1500 Burial <u>OK</u>	\$3500 Burial <u>OK</u> \$2500 Resource	\$5000 Burial <u>OK</u> \$500 Resource	\$1500 Burial \$1500 Resource (OK If \$3000 Split)	\$6000 Burial OK \$3000 Resource	\$1500 Burial \$1500 Resource (OK If \$1600 Split)	\$1500 Burial \$2200 Resource (If \$3200 Split)

# Medical Services – Appendix B, Transportation Procedures

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## Transportation Services

Federal regulations require that non-emergency transportation services be provided to certain Medicaid recipients:

- When necessary for medical care (diagnosis or treatment);
- When transportation is otherwise not available;
- In the least expensive means suitable to the recipient's medical needs; and
- To transport recipients to qualified providers who are generally available and used by other residents of the community.

Transportation services cannot be used by individuals enrolled in ARKids B, Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SMB), and Qualified Disabled Working Individuals (QDWI).

ICF/IID (Intermediate Care Facilities/Individuals with Intellectual Disabilities), nursing home facilities, and the Hot Springs Rehabilitation Center are responsible for transporting their clients.

If a nursing home facility administrator believes that unusual circumstances place transportation services outside the scope of his responsibility and requests assistance, the administrator should call the Office of Long Term Care (**501-682-8430**) for assistance.

## Services for Which Transportation is Paid

Transportation may be provided when a recipient needs to travel to and from a medical facility that provides medical services covered by Medicaid. A medical facility is defined as a place where medical examinations and treatment are received. Medical facilities include hospitals, doctors' offices, dentists' offices, clinics, independent laboratories, X-ray facilities, Developmental Day Treatment Clinics, pharmacies and drug stores (for purchase of prescription drugs and prescription medical supplies), and the Health Department.

Medicaid transportation will not be provided for a non-Medicaid-covered service (e.g., transportation would not be authorized to a psychologist for an individual over age 21, since this is not a covered service). "Arkansas Medicaid, ARKids First & You" handbook lists the services covered by Medicaid.

## Primary Care Physicians

Some Medicaid recipients are required to choose a primary care physician (PCP) to take care of their medical needs, and can generally obtain other medical services only upon a referral from their PCP. If a recipient is required to have a PCP, transportation only to the PCP or to a physician or the medical services referred to by the PCP when a referral is required, will be provided.

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Some individuals are excluded from PCP selection. They are nursing home and ICF/IID (Intermediate Care Facilities/Individuals with Intellectual Disabilities), Home and Community Based Waiver, Medicare, DDS Children's Services, Medically Needy Spend Down recipients, and those who have retroactive eligibility only or who are temporarily absent from the state (e.g., a foster child placed out of Arkansas).

There are some Medicaid services a recipient can receive without a referral from a PCP (e.g., dental services for children under age 21). For a list of services that do not need a PCP referral, see DCO-2613.

## Freedom of Choice (Non-PCP Recipients)

When a recipient is not required to have a PCP or a PCP referral to obtain a Medicaid covered service, a recipient may go to any enrolled Medicaid provider he/she chooses.

Transportation for non-PCP recipients may also be provided for a recipient if a referral has been made by a physician or other health care specialist (e.g., an RN at the Health Department) to a provider who is not the nearest qualified provider.

## Methods of Transportation and Payment

Medicaid transportation is provided and paid for as follows:

1. The NET (Non-Emergency Transportation) Program - The NET brokers give Medicaid recipients rides (free of charge) to and from doctor appointments or other covered Medicaid services. It is the responsibility of the Medicaid recipient to call the transportation broker (the company that provides the ride) to schedule a ride. To find the broker in his/her region, the recipient can call the Medicaid Transportation Helpline at 1-888-987-1200 or visit <https://afmc.org/services/> and select Medicaid Non-Emergency Transportation. The transportation broker must be called 48 hours (two full business days) before the scheduled appointment. Weekends and recognized state holidays are not business days. Rides are offered Monday through Friday, 8 am to 5 pm.
2. Ambulance Transportation- Ground and air ambulance transportation providers must be licensed by the Arkansas State Ambulance Board and enrolled in the Title XVIII (Medicare) Program. Ambulance service for eligible Medicaid recipients is covered by Medicaid when a physician certifies that the ambulance transportation is medically necessary. It is the responsibility of the transportation provider to obtain prior authorization for non-emergency transportation from the Division of Medical Services (DMS) Utilization Review Section.

All of the above enrolled as Medicaid transportation providers bill Medicaid directly for their services. County offices do not authorize or pay for Medicaid transportation in any situation.

## Loaded Miles

Medicaid transportation costs cannot be reimbursed for loaded miles.

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## Therapeutic Visits

A therapeutic visit is defined as a meeting of a child with his parents, guardian or foster parents as a part of a treatment plan to help reunite a family whose members have been separated due to the necessity of inpatient psychiatric care for the child.

Three (3) therapeutic visits (either for the child to visit the parents or for the non-Medicaid eligible parents, etc. to visit the child) in a calendar year may be authorized by the Division of Medical Services (DMS) Utilization Review Section for a family whose child is in an out-of-state facility when a psychologist or psychiatrist has recommended in writing that the visits are medically necessary as a part of the recipient's therapeutic treatment plan (See section below for out-of-state travel). NET should be contacted for information and for transportation arrangement.

If the facility is in Arkansas, a parent, foster parent or guardian is eligible for transportation by NET to visit a minor Medicaid recipient. There is a limit of one (1) trip to and from the facility per episode of care. The parent, foster parent, or guardian contacts NET to schedule the appointment.

Only one (1) round transportation trip will be authorized by the DMS Utilization Review Section for parents who take their child home from a facility (e.g., weekend visit) and later return the child back to the facility.

## Emergency Transportation

When an emergency occurs and the attending doctor advises the client to obtain medical care immediately, the doctor will call the NET transportation broker and inform the broker that the client has an "urgent medical situation." The broker will provide transportation without 48 hour notice.

Emergency ambulance services may be covered only when provided by an ambulance company that is licensed by the Arkansas State Ambulance Board and is an enrolled provider in the Arkansas Medicaid Program. Medicaid will cover the ambulance transportation only when the Medicaid recipient is admitted to the hospital or when the patient's condition is an emergency.

## Visits for Prolonged Treatment

When it is necessary for a client to see the doctor at the same time each week (e.g., for dialysis or radiation therapy), the client should contact the broker and ask if a regular schedule can be setup for that time period.

## Out-of-State Transportation

The Division of Medical Services (DMS) Utilization Review Section authorizes all out of state transportation including air travel.

The provider must obtain prior authorization from the DMS Utilization Review Section for ground ambulance trips to a medical facility outside the State of Arkansas, unless the medical facility is within a 50-mile trade area and is the nearest hospital or nursing home from the point of pick-up.

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All requests which require authorization by Utilization Review should be submitted at least 2 weeks in advance of the scheduled departure date. Requests for travel should be made to:

**Division of Medical Services  
Utilization Review  
P.O. Box 1437, Slot S413  
Little Rock, AR, 72203-1437**

In cases of extreme emergency or when further information is needed concerning a request, Utilization Review may be contacted at **501-682-8340**.

### **Transportation of Former Recipients for Utilization Review**

Transportation may not be authorized for former Medicaid recipients.

# Medical Services – Appendix C, Verification of Citizenship, Alien Status and SSN Enumeration

## I. Citizenship Verification - Acceptable Documents for Proof of Citizenship

When citizenship cannot be verified through the Federal Data Services Hub (FDSH) or the SSA match, the worker must access Vital Records through ARFinds for verification of birth. If citizenship documentation cannot be obtained through Vital Records, specific forms of documentation may be acceptable evidence of citizenship. If an individual presents evidence from the listing of Primary Documentation, no other information is required.

To establish U.S. citizenship, the document must show a U.S. place of birth and that the person is a U.S. citizen. The documents must be original or certified copies. Copies of documents already obtained will be accepted as assumed made from the original unless questionable (e.g. stamped “copy”, or unreadable).

In general, the caseworker should obtain primary evidence of citizenship before using the secondary documentation or tertiary list. The following forms of documentation may be accepted:

**Primary documentation**– The highest reliability that conclusively establishes identification and citizenship.

- A U.S. Passport.
- A Certificate of Naturalization (United States Department of Homeland Security (USDHS) Forms N-550 or N-570).
- A Certificate of U.S. Citizenship (USDHS Forms N-560 or N-561).

**Secondary documentation**– Secondary evidence of citizenship is documentary evidence of satisfactory reliability that is used when primary evidence of citizenship is not available.

- A U.S. birth certificate.
- A Certification of birth issued by the Department of State (Form DS-1350).
- A Report of Birth Abroad of a U.S. Citizen (Form FS-240).
- A Certification of Birth Abroad (FS-545).
- An American Indian Card issued by the Department of Homeland Security with the classification code “KIC”. (Issued by DHS to identify U.S. citizen members of the Texas Band of Kickapoos living near the U.S./Mexican border).
- Final adoption decree.
- Evidence of civil service employment by the U.S. government before June 1976.

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- An official military record of service showing a U.S. place of birth.
- A Northern Mariana Identification Card (issued by the USDHS to a collectively naturalized citizen of the United States who was born in the Northern Mariana Islands before November 4, 1986).

**Third level documentation**– Third level evidence of U.S. citizenship is documentary evidence of satisfactory reliability that is used when neither primary nor secondary evidence of citizenship is available. This documentation includes:

- Extract of U.S. hospital record of birth established at the time of the person’s birth, created at least 5 years before the initial application date and indicating a U.S. place of birth.
- Life or health or other insurance record created at least 5 years before the initial application date showing a U.S. place of birth.
- Religious records recorded in the U.S. within 3 months after the birth which show that the birth occurred in the U.S. showing the date of the birth of the individual or the individual’s age at the time the record was made. These must be official records recorded with the religious organization (e.g., baptismal certificates). Entries in a family bible are not considered recorded religious records.
- Early school records which show the name of the child, the date of admission to the school, the date of birth (or age at the time the record was made), a U. S. place of birth, and the name(s) and place(s) of birth of the applicant’s parents.

**Fourth level documentation** – Fourth level evidence of U.S. citizenship is documentary evidence of the lowest reliability. This level should **only** be used in the rarest of circumstances. This level of evidence is used only when primary evidence is not available, both secondary and third level evidence do not exist or cannot be obtained within the reasonable opportunity period, and the applicant alleges a U.S. place of birth. This documentation includes:

- Federal or State census record showing U.S. citizenship or a U.S. place of birth, as well as the applicant’s age.
- Birth records that were recorded with vital statistics 5 years after a birth (a delayed birth record).
- Institutional admission papers from a nursing home, skilled nursing care facility or other institution created at least 5 years before the initial application date and which indicate a U.S. place of birth.

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- Medical (clinic, doctor, or hospital) record which was created at least 5 years before the initial application date and indicates a U.S. place of birth unless the application is for a child under 5.
- Other document that was created at least five years before application for Medicaid. These documents are Seneca Indian tribal census record, Bureau of Indian Affairs tribal census records of the Navaho Indians, U.S. State Vital Statistics official notification of birth registration, an amended U.S. public birth record that is amended more than 5 years after the person's birth or a statement signed by the physician or midwife who was in attendance at the time of birth.
- The Roll of Alaska Natives maintained by the Bureau of Indian Affairs.
- Written affidavit. This should be in rare circumstances when the applicant or recipient cannot provide evidence from another listing.

**Written affidavits** may be used in circumstances when the state is unable to secure evidence of citizenship from another listing. The affidavits must be supplied by at least two individuals, one of whom is not related to the recipient. Each must attest to having a personal knowledge of the event(s) establishing the recipient's claim of citizenship. Those making affidavits will be subject to prosecution for perjury. If the persons claiming knowledge of another's citizenship has information, which explains why documentary evidence establishing the claim of citizenship does not exist or cannot be readily obtained, the affidavit should contain this information as well.

A second affidavit from the recipient or other knowledgeable individual explaining why documentary evidence does not exist or cannot be readily obtained must also be requested.

### II. Identity

If citizenship is verified with a document on the secondary or lower level listed above, providing proof of identity will be required. Acceptable forms of identity are:

1. 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.
2. Identification card issued by the Federal, State or local government with the same information included on driver's licenses (e.g., ID card issued by DF&A).
3. School identification card with a photograph of the individual.

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4. U.S. military card or draft card.
5. Military dependent's identification card.
6. Certificate of Degree of Indian Blood or other U.S. American Indian/Alaska Native tribal document. This document must carry a photograph of the applicant or recipient.
7. Native American Tribal document.
8. U.S. Coast Guard Merchant Mariner card.
9. Sentencing order from a correctional facility.

**NOTE:** If the expiration date has expired, the ID is still acceptable.

### III. Alien Status Verification - Using SAVE (Systematic Alien Verification for Entitlement)

At application, individuals will be requested to provide information of alien status including document type, alien number, document ID, date of entry into the United States and expiration date of document. This information will be electronically verified using the Verify Lawful Presence (VLP) service through the Federal Data Services Hub (Hub) for the MAGI population or through the web-based connection to SAVE for the non-MAGI population.

#### Electronic Verification

SAVE electronically verifies immigration status or naturalized or derived citizenship using a three-step process:

- **Initial Verification** (first step) - electronically compares information the agency enters against immigration databases and returns a response within seconds. The system will respond with the applicant's current immigration status and a unique USDHS ID. A code will be provided by USDHS identifying the next verification steps to take as necessary. If the information provided in the initial response is sufficient to make an eligibility determination, no additional verification is necessary. When USDHS cannot immediately verify information provided by the individual, a code will be returned instructing the agency to review and correct the information, or to institute additional verification.
- **Additional Verification** (second step) - is initiated electronically by the agency when the system returns information that varies from what the individual presents. This step takes between 3–5 federal working days. The SAVE system will populate the agency

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action field with the next possible steps. If information is sufficient to determine eligibility, no further verification is needed. Third Step Verification will be initiated if eligibility cannot be determined based on the code received.

- **Third Step Verification** - is an electronic process initiated by the agency. The agency must submit photocopies (front and back) of the applicant’s relevant immigration documents using the scan and upload function.
- **Close Case** – After a response has been received with enough information to make an eligibility determination, or all electronic methods of verification have been exhausted, the USDHS SAVE case should be closed through the SAVE program.

### IV. Alien Documentation Chart

The chart below shows the types of documentation that can be used to verify alien status, and additional verification that certain aliens must provide to verify that they are eligible for Medicaid (e.g., the date they were admitted to the U.S., or the date a particular alien status was granted or adjusted).

**NOTE:** USDHS Form I-94 is processed electronically and can be retrieved online at [www.cbp.gov/I94](http://www.cbp.gov/I94).

Alien Status	Acceptable Documentation of Alien Status	Medicaid Status
Amerasian Immigrant	<ul style="list-style-type: none"><li>• USDHS Form I-551, Permanent Resident Card, annotated AM6, AM7 or AM8.</li><li>• Unexpired temporary I-551 stamp in a foreign passport annotated AM1, AM2 or AM3.</li><li>• USDHS Form I-94, Arrival/Departure Record, annotated AM1, AM2 or AM3.</li></ul>	Eligible Regardless of U.S. entry date

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Alien Status	Acceptable Documentation of Alien Status	Medicaid Status
<b>Asylee</b>	<ul style="list-style-type: none"> <li>• USDHS Form I-94, Arrival/Departure Record, noting admittance under section 208 of the INA.</li> <li>• USDHS Form I-94, Arrival/Departure Record, annotated AS-1, AS-2 or AS-3.</li> <li>• USDHS Form I-94, Arrival/Departure Record, with Visa 92 or V-92.</li> <li>• Order of an immigration judge granting asylum.</li> <li>• Written decision letter from the Board of Immigration Appeals.</li> <li>• USDHS Form I-730, Approval Letter.</li> <li>• USDHS Form I-766, Employment Authorization Document, annotated "A5."</li> </ul>	Eligible as of date asylum is granted
<b>Battered Alien</b>	<p>Proof of admission of entry date and one of the following documents:</p> <ul style="list-style-type: none"> <li>• I-360 or I-130 petition with proof of filing (a file-stamped copy of the petition or another document demonstrating filing, such as a signed certified return receipt or cash register or computer-generated receipt).</li> <li>• Order or document from the Immigration Court or Board of Immigration Appeals granting suspension of deportation under INA section 244(a)(3), or cancellation or removal under INA section 204A(b)(2).</li> <li>• Application for cancellation of removal (Form EOIR 42B) or suspension of deportation (Form EOIR 40) with proof of filing (a file-stamped copy of the application or another document demonstrating filing, such as a signed certified return receipt or cash register or computer-generated receipt).</li> <li>• A document from the Immigration Court or Board of Immigration Appeals indicating that the applicant has established a prima facie case for suspension of deportation under INA section 244(a)(3), or cancellation of removal under INA section 204A(b)(2).</li> </ul>	<p>Barred for five (5) years if entered U.S. on or after 8/22/96</p> <p>Eligible if entered U.S. before 8/22/96</p>
<b>Canadian-born American Indian</b>	<ul style="list-style-type: none"> <li>• USDHS Form I-551, Alien Registration Receipt Card, coded S13.</li> <li>• I-551 stamp in a Canadian passport coded S13.</li> <li>• USDHS Form I-94, Arrival/Departure Record, coded S13.</li> <li>• Proof of tribal membership or a tribal document showing the individual has at least 50% American Indian blood. Proof of membership can be a tribal membership card, other tribal documents showing membership, or collateral contact with the tribe's government.</li> </ul>	Eligible Regardless of U.S. entry date

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Alien Status	Acceptable Documentation of Alien Status	Medicaid Status
<b>Conditional Entrant</b>	<p>Proof of admission or entry date and one of the following documents:</p> <ul style="list-style-type: none"> <li>• USDHS Form I-94, Arrival/Departure Record, with stamp showing admission under section 203(a)(7) of the INA.</li> <li>• USDHS Form I-766, Employment Authorization Document, annotated “A3.”</li> </ul>	<p>Barred for five years if entered U.S. on or after 8/22/96. Eligible if entered U.S. before 8/22/96</p>
<b>Cuban or Haitian Entrant</b>	<ul style="list-style-type: none"> <li>• USDHS Form I-551, Permanent Resident Card, annotated CU6, CU7 or CH6.</li> <li>• Unexpired temporary I-551 stamp in a foreign passport annotated AM1, AM2 or AM3.</li> <li>• USDHS Form I-94, Arrival/Departure Record, annotated CU6 or CU7, or with a stamp showing parole as “Cuban/Haitian Entrant” under section 212(d)(5) of the INA.</li> </ul>	<p>Eligible regardless of U.S. entry date</p>
<b>Cuban or Haitian Entrants in the Haitian Family Reunification Program</b>	<ul style="list-style-type: none"> <li>• USDHS Form I-130, Petition for Alien Relative.</li> <li>• USDHS Form I-131, Application for Travel Document.</li> <li>• USDHS Form I-134, Affidavit of Support.</li> <li>• USDHS Form I-765, Application for Employment Authorization.</li> </ul> <p>Once paroled into the United States, HFRP Program beneficiaries will meet the definition of Cuban/Haitian entrants under section 501(e)(1) of the Refugee Education and Assistance Act of 1980, as amended, and will be qualified aliens</p>	<p>Eligible regardless of U.S. entry date.</p>
<b>Deportation or removal withheld</b>	<ul style="list-style-type: none"> <li>• USDHS Form I-766, Employment Authorization Document, annotated “A10.”</li> <li>• Order of an immigration judge showing deportation withheld under section 243(h) or removal withheld under section 241(b)(3) of the INA and date of grant.</li> </ul>	<p>Eligible Regardless of U.S. entry date</p>
<b>Lawfully admitted for permanent residence</b>	<ul style="list-style-type: none"> <li>• USDHS Form I-551, Permanent Resident Card.</li> <li>• Unexpired “Temporary I-551” stamp in a foreign passport.</li> <li>• USDHS Form I-94, Arrival/Departure Record, with a temporary I-551 stamp.</li> </ul>	<p>Barred for five years if entered U.S. on or after 8/22/96 Eligible if entered U.S. before 8/22/96</p>
<b>Paroled into U.S. for at least one year</b>	<p>Proof of admission or entry date and USDHS Form I-94, Arrival/Departure Record, showing admission for at least one year under section 212(d)(5) of the INA.</p> <p><b>NOTE:</b> The applicant cannot use admission periods for less than one year to meet the one-year requirement.</p>	<p>Barred for five years if entered U.S. on or after 8/22/96 Eligible if entered U.S. before 8/22/96</p>

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Alien Status	Acceptable Documentation of Alien Status	Medicaid Status
<b>Refugee</b>	<ul style="list-style-type: none"> <li>• USDHS Form I-94, Arrival/Departure Record, showing entry under section 207 of the INA.</li> <li>• USDHS Form I-766, Employment Authorization Document, annotated “A3.”</li> <li>• USDHS Form I-571, Refugee Travel Document.</li> </ul> <p><b>NOTE:</b> Refugees who have adjusted to lawful permanent resident status are still considered refugees for Medicaid eligibility. If a refugee has a Form I-551, Permanent Resident Card*, it will be annotated RE-6, RE-7, RE-8, RE-9 or R8-6.</p>	Eligible regardless of U.S. entry date
<b>Veteran or active duty military personnel lawfully admitted for permanent residence (and families)</b>	<p>To verify alien status:</p> <ul style="list-style-type: none"> <li>• USDHS Form I-551, Permanent Resident Card.</li> <li>• Unexpired “Temporary I-551” stamp in a foreign passport.</li> <li>• USDHS Form I-94, Arrival/Departure Record, with a “Temporary I-551” stamp.</li> </ul> <p>To verify military status:</p> <ul style="list-style-type: none"> <li>• Honorably discharged veteran: Original or notarized copy of form DD214 (discharge papers).</li> </ul> <p><b>NOTE:</b> This verification is sufficient when the veteran is a U.S. citizen, and the spouse or unmarried dependent children (or surviving spouse and unmarried dependent children of a deceased veteran) are aliens.</p> <ul style="list-style-type: none"> <li>• Active duty: Original or notarized copy of the current orders showing the person is on full-time duty in the U.S. Army, Navy, Air Force, Marine Corps, or Coast Guard, or a DD form 2 military ID card (active duty papers).</li> </ul>	Eligible regardless of U.S. entry date
<b>Other (legal or illegal)</b>	Documents that indicate the person’s alien status is one other than those specifically listed under <b>Aliens Subject to Five-Year Bar</b> ( <a href="#">MS D-223</a> ) or under <b>Aliens Exempt from Five-Year Bar</b> ( <a href="#">MS D-224</a> ).	Ineligible regardless of U.S. entry date

The below chart lists the immigration status for lawfully present alien children under age 19 and pregnant women who are exempted from the five year bar waiting period:

Alien Status	Acceptable Documentation of Alien Status	Children under 19 and Pregnant Women
<b>Qualified alien</b>	<ul style="list-style-type: none"> <li>• USDHS Form I-551, Permanent Resident Card.</li> <li>• Any verification from the immigration authorities or other authoritative documents indicating Qualified Alien.</li> </ul>	Eligible and exempted from the 5 year bar.
<b>Valid Non-immigrant Status</b>	<ul style="list-style-type: none"> <li>• USDHS Form I-94, Arrival/Departure record.</li> <li>• Any verification from the immigration authorities or other authoritative documents indicating nonimmigrant status.</li> </ul>	Eligible and exempted from the 5 year bar.  <b>(This status includes non-immigrants from Micronesia, Marshall Islands, and Palau.)</b>

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<b>Paroled into United States for less than 1 year</b>	<ul style="list-style-type: none"> <li>• USDHS Form I-94, Arrival/Departure Card with a stamp displaying a grant of parole under Section 212 (d)(5) of the INA. The I-94 may be stamped “PIP” or “HP”</li> <li>• USDHS Form I-765, Application for Employment Authorization, or receipt from USCIS indicating filing of application.</li> <li>• USDHS Form I-766, Employment Authorization Document.</li> <li>• USDHS Form I-512 Parole Authorization annotated with the reason parole was granted under section 8 CFR.</li> </ul>	Eligible and exempted from the 5 year bar.
<b>Temporary Resident Status</b>	<ul style="list-style-type: none"> <li>• USDHS Form I-687, Application for Status as a Temporary Resident.</li> <li>• Any verification from the immigration authorities or other authoritative documents indicating Temporary Status.</li> </ul>	Eligible and exempted from the 5 year bar.
<b>Temporary Protected Status (TPS)</b>	<ul style="list-style-type: none"> <li>• USDHS Form I-765, Application for Employment Authorization, or receipt from USCIS indicating filing of application.</li> <li>• USDHS Form I-766, Employment Authorization Document.</li> <li>• Any verification from the immigration authorities or other authoritative documents indicating Temporary Protected Status.</li> </ul>	Eligible and exempted from the 5 year bar.
<b>Employment Authorization</b>	<ul style="list-style-type: none"> <li>• USDHS Form I-765, Application for Employment Authorization.</li> <li>• Any verification from the immigration authorities or other authoritative documents indicating Employment Authorization.</li> </ul>	Eligible and exempted from the 5 year bar.
<b>Family Unity Beneficiary</b>	<ul style="list-style-type: none"> <li>• USDHS Form I-797, Notice of Action showing approval of I-817, Application for Family Unity.</li> <li>• USDHS Form I-765, Application for Employment Authorization, or receipt from USCIS indicating filing of application.</li> <li>• USDHS Form I-765, Employment Authorization Document.</li> <li>• Any verification from the immigration authorities or other authoritative documents indicating Family Unity status.</li> </ul>	Eligible and exempted from the 5 year bar.
<b>Deferred Enforced Departure (DED)</b>	<ul style="list-style-type: none"> <li>• USDHS Form I-765, Application for Employment Authorization, or receipt from USCIS indicating filing of application.</li> <li>• USDHS Form I-766, Employment Authorization Document.</li> <li>• Any verification from the immigration authorities or other authoritative documents indicating Deferred Enforced Departure status.</li> </ul>	Eligible and exempted from the 5 year bar.

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<b>Deferred Action Status</b>	<ul style="list-style-type: none"> <li>• USDHS Form I-797 indicating a notice of action for Deferred Action.</li> <li>• USDHS Form I-765, Application for Employment Authorization or receipt from USCIS indicating filing of application.</li> <li>• USDHS Form I-766, Employment Authorization Document.</li> <li>• Any verification from the immigration authorities or other authoritative documents indicating Deferred Action Status.</li> </ul>	Eligible and exempted from the 5 year bar except noncitizens granted deferred action under the Deferred Action for Childhood Arrivals (DACA) process are not considered lawfully present and is not eligible for Medicaid.
<b>Administrative Stay of Removal</b>	<ul style="list-style-type: none"> <li>• USDHS Form I-246, Stay of Removal.</li> <li>• Any verification from the immigration authorities or other authoritative documents indicating Administrative Stay of Removal.</li> </ul>	Eligible and exempted from the 5 year bar.
<b>VISA with Adjustment of Status</b>	<ul style="list-style-type: none"> <li>• USDHS Form I-94, Arrival/Departure Record.</li> <li>• USDHS Form I-485, Application to Register Permanent Residence or Adjust Status.</li> <li>• Any verification from the immigration authorities or other authoritative documents indicating VISA with Adjustment of Status.</li> </ul>	Eligible and exempted from the 5 year bar.
<b>Asylum and for Withholding of Removal</b>	<ul style="list-style-type: none"> <li>• USDHS Form I-589, Application for Asylum and Withholding, filed.</li> <li>• USDHS Form I-765, Application for Employment Authorization, filed.</li> <li>• USDHS Form I-766, Employment Authorization Document</li> </ul>	Eligible and exempted from the 5 year bar.
<b>Withholding of Removal under the Convention Against Torture</b>	<ul style="list-style-type: none"> <li>• USDHS Form I-589, Application for Asylum and for Withholding of Removal.</li> <li>• Any verification from the immigration authorities or other authoritative documents indicating Withholding of Removal under the Convention Against Torture.</li> </ul>	Eligible and exempted from the 5 year bar.
<b>Special Immigrant Juvenile</b>	<ul style="list-style-type: none"> <li>• USDHS Form I-360, Petition for Amerasian, Widow(er), or Special Immigrant.</li> <li>• Any verification from the immigration authorities or other authoritative documents indicating Special Immigrant Juvenile.</li> </ul>	Eligible and exempted from the 5 year bar.
<b>Victim of Severe Trafficking</b>	<ul style="list-style-type: none"> <li>• USDHS Form I-914, Application for T-Nonimmigrant Status.</li> <li>• USDHS Form I-918, Petition for U-Nonimmigrant Status.</li> <li>• Any verification from the immigration authorities or other authoritative documents indicating Victim of Severe Trafficking.</li> </ul>	Eligible and exempted from the 5 year bar.

### V. Social Security Number (SSN) Enumeration

## Medical Services – Appendix C, Verification of Citizenship, Alien Status and SSN Enumeration

SSNs that have mismatched through the electronic verification process will be submitted to the queue with a message that the SSN could not be verified.

To resolve the mismatch, first check for obvious mismatches, (e.g., errors in keying the SSN, sex, name or date of birth). Next check SOLQ to determine if a correction can be made in the system from the SSA data on SOLQ.

Other methods of resolving a mismatch include:

- Viewing the social security card. The name in the system must match the name on the social security card; and
- Viewing a copy of the birth certificate or other proof of age or date of birth mismatch.

### Household Cooperation in Clearing the Mismatch

When declared SSNs are returned by SSA as unverified, it is often necessary for the household to furnish the information necessary to resolve the mismatch.

A request for contact must be issued by the caseworker to advise the recipient of the mismatch, what caused the problem (e.g., name is incorrect) and what information must be provided to resolve the problem. The recipient will be given 10 days to furnish the information. If the household does not furnish the needed information by the end of the designated 10-day period an advance notice of adverse action will be issued.

The notice will specify that:

1. the recipient has 10 days to furnish the information needed to clear the SSN mismatch;
2. failure to provide the information will result in terminating eligibility for the individual whose SSN has not been verified or closure of the case if applicable; and
3. If there are problems in obtaining the needed material the recipient should contact the DCO county office at once.

If the recipient claims that the information needed to clear the mismatch report cannot be furnished, the caseworker must substantiate the inability to provide the needed information. For example, a household may claim it cannot verify a name change because official records were destroyed in a fire. The case worker would attempt to verify the occurrence of the fire because SSA records cannot be corrected without the missing documentation. If the caseworker verifies that the recipient cannot provide the information needed to verify the SSN, the individual may continue to participate if otherwise eligible.

Revised (05/18)

## **Medical Services – Appendix C, Verification of Citizenship, Alien Status and SSN Enumeration**

All actions taken to clear SSN mismatches must be fully documented in the system.

### **Monitoring**

The DCO Supervisor, or designee in the absence of the supervisor, will be responsible for monitoring the mismatch notifications.

## Medical Services – Appendix D, Benefits Available Under Medicaid and ARKids First

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01/01/19

Generally, there is no limit on benefits to individuals under age 21 who are enrolled in the Child Health Services Program (EPSDT). There may be benefit limits to individuals over age 21. Below is a description of some of the benefits available either through Medicaid or ARKids First.

Ambulatory Surgical Center (ASC) Services – Ambulatory surgical centers provide surgeries that do not require an overnight hospital stay. Recipients of ARKids B have to pay a co-payment for these services.

ARChoices – This waiver service is for adults age 21 and over who need special care to live at home or in the community instead of a nursing home. These Individuals must have a physical disability as determined by SSI/SSA, Railroad Retirement or DHS Medical Review Team. Refer to [MS B-314](#) for additional information about this program.

Autism Services – One-on-one intensive early intervention treatment for Medicaid recipients ages eighteen (18) months through seven (7) years with a diagnosis of autism. Refer to [MS B-316](#) for additional information about this program.

Child Health Management Services (CHMS) – Medicaid or ARKids A will pay for many different services for a child under 21 that is found to have a health problem or is not developing normally. These services can include medical, psychological, speech and language pathology, occupational therapy, physical therapy, behavioral therapy and audiology.

Child Health Services (CHS) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) CHS is a free comprehensive health care service for eligible recipients from birth to age 21. This program is administered through the Division of Medical Services (DMS).

Chiropractic Services - Chiropractic services are limited to manipulation of the spine.

Dental Services – Dental care is covered for children under age 21 with ARKids A, Medicaid and adults with full Medicaid. Orthodontia and limited dental care services are available for children with ARKids B.

DDS Alternative Community (ACS) Waiver Services – The service offers certain “home and community-based services” as an alternative to institutionalization for recipients who have a developmental disability and need special care no matter how old they are. Refer to [MS B-317](#).

Developmental Day Treatment Clinic Services (DDTCS) – Services provided to adults and children with developmental disabilities, such as autism or severe learning disabilities.

Durable Medical Equipment (DME) – Medicaid and ARKids will pay for some durable medical equipment. A prescription and a referral from the PCP are required.

Emergency Services – Medicaid will pay for services provided in a hospital emergency room only if the services meet the Medicaid emergency criteria.

Family Planning Services – Medicaid pays for these services for recipients who are of childbearing age.

# Medical Services – Appendix D, Benefits Available Under Medicaid and ARKids First

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01/01/19

Federally Qualified Health Center – Medicaid pays for a range of medically necessary procedures provided in a certified Federally Qualified Health Center.

Hearing Services – Medicaid covers hearing tests and hearing aids for children under age 21 who are enrolled in the Child Health Services (EPSDT) Program.

Home Health Care - Home health services are provided in the eligible person's home.

Hospice – Services for recipients who are terminally ill and not expected to live for a long period of time.

Hyperalimentation Services - Fluids, equipment and supplies necessary for the administration of fluids in the recipient's home for parenteral and enteral nutrition therapy are covered by Medicaid.

Injections – Allergy shots and immunizations for recipients under age 21 are covered through the Child Health Services (EPDST) Program, if medically necessary. Although some other injections are covered by Medicaid, coverage is limited for adults.

Inpatient Hospital Services – Medicaid pays for hospitalization when it is medically necessary.

Inpatient Psychiatric Program - Coverage of Inpatient Psychiatric Services for individuals under age 21 and ARKids B recipients.

Laboratory and X-Ray Services – Labs and x-rays are covered if requested by the doctor. There is a limit on the number of tests and x-rays for recipients age 21 or older.

Living Choices Assisted Living (ALF) – Medicaid pays for apartment-styled housing for recipients (age 65 or older or age 21 through 64 determined as meeting a physical disability by SSA or DHS Medical Review Team) who are at risk of being placed in a nursing home or who already live in a nursing home and want more independence. Refer to [MS B-312](#) for more information about this program.

Long Term Care (Nursing Facility) – Medicaid pays for nursing home care in a Medicaid certified nursing home. Nursing home care must be recommended by a doctor. Refer to [MS B-311](#) for more information about this program.

Nurse-Midwife Service – Medicaid will pay for a certified nurse-midwife trained to deliver babies in a hospital, birthing center or clinic, or in the patient's home, and to care for a woman while she is pregnant and just after she has the baby. ARKids B recipients have to pay a co-payment for each visit.

Nurse Practitioner Services – Nurse practitioners are nurses with special training that can do some of the things a doctor can do. Medicaid will pay for a certain number of visits with a nurse practitioner. A doctor's referral may be required. ARKids B recipients may have to pay a co-pay.

Organ Transplants - Medicaid will pay for services required for certain organ transplants. Prior authorization is required.

## Medical Services – Appendix D, Benefits Available Under Medicaid and ARKids First

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01/01/19

Outpatient Hospital Services – Most outpatient hospital care is covered, however there may be some charges the recipient may have to pay. There is a limit on the number of visits for adults aged 21 or older. ARKids B coverage requires a co-payment.

Personal Care Services - Personal care services will be paid if they are prescribed by a physician and provided according to a plan of care in the recipient's home.

Physician Services - Medicaid will pay for a limited number of physician services for recipients aged 21 or older each year.

Podiatrist Services – A podiatrist specializes in problems of the feet. Recipients age 21 or older have a limit number of visits Medicaid will pay for. ARKids B requires a copayment.

Prescription Drugs – Medicaid and ARKids cover most prescription drugs. Some prescriptions will require prior approval. ARKids B recipients may have to pay a copay.

Private Duty Nursing Services (PDN) - Nursing services may be covered for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of a hospital or skilled nursing facility.

Prosthetics - A range of prosthetic services is available to Medicaid recipients based on the age of the recipient.

Psychology Services – A broad range of psychology services for recipients under age 21 is provided through the Child Health Services (EPDST) Program.

Rehabilitative Services for Persons with Mental Illness (RSPMI) – Medicaid will pay for some rehabilitative services for mental illness.

Rehabilitative Services for Persons with Physical Disabilities (RSPD) – Medicaid pays for rehabilitation services for children under age 21 with physical disabilities, if services are recommended by a doctor or other licensed medical worker. The child must have had a severe brain injury or a spinal cord disorder or injury.

Rural Health Clinic Services – Medicaid will pay for a limited number of visits to a rural health clinic for individuals aged 21 or older.

Targeted Case Management – Targeted case managers help patients find and get the medical services needed as prescribed by a doctor. The patient may be able to get this service if younger than 21 and referred as a result of a well-child check-up; has ARKids A or regular Medicaid; has a developmental disability; is aged 60 or older; or is pregnant.

TEFRA Services – Medicaid pays for services in the home for certain children (aged 18 or younger) with disabilities if they would qualify for Medicaid as residents of a hospital, skilled nursing facility, or ICF/IID (Intermediate Care Facilities/Individuals with Intellectual Disabilities).

## Medical Services – Appendix D, Benefits Available Under Medicaid and ARKids First

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Therapy Services – Occupational, physical, and speech therapy services are provided to recipients under age 21 through the Child Health Services (EPDST) Program. These services are also provided to ARKids A and B recipients. Therapy services for individuals aged 21 and older are only covered when provided through the following Medicaid Programs: Developmental Day Treatment Clinic Services (DDTCS), Hospital/Critical Access Hospital (CAH)/End-Stage Renal Disease (ESRD), Home Health, Hospice and Physician/Independent Lab/CRNA/Radiation Therapy Center.

Transportation – Medical transportation may be covered for certain Medicaid recipients needing to travel to and from a medical facility that provides medical services covered by Medicaid. Refer to ([MS Appendix B](#)) for a description of Transportation Services.

Ventilator Equipment – Equipment in the recipient’s place of residence (own dwelling, a relative’s home or a nursing facility) may be covered only when determined to be medically necessary and prescribed by a physician. Ventilator equipment is not covered in a boarding home or a residential care facility.

Vision Care Services – Medicaid will pay for services that include a limited number of vision examinations, eyeglasses, replacements and repair of eyeglasses.

## Medical Services –Appendix E, Dependent Filing Requirements and MAGI

MS Manual E-263

To determine if a child is required to file a tax return, see the chart below.

### 2019 Filing Requirement for Dependents

If your parent (or someone else) can claim you as a dependent, use this table to see if you must file a return.
<b>Single dependents</b> —Were you <b>either</b> age 65 or older <b>or</b> blind?
<b>No.</b> You must file a return if <b>any</b> of the following apply.
<ul style="list-style-type: none"> <li>• Your unearned income was over \$1,100.</li> <li>• Your earned income was over \$12,200.</li> <li>• Your gross income was more than the larger of—                             <ul style="list-style-type: none"> <li>• \$1,100, or</li> <li>• Your earned income (up to \$11,850) plus \$350.</li> </ul> </li> </ul>
<b>Yes.</b> You must file a return if any of the following apply.
<ul style="list-style-type: none"> <li>• Your unearned income was over \$2,750 (\$4,400 if 65 or older and blind).</li> <li>• Your earned income was over \$13,850 (\$15,500 if 65 or older and blind).</li> <li>• Your gross income was more than the larger of—                             <ul style="list-style-type: none"> <li>• \$2,750 (\$4,400 if 65 or older and blind), or</li> <li>• Your earned income (up to \$11,850) plus \$2,000 (\$3,650 if 65 or older and blind).</li> </ul> </li> </ul>
<b>Married dependents</b> —Were you <b>either</b> age 65 or older <b>or</b> blind?
<b>No.</b> You must file a return if any of the following apply:
<ul style="list-style-type: none"> <li>• Your gross income was at least \$5 and your spouse files a separate return and itemizes deductions.</li> <li>• Your unearned income was over \$1,100.</li> <li>• Your earned income was over \$12,200.</li> <li>• Your gross income was more than the larger of—                             <ul style="list-style-type: none"> <li>• \$1,100, or</li> <li>• Your earned income (up to \$11,850) plus \$350.</li> </ul> </li> </ul>
<b>Yes.</b> You must file a return if any of the following apply:
<ul style="list-style-type: none"> <li>• Your gross income was at least \$5 and your spouse files a separate return and itemizes deductions.</li> <li>• Your unearned income was over \$2,400 (\$3,700 if 65 or older and blind).</li> <li>• Your earned income was over \$13,500 (\$14,800 if 65 or older and blind).</li> <li>• Your gross income was more than the larger of—                             <ul style="list-style-type: none"> <li>• \$2,400 (\$3,700 if 65 or older and blind), or</li> <li>• Your earned income (up to \$11,850) plus \$1,650 (\$2,950 of 65 or older and blind).</li> </ul> </li> </ul>

**Example:** Sarah is 18 and single. Her parents can claim her as a dependent on their income tax return. She received \$1,970 of taxable interest and dividend income. She didn't work during the year. She must file a tax return because she has unearned income only and her gross income is more than \$1,100. If she is blind, she doesn't have to file a return because she has unearned income only and her gross income isn't more than \$2,750.

**2018 Filing Requirement for Dependents**

If your parent (or someone else) can claim you as a dependent, use this table to see if you must file a return.
<b>Single dependents—Were you either age 65 or older or blind?</b>
<b>No.</b> You must file a return if <b>any</b> of the following apply.
• Your unearned income was over \$1,050.
• Your earned income was over \$12,000.
• Your gross income was more than the larger of—
• \$1,050, or
• Your earned income (up to \$11,650) plus \$350.
<b>Yes.</b> You must file a return if any of the following apply.
• Your unearned income was over \$2,650 (\$4,250 if 65 or older <b>and</b> blind).
• Your earned income was over \$13,600 (\$15,200 if 65 or older <b>and</b> blind).
• Your gross income was more than the <b>larger</b> of—
• \$2,650 (\$4,250 if 65 or older <b>and</b> blind), or
• Your earned income (up to \$11,650) plus \$1,950 (\$3,550 if 65 or older <b>and</b> blind).
<b>Married dependents—Were you either age 65 or older or blind?</b>
<b>No.</b> You must file a return if any of the following apply:
• Your gross income was at least \$5 and your spouse files a separate return and itemizes deductions.
• Your unearned income was over \$1,050.
• Your earned income was over \$12,000.
• Your gross income was more than the <b>larger</b> of—
• \$1,050, or
• Your earned income (up to \$11,650) plus \$350.
<b>Yes.</b> You must file a return if any of the following apply:
• Your gross income was at least \$5 and your spouse files a separate return and itemizes deductions.
• Your unearned income was over \$2,350 (\$3,650 if 65 or older <b>and</b> blind).
• Your earned income was over \$13,300 (\$14,600 if 65 or older <b>and</b> blind).
• Your gross income was more than the <b>larger</b> of—
• \$2,350 (\$3,650 if 65 or older <b>and</b> blind), or
• Your earned income (up to \$11,650) plus \$1,650 (\$2,950 of 65 or older <b>and</b> blind).

**Example:** Sarah is 18 and single. Her parents can claim her as a dependent on their income tax. Return. She received \$1,970 of taxable interest and dividend income. She didn't work during the work during the year. She must file a tax return because she has unearned income only and her gross income is more than \$1,050. If she is blind, she doesn't have to file a return because she has unearned income only and her gross income isn't more than \$2,650.

2017 Filing Requirement for Dependents

If your parent (or someone else) can claim you as a dependent, use this table to see if you must file a return.
<b>Single dependents</b> —Were you <b>either</b> age 65 or older <b>or</b> blind?
<b>No.</b> You must file a return if <b>any</b> of the following apply.
• Your unearned income was over \$1,050.
• Your earned income was over \$6,350
• Your gross income was more than the <b>larger</b> of—
• \$1,050, or
• Your earned income (up to \$6,000) plus \$350.
<b>Yes.</b> You must file a return if any of the following apply.
• Your unearned income was over \$2,600 (\$4,150 if 65 or older <b>and</b> blind).
• Your earned income was over \$7,900 (\$9,450 if 65 or older <b>and</b> blind).
• Your gross income was more than the <b>larger</b> of—
• \$2,600 (\$4,150 if 65 or older <b>and</b> blind), or
• Your earned income (up to \$6,000) plus \$1,900 (\$3,450 if 65 or older <b>and</b> blind).
<b>Married dependents</b> —Were you <b>either</b> age 65 or older <b>or</b> blind?
<b>No.</b> You must file a return if <b>any</b> of the following apply:
• Your gross income was at least \$5 and your spouse files a separate return and itemizes deductions.
• Your unearned income was over \$1,050.
• Your earned income was over \$6,350.
• Your gross income was more than the <b>larger</b> of—
• \$1,050, or
• Your earned income (up to \$6,000) plus \$350.
<b>Yes.</b> You must file a return if any of the following apply:
• Your gross income was at least \$5 and your spouse files a separate return and itemizes deductions.
• Your unearned income was over \$2,300 (\$3,550 if 65 or older <b>and</b> blind).
• Your earned income was over \$7,600 (\$8,850 if 65 or older <b>and</b> blind).
• Your gross income was more than the <b>larger</b> of—
• \$2,300 (\$3,550 if 65 or older <b>and</b> blind), or
• Your earned income (up to \$6,000) plus \$1,600 (\$2,850 of 65 or older <b>and</b> blind).

**Example:** Sarah is 18 and single. Her parents can claim an exemption for her on their income tax return. She received \$1,970 of taxable interest and dividend income. She didn't work during the year. She must file a tax return because she has unearned income only and her gross income is more than \$1,050. If she is blind, she doesn't have to file a return because she has unearned income only and her gross income isn't more than \$2,600.

**2016 Filing Requirement for Dependents**

If your parent (or someone else) can claim you as a dependent, use this table to see if you must file a return.
<b>Single dependents</b> —Were you <b>either</b> age 65 or older <b>or</b> blind?
<b>No.</b> You must file a return if <b>any</b> of the following apply.
• Your unearned income was over \$1,050.
• Your earned income was over \$6,300.
• Your gross income was more than the <b>larger</b> of—
• \$1,050, or
• Your earned income (up to \$5,950) plus \$350.
<b>Yes.</b> You must file a return if any of the following apply.
• Your unearned income was over \$2,600 (\$4,150 if 65 or older <b>and</b> blind).
• Your earned income was over \$7,850 (\$9,400 if 65 or older <b>and</b> blind).
• Your gross income was more than the <b>larger</b> of—
• \$2,600 (\$4,150 if 65 or older <b>and</b> blind), or
• Your earned income (up to \$5,950) plus \$1,900 (\$3,450 if 65 or older <b>and</b> blind).
<b>Married dependents</b> —Were you <b>either</b> age 65 or older <b>or</b> blind?
<b>No.</b> You must file a return if <b>any</b> of the following apply:
• Your gross income was at least \$5 and your spouse files a separate return and itemizes deductions.
• Your unearned income was over \$1,050.
• Your earned income was over \$6,300.
• Your gross income was more than the <b>larger</b> of—
• \$1,050, or
• Your earned income (up to \$5,950) plus \$350.
<b>Yes.</b> You must file a return if any of the following apply:
• Your gross income was at least \$5 and your spouse files a separate return and itemizes deductions.
• Your unearned income was over \$2,300 (\$3,550 65 or older <b>and</b> blind).
• Your earned income was over \$7,550 (\$8,800 if 65 or older <b>and</b> blind).
• Your gross income was more than the <b>larger</b> of—
• \$2,300 (\$3,550 if 65 or older <b>and</b> blind), or
• Your earned income (up to \$5,950) plus \$1,600 (\$2,850 of 65 or older <b>and</b> blind).

**Example:** Sarah is 18 and single. Her parents can claim an exemption for her on their income tax return. She received \$1,970 of taxable interest and dividend income. She didn't work during the year. She must file a tax return because she has unearned income only and her gross income is more than \$1,050. If she is blind, she doesn't have to file a return because she has unearned income only and her gross income isn't more than \$2,600.

**2015 Filing Requirement for Dependents**

If your parent (or someone else) can claim you as a dependent, use this table to see if you must file a return.	
<b>Single dependents</b> —Were you <b>either</b> age 65 or older <b>or</b> blind?	
<b>No.</b> You must file a return if <b>any</b> of the following apply.	
• Your unearned income was over \$1,050.	
• Your earned income was over \$6,300.	
• Your gross income was more than the <b>larger</b> of—	
• \$1,050, or	
• Your earned income (up to \$5,950) plus \$350.	
<b>Yes.</b> You must file a return if any of the following apply.	
• Your unearned income was over \$2,600 (\$4,150 if 65 or older <b>and</b> blind).	
• Your earned income was over \$7,850 (\$9,400 if 65 or older <b>and</b> blind).	
• Your gross income was more than the <b>larger</b> of—	
• \$2,600 (\$4,150 if 65 or older <b>and</b> blind), or	
• Your earned income (up to \$5,950) plus \$1,900 (\$3,450 if 65 or older <b>and</b> blind).	
<b>Married dependents</b> —Were you <b>either</b> age 65 or older <b>or</b> blind?	
<b>No.</b> You must file a return if <b>any</b> of the following apply:	
• Your gross income was at least \$5 and your spouse files a separate return and itemizes deductions.	
• Your unearned income was over \$1,050.	
• Your earned income was over \$6,300.	
• Your gross income was more than the <b>larger</b> of—	
• \$1,050, or	
• Your earned income (up to \$5,950) plus \$350.	
<b>Yes.</b> You must file a return if any of the following apply:	
• Your gross income was at least \$5 and your spouse files a separate return and itemizes deductions.	
• Your unearned income was over \$2,300 (\$3,550 if 65 or older <b>and</b> blind).	
• Your earned income was over \$7,550 (\$8,800 if 65 or older <b>and</b> blind).	
• Your gross income was more than the <b>larger</b> of—	
• \$2,300 (\$3,550 if 65 or older <b>and</b> blind), or	
• Your earned income (up to \$5,950) plus \$1,600 (\$2,850 of 65 or older <b>and</b> blind).	

**Example:** Sarah is 18 and single. Her parents can claim an exemption for her on their income tax return. She received \$1,970 of taxable interest and dividend income. She did not work during the year. She must file a tax return because she has unearned income only and her gross income is more than \$1,050. If she is blind, she does not have to file a return because she has unearned income only and her gross income is not more than \$2,600.

**Calculating a child's income in MAGI:**

**Child receives only SSA income:**

Is  $\frac{1}{2}$  the child's yearly SSA equal to or less than \$25,000?

**Yes**—NONE of the SSA is taxable and you count \$0 SSA for MAGI. You are done, no additional calculations needed. Enter the income amount the child receives as SSA income and Cúram will do the calculations for you.

**No**—Some or all the SSA will be taxable, you will enter the full amount of the SSA income for MAGI.

**Example 1:** *Child receives \$900.00 monthly SSA = \$10,800 yearly SSA.  $\frac{1}{2}$  of \$10,800 = \$5,400.00. Since \$5,400.00 is less than the base amount of \$25,000, the child's income is not taxable and therefore not counted in MAGI.*

**Child receives SSA and other income:**

Is  $\frac{1}{2}$  the child's yearly SSA **plus** all the other income equal to or less than \$25,000?

**Yes**—NONE of the SSA is taxable and you count \$0 SSA for MAGI. Enter the income amount the child receives as SSA income and Cúram will do the calculations for you.

**No**—Some or all the income may be taxable. If the other unearned income received or the earned income received are over the filing threshold amounts, all the child's income is counted in MAGI.

**Example 2:** *Child receives \$2,200.00 monthly SSA = \$26,400 yearly SSA.  $\frac{1}{2}$  of \$26,400 = \$13,200. Child also receives \$14,000 in yearly interest.  $\$13,200 + \$14,000 = \$27,200$ . Since the child's total calculated income is over the base amount of \$25,000, some or all of the income may be taxable. Furthermore, since the other unearned income (\$14,000 yearly interest) is over the threshold requirements of \$1100.00, all the child's income is counted in MAGI.*

**Example 3:** *Child receives \$2,200.00 monthly SSA = \$26,400 yearly SSA.  $\frac{1}{2}$  of \$26,400 = \$13,200. Child also receives \$13,000 in yearly earnings.  $\$13,200 + \$13,000 = \$26,200$ . Since the child's total calculated income is over the base amount of \$25,000, some or all of the income may be taxable. Furthermore, since the earned income (\$13,000 yearly earnings) alone is over the threshold requirements of \$12,200.00, all the child's income is counted in MAGI.*

**Examples of Determining Households**

**Example 1: Grandmother claiming daughter and granddaughter as tax dependents**

Bertha is a working grandmother who claims her daughter Audrey, age 20 and a full-time student, and granddaughter Chloe (Audrey’s daughter), age 2, as tax dependents. The household consists of these three only. All are applying for medical assistance.

<b>Bertha’s Household</b>			
1.	Does Bertha expect to file a tax return?	Yes	Continue to Question 1a.
1a.	Does Bertha expect to be claimed as a tax dependent by anyone else?	No	
Bertha’s household:		Bertha (applicant and taxpayer) Audrey (tax dependent) Chloe (tax dependent)	

<b>Audrey’s Household</b>			
1.	Does Audrey expect to file a tax return?	No	Continue to Question 2.
2.	Does Audrey expect to be claimed as a tax dependent?	Yes	Continue to Question 2a.
2a.	Does Audrey expect to be claimed as a tax dependent of someone other than a spouse or biological, adopted or step-parent?	No	
	Is Audrey under age 19 living with both parents but the parents do not expect to file a joint tax return?	No	
	Is Audrey under age 19 and expecting to be claimed by a non-custodial parent?	No	
Audrey’s household:		Audrey (applicant) Bertha (taxpayer) Chloe (tax dependent)	

<b>Chloe’s Household</b>			
1.	Does Chloe expect to file a tax return?	No	Continue to Question 2.
2.	Does Chloe expect to be claimed as a tax dependent?	Yes	Continue to Question 2a.

**Medical Services –Appendix E, Dependent Filing Requirements and MAGI**

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2a.	Does Chloe expect to be claimed as a tax dependent of someone other than a spouse or a biological, adopted or step-parent?	Yes	<i>See MS E-250</i> Chloe is claimed by her grandmother Gloria. Since she falls into one of the exceptions under 2a, we look to the rules of non-filers to determine Chloe’s household
Chloe is under age 19 and is claimed as a tax dependent by her grandmother, Bertha.			
Chloe’s household includes the person or persons who live in the home with her:			
Spouse			No
Children (biological, adopted and step children) under age 19			None
Parents (biological, adopted and step-parents)			Yes
Siblings (biological, adopted and step siblings) under age 19			None
Chloe’s household is: Chloe Audrey (Chloe’s parent living in the home with her)			

**Bertha’s and Audrey’s Household Composition (which determines whose income is counted)**

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

**Chloe’s Household**

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

## Medical Services –Appendix E, Dependent Filing Requirements and MAGI

		child nor tax dependent of any of the other members of this household, i.e., Chloe.
Chloe	Child Support	No – Chloe is Audrey’s child; child support income is not counted.
<p>Bertha works full time as the vice president of the High Rise Corporation. She reported that the annual income amount returned from the Federal Data Services Hub (\$96,000) was reflective of her current salary and that she receives the same amount each month. Therefore, the annual income amount can be divided by 12 months to arrive at her current monthly income (\$8,000).</p>		
<p>Audrey just started working part time (10 hours per week) at the daycare center where Chloe attends. She earns \$7.25 per hour. Her current monthly income is determined as follows:                      1. <math>\\$7.25 \times 10 = \\$72.50</math>                      2. <math>\\$72.50 \times 4.334 = \\$314.22</math> monthly income</p>		

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

- Bertha earns \$8,000.00 per month which equals \$96,000 annually.
- Audrey earns \$314.22 per month which equals \$3,770.64 annually.
- Audrey is the child and tax dependent of Bertha. Audrey is not required to file taxes; therefore, her income doesn’t count. Bertha’s income is counted.
- Bertha’s household size is 3.
- Compare the \$8,000.00 monthly income to the Adult Expansion Program standard of 138% for 3, \$2,245.95.
- Bertha and Audrey are not eligible for the Adult Expansion Program; therefore, the agency will electronically transfer their account to the Exchange for possible eligibility for premium tax credits and cost sharing reductions.

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

- Audrey earns \$314.22 per month which equals \$3,770.64 annually.
- Audrey’s income will be counted because neither her mother, nor father is included in this household. Chloe’s child support income is disregarded.
- Chloe’s household size is 2.
- Compare the \$314.22 monthly income to the ARKids A standard of 142% for 2, \$1,835.35.
- Chloe is eligible for ARKids A.

## Medical Services –Appendix E, Dependent Filing Requirements and MAGI

### Example 2: Single parent and child

Gloria is 47 years old. She is a single mother that has a 13 year old daughter, FeFe. Gloria claims FeFe as her tax dependent when filing her taxes. Gloria is applying for medical assistance for herself and her daughter.

<b>Gloria’s Household</b>			
1.	Does Gloria expect to file a tax return?	Yes	Continue to Question 1a
1a.	Does Gloria expect to be claimed as a tax dependent by anyone else?	No	
Gloria’s household:		Gloria (taxpayer) FeFe (tax dependent)	

<b>FeFe’s Household</b>			
1.	Does FeFe expect to file a tax return?	No	Continue to Question 2.
2.	Does FeFe expect to be claimed as a tax dependent by someone else?	Yes	Continue to Question 2a.
2.a.	Does FeFe expect to be claimed as a tax dependent by someone other than a spouse or a biological, adopted or step-parent?	No	
	Is FeFe under age 19 living with both parents but the parents do not expect to file a joint tax return?	No	
	Is FeFe under age 19 and expect to be claimed as a tax dependent by a non-custodial parent?	No	
FeFe’s household:		Gloria (taxpayer) FeFe (tax dependent)	
<p>Since all the answers to Question 2a are “No”, FeFe’s household is the same as Gloria’s household, that is the household of the taxpayer claiming her as a dependent.</p> <p>Gloria works full time at Rising Boutique and earns \$7.25 per hour. She is paid weekly. Gloria receives \$500.00 per month in child support for FeFe. Her monthly earned income is \$1,256.86.</p> <ul style="list-style-type: none"> <li>• <math>\\$7.25 \times 40 = \\$290.00</math>.</li> <li>• <math>\\$290.00 \times 4.334 = \\$1,256.86</math>.</li> </ul> <p>Child support income is disregarded.</p>			

## Medical Services –Appendix E, Dependent Filing Requirements and MAGI

Gloria and FeFe’s households are the same: Gloria and FeFe.

- Gloria earns \$1,256.86 per month which equals \$15,082.32 annually.
- FeFe is the tax dependent of Gloria.
- FeFe’s child support income is not counted.
- Gloria’s household size is 2.
- Compare the \$1,256.86 monthly income to the \$220.00 Parent/Caretaker Relative standard for 2.
- Compare the \$1,256.86 monthly income to the \$1,719.03 Adult Expansion Program.
- Compare the \$1,256.86 monthly income to the ARKids A standard of 142% for 2, \$1,835.35.
- FeFe is eligible for ARKids A.

Gloria is eligible for the Adult Expansion Program without applying the 5% disregard.

### **Example 3: Single adult who files taxes**

Linda is 21 years old and lives at home with her parents. Linda files income taxes and her parents do not claim her as a tax dependent. Linda is applying for medical assistance because she does not have health insurance.

<b>Linda’s Household</b>			
1.	Does Linda expect to file a tax return?	Yes	Continue to Question 1a.
1a.	Does Linda expect to be claimed as a tax dependent by someone else?	No	
Linda’s household:		Linda (taxpayer)	
Linda works full time at the Hardware Store and earns \$8.50 per hour. She is paid bi-weekly. Her monthly earned income is \$1,473.56. <ul style="list-style-type: none"> <li>• <math>\\$8.50 \times 80 = \\$680.00</math></li> <li>• <math>\\$680.00 \times 2.167 = \\$1,473.56</math></li> </ul>			

- Linda earns \$1,473.56 per month which equals \$17,682.72 annually.
- Linda is expected to file a tax return.
- Linda household size is 1.
- Compare the \$1,473.56 monthly income to the \$1,321.35 (with 5% disregard) Adult Expansion Program standard for 1.
- Linda is not eligible for the Adult Expansion Program; therefore, the agency will electronically transfer their account to the Exchange for possible eligibility for premium tax credits and cost sharing reductions.

## Medical Services –Appendix E, Dependent Filing Requirements and MAGI

### Example 4: Single adult claimed as tax dependent

Willis is 27 years old, attending college and living with his parents, Gary and Rose. Willis is not filing a tax return because he hasn't worked in the last 5 years. The parents file joint tax returns and claim Willis as a tax dependent. The household consists of Gary, Rose and Willis. Willis is applying for medical assistance.

<b>Willis' Household</b>			
1.	Does Willis expect to file a tax return?	No	Continue to Question 2.
2.	Does Willis expect to be claimed as a tax dependent?	Yes	Continue to Question 2a.
2a.	Does Willis expect to be claimed as a tax dependent of someone other than a spouse or a biological, adopted or step-parent?	No	
	Is Willis under age 19 living with both parents but the parents do not expect to file a joint tax return?	No	
	Is Willis under age 19 and expecting to be claimed by a non-custodial parent?	No	
Willis' household:		Willis (tax dependent) Rose (taxpayer) Gary (taxpayer and Rose's spouse)	
<p>Rose works full time as a registered nurse and Gary works full time as a licensed practical nurse. Rose earns \$35.00 per hour and Gary earns \$20.00 per hour. Both are paid once a month. Their monthly earned income is \$8,800.00.</p> <ul style="list-style-type: none"> <li>• \$35.00 x 160 (40 hours per week) = \$5,600.00.</li> <li>• \$20.00 x 160 (40 hours per week) = \$3,200.00.</li> </ul>			

- Willis earns no income.
- Willis parent's income will be counted because he lives with them and they carry him as a tax dependent.
- Willis household size is 3.
- Compare the \$8,800.00 monthly income to the \$2,245.95 (with 5% disregard) Adult Expansion Program standard for 3 people.
- Willis is not eligible for the Adult Expansion Program; therefore, the agency will electronically transfer his account to the Exchange for possible eligibility for premium tax credits and cost sharing reductions.

## Medical Services –Appendix E, Dependent Filing Requirements and MAGI

### **Example 5: Single adult with a child who is claimed as a tax dependent by the non-custodial parent**

Crissy is 27 years old and has an 11 year old daughter, Hanna. Crissy is filing taxes this year, but Hanna is being claimed as a tax dependent by her father who doesn't live in the home with Crissy and Hanna. Crissy is applying for medical assistance for herself and Hanna.

<b>Crissy's Household</b>			
1.	Does Crissy expect to file a tax return?	Yes	Continue to Question 1a
1a.	Does Crissy expect to be claimed as a tax dependent	No	
Crissy's household:		Herself (taxpayer) Because she doesn't have a spouse living with her and she doesn't expect to claim anyone else as a tax dependent, she is the only member of her household for Medicaid purposes.	
<b>Hanna's Household</b>			
1.	Does Hanna expect to file a tax return?	No	Continue to Question 2
2.	Does Hanna expect to be claimed as a tax dependent?	Yes	Continue to Question 2a
2a.	Is Hanna expected to be claimed as a tax dependent of someone other than a spouse or a biological, adopted, or step-parent?	No	<i>See MS E-250</i> Hanna is claimed by her non-custodial parent. Since she falls into one of the exceptions under 2a, we look to the rules of non-filers to determine Hanna's household.
	Is Hanna under age 19 living with both parents but the parents do not expect to file a joint tax return?	No	
	Is Hanna under age 19 and expects to be claimed by a non-custodial parent?	Yes	
3.	Hanna's household includes the person or persons who live in the home with her:		Hanna (tax dependent of non-custodial parent) Crissy (Hanna's mother)
	Spouse	No	
	Children (biological, adopted, and step) under age 19	No	
	Parents (biological, adopted, and step)	Yes	

## Medical Services –Appendix E, Dependent Filing Requirements and MAGI

	Siblings (biological, adopted and step) under age 19	No	
Crissy works part time at the Grocery Store and earns \$10.50 per hour. She is paid bi-weekly. Crissy's monthly earned income is \$1,365.21. <ul style="list-style-type: none"><li>• <math>\\$10.50 \times 60 = \\$630.00</math></li><li>• <math>\\$630.00 \times 2.167 = \\$1,365.21</math></li></ul>			

- Crissy earns \$1,365.21 per month which equals \$16,382.52 annually.
- Hanna's child support is disregarded.
- Crissy's household size is 1.
- Compare the \$1,365.21 monthly income to the \$220.00 Parent/Caretaker Relative standard for 1 person.
- Compare the \$1,365.21 monthly income to the \$1,321.35 (with the 5% disregard) Adult Expansion Program standard for 1 person.
- Compare the \$1,365.21 monthly income to the 142% ARKids A standard for 2 people, \$1,835.35.
- Crissy is not eligible for the Adult Expansion Program.
- Hanna is eligible for ARKids A.

**Example 6: Single adult who doesn't file tax**

Brenda is 26 years old, unemployed and lives alone. Brenda has exhausted all her unemployment benefits because she has been unemployed for the last 3 years and for the last 12 months she has not received any unemployment benefits. Brenda is applying for medical assistance.

<b>Brenda's Household</b>		
1.	Does Brenda expect to file taxes?	No
2.	Does Brenda expect to be claimed as a tax dependent?	No
Brenda's Household:		Brenda Her household is based on the non-filer rules due to: not being a taxpayer, claimed as a tax dependent, or expected to file a federal income tax return for the current year. She will include herself only, because she doesn't have a spouse, biological/adopted/step children, or biological/adopted/step-parent living with her.
Brenda does not have income.		

Brenda's household consists of herself only.

- Brenda doesn't receive any income.
- Brenda is eligible for the Adult Expansion Program without applying the 5% disregard.

**Example 7:** Jonathan and Shelia have legal guardianship of their nephew, Mason. They are applying for Medical assistance for Mason.

<b>Mason’s Household</b>			
1.	Does Mason expect to file taxes?	No	Continue to Question 2
2.	Does Mason expect to be claimed as a tax dependent?	Yes	Continue to Question 2a
2a.	Is Mason expected to be claimed as a tax dependent by someone other than a spouse or a biological, adopted or step-parent?	Yes	<i>See MS E-250</i> Mason is claimed as a tax dependent by his uncle and aunt who have legal guardianship of him. Since he falls into one of the exceptions under 2a, we look to the rules of non-filers to determine Mason’s household
Mason’s household:			Mason (tax dependent)
Includes the following persons who live in the home with Mason:			
	Spouse	None	
	Children (biological, adopted and step children) under age 19	None	
	Parents (biological, adopted and step)	None	
	Siblings (biological, adopted and step) under age 19	None	
Mason doesn’t receive any income.			

Mason’s household consists of himself only.

- Mason doesn’t have any income.
- Mason is eligible for ARKids A.

**Medical Services –Appendix E, Dependent Filing Requirements and MAGI**

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**Example 8:** Martha is applying for Medicaid for her son Matthew. Martha is pregnant with twins. Martha works fulltime as an elementary school teacher. She has health insurance for herself.

<b>Matthew’s Household</b>			
1.	Does Matthew expect to file a tax return?	No	Continue to Question 2
2.	Does Matthew expect to be claimed as a tax dependent?	Yes	Continue to Question 2a
2.a.	Does the Matthew meet any of the following exceptions?		
	Expects to be claimed as a tax dependent of someone other than a spouse or parent (biological, adoptive or step-parent)?	No	
	Is a child under age 19 living with both parents but the parents do not expect to file a joint tax return?	No	
	Is a child under age 19 who expects to be claimed by a non-custodial parent?	No	
Matthew’s household is: Martha (the tax payer) Matthew (the tax dependent) The twins Martha is expecting			
Martha earns \$2,900.00 per month.			

Matthew household consists of himself.

- Matthew doesn’t have any income. Martha’s income is counted.
- Matthew is a tax dependent of Martha, his mother.
- Martha earns \$2,900.00 per month which equals \$34,800.00 annually.
- Compare the \$2,900.00 monthly income to the 2,884.88 (with the 5% disregard) ARKids A standard for 4 people.
- Matthew is not eligible for ARKids A.
- Compare the \$2,900.00 monthly income to the \$4,140.88 (without the 5% disregard) ARKids B standard for 4 people.
- Matthew is eligible for ARKids B.

**MEDICAL SERVICES – APPENDIX F, FEDERAL POVERTY LEVELS**

**Monthly Levels (April 1, 2020 through March 31, 2021)**

04/01/2020

**Families and Individuals Medicaid Categories**

Family Size	Adult Expansion Group 133%	Adult Expansion Group with 5% Disregard 138%	ARKids A 142%	ARKids A with 5% Disregard 147%	ARKids B 211%	ARKids B with 5% Disregard 216%	Full Pregnant Women & Parents/ Caretaker Relatives	Transitional Medicaid 185%	Limited PW/Unborn Child 209%	Limited PW/Unborn Child with 5% Disregard 214%
1	1414.23	1467.40	1509.93	1563.10	2243.63	2296.80	124.00	1967.17	2222.37	2275.53
2	1910.77	1982.60	2040.07	2111.90	3031.37	3103.20	220.00	2657.83	3002.63	3074.47
3	2407.30	2497.80	2570.20	2660.70	3819.10	3909.60	276.00	3348.50	3782.90	3873.40
4	2903.83	3013.00	3100.33	3209.50	4606.83	4716.00	334.00	4039.17	4563.17	4672.33
5	3400.37	3528.20	3630.47	3758.30	5394.57	5552.40	388.00	4729.83	5343.43	5471.27
6	3896.90	4043.40	4160.60	4307.10	6182.30	6328.80	448.00	5420.50	6123.70	6270.20
7	4393.43	4558.60	4690.73	4855.90	6970.03	7135.20	505.00	6111.17	6903.97	7069.13
8	4889.97	5073.80	5220.87	5404.70	7757.77	7941.60	561.00	6801.83	7684.23	7868.07
9	5386.50	5589.00	5751.00	5953.50	8545.50	8748.00	618.00	7492.50	8464.50	8667.00
10	5883.03	6104.20	6281.13	6502.30	9333.23	9554.40	618.00	8183.17	9244.77	9465.93
Each addl member add:	496.53	515.20	530.13	548.80	787.73	806.40	9 and greater 618.00	690.67	780.27	798.93

**AABD Medicaid Categories**

	ARSeniors Equal to or Below 80%	QMB Equal To or Below 100%	SMB Between 100% & 120%	QI-1 At least 120% but Less Than 135%	QDWI Equal To or Below 200%
Individual	850.67	1063.33	1276.00	1435.50	2126.67
Couple	1149.33	1436.67	1724.00	1939.50	2873.33

## Medical Services – Appendix G, ARKids Extent of Services

01/01/19

### Extent of Services

Both ARKids A and ARKids B provide basic health insurance coverage. Infants and children found eligible for benefits under ARKids A are entitled to the full range of services that Medicaid provides, including Child Health Services (EPSDT). There are no copayments in ARKids A for individuals under the age of 18.

Participants in ARKids B are not eligible for the full range of Medicaid services. Co-payments and coinsurance will apply, as appropriate, for all services with the exception of immunizations, preventive health screenings, family planning, and prenatal care. There is no co-pay for dental checkups. Child Health Services (EPSDT) are not offered.

Based on the family's countable income and size, eligibility will be determined in the appropriate ARKids category. Below is a chart that shows a summary comparison of the two ARKids benefit packages:

Coverage Type	Description	ARKids A	ARKids B
<b>Basic Coverage</b>	Physician, prescription drugs, hospital, ambulance (emergency only), dental and orthodontia, medical equipment, medical supplies, emergency department services, eye glasses, family planning, health screens, home health services, laboratory and x-ray, inpatient and outpatient psychiatric, podiatry, speech, occupational and physical therapy, vision, chiropractor, immunizations, nurse midwife, and nurse practitioner.	Yes	Yes
<b>Additional Coverage</b>	Audiology, child health management services, developmental day treatment clinic services, end stage renal disease services, hearing aids, hospice, hyperalimentation, nursing facilities, orthotics, personal care, transportation (non-emergency), private duty nursing, prosthetics, ventilator services, and targeted case management.	Yes	No
<b>Screenings (through Child Health Services)</b>	If the child receives periodic Child Health Services checkups, benefits are unlimited for covered services that are medically necessary.	Yes	No
<b>Co-Payments</b>	ARKids B requires co-pays as follows: \$5.00 per prescription drug, \$10.00 per medical visit, \$10.00 per emergency ambulance trip, 10% of the 1st day of inpatient hospitalization, and 10% of Medicaid allowed amount for each item of durable medical equipment. A co-payment is not required for preventative health screens, family planning services, and dental checkups. ARKids B families will have an annual cumulative cost-sharing (co-payments & coinsurance) maximum of 5% of the family's gross annual income. The annual period is the state fiscal year (SFY) of July 1 through June 30th. The annual cost-sharing maximum will be recalculated and the cumulative cost-sharing counter will be reset each July 1.  <b>Note:</b> A co-pay of \$.50 to \$3.00 for prescription drugs and a small percentage of the first day cost in a hospital will be required for an 18 year old receiving ARKids A.	No	Yes

## Medical Services – Appendix H, Transfer of Resources-History

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01/01/14

Treatment of resource transfers for less than fair market value made by an applicant/recipient, his/her eligible spouse, or their representative are governed by the date of transfer, the institutional or waiver status of the applicant/recipient, and whether the transfer was to the applicant/recipient's spouse. Prior to 9/1/81 there was no applicable transfer of resources policy for Medicaid applicants/recipients.

### **Look Back Date**

The look back period is the time frame for which the caseworker determines whether an individual transferred resources for less than fair market value. The caseworker will look at all transfers made during the look back period.

### **9/1/81 through 6/30/88 (through 9/30/89 for Inter-Spousal Transfers)**

The look back date for the period of 9/1/81 through 6/30/88 (through 9/30/89 for Inter-Spousal Transfers) was 24 months prior to the month of application/redetermination.

### **7/1/88 through 8/10/93**

The look back date for the period of 7/1/88 through 8/10/93 was 30 months prior to the date of institutionalization or entry into the Waiver program for Medicaid recipients. If the individual was not a Medicaid recipient on the date of institutionalization or application for the Waiver program, the look back period will be the 30 months prior to the date of application.

### **8/11/93 through 2/8/06**

The look back date for 8/11/93 through 2/8/06 was 36 months from the date on which an individual was both in an institution and had applied for medical assistance or, in the case of a Waiver individual, from the date on which the individual applied for Waiver assistance.

The 36 month look back date was effective with enactment of OBRA, 1993, for transfers occurring 8/11/93 and later. However, county workers could not begin asking "Have you transferred resources in the past 36 months?" until 36 months had passed since enactment of OBRA, 1993. Therefore, the following dates were utilized in investigating transfers by NF and Waiver applicants/recipients:

- 8/11/93 through 2/10/96 - Inquire about transfers in the last 30 months
- 2/11/96 through 8/10/96 - Inquire about transfers made 8/11/93 or later
- 8/11/96 and later - Inquire about transfers in the last 36 months.

If an institutionalized or Waiver individual was not eligible when he first applied for assistance and later reapplied, the county worker would ask about transfers in the appropriate look back period from the

## Medical Services – Appendix H, Transfer of Resources-History

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date of the second application, or the dates of subsequent applications if not eligible at the second application.

### **Imposition of Penalty Period**

#### **When Transfer Occurred 9/1/81 through 6/30/88 (through 9/30/89 for Inter-Spousal Transfers)**

The value of uncompensated transfers occurring within 24 months prior to the month of application/redetermination will be divided by \$1000 to determine the number of months of ineligibility for all Medicaid services. Any remainder will count as an additional month. For example, an uncompensated transfer of \$41,500 divided by \$1000 equals 41.5 months, or 42 months of ineligibility. The first month of ineligibility will be the month following the month of transfer.

#### **When Transfer Occurred 7/1/88 through 8/10/93**

The length of the period of ineligibility will be the lesser of:

- a. 30 months, or
- b. A number of months equal to the total uncompensated value of the transferred resources (the difference between the FMV of the resources at the time of transfer and the value of compensation received for the resources) divided by \$1500.00. Any remainder from the division will be dropped.

**EXAMPLE:** A \$15,500 uncompensated transfer would result in 10 months of ineligibility (\$15,500 divided by \$1500 equals 10, with \$500 remaining. The \$500 would be disregarded, and would not count for an additional month of ineligibility.

For uncompensated transfers made 7/1/88 or later, the period of ineligibility will begin in the same month that the transfer was made, NOT in the month following the month of transfer;

#### **AND**

When uncompensated transfers are made 7/1/88 or later and an individual applies for nursing facility or Waiver services, that individual will not be eligible for a vendor payment or Waiver services until the period of ineligibility has expired. An individual in a nursing facility WILL be eligible to receive a Medicaid card during the period of ineligibility, provided he/she is otherwise eligible. However, an individual who has applied for Waiver Services will NOT be eligible for a Medicaid card only, unless that individual is found eligible in some category other than a Waiver category.

#### **When Transfer Occurred 8/11/93 through 9/30/93**

## Medical Services – Appendix H, Transfer of Resources-History

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If an individual had transferred resources during the period of 8/11/93 through 9/30/93, the period of ineligibility would have begun in August or September, 1993, but the agency was not allowed to withhold vendor payments until October 1, 1993, for transfers occurring during those two months.

### **Determination of Period of Ineligibility for Resource Transfers 8/11/93 through 2/8/06**

The number of months of ineligibility for facility/Waiver services was determined by dividing the uncompensated value of all resources transferred by the individual or spouse on or after the look back date by the current divisor (see Appendix R).

If the client was not currently receiving LTC or Home and Community Based Waiver Medicaid, but reapplied and was under a previously imposed penalty, the penalty period was reassessed using the current divisor. If eligible, the case was approved with coverage not granted before April 1st or before the three-month retro period based on the most recent application, whichever was later.

There was no cap on the total number of months of ineligibility. Any fraction remaining after dividing the total uncompensated value by the divisor was dropped. The period of ineligibility began on the first day of the first month during which resources were transferred.

### **Multiple Transfers Made That Do Not Result in Overlapping Penalties 8/11/93 through 2/8/06**

If an individual made multiple transfers that did not result in overlapping penalty periods, a separate penalty period was assigned to each transfer.

### **Multiple Transfers Made That Do Result in Overlapping Penalties 8/11/93 through 2/8/06**

The sum total of all transfers made was divided by the current divisor to determine the period of ineligibility.

## Medical Services - Appendix I, Application Form Chart

Eligibility Group	DCO-0151 or DCO-0152	DCO-0645 or DCO-0152	DHS-0777	DCO-0808	DCO-0950	DCO-9700	DCO-0095	DCO-0081	DCO-0090 and DCO-0105	DCO-0662	DCO-0702	DHS-0704	DCO-0710	DHS-0712	DHS-0713	DHS-0727	DCO-0778 & DHS-0732	DCO-0730	Pub 405	Pub 407	DCO-0107 or DCO-0701	DCO-0108 or 0108C	DHS-4000	DHS-3330	DMS-2602 & DCO-2603
<b>Families and Individuals (MAGI) Groups</b>																									
ARKids A	X							*											X						
ARKids B	X							*											X						
Newborns		X						*											X						
Parents & Caretakers	X																		X						
Pregnant Women Limited	X																		X						
Pregnant Women Low Income	X																		X						
Unborn Child	X																		X						
Former Foster Care	X																		X						
Adult Expansion Group	X																		X						
<b>Aid to Aged, Blind or Disabled</b>																									
<b>Long Term Services and Supports</b>																									
Nursing Facility			X					*	*	X	X	*	*	*	X	*	*		X	•	•	•			
Assisted Living Facility			X					*	*	X	X	*	*	*	X	*	*		X	•	•	•	X		
ARChoices Waiver			X					*	*	X	*	*	*	X	*	*		X	•	•	•	X			
PACE			X					*	*	X	*	*	*	X	*	*		X	•	•	•	X			
DDS Waiver			X					*	*	X	*	*	*	X	*	*		X	•	•	•	X			
<b>Medicare Savings Program</b>																									
ARSeniors			X																X						
QMB			X																X						
SMB			X																X						
QI-1			X																X						
QDWI			X																X						

A **green X** signifies this form will be needed for an application.

A **red dot •** signifies this form will be needed for an application **if** a disability determination from MRT is needed.

A **blue asterisk \*** signifies this form **may** be needed, depending on the circumstances. (e.g. DCO-0090 when there is an absent parent)

## Medical Services - Appendix I, Application Form Chart

Eligibility Group	DCO-0151 or DCO-0152	DCO-0645 or DCO-0152	DHS-0777	DCO-0808	DCO-0950	DCO-9700	DCO-0095	DCO-0081	DCO-0090 and DCO-0105	DCO-0662	DCO-0702	DHS-0704	DCO-0710	DHS-0712	DHS-0713	DHS-0727	DCO-0778 & DHS-0732	DCO-0730	Pub 405	Pub 407	DCO-0107 or DCO-0701	DCO-0108 or 0108C	DHS-4000	DHS-3330	DMS-2602 and DCO-2603
<b>Waivers</b>																									
TEFRA					X			*	*		X							X	X		•	•	•		X
Autism				X				*	*		X								X		•	•	•		
<b>Miscellaneous</b>																									
Workers with Disabilities				X				*	*										X		•	•	•		
Aged Individual-EC						X	*		*										X						
Aged Individual-SD						X	*		*										X						
AFDC-EC						X	*	*	*										X		•	•	•		
AFDC-SD						X	*	*	*										X		•	•	•		
Blind Individual-EC						X	*	*	*										X		•	•	•		
Blind Individual-SD						X	*	*	*										X		•	•	•		
Disabled Individual-EC						X	*	*	*										X		•	•	•		
Disabled Individual-SD						X	*	*	*										X		•	•	•		
Under 18 Years of Age-SD						X	*	*	*										X						
Pregnant Woman-EC						X	*		*										X						
Pregnant Woman-SD						X	*		*										X						
AFDC-UP-EC						X	*		*										X						
AFDC-UP-SD						X	*		*										X						
Refugee Resettlement-EC						X	*		*										X		•	•	•		
Refugee Resettlement -SD						X	*		*										X		•	•	•		
Foster Care-EC						X	*	*	*										X						
Foster Care-SD						X	*	*	*										X						
<b>Former SSI Medicaid Categories</b>	<b>Must have been an SSI Recipient</b>																								
Pickle (COLA)						X	*		*										X						
Disabled Adult Child (DAC)						X	*		*										X						
Widows or Widowers (OBRA 90)						X	*		*										X						

A **green X** signifies this form will be needed for an application.

A **red dot •** signifies this form will be needed for an application **if** a disability determination from MRT is needed.

A **blue asterisk \*** signifies this form **may** be needed, depending on the circumstances. (e.g. DCO-0090 when there is an absent parent)

## Medical Services - Appendix J Eligibility Table

Eligibility Group	General	Age	Disability	Income	Resources	Med Necessity	Relationship	OCSE Coop	Other
Policy Reference	Section D	MS F-110	MS F-120	MS E-100	MS E-500	MS F-151	MS F-110	MS F-130	Sections F and H
<b>Families &amp; Individuals</b>									
ARKids A	●	●		●			●	*	
ARKids B	●	●		●			●	*	No Ins Coverage
Newborns	●	●					●	*	Medicaid Mom
Parents & Caretakers	●			●			●	●	
Pregnant Woman (Limited PW)	●	●		●					Must Be Pregnant
Pregnant Woman (PW) Low Income	●	●		●				●	Must Be Pregnant
Unborn Child				●					No Creditable Coverage
Adult Expansion Group	●	●		●				●	Not Medicare Eligible
Former Foster Care	●	●						●	Former Foster Care Status
<b>Aid to Aged, Blind or Disabled</b> To qualify for one of these categories, the individual must be aged, blind, or have a disability.									
<b>Long Term Services and Supports</b>									
Nursing Facility	●	●	●	●	●	●		●	Transfer Penalty; Spousal Rules
Assisted Living Facility	●	●	●	●	●	●		●	Cost Effective; Transfer Penalty; Spousal Rules
ARChoices Waiver	●	●	●	●	●	●		●	Cost Effective; Transfer Penalty; Spousal Rules
PACE	●	●	●	●	●	●		●	Cost Effective; Spousal Rules
DDS Waiver	●		●	●	●	●		●	Cost Effective; Transfer Penalty; Spousal Rules
<b>Medicare Savings Program</b>									
ARSeniors	●	●		●	●			●	
QMB	●	●	●	●	●			●	
SMB	●	●	●	●	●			●	
QI-1	●	●	●	●	●			●	
QDWI	●	●	●	●	●			●	

A green dot signifies that there is an eligibility criteria in that column that must be met for the indicated Medicaid category to be approved.

**General** heading includes: Citizenship, Residency, Social Security Enumeration and TPL Assignment.

(Relationship = Living with a Specified Relative) (Medicaid Mom = Mother eligible for Medicaid coverage at child's birth)

\* An OCSE referral is not required for a child to receive coverage, but a parent or caretaker relative who receives Medicaid must comply with OCSE to maintain coverage.

## Medical Services - Appendix J, Eligibility Table

Eligibility Group	General	Age	Disability	Income	Resources	Med Necessity	Relationship	OCSE Coop	Other
Policy Reference	Section D	MS F-110	MS F-120	MS E-100	MS E-500	MS F-151	MS F-110	MS F-130	Sections F and H
<b>Waivers</b>									
TEFRA	●	●	●	●	●	●		*	Appropriateness of Care; Cost Effectiveness
Autism	●	●	●	●	●	●		●	Appropriateness of Care; Cost Effectiveness
Workers with Disabilities	●	●	●					●	Must Be Working; Unearned income under SSI/SPA
<b>Miscellaneous</b>									
Aged Individual-EC & SD	●	●		●	●			●	
AFDC-EC & SD	●	●		●	●		●	●	
Blind Individual-EC & SD	●			●	●			●	
Disabled Individual-EC & SD	●	●	●	●	●			●	
Under 18 Years of Age-SD	●	●		●	●		●	●	
Pregnant Woman-EC	●			●	●			●	Must Be Pregnant
Pregnant Woman-SD	●			●	●			●	
AFDC-UP-EC & SD	●	●		●	●		●	●	
Refugee Resettlement-EC & SD	●			●	●			●	
Foster Care-EC & SD	●	●		●	●			●	
Foster Care (Non-IVE or IVE)	●	●		●	●			●	
<b>SSI Medicaid</b> <b>Must have been a SSI Recipient</b>									
Pickle (COLA)	●			●	●			●	
Disabled Adult Child (DAC)	●	●	●	●	●			●	
Widows, Widowers with a Disability & Divorced Surviving Spouse with a Disability (OBRA 90)	●	●	●	●	●			●	Not Medicare Eligible

A green dot signifies that there is an eligibility criterion in that column that must be met for the indicated Medicaid category to be approved.

**General** heading includes: Citizenship, Residency, Social Security Enumeration and TPL Assignment.

(Relationship = Living with a Specified Relative) (Medicaid Mom = Mother eligible for Medicaid coverage at child's birth)

\* An OCSE referral is not required for a child to receive coverage, but a parent or caretaker relative who receives Medicaid must comply with OCSE to maintain coverage.

## Medical Services – Appendix K, PACE Service Counties

03/19/19

There are three PACE providers in the State of Arkansas:

1. Total Life Healthcare, which is located in Jonesboro, Craighead County. The provider service area includes specific zip codes in Craighead, Cross, Greene, Lawrence, Mississippi, Poinsett, and Randolph counties.
2. Complete Health with PACE, which is located in North Little Rock, Pulaski County. The provider service area includes specific zip codes in Faulkner, Lonoke, Pulaski, and Saline counties.
3. PACE of the Ozarks, which is located in Springdale, Washington County. The provider service area includes specific zip codes in Benton, Madison, and Washington counties.

Below is the list of the counties and the zip codes:

<b>Total Life Healthcare (Northeast Arkansas)</b>			
<b>Craighead</b> All Craighead County zip codes are covered		<b>Cross</b> Cherry Valley 72324 Parkin 72373 Vanndale 72387 Wynne 72396	
<b>Lawrence</b> Hoxie 72433 Sedgwick 72465 Walnut Ridge 72476		<b>Mississippi</b> Blytheville 72315 Gosnell 72319 Leachville 72438 Manila 72442	
		<b>Greene</b> Paragould 72450	
		<b>Poinsett</b> Harrisburg 72432 Lepanto 72354 Marked Tree 72365 Trumann 72472	
		<b>Randolph</b> Pocahontas 72455	
<b>Complete Health with PACE (Central Arkansas)</b>			
<b>Faulkner</b> Conway 72032, 72034 Mayflower 72106 Vilonia 72173		<b>Lonoke</b> Cabot 72023 England 72046 Keo 72083 Lonoke 72086	
		<b>Saline</b> Alexander 72002 Bauxite 72011 Benton 72015, 72019, 72022 East End 72065 Mabelvale 72103	
<b>Pulaski</b> Jacksonville 72076 Sherwood 72120 Maumelle 72113 Roland 72135		Little Rock 72201, 72202, 72204, 72205, 72206, 72207, 72209, 72210, 72211, 72212, 72223, 72227 No. Little Rock 72114, 72116, 72117, 72118, 72119 Scott 72142	

# Medical Services – Appendix K, PACE Service Counties

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03/19/19

<b>PACE of the Ozarks (Northwest Arkansas)</b>					
<b>Benton</b>				<b>Madison</b>	
Bentonville	72712	Gravette	72736	Hindsville	72738
Bella Vista	72714, 72715	Hiwasse	72739	Huntsville	72740
Cave Springs	72718	Lowell	72745	Wesley	72773
Centerton	72719	Pea Ridge	72751		
Decatur	72722	Rogers	72756, 72758		
Gentry	72734	Siloam Springs	72761		
<b>Washington</b>					
Fayetteville	72701, 72703, 72704	Prairie Grove	72753		
Elkins	72727	Springdale	72762, 72764		
Farmington	72730	West Fork	72774		
Lincoln	72744	Winslow	72959		

## Medical Services – Appendix L, Life Expectancy Table

MS Manual 03/16/18

Table 1: Male		Table 2: Female	
Age	Average Number of Years of Life Remaining	Age	Average Number of Years of Life Remaining
0	77.14	0	81.69
10	67.70	10	72.18
20	57.91	20	62.29
30	48.56	30	52.57
40	39.26	40	42.98
50	30.25	50	33.70
60	22.12	60	24.98
61	21.36	61	24.13
62	20.60	62	23.29
63	19.84	63	22.45
64	19.09	64	21.62
65	18.35	65	20.80
66	17.62	66	19.98
67	16.89	67	19.18
68	16.17	68	18.39
69	15.47	69	17.61
70	14.77	70	16.84
71	14.08	71	16.08
72	13.41	72	15.33
73	12.75	73	14.59
74	12.10	74	13.87
75	11.46	75	13.17
76	10.84	76	12.48
77	10.24	77	11.81
78	9.65	78	11.16
79	9.08	79	10.52
80	8.53	80	9.90
81	8.00	81	9.31
82	7.49	82	8.73
83	7.00	83	8.18

## Medical Services – Appendix L, Life Expectancy Table

MS Manual 03/16/18

<b>Age</b>	<b>Average Number of Years of Life Remaining</b>	<b>Age</b>	<b>Average Number of Years of Life Remaining</b>
84	6.53	84	7.65
85	6.09	85	7.14
86	5.66	86	6.65
87	5.27	87	6.19
88	4.89	88	5.75
89	4.54	89	5.35
<b>90</b>	4.22	90	4.96
<b>91</b>	3.92	91	4.61
<b>92</b>	3.64	92	4.28
<b>93</b>	3.39	93	3.98
<b>94</b>	3.16	94	3.71
<b>95</b>	2.96	95	3.47
<b>96</b>	2.79	96	3.25
<b>97</b>	2.63	97	3.05
<b>98</b>	2.49	98	2.87
99	2.37	99	2.71
<b>100</b>	2.25	100	2.55
<b>101</b>	2.13	101	2.40
<b>102</b>	2.02	102	2.26
<b>103</b>	1.91	103	2.12
<b>104</b>	1.80	104	1.99
<b>105</b>	1.71	105	1.87
<b>106</b>	1.61	106	1.75
<b>107</b>	1.52	107	1.63
<b>108</b>	1.43	108	1.52
<b>109</b>	1.34	109	1.42
<b>110</b>	1.26	110	1.32

Source: SSA, Office of the Actuary

MS Manual 01/01/14

The Family Support Act of 1988 (Public Law 100-485), requires that certain AFDC families (Category 20) who lose eligibility April 1, 1990, or later, due to earned income must be given six (6) months of Initial Transitional Medicaid benefits without an application for such assistance. These families may also qualify for an Additional 6 Months Transitional Medicaid Extension.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 extended this requirement to certain Medicaid families following replacement of the AFDC program with the TANF program. In Arkansas, families who lose eligibility for TEA Medicaid due to earnings are eligible for this extension.

### **Extent of Services**

Individuals approved for Transitional Medicaid will be eligible for the full range of Medicaid services, including services under the Children's Health Services Program.

### **Eligibility Requirements**

In addition to the standard Medicaid eligibility requirements of citizenship, enumeration and child support enforcement, the following requirements must be met in determining eligibility for the Initial 6 Months TM Extension period:

1. The family must have become ineligible for TEA Medicaid due to increased wages or increased hours of employment (Re. MS Appendix M).
2. The family must have received TEA Medicaid in at least 3 of the 6 months immediate preceding the first month of TEA Medicaid ineligibility. Retroactive months count for this purpose (Re. MS Appendix M).
3. The family members must have been residents of Arkansas in the last month of TEA Medicaid eligibility, and must continue to reside in Arkansas.
4. There must be a dependent child under age 18 in the home (Re. MS Appendix M).

In addition to the eligibility criteria stated above, the following eligibility requirements must also be met in the Additional 6 months TM extension period:

1. The family must have received TM in each month of the Initial 6 Months TM extension period.
2. There must continue to be a dependent child under age 18 in the home.
3. The parent (or non-parent specified relative) must have met the reporting requirements in the 1st and 4th months of the Additional TM Extension period (Re. MS 2061.7 and MS 2062.1).
4. The parent (or non-parent specified relative) must continue to be employed and receive earnings in each month preceding the 2nd and 3rd report periods of the additional TM extension period, unless good cause exists.

## Medical Services – Appendix M, Transitional Medicaid

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The average monthly gross earnings of the eligible members (less paid child care costs) cannot exceed 185% of the Federal Poverty Level (Re. [FPL Chart at Appendix F](#)).

Resources, deprivation, and unearned income are not eligibility factors for TM.

A re-referral to OCSE is not required.

### **TEA Medicaid Case Closure - Due to Earnings**

The Tea Medicaid case closure must be due solely to increased wages or increased hours of employment. If a TEA Medicaid family becomes ineligible due to earnings and for another reason in the same month, the family will be ineligible for Transitional Medicaid. For example, if the absent parent of all the TEA Medicaid children returns home and the caretaker parent becomes employed in the same month, the family will not be eligible for TM since earned income is not the sole reason for ineligibility. If, however, the TEA Medicaid family began receiving unearned income and earned income (of the caretaker parent) in the same month, a budget will be worked without the earned income. If the TEA Medicaid case remains eligible without the earned income and the inclusion of the earned income is the sole reason for TEA Medicaid closure, this requirement for TM has been met.

The increased earnings must be of the child's parent (or non-parent specified relative) who was included in the TEA Medicaid case as an eligible member in the last month of eligibility. The client's declaration of earnings will be accepted to determine continued Medicaid eligibility when the TEA cash assistance case closes due to employment. If at the first quarterly report the caseworker determines that the family should have remained in the TEA Medicaid, the case will be converted back to TEA Medicaid.

When it is determined that the family is ineligible for TEA Medicaid, and eligible for the Initial 6 Months Transitional Medicaid Extension, the caseworker will manually issue Form DCO-123 to notify the family of their TEA cash case closure; and to inform them of their eligibility for Transitional Medicaid and of the reporting requirement in the Initial 6 Months Transitional Medicaid Extension Period.

The TEA Medicaid case will be closed using "Convert to TM" and the appropriate reason will be entered in ANSWER. The earnings that resulted in TEA Medicaid ineligibility will be entered in ANSWER. The Transitional Medicaid case will be keyed to the WATM screen, using Form DCO-125, and the TEA Medicaid case number.

The Initial 6 Months TM Extension will begin with the first month following the last month of TEA Medicaid eligibility. The begin date will be entered in the Transitional Medicaid Begin Date on WATM. Individuals included in the budget group in the last month of TEA Medicaid eligibility will be entitled to the Initial 6 Months TM Medicaid Extension. Night Edit will convert the case to Category 25 for all open members if the income keyed, when calculated by the system, shows the case to be ineligible for TEA Medicaid.

### **Received TEA Medicaid in 3 of the last 6 Months**

The family must have received TEA Medicaid in at least 3 of the 6 months immediately preceding the first month of TEA Medicaid ineligibility in order to qualify for TM. Eligibility for retroactive TEA Medicaid can count toward the 3 months. This requirement must always be met. For example, after receiving TM for 4 months or longer, if the parent (or non-parent specified relative) loses employment, receives TEA Medicaid for two months, then loses TEA Medicaid eligibility again due to employment, the family will not be eligible for TM, as they did not receive TEA Medicaid in 3 of the last 6 months immediately preceding the first month of TEA Medicaid ineligibility.

If a family received TEA in another state at any time during the 6 months immediately preceding the first month of TEA ineligibility, this period can be used to determine eligibility for TM.

The family will not be eligible for Transitional Medicaid if it is determined that the family was ineligible for TEA Medicaid at any time during the 6 months immediately preceding TEA Medicaid ineligibility due to fraud (under current policy, only a court can make a determination of fraud).

### **Residence**

The family members must be residents of Arkansas at the time they became ineligible for TEA Medicaid, and must continue to reside in Arkansas throughout the Transitional Medicaid period. Residence is not affected by temporary absence from the state (e.g., on vacation). The TM case will be closed if the family moves out of Arkansas. Subsequently, if the family returns to Arkansas after the TM case has been closed, the TM case cannot be reopened. The family will have to make an application, and eligibility will be determined in another category.

### **Dependent Child**

“Dependent Child” is defined, for TM purposes, as a child who is under age 18 who was living in the home in the last month of TEA Medicaid eligibility, and whose presence in the home helped establish TEA Medicaid eligibility. As a condition of TM eligibility, there must be a dependent child in the home in each month of TM. Eligibility for TM will terminate at the end of the first month in which the family ceases to include a dependent child. If the only dependent child leaves home and later returns after the TM case has been closed, the TM case may not be reopened, even if a portion of the 12 month TM period remains.

### **Reporting Requirements in the Initial 6 Months Transitional Medicaid Extension Period (First Six Months)**

#### First Report

On the 6th workday from the end of the 3rd month of the Initial 6 Months Extension Period, the system will generate a notice and report form, DCO-124, to the family to be returned to the County Office by the 5th day of the 4th month. The parent (or non-parent specified relative) must report the household composition, the amount of gross earnings received, the amount of child care paid, and other circumstances which existed in the first 3 months of the Initial 6 Months TM Period. The DCO-124 will inform the family of its option for an additional 6 months period of TM which will be, in part, dependent

## Medical Services – Appendix M, Transitional Medicaid

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upon the return of the DCO-124 report form in the 4th month of the Initial 6 Months TM Extension Period.

Upon receipt of a complete DCO-124, the County will key a “Y” in the “Report Received by County” field on WATM and will enter the date the report was received. This must be keyed to WATM no later than the 7th workday from the end of the 4th month. The earnings will be keyed into the income section in ANSWER, but continuing eligibility is not based on the amount of earnings received in the first 3 months of the Initial Extension Period. If there is any unearned income in the budget fields, it should be removed with zeros (00s). Zeros should also be entered in the deduction fields. The only entries needed in the budget fields are gross earned income and child care. The system will compute the net earned income.

If the DCO-124 has not been received in the County Office by the 5th day of the report month (or the following workday if the 5th falls on a non-workday) or, if an incomplete DCO-124 is received, the following procedures will be used:

1. Notice DCO-126 and Form DCO-124 will be manually issued to the parent (or non-parent specified relative) no later than the 1st workday following the 5th day of the report month. The DCO-126 will advise the parent (or non-parent specified relative) that the DCO-124 must be returned in 10 days, or eligibility will not be granted for the Additional 6 months TM Extension period.
2. If the client returns an incomplete DCO-124, the caseworker will mail the incomplete form back with the DCO-126 and advise the client in the space provided on the DCO-126 which questions must be completed or what verification is required. The client will also be advised that failure to return the completed DCO-124 in 10 days will result in ineligibility for the Additional 6 Months TM Period.

A “complete” DCO-124 is defined as one in which each “Yes or No” question is answered, the explanations related to a “Yes” response are completed, and required verification is attached. Part I, Household Information, will be considered complete if sufficient information is shown to determine household composition.

If the county has not keyed a “Y” to WATM by the 7th workday from the end of the month, the system will close the case with a Medicaid end date effective the last day of the 6th month and will send a closure notice to the family. If the client returns a complete report form after the 7th workday from the end of the 4th month and good cause for an untimely report is established, or the County failed to key a “Y” by the 7th workday from the end of the month, the County will reinstate the case in ANSWER and key “Y” in the Override Indicator” field on WATM and the date the report was received. The original Med Begin Date will be rekeyed and the Med End Date zeroed out. When the County reopens a case in this situation, it will not be necessary to register a new application.



**NOTE:** Good Cause for untimely reports (DCO-124): An untimely DCO-124 is one which is received after the 10 day notice period specified on the DCO-126. The client must establish good

cause for an untimely report in order for the report requirement to be met. The determination as to whether good cause exists for returning an “untimely” report will be left to the judgment of the caseworker, with approval by the Supervisor or his/her designated representative. Some examples of situations which might result in good cause are hospitalization, client is out of town, client’s new address had not been keyed by County which resulted in the client not receiving the report form, etc.

### **Determining Initial Eligibility When There Was an Untimely Report of Earnings**

In the event the County Office is not informed by a TEA Medicaid recipient of increased earnings in a “timely” manner, eligibility for Transitional Medicaid will be determined from the month the family actually became ineligible for TEA Medicaid.

If the County Office is informed of a TEA Medicaid family’s increase in earnings as late as the 5<sup>th</sup> day of the 4<sup>th</sup> month of TEA Medicaid ineligibility, eligibility will be determined for TM in each of the months succeeding the last month of TEA Medicaid eligibility. If the eligibility requirements in the Initial 4 Months TM Extension period (MS Appendix M) are not met, no additional benefits will be authorized. If the eligibility requirements in the Initial 4 Months Extension period (MS Appendix M) are met, continuing TM benefits will be authorized. The County will manually issue Form DCO-124 to the family, if it is later than the 3<sup>rd</sup> month of TEA Medicaid ineligibility. This report must be returned to the County by the last day of the 4<sup>th</sup> month of the Initial TM Extension Period in order for the family to qualify for the Additional 6 Months TM Extension period.

If the earned income is reported or discovered after the 5<sup>th</sup> day of the 4<sup>th</sup> month of TEA Medicaid ineligibility, eligibility for the Initial TM period will be determined (for purposes of an overpayment only) but the family will not be entitled to receive any Additional TM benefits.

### **Determining Initial Eligibility When There Was an Untimely Report of Earnings**

In the event the County Office is not informed by a TEA Medicaid recipient of increased earnings in a “timely” manner, eligibility for Transitional Medicaid will be determined from the month the family actually became ineligible for TEA Medicaid.

If the county Office is informed of a TEA Medicaid family’s increase in earnings as late as the 5<sup>th</sup> day of the 4<sup>th</sup> month of TEA Medicaid ineligibility, eligibility will be determined for TM in each of the months succeeding the last month of TEA Medicaid eligibility. If the eligibility requirements in the Initial 4 Months TM Extension period (MS Appendix M) are not met, no additional benefits will be authorized. If the eligibility requirements in the Initial 4 Months Extension period (MS Appendix M) are met, continuing TM benefits will be authorized. The County will manually issue Form DCO-124 to the family, if it is later than the 3<sup>rd</sup> month of TEA Medicaid ineligibility. This report must be returned to the County by the last day of the 4<sup>th</sup> month of Initial TM Extension Period in order for the family to qualify for the Additional 6 Months TM Extension period.

If the earned income is report or discovered after the 5<sup>th</sup> day of the 4<sup>th</sup> month of TEA Medicaid ineligibility, eligibility for the Initial TM period will be determined (for purposes of an overpayment only) but the family will not be entitled to receive any Additional TM benefits.

### **Six Months TM Extension Period (Second Six Months)**

In addition to continuing to meet each eligibility factor listed in MS Appendix M, the eligibility criteria specified in MS Appendix M must also be met for the Additional 6 Months of TM.

The family must have received TM in each of the 6 months of the Initial Transitional Medicaid Extension Period. If the TM case is closed at any point during the Initial 6 months Transitional Medicaid Extension period (e.g., no eligible child in the home or moved out of Arkansas

### **Reporting Requirements in the Additional 6 months Extension Period (Second Six Months)**

#### Second Report

On the 6th workday from the end of the 6th month of the Initial 6 Months Extension Period, the system will generate a notice and report form, DCO-124; to those families who met the eligibility factors in the Initial 6 months Extension Period. This report should be returned to the County Office by the 5th day of the 1st month of the Additional 6 Months TM Extension Period (the 7th month). The parent (or non-parent specified relative) must again report the household composition, the amount of gross earnings received, the amount of child care paid, and other circumstances which existed in the last 3 months of the Initial TM Extension Period.

Upon receipt of a complete DCO-124, the caseworker will determine the client's continued eligibility for TM and, if eligible, the County will document the case.

If a complete report form, DCO-124 is not returned by the 5th day of the 1st month of the Additional 6 Months Extension Period (the 7th month), or the following workday if the 5th falls on a non-workday or, an incomplete DCO-124 is received, the following procedures will be used:

1. Notice DCO-126 and Form DCO-124 will be manually issued to the parent (or non-parent specified relative) no later than the 1<sup>st</sup> working day following the 5<sup>th</sup> day of the month. The DCO-126 will advise the client that the DCO-124 must be returned in 10 days or the case will be closed.
2. If the client returned an incomplete DCO-124, the caseworker will mail the incomplete form back with the DCO-126 and advise the client, in the space provided on the DCO-126, which questions must be completed and what verification is required. The client will be advised that failure to return the DCO-124 in 10 days will result in case closure.

If a complete DCO-124 is not received by the 7th workday from the end of the 1st month of the Additional 6 Months Extension Period (the 7th month), the caseworker will close the case on WATM and in ANSWER with a Medicaid End Date effective the last day of that month. If the client returns the report form after the 7th workday from the end of the month, the case has been closed, and good cause is

## Medical Services – Appendix M, Transitional Medicaid

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established, the caseworker will reopen in ANSWER, and WATM (“Convert to TM” and use the appropriate Action Reason, no new application necessary). The original Med. Begin Date will be entered, and the End Date will be zeroed out.

### Third Report

On the 6th workday from the end of the 3rd month of the Additional 6 Months Extension Period (9th month), if the case remains open, the system will generate a notice and report form, DCO-124, to the family to be returned by the 5th day of the 4th month of the Additional Extension Period (10th month).

Upon receipt of a complete DCO-124, the caseworker will determine the client’s continued eligibility for TM and, if eligible, the County will document the case.

If a complete report form, DCO-124 is not returned by the 5th day of the 4th month of the Additional 6 Months Extension Period (the 10th month) (or the following workday if the 5th falls on a non-workday) or an incomplete DCO-124 is received, the following procedures will be used:

1. Notice DCO-126 and Form DCO-124 will be manually issued to the parent (or non-parent specified relative) no later than the 1<sup>st</sup> working day following the 5<sup>th</sup> day of the month. The DCO-126 will advise the client that the DCO-124 must be returned in 10 days or the case will be closed.
2. If the client returns an incomplete DCO-124, the caseworker will mail the incomplete form back with the DCO-126 and advise the client, in the space provided on the DCO-126, which questions must be completed and what verification is required. The client will be advised that failure to return the DCO-124 in 10 days will result in the case closure.

If a complete DCO-124 is not received by the 7th workday from the end of the 4th month of the Additional 6 Months Extension Period (the 10th month), the County will close the case on WATM and in ANSWER, with a Medicaid End Date effective the last day of that month. If the client returns the report form after the 7th workday from the end of the month, the case has been closed, and good cause is established, the County will reinstate the case (“Convert to TM” and use the appropriate action reason, no new application necessary). The original Med. Begin Date will be reentered, and the Med. End Date will be zeroed out.



**NOTE:** There are no automatic system closures in the Additional 6 Months Extension Period, except at the end of the 12th month.

### **Employment Requirement**

In order for extended benefits to continue in the second 6-month period, the parent (or non-parent specified relative) must continue to be employed and receive earnings in each month preceding the 2nd and 3rd reports unless good cause exists.

Examples of good cause for loss of employment are illness, involuntary layoff, etc.

## Medical Services – Appendix M, Transitional Medicaid

### The 185% Earned Income Test and Computation of Average Monthly Gross Earnings

The family's average monthly gross earnings (less paid child care costs necessary for the parent, or non-parent specified relative, to maintain employment) cannot exceed 185% of the Federal Poverty Level (Re. [FPL Chart at Appendix F](#)).

To compute average monthly gross earnings:

1. Total for each month the earning received by all eligible family members in each of the 3 reporting months. Unearned income will be disregarded;
2. Subtract, from each month's total, the amount of child care paid in that month that was necessary for the parent ( or non-parent specified relative) to maintain employment (use the actual child care paid);
3. Add the net results from each of these months; and
4. Divide the result by 3.

This figure is the family's average monthly gross earnings.

**EXAMPLE:** A family of 4 has earnings and paid child care for the reporting period as follows:

	Earnings		Child Care Paid		Net Income
Month #1	\$1,200.00	–	\$180.00	=	\$1,020.00
Month #2	\$ 925.00	–	\$150.00	=	\$ 775.00
Month #3	\$1,450.00	–	\$200.00	=	\$1,250.00

$\$1,020.00 + \$775.00 + \$1,250.00 = \$3,045.00$  divided by 3 =  $\$1,015$  average gross monthly earnings. Compare the average gross monthly earnings to 185% of the Federal Poverty Level (Re. [FPL Chart at Appendix F](#)).



**NOTE:** The FPL is adjusted annually due to changes in the Consumer Price Index. For continuing eligibility, the average monthly gross income, as computed above, will be compared to the FPL in effect during the report month, if different from the preceding months.

If the family's average gross monthly earnings (less paid child care) do not exceed 185% of Federal Poverty Level, the family will remain eligible. The case will be documented

If the family's average gross monthly earnings (less paid child care) exceed 185% of the FPL, the County will send a notice of closure to the family, and will key a closure to the Transitional Medicaid case in ANSWER with a Medicaid End Date effective the last day of the report month. Earnings that resulted in

## Medical Services – Appendix M, Transitional Medicaid

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Transitional Medicaid closure will be entered in the budget section. Night Edit will convert all open members in category 25 to closed status.

### **Changes in the Transitional Medicaid Period**

Minor children entering the household, who were not in the budget group at the time the group became TEA Medicaid ineligible, will not be eligible for Transitional Medicaid and will not be added to the case. If an excluded child has earnings, they will not be considered in computing the family's average gross monthly earnings. The caseworker will determine eligibility for this child in another category, counting only the child and the child's parent(s) in the unit, and considering only their income.

Minor children, who were in the home and included in the TEA Medicaid case during the last month of TEA Medicaid eligibility, who later leave the home, will be dropped (a 10 day notice will be given). If he/she subsequently reenters the home while the family is receiving TM, he/she will be added to the Transitional Medicaid case. Any earnings that this child may have will be considered in computing the family's average gross monthly earnings.

The return of an absent parent to the home during Transitional Medicaid is not, in itself, a reason for closure (i.e., deprivation is not an eligibility factor for Transitional Medicaid). The absent parent, who returns, if he/she was not in the budget group at the time of the TEA Medicaid case closure, will not be eligible for Transitional Medicaid and will not be added to the case. Any earnings of the returning parent, however, will be used in computing the family's average gross monthly earnings.

If the only child in the home becomes eligible for SSI, the parent(s) (or non-parent specified relative) will remain eligible for Transitional Medicaid as long as the SSI child is under age 18. However, the County will receive a Systems Action Report notifying them that the case has been closed. The caseworker will reopen the Transitional Medicaid case for the adult(s) by using "Converting to TM" and the appropriate action reason. The Transitional Medicaid Status on WATM will be changed to open status. The adult(s) must continue to meet all other eligibility requirements in order to remain eligible for Transitional Medicaid.

### **System Closures, System Reports, and County Responsibilities**

On the first workday of each month the system will search all Transitional Medicaid records for children who will reach the age of 18 that month. If the only child in the home is reaching age 18, the system will close the case and send a notice of case closure to the family. If there are other children under 18 in the home, the system will close only the 18-year-old and leave the remaining individuals open.

The Counties will receive a Systems Action Report that will inform them of Transitional Medicaid 18 year olds and cases closed by the system.

When the system has closed an 18 year old, or at any time a member or a case is found ineligible for Transitional Medicaid, the County Office will make a determination and document the case record as to whether or not the ineligible member(s) meets the eligibility criteria in any other Medicaid Category

## Medical Services – Appendix M, Transitional Medicaid

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(e.g., PW, MN-SD, etc.). If it appears that a member or the case would be eligible in another category, an application and notice of potential benefits will be sent to the individual(s).

During the Additional 6 Months TM Extension Period (Second Six Months), a monthly report titled “Transitional Medicaid Cases” will be generated to the Counties to assist them in tracking the Transitional Medicaid cases. This report will list the Case Number, Case head Name, Worker Number, Transitional Medicaid Begin Date, Current Month of Transitional Medicaid and the next month in which a Transitional Medicaid Report (DCO-124) is due.

At the end of the 12th month, the system will send a notice and close all Transitional Medicaid cases which remained open throughout both 6-month periods.

### **Summary of Sequence of Notices/Reports in Transitional Medicaid**

Found TEA Medicaid ineligible prospectively. Determined Transitional Medicaid eligible:

- Form DCO-123 manually issued to family.

#### Initial 6 months Extension Period

##### 1st Month

- 1st month of TEA Medicaid ineligibility.

##### 2nd Month

##### 3rd Month

- Notice/Report Form DCO-124 system generated to case head on the 6th workday from the end of the month.

##### 4th Month

- Case head must return DCO-124 with income and child care verification by the 5th day of the month. County completes DCO-125 and keys “Y” to WATM by the 7th workday from the end of the month. If the “Y” is not keyed, the system will generate a notice and close the case with a Medicaid End Date effective the last day of the 6th month.

##### 5th Month

##### 6th Month

- Notice/Report Form DCO-124 system generated to the case head on the 6th workday from the end of the month.

#### Additional 6 months Extension Period

## Medical Services – Appendix M, Transitional Medicaid

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### 7th Month

- Case head must return DCO-124 with income and child care verification by the 5th day of the month. If family eligible, County documents case. If family ineligible, County must key closure to ANSWER and WATM with a Medicaid End Date equal to the last day of the 7th month.

### 8th Month

### 9th Month

- Notice/Report Form DCO-124 system generated to the case head on the 6th workday from the end of the month.

### 10th Month

- Case head must return DCO-124 with income and child care verification by the 5th day of the month. If family eligible, County documents case. If family ineligible, County must key closure in ANSWER and WATM with a Medicaid End Date equal to the last day of the 10th month.

### 11th Month

### 12th Month

- System closes.

### **Extended Medicaid Eligibility When TEA Medicaid Case Closed Due to Child Support Income**

Three months of extended Medicaid will be authorized when a TEA Medicaid case is closed due to child support income provided the case was open for at least three of the six months immediately preceding the first month of ineligibility. The three months will begin with the month following the first month in which the case became ineligible due to child support income. The TEA Medicaid ineligibility may have been caused in whole or in part by the child support income. Only those persons who were included in the budget in the last month of TEA Medicaid eligibility will be entitled to the three months of extended Medicaid.

## MEDICAL SERVICES – APPENDIX N, FAMILY MEDICALLY NEEDED RESOURCE AND INCOME LEVELS

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### I. Resources for Medically Needy (MN) Categories

The resource guidelines in this section provide general guidelines used in determining resource eligibility for the Family Medically Needy (MN) categories. The chart below provides the most current Family MN categories including the resource limit for each.

Category	Resource Limit
<u>Family MN: (EC &amp; SD)</u>	<u>Family Size-Limit</u>
AFDC	1-\$2000
U-18 (SD only)	2-\$3000
Unemployed Parent	3-\$3100
Pregnant Women	4-\$3200
	5-\$3300
	6-\$3400
	Add \$100 for each additional person

#### A. Definition of a Resource

A resource is any real or personal property available to an individual to meet his needs. Only those resources currently available, or for which the individual has the legal ability to make available, will be considered. Accumulations in trust funds, retirement and profit-sharing plans, or other arrangements, which preclude the use of the property for meeting current needs, will not be considered until such time as the property is actually available to the individual.

All or any portion of a payment, which is considered as income in the month of receipt, cannot be considered as a resource in the same month.

**EXAMPLE:** Ms. Smith has a checking account with a balance of \$750. On March 5, she deposits her regular monthly \$100 Social Security check into it. Since the \$100 she deposited is income for March, it cannot be included as part of the resource (the checking account) for March. Any of the March \$100 remaining in the account as of April 1, however, would then be considered as a resource.



**NOTE:** The Medicaid household unit must be income and resource eligible for the entire month for Medicaid eligibility to be considered to exist for the month.

#### Verification of Resources

All resources claimed by the household must be verified. If retroactive coverage is requested, resources must be verified in each retroactive month.

## MEDICAL SERVICES – APPENDIX N, FAMILY MEDICALLY NEEDY RESOURCE AND INCOME LEVELS

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### **B. Resource Limit**

The equity value of all resources available to the assistance unit, except those specifically disregarded below, must be determined. Equity value is the fair market value of the property less any liens or encumbrances.

The total equity value of all countable resources available to the assistance unit, except for that amount specifically disregarded from the equity of certain resources specified below, cannot exceed the resource limit for the category of Medicaid for which the client applied.

### **C. Resources to be Disregarded**

The following resources are not considered in determining Family Medicaid eligibility:

1. The homestead;
2. Household furniture, appliances, and personal effects;
3. Farm or other equipment used to produce income;
4. The stock and inventory of a self-employment enterprise;
5. Livestock used for subsistence;
6. Loan obtained under Title III – EOA;
  - a. Grants or loans to an undergraduate student for educational purposes made or incurred under any program administered by the Commissioner of Education.
  - b. Educational assistance provided for attendance costs under programs in the Carl D. Perkins Vocational and Applied Technology Education Act.
7. That portion of a grant, scholarship, payment under the Veterans' Educational Assistance Program (GI Bill), or unearned income paid to or for an individual conditioned upon school attendance which is used for items necessary for school attendance, such as tuition, books, fees, equipment, special clothing needs, transportation, and child care services.
8. Bona fide loans from any source (e.g., bank, any other establishment engaged in the business of making loans, or an individual). Interest received on loans and retained in the months following the month the interest was received is considered a resource.
9. Relocation allowances and adjustment payments made by Federal agencies under any federally financed relocation assistance program.

## MEDICAL SERVICES – APPENDIX N, FAMILY MEDICALLY NEDDY RESOURCE AND INCOME LEVELS

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10. That portion of payments received as a settlement (insurance, law suit, etc.) which is intended and used for a specific purpose, such as medical bills, attorney's fees, etc. or as compensation for the loss of a resource (example – to repair or replace a vehicle).
11. Funds distributed to members of the Red Lake Band of Chippewa Indian pursuant to Public Law 98-123, enacted October 13, 1983, and funds distributed to members of the Assiniboine Tribe of the Fort Belknap Indian Community and the Assiniboine Tribe of the Fort Belknap Indian Community and the Assiniboine Tribe of the Fort Peck Indian Reservation pursuant to Public Law 98-124, enacted October 13, 1983.
12. One burial plot per assistance unit member.
13. The total amount of federal tax refunds or advance payments for a period of 12 months following the date of receipt. Earned Income Credit (EIC) payments are totally disregarded as income or resources.
14. Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation retroactive to January 1, 1989.
15. Payments made under the Radiation Exposure Act (Public Law 101-426) retroactive to October 15, 1990. These payments may be made to individuals in which injury or death resulted from the exposure to radiation from nuclear testing and uranium mining.
16. Payments made under the Civil Liberties Act of 1988 (Title I of Public Law 100-383) and under the Aleutian and Pribilof Islands Restitution Act (Title II of Public Law 100-383) to Aleuts. These Acts provide for the federal government to make restitution payments to the individuals or if deceased, the individual's spouse, children or parents, who were interned during World War II.
17. Payments made under the Maine Indian Claims Settlement Act of 1980. These payments are made to members of the Passamaquoddy Indian Tribe, the Penobscot Nation and the Houlton Band of Maliseet Indians for the settlement of land claims.
18. Payments made under the Aroostook Band of Micmacs Settlement Act. These payments are made to members of the Aroostook Band of Micmacs for the settlement of land claims.
19. Major disaster and emergency payments made to individuals and families under the Disaster Relief Act of 1974 and comparable disaster assistance provided by States, local governments, and disaster assistance organizations.
20. Payments made from any fund established as a result of a class settlement in the case of Susan Walker vs. Bayer Corporation are in accordance with Section 4735 of the Balanced Budget Act of 1997 (Public Law 105-33) . This case involved hemophiliacs who contracted the HIV virus from contaminated blood products. Also excluded from countable resources are payments made

## MEDICAL SERVICES – APPENDIX N, FAMILY MEDICALLY NEEDY RESOURCE AND INCOME LEVELS

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pursuant to a release of all claims in a case that is entered into in lieu of the Walker vs. Bayer class settlement and that is signed by all affected parties on or before the later of December 31, 1997, or 270 days after the date on which the release is first sent to the persons to whom the payment is to be made.



**NOTE:** Interest earned by these lump sum funds and allowed to accrue is not excluded from countable resources.

### **The Homestead**

The value of real property used by the assistance unit as a homestead is totally disregarded in determining Medicaid eligibility for the MN categories.

A homestead is a house and tract of land, which a person considers his or her home. A mobile home or trailer used as a home will be considered as a homestead, regardless of whether the person also owns the property on which the mobile home is situated.

Only one such tract will be considered a homestead. However, there is no limit to the acreage or number of lots so long as the property is contiguous. Any other dwelling units or apartments on the property will be considered a part of the homestead.

The family must be presently residing on the property or intend to move on to it within a period of six months from the date of application or date of purchase, whichever is later.

If the family ceases to live on the property, it will continue to be regarded as a homestead for a period of six months from the date they left the home or the date of application, whichever was later, provided they intended to return to it. The recipient will be advised that the homestead becomes excess property after six months.

If the homestead is sold, the net proceeds received from the sale will be disregarded for a period of six months provided the casehead intends to apply such proceeds towards the purchase of another homestead. When the conditions of the sale of the homestead are such that the proceeds will be received through installment payments, then such proceeds will be disregarded as they are received provided they are applied to the payment of another homestead.

Only that portion of the proceeds, whether received in full or through installment payments, which are actually applied towards the purchase of the new homestead may be disregarded. Any remaining amount will be considered according to #2 or #3 under Sale of a Resource, as appropriate.

**EXAMPLE #1:** A client receives \$10,000 for his homestead. He re-invests only \$8000 into a new home. Therefore, the remaining \$2000 will be considered a resource.

## MEDICAL SERVICES – APPENDIX N, FAMILY MEDICALLY NEEDED RESOURCE AND INCOME LEVELS

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**EXAMPLE #2:** A client sells his homestead through an installment payment contract for which the entire balance is not payable upon demand. The monthly payment from the sale is \$200. He uses \$150 from that payment to make the payment on his new home. Therefore, the remaining \$50 will be considered as unearned income.

The casehead will be advised that if another homestead is not purchased within the six month period, then at the beginning of the seventh month the entire amount received for the sale of the home will be considered a resource if received in full, or as unearned income if received in installment payments (refer to "Sale of a Resource"). If a client who is receiving installment payments later purchases another homestead and applies the installment payment to the new home, then that portion applied may be disregarded.

### **D. Resources Considered With Special Exemptions or Exclusions**

#### **Motor Vehicles**

Each assistance unit will be allowed a disregard of \$1500 of the equity in one motor vehicle. Equity is the vehicle's wholesale market value less any liens or encumbrances. The full equity value of any other vehicle owned by the persons whose resources must be considered plus any equity in the first vehicle in excess of the \$1500 disregard is considered a resource.

Value determinations for vehicles will be made using one of the following web sites: CarPrices.com, Autopricing.com, Intellichoice.com, Edmunds.com, and Kelley Blue Book (kbb.com). No other web sites will be considered acceptable. A copy of the web page showing the vehicle value must be scanned into the electronic case record.

If more than one vehicle is owned, then the equity in each vehicle will be determined. Since the \$1500 disregard can be applied to only one vehicle, it will be applied to the vehicle with the greatest equity value. No amount can be disregarded from the equity value of the remaining vehicles even if the value of the first vehicle was less than the \$1500 disregard.

Value determination for other types of personal transportation such as boats, buses, motorcycles, etc., should be obtained by the caseworker through contact with a knowledgeable source such as a local dealer, automobile insurance company or the county personal property tax office. Complete information should be given to the contact regarding the particular make, model, and year of the motor vehicle. The case narrative should be documented as to the source of the valuation and the valuation given. If the casehead disagrees with the value determination, he or she may obtain at least two written appraisals of the value from knowledgeable sources. If the appraisals appear to be questionable, the caseworker should verify their accuracy with the knowledgeable sources. If the caseworker determines the appraisals are accurate, the equity in the vehicle(s) will be redetermined.

## MEDICAL SERVICES – APPENDIX N, FAMILY MEDICALLY NEEDY RESOURCE AND INCOME LEVELS

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### **Jointly Owned Vehicles**

When a vehicle is jointly owned by a Medicaid client and another person whose needs are not included in the same assistance unit, only the Medicaid client's prorata share of the vehicle's equity value will be considered. The \$1500 disregard will be applied to the Medicaid client's share of the equity value (if not already applied to another vehicle).

**EXAMPLE:** This applies equally to situations in which the co-owner is, or is not, an SSI recipient. In either case, the Medicaid client's prorata share of the equity value will be considered in determining his/her Medicaid eligibility. Mr. and Mrs. Smith jointly own a car. Both their names are on the title as "John or Jane Smith." Mrs. Smith receives Medicaid (U-18 SD) for a child from a previous marriage. Their total net equity in the car is determined to be \$2000 of which Mrs. Smith's prorata share (1/2) is \$1000. Since Mr. Smith is a stepparent, his resources are not considered. Therefore, only Mrs. Smith's \$1000 equity will be considered. The \$1500 disregard is applied to her \$1000 share of the equity resulting in zero equity to consider as a resource.



**NOTE:** If a Medicaid client is the sole owner of a vehicle, which was purchased with an SSI child's funds, then the full equity value is considered as belonging to the Medicaid client.

### **Determining Net Equity**

To determine the amount of equity to be considered, the following procedure will be followed:

1. Determine the amount of net equity in each vehicle owned by:
  - a. Making a value determination for the vehicle as described above.
  - b. Subtracting from the determination the amounts of any liens or encumbrances.
2. If the vehicle is jointly owned, determine the Medicaid client's prorata share of the net equity.
3. Subtract up to \$1,500 from the client's net equity of the vehicle with the highest equity value. Any amount remaining of the \$1500 disregard may not be applied to other vehicles.
4. Add the client's full net equity of any other vehicles to the amount remaining after the \$1500 disregard. The total will be considered as a resource.

### **Funeral Agreements**

Each assistance unit member will be allowed a disregard of \$1500 of the current equity value in funeral agreements. Any equity value in excess of \$1500 is considered a resource.

## MEDICAL SERVICES – APPENDIX N, FAMILY MEDICALLY NEEDED RESOURCE AND INCOME LEVELS

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The term "funeral agreements" includes burial insurance, pre-paid funeral arrangement contracts, and life insurance policies issued by funeral homes. The term "current equity value" is defined as the value of the agreement, which can legally be converted, to cash by the client.

If a funeral agreement has no current equity value, then it is not considered as an available resource. For example, a burial insurance policy with no cash surrender value or an irrevocable pre-paid funeral contract have no current equity value to the client.

### **E. Resources Considered in Full**

Except for property specifically disregarded under section "Resources to be Disregarded" or considered according to section "Resources Considered With Special Exemptions or Exclusions", the equity value of any other real or personal property available to the assistance unit will be considered in full.

When an applicant/recipient has joint ownership of a resource, their ownership interest and the availability of the resource to the assistance unit must be determined. If the resource is available to the unit, the net equity must then be determined.

Resources of an alien's sponsor and the sponsor's spouse must be considered as fully available to the alien and his or her family.



**NOTE:** If excluded resources are commingled with countable resources, the full value of the resources will be countable.

### **F. Requesting a Legal Opinion on Resource Ownership or Availability**

There are situations in which the client's ownership interest or ability to access the resource are not clearly evident. In such situations, it may be necessary to request a legal opinion from the DHS Office of Chief Counsel (OCC). All such requests for a legal opinion will be submitted through the DCO Office of Program Planning and Development (OPPD) according to the following procedures.

1. The caseworker will scan the documents for the legal opinion request in the proper order into the eDoctus library, "County Request for Medicaid Decision." The proper order to scan documents into eDoctus can be found on the OPPD/OCC legal document review checklist, which can be obtained from a Program Eligibility Analyst (PEA).
2. This will trigger an email message to the Program Eligibility Analysts (PEA) for the area in which the county office is located.
3. The PEAs of the specified area will check the "County Request for Medicaid Decision" library on eDoctus to determine where the request originated.
4. The appropriate PEA will review the eDoctus documentation based on the guidelines provided by OPPD/OCC legal document checklist to ensure that the documentation is complete, in the proper order and ready for submission to OPPD.

## MEDICAL SERVICES – APPENDIX N, FAMILY MEDICALLY NEEDY RESOURCE AND INCOME LEVELS

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5. Once the review is complete and any discrepancies have been corrected, the PEA will select the option of submitting the request to OPPD.
6. OPPD will review and submit the request to OCC if needed. OPPD will provide an opinion on the requests that do not require an opinion from OCC.
7. All opinions will be forwarded in an email message to the PEA and the county worker who requested the opinion.
8. The county worker will index the document in the client's electronic record. The Medicaid Eligibility Unit will scan the opinion into the client's electronic record on eDoctus.

### **G. Sale of a Resource**

The sale of a resource, including disregarded resources, is considered a conversion of one type of resource (property) to another type (cash) except when the terms and conditions of the sale preclude the seller's ability to obtain full payment on demand. When an individual sells either real or personal property, the caseworker will determine the amount the individual received for the property and any terms or conditions of the sale.

The net proceeds from the sale (sale price less any outstanding liens or encumbrances and costs related to the sale) will be considered as follows:

1. If the homestead was sold, refer to section "The Homestead".
2. If the individual received full payment for the property, apply the amount received to the resource limit.
3. If the individual entered into a legal agreement or contract with the buyer by which payment is made through installment payments, then the caseworker will determine whether the individual can require full payment on demand.

If the entire balance is payable on demand, then the individual's equity in such balance will be applied to the resource limit. If such amount, combined with other countable resources, does not exceed the resource limit and the case remains eligible, then only the interest portion of the installment payment will be considered as unearned income. The individual's equity in the balance will continue to be applied to the resource limit.

If the entire balance is not payable on demand, then the entire installment payment, less any amount for which the seller is obligated to pay on the sold property, will be considered as unearned income.

### **H. Excess Real Property**

The equity value of any real property not used as a homestead (excess property) will be considered a resource in determining Medicaid eligibility.

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### **Determining Ownership**

Ownership will be verified by deeds, wills, contract of purchase or other documentary evidence. When two or more persons own an interest in the property, the client's ownership interest and the availability of the property as a resource to the assistance unit must be determined (Refer to [MS E-512 and E-513](#)).

Questions of title, ownership, and property interest which cannot be resolved by the County Office will be submitted by e-mail or memorandum to the Office of Program Planning and Development, Slot S333 following procedures at "Requesting a Legal Opinion on Resource Ownership or Availability".

### **Determining Market Value and Net Equity**

The market value of real property is determined by obtaining an estimate of current market value from a knowledgeable source. Knowledgeable sources include:

1. Real estate brokers.
2. Local office of the USDA, Rural Development (for rural land).
3. Local office of the USDA, Farm Services Agency (for rural land).
4. Banks, savings and loan associations, mortgage companies, and similar lending institutions.
5. County Cooperative Extension Service (for rural land).

The estimate must be written, signed and dated, and have enough information so the source can be identified.

The client will be primarily responsible for obtaining the estimate. However, if requested, the caseworker will assist the client or attempt to obtain a free estimate. If an estimate cannot be obtained from any other knowledgeable source, then the assessed value from the tax assessor of the county in which the property is located, multiplied by the county multiplier, 5, will be used. If this method is used, the narrative will be updated in the electronic record to document that no other knowledgeable source estimate could be obtained.

Only the net equity in the property will be considered. Net equity is determined by subtracting the value of any liens, mortgages, or other encumbrances from the market value. If the market value of the property exceeds the maximum limitation, the amount of any encumbrances will be verified.

### **I. Personal Property**

Personal property is property other than real property and consists primarily of liquid assets. Ownership of personal property can be in the same form as real property. (Refer to [MS E-512-E-513](#) concerning forms of ownership.) The following sections describe more commonly held types of personal property.

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### **Cash and Money on Deposit**

Cash on hand includes amounts that the individual has on his person, amounts that he has at home, amounts in safety deposits boxes and/or amounts that belong to the individual but is being held by someone else. This amount, less any received during the month and counted as income, is a countable resource.

Money on deposit in a bank, savings and loan, credit union, or other financial institution must be considered a countable resource. Money on deposit includes checking accounts, savings accounts, certificates of deposit, retirement accounts, etc.

### **Jointly Held Bank Accounts With Non-SSI Recipients**

When a Medicaid client has a bank account with a non-SSI person, ownership of the jointly held bank account must be determined prior to determining whether it is a resource to the client. This applies to all situations in which at least one of the persons named on the account, including the client's spouse, is a non-Medicaid person whose resources would not be considered in determining eligibility. (If one of the persons named on the account is an SSI recipient, see the following Section). A person is considered as the owner of funds in a bank account if that person earned, received, or was given the funds in the account.

As this relates to married couples, for Medicaid purposes, it is normally presumed that both spouses are joint owners of funds in a jointly held bank account. However, when there is written documentation clearly establishing that joint ownership is not intended, then ownership by just one will be determined to exist.

Ownership will be verified by written statements from the persons whose names are on the account, if at all possible, or if not, through collateral contacts. If it is determined that the Medicaid client does not actually own the funds in the account, then none will be considered a resource to the client. If joint ownership does actually exist, then the amount considered to be owned by each of the joint owners will be a prorata amount rather than the full amount.

**EXAMPLE:** Mr. and Mrs. Jones have a joint savings account with a balance of \$1,500. Joint ownership does exist, so one half, or \$750, will be considered to be owned by each one. Since Mr. Jones is the Medicaid (Medicaid category U-18 SD) child's stepfather, his resources are not considered. Therefore, \$750, Mrs. Jones' share, will be considered a countable resource in determining eligibility.

### **Jointly Held Bank Accounts With SSI Recipients**

Any funds in a jointly held bank account which are being considered in determining an SSI recipient's eligibility cannot be considered in determining Family Medicaid eligibility. This applies to all situations in

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which a Family Medicaid client's name is on a bank account with an SSI recipient, including situations in which the SSI recipient is the Family Medicaid client's child or spouse.

SSI policy presumes that all funds in a bank account which is jointly owned by an SSI recipient and another person belong to the SSI recipient. The SSI recipient may rebut this presumption if some or all of the funds belong to the other person. However, unless the SSI recipient successfully rebuts the presumption, then SSI will consider all of the funds in the account for SSI purposes. In that case, none of the funds can be considered for Family Medicaid purposes even if the Family Medicaid client's name is on the bank account.

When a Family Medicaid client's name is on any type of bank account with an SSI recipient, it will be presumed that all of the funds in the account are being considered for SSI purposes. It will not be necessary to verify with SSI whether the bank account funds are being considered for SSI purposes unless the Family Medicaid client advises that SSI is not considering all of the funds, or the amount in the account would appear to cause SSI ineligibility if considered. In either of those situations, the Medicaid caseworker will verify with SSI whether the funds are being considered in determining the SSI recipient's eligibility. Any funds not being considered for SSI purposes will be subject to Family Medicaid consideration as described in the above section. That is, if the Family Medicaid client is the only other owner, then the funds not considered for SSI will be considered for Family Medicaid. If, though, there are other owners besides the Family Medicaid client and SSI recipient, then ownership and prorata shares will be determined.

Except in the above two situations, it will not be necessary to verify with SSI whether the bank account funds are being considered for SSI purposes. It will be presumed that they are being considered for SSI and therefore, will not be considered for Family Medicaid eligibility purposes.

### **Life Insurance Policies**

The total cash surrender value (CSV) of all life insurance policies, except those issued by a funeral home and considered as a funeral agreement, will be considered when determining the resources available to the assistance unit. The cash surrender value of any life insurance policy which is accessible to any of the persons whose resources must be considered will be included regardless of whether the insured person is a member of the assistance unit.

### **Tax Refunds**

Federal tax refunds or advance payments are excluded as income and disregarded as a resource for 12 months following the date of receipt. Earned Income Credit (EIC) payments are totally disregarded as income or resources.

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### **Joint Refunds (Client and Spouse)**

The client's portion of a joint tax return will be excluded as income and disregarded as a resource for 12 months following the date of receipt.

### **U.S. Savings Bonds**

A U.S. Savings Bond is an obligation of the Federal government, which is nontransferable. These bonds are normally owned by the owner(s) shown on the front of the bond. If bond ownership is shared, each person's share as a resource is equal, even though any of the owner's listed on the bond may dispose of it. Value determination should be secured by contact with a bank or from the website

<http://www.treasurydirect.gov/BC/SBCPrice>.

### **Stocks and Bonds**

Shares of stock represent ownership in a corporation. Stock value is determined by the closing price at the time of application or redetermination. Verification of stock value may be made by consulting the financial section of a newspaper or online listings. If these bids are not listed in the newspaper, contact will be made with a local securities firm for verification.

### **J. Other Types of Personal Property**

Any other available property, including livestock not used for subsistence and farming or other self-employment tools and equipment, which are no longer used to produce income, will be counted as a resource.

## **II. Income for Medically Needy Categories**

### **A. Income**

Income is classified as earned or unearned. Voluntary deductions from income are considered to have been received by the individual (e.g., Medicare premiums, credit union shares, etc.). The income guidelines in this section are general guidelines used in determining income eligibility for the Medically Needy categories (i.e., AFDC, U-18, Unemployed Parent, Pregnant Woman, Foster Care and Refugee). These guidelines are not used in AABD Medicaid.

### **B. Income to be Disregarded**

The following sources of income are not considered in determining eligibility for family Medicaid.

1. Home Energy Assistance Program (HEAP) payments.
2. TEA cash payments or reimbursements for participating in an assigned work activity.
3. Supplemental Security Income (SSI) benefits and other income of SSI recipients/eligibles. This includes the income of individuals whose Medicaid continues after SSI stops and who were certified in the following categories:

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- a. Disabled Widows or Widowers who would be eligible for SSI if the 1984 Reduction Factor Increase and any subsequent COLAS were disregarded ([MS B-343](#)) (Categories 11, 31, and 41).
  - b. Disabled Widows or Widowers over age 60 (Categories 31 and 41) ([MS B-344](#)).
  - c. Lynch Rank Eligibles (Categories 11, 31 or 41) ([MS B-342](#)).
  - d. Disabled Widows, Widowers, and Disabled Surviving Divorced Spouses (Categories 31 or 41) ([MS B-345](#)).
  - e. Disabled Adult Children (Categories 31 or 41) ([MS B-346](#)).
4. Assistance, including educational assistance, from other agencies and organizations to the extent that such payments are not intended to cover food, clothing or shelter with the exception of funds intended for special clothing needed for educational purposes.

### EXAMPLES INCLUDE:

- Basic Education Opportunity Grant (BEOG or PELL)
  - Supplemental Educational Opportunity Grants (SEOG)
  - College Work Study
  - Supplemental State Income Grant (SSIG)
5. SNAP (Supplemental Nutrition Assistance Program) benefits.
  6. The value of U.S. Department of Agriculture Donated Foods.
  7. Items of food produced and consumed by the applicant or other persons in the household.
  8. Payments for supporting services or reimbursement of out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aides, or senior companions and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE) and any other programs under Titles II and III, pursuant to Section 418 of Public Law 93-113.
  9. Payments to VISTA volunteers under Title I of Public Law 93-113, pursuant to Section 404 (g) of Public Law 93-113.
  10. The value of supplemental SNAP assistance received under the Child Nutrition Act of 1966, as amended, and the special food service program for children under the National School Lunch Act, as amended. (P. L. 92-443 and P. L. 93-150)
  11. Payments made directly to landlords and other vendors.
  12. Small cash gifts of \$30 or less per person made for a specific occasion (e.g., birthday, Christmas, graduation, etc.).
  13. Federal tax refunds or advance payments. Earned Income Credit (EIC) payments are totally disregarded as income or resources.
  14. The first \$50 of the total child support paid directly to the assistance unit and/or collected by the OCSE.

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15. Child support refunds paid by the Office of Child Support Enforcement, which represents several months of the \$50 disregard (e.g., \$150 refund for 3 past months of collections).
16. Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation retroactive to January 1, 1989.
17. Governmental (federal, state, or local) rent and housing subsidies, including payments made directly to the applicant/recipient for housing or utility costs, e.g., HUD utility allowances.
18. Bona fide loans from any source (e.g., bank, any other establishment engaged in the business of making loans, or an individual).

A loan is considered bona fide if it meets any of the following conditions.

- a. There is a written agreement to repay the money within a specified time, or it was obtained from an individual or establishment engaged in the business of making loans, or
- b. The borrower acknowledges the obligation to repay (with or without interest); or
- c. The borrower expresses intent to repay either by pledging real or personal property or anticipated income. It is not necessary that the loan be secured solely by specific items of collateral such as real or personal property. It is only necessary that the borrower express the intent to repay the loan when funds become available in the future and indicate that repayment of the loan will begin when future anticipated income is received.

This loan criteria applies to the Medically Needy categories only.



**NOTE:** Interest earned on the proceeds of a loan will be counted as unearned income in the month of receipt.

19. Major disaster and emergency payments made to individuals and families under the Disaster Relief Act of 1974 and comparable disaster assistance provided by States, local governments, and disaster assistance organizations.
20. Any type of income, which must be disregarded according to federal or state statute. If there is a question as to whether a particular payment may be disregarded, the pertinent documents concerning the payment should be submitted to the Office of Program Planning and Development (OPPD) for a determination. This information should include the specific federal or state statute under which it is believed the disregard treatment is required.

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### **Income Disregards of a Minor Child**



**NOTE:** The following disregards apply only to income received by a person under 18 years of age who is included in the assistance unit as a minor child.

1. Any unearned income received by a minor child, which is derived from a program, carried out under the Workforce Investment Act of 1998. Such income includes need-based payments, cash payments for supportive services such as transportation, childcare, etc., payments made to participants in tryout employment in lieu of wages, and payments to Job Corps participants or from any welfare to work (WTW) agency.
2. For a maximum of six months per calendar year, the earnings of a minor child, which are derived from a program carried out under the Workforce Investment Act. Once earnings have been disregarded for six months in a calendar year, then such earnings must be considered in determining eligibility for the remainder of the year.
3. For a maximum of six months per calendar year, the non-Work Force Investment Act related earnings of a minor child who is a full-time student. Any month in which the earnings would not affect the unit's eligibility if such earnings were considered will not be counted as one of the 6 disregard months.

### **C. Earned Income**

Earned income includes wages, salaries, tips, commissions, and any other payment, including in-kind earned income, resulting from labor or personal service.

Earned Income Credit (EIC) payments are totally disregarded as income or resources. This disregard applies equally to advance EIC payments, which are paid with an employee's regular earnings and to EIC refunds received as lump sum payments.

#### **In-kind Earned Income**

In-kind earned income exists when a person is employed by an individual or business but is paid an in-kind benefit rather than wages (e.g., free rent, groceries, etc.). The value of the in-kind benefit will be considered gross earned income.

#### **Verification of Earned Income**

Verification of earnings from employment will be by check stubs, pay slips, or collateral contact with the employer. Sufficient verification must be obtained so that the actual income of the employee can be determined. The caseworker should not automatically assume that one check stub accurately reflects earnings for an entire month. Verification of payment for the last 60 days will be required. If a person is paid weekly, then the latest 8 consecutive check stubs will be required. If the person is paid every other week or twice a month, then the latest 4 check stubs will be required, and if paid monthly, then the

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latest 2 check stub will be required. If the client does not have the required verification, then verification from the employer will be required.



**NOTE:** If retroactive coverage is requested, actual income will be verified for each retroactive month.

**EXCEPTION:** For cases in which the individual has recently started employment and 60 days of verification is not available, the caseworker will compute the income from the best information available. Verification of all, if any, paychecks already received by the individual should be obtained and/or an employer's statement of anticipated earnings (e.g., hourly wage, number of hours expected to work/week, etc.).

Verification of earnings from self-employment will be by Federal Income Tax Return, purchase, sales, and account books or by any other source which establishes the source and amount of income. As soon as an individual is known to be engaged in a farming, business, or other self-employment enterprise, he will be advised of the necessity of keeping accurate records so that his income can be determined.

Verification of in-kind earned income (e.g., free rent, groceries, etc.) will be obtained from the employer. The verification must include the value of the in-kind benefit (e.g., the rent amount the client would otherwise pay, the cost of groceries provided, etc.) and how often it is provided (e.g., monthly, weekly, etc.). If the amount fluctuates from week to week or month to month, then verification of the in-kind earned income paid during the last 2 months should be obtained.

### **D. Computation of Earnings Received as an Employee**

The gross earned income amount which must be included in the budget is an estimate of the amount which the individual can reasonably be expected to have available in the next month(s).

The estimate of monthly earnings is usually based on the assumption that the earnings received in the most recent month are reflective of the earnings which will be received in the current and following months. However, in some situations, this assumption will not hold true. Therefore, the estimate of monthly earnings must be based on the latest information which is available at the time the client is interviewed, or at the time verification of earnings is requested in writing.

In most situations, the estimate will be an average of the latest months' gross earnings. In situations, though, in which the client started employment within the last month, or in which a change (e.g., pay raise, change in number of hours worked, etc.) has occurred within the last month, another method which more accurately reflects the current earnings will be used.

The first step in computing monthly gross earned income of an employee is to determine the average gross pay per pay period. Any advance EIC payments paid to the employee with his regular earnings will be excluded. The average gross monthly earnings are then determined by multiplying the average pay per pay period by the appropriate multiplier for the pay frequency (e.g., weekly, bi-weekly, etc.). The

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chart below shows for each pay frequency the appropriate multiplier for determining gross monthly earnings.

Pay Frequency	Multiplier
Weekly	4.334
Bi-Weekly	2.167
Semi-Monthly	2
Monthly	1
More Often than Weekly	None

If the employee is paid more frequently than weekly (e.g., daily), the worker will determine the monthly gross for the latest calendar month by adding all the pay checks received in the month.

In some situations, the above method of obtaining an average pay per pay period cannot be used because the client has not yet worked a full month, or a change has occurred within the past month which has affected current earnings. In these situations, another method which will give a more accurate reflection of the client's earnings will be used to obtain an average pay per pay period. Therefore, the caseworker should carefully consider the method to be used to ensure that it will give the most accurate reflection of the client's monthly earnings and document the case narrative accordingly.

### **E. Computation of Earnings From Self-Employment**

Like employee earnings, the monthly amount of self-employment earnings which must be included in the budget is the Agency's best estimate of earned income which will be available to the individual in a month or months. However, self-employment earnings are usually not as predictable as employee earnings and are often received less frequently than monthly.

Therefore, in most situations, a time period longer than one month will be used to determine average monthly self-employment earnings.

Costs directly related to producing the income are subtracted from the self-employment gross before the monthly earnings are included in the budget. Only those costs without which the income could not be produced may be subtracted. Such costs may not include depreciation, personal business and entertainment expenses, personal transportation, purchase of capital equipment and payments on the principal of loans for capital assets or durable goods. For room and board income, a standard \$70 per roomer/boarder will be subtracted as the costs related to producing the income.

#### **1. Income Received Less Frequently Than Monthly (Quarterly, Annually, Etc.)**

Income of this type may include farming (including soil bank and related diversion payments), cattle ranching, business, or any other type of self-employment enterprise in which the income resulting from work performed over a period of time is received at one time rather than during the period in which the work is being performed.

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The first step in computing monthly gross income in these situations is to calculate the gross annual income for the previous calendar year. If available, the individual's Federal Income Tax Return may be used to determine the annual income and the amount of costs related to producing the income. The annual allowable costs are subtracted from the gross annual income. The remainder is then divided by 12 to arrive at an average monthly amount. This figure is treated as gross earned income in the budget

If the previous year's income is not a fair reflection of the current year's income, the worker will determine, by averaging recent months or other means, an amount which will fairly reflect the current year's income. If the individual has been self-employed in the current enterprise for less than one year, the caseworker will average the income received to date to project future income. The worker will document the case record to clearly reflect the manner in which the income was determined and the justification for considering it a fair reflection of the current year's income.

### **2. Income Received Monthly or More Frequently (Weekly, Daily, Etc.)**

Income of this type may include room and board, babysitting, sales from Avon, Tupperware, etc., or any other type of self-employment in which the income is received at least monthly as the work is performed.

The first step in computing monthly gross income in these situations is to determine an average monthly gross based on the latest two months' income. Verification of the latest two months' gross income and costs related to producing the income will be obtained. After allowable self-employment costs are subtracted from the monthly gross, an average of the latest two months will be determined to arrive at the monthly gross earnings which will be included in the budget.

If the latest two month's income is not a fair reflection of the individual's current income, then another method to determine the average monthly income will be used (e.g., an average of more than two months' income). The worker will document the case record to clearly reflect the manner in which the income was determined and the justification for considering it a fair reflection of current income.

### **F. Sources of Unearned Income**

The following are possible sources of unearned income:

1. Pensions, annuities, insurance benefits, Social Security, Railroad Retirement, Veterans' Benefits, military allotments, Teachers' Retirement, State Retirement, Workmen's Compensation, Miners Pensions.
2. Payments received for the rental of rooms, apartments, dwelling units, building, or land. Taxes and the expenses of upkeep may be deducted.

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3. Interest, dividends, and income from capital investments.
4. Royalty income from oil, gas or other mineral leases.
5. Payments from estates, trust funds, or other personal property which cannot be converted into cash because of legal provisions.
6. Child Support payments.
7. That portion of the income of an alien's sponsor which must be deemed available to the alien, [MS E-300](#).
8. That portion of the income of certain relatives living with the assistance unit which must be deemed available to the unit.
9. Lump sum payments.
10. Regular contributions from organizations, churches, friends, relatives, or social agencies.

## Medical Services – Appendix O, Renewal Forms Chart

Eligibility Group	MAGI Renewal	DCO-95	DCO-777	DCO-811	DCO-950	DCO-7779	DCO-7781	DCO-81	DCO-237	DCO-662	DCO-702	DCO-704	DCO-710	DCO-712	DCO-713	DCO-727	Pub 405	Pub 407	DCO-106	DCO-107	DCO-108/108C	DMS-2602	DCO-2603	DHS-3330	DCO-4000
<b>Families &amp; Individuals</b>																									
ARKids A	X									X								X							
ARKids B	X									X								X							
Newborns	X									X								X							
Parents & Caretakers	X									X								X							
Former Foster Care	X									X								X							
Adult Expansion Group	X																	X							
<b>Aid to Aged, Blind or Disabled</b>																									
<b>Long Term Services and Supports</b>																									
Nursing Facility							X			X		X		X				X	•	•	•				•
Assisted Living Facility							X			X		X		X				X	•	•	•			X	•
ARChoices Waiver							X			X		X						X	•	•	•			X	•
DDS Waiver							X			X		X						X	•	•	•			X	•
<b>Medicare Savings Program</b>																									
ARSeniors				X						X								X							
QMB				X						X								X							
SMB				X						X								X							
QI-1				X						X								X							
QDWI				X						X								X							
<b>Waivers</b>																									
TEFRA						X			X	X		X					X	X	•	•	•	•	•		•
Autism						X			X	X		X						X	•	•	•				•
Workers with Disabilities					X				X	X								X	•	•	•				•

A green X signifies this form will be needed for a renewal.

A red dot signifies this form will be needed for a renewal if a disability determination from MRT is needed.

## Medical Services - Appendix O, Renewal Forms Chart

Eligibility Group	MAGI Renewal	DCO-95	DCO-777	DCO-811	DCO-950	DCO-7779	DCO-7781	DCO-81	DCO-237	DCO-662	DCO-702	DCO-704	DCO-710	DCO-712	DCO-713	DCO-727	Pub 405	Pub 407	DCO-106	DCO-107	DCO-108/108C	DMS-2602	DCO-2603	DHS-3330	DCO-4000
<b>Miscellaneous</b>																									
PACE							X	X	X	X	X	X		X				X	•	•	•			X	•
Foster Care (CHRIS)																		X							
Aged Individual-EC		X								X								X							
Foster Care-EC (CHRIS)																		X							
<b>SSI Medicaid                      Must be an SSI Recipient</b>																									
Pickle (COLA)		X							X	X								X							
Disabled Adult Child (DAC)		X							X	X								X							
Widows or Widowers (OBRA)		X							X	X								X							

A green X signifies this form will be needed for a renewal.

A red dot signifies this form will be needed for a renewal if a disability determination from MRT is needed.

The eligibility groups with (CHRIS) signifies completion by the Foster Care Eligibility Unit through the CHRIS system.

DCO-662 is required at renewal if there is a change in insurance information.

**APPENDIX P TEFRA**  
**Premium Schedule**  
**How to determine TEFRA Premium Range**

**Step 1**

Look at the chart below. If the family has income after allowable deductions at or below the amount listed for the household size, a premium will not be assessed.

If the household has income that is greater than the amount listed below for the household size, continue to Step 2.

Family Size	150% FPL
1	\$19,140.00
2	\$25,860.00
3	\$32,580.00
4	\$39,300.00
5	\$46,020.00
6	\$52,740.00
7	\$59,460.00
8	\$66,180.00
For each additional member add:	\$6,720.00

**Step 2**

Find the income here to determine the TEFRA Premium Range

Annual Income		Monthly Premiums		
From	To	Percent %	From	To
\$0	\$25,000	0.0%	\$0	\$0
\$25,001	\$50,000	1.00%	\$20	\$41
\$50,001	\$75,000	1.25%	\$52	\$78
\$75,001	\$100,000	1.50%	\$93	\$125
\$100,001	\$125,000	1.75%	\$145	\$182
\$125,001	\$150,000	2.00%	\$208	\$250
\$150,001	\$175,000	2.25%	\$281	\$328
\$175,001	\$200,000	2.50%	\$364	\$416
\$200,001	Unlimited	2.75%	\$458	\$458

# Medical Services - Appendix Q, Schedule C

## SCHEDULE C (Form 1040)

Department of the Treasury  
Internal Revenue Service (99)

## Profit or Loss From Business (Sole Proprietorship)

▶ Go to [www.irs.gov/ScheduleC](http://www.irs.gov/ScheduleC) for instructions and the latest information.  
▶ Attach to Form 1040, 1040NR, or 1041; partnerships generally must file Form 1065.

OMB No. 1545-0074

**2018**  
Attachment  
Sequence No. **09**

Name of proprietor	Social security number (SSN)
<b>A</b> Principal business or profession, including product or service (see instructions)	<b>B</b> Enter code from instructions ▶
<b>C</b> Business name. If no separate business name, leave blank.	<b>D</b> Employer ID number (EIN) (see instr.) 
<b>E</b> Business address (including suite or room no.) ▶ City, town or post office, state, and ZIP code	
<b>F</b> Accounting method: (1) <input type="checkbox"/> Cash (2) <input type="checkbox"/> Accrual (3) <input type="checkbox"/> Other (specify) ▶	
<b>G</b> Did you "materially participate" in the operation of this business during 2018? If "No," see instructions for limit on losses . . . <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>H</b> If you started or acquired this business during 2018, check here . . . <input type="checkbox"/>	
<b>I</b> Did you make any payments in 2018 that would require you to file Form(s) 1099? (see instructions) . . . <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>J</b> If "Yes," did you or will you file required Forms 1099? . . . <input type="checkbox"/> Yes <input type="checkbox"/> No	

### Part I Income

<b>1</b> Gross receipts or sales. See instructions for line 1 and check the box if this income was reported to you on Form W-2 and the "Statutory employee" box on that form was checked . . . ▶ <input type="checkbox"/>	<b>1</b>		
<b>2</b> Returns and allowances . . . . .	<b>2</b>		
<b>3</b> Subtract line 2 from line 1 . . . . .	<b>3</b>		
<b>4</b> Cost of goods sold (from line 42) . . . . .	<b>4</b>		
<b>5</b> <b>Gross profit.</b> Subtract line 4 from line 3 . . . . .	<b>5</b>		
<b>6</b> Other income, including federal and state gasoline or fuel tax credit or refund (see instructions) . . . . .	<b>6</b>		
<b>7</b> <b>Gross income.</b> Add lines 5 and 6 . . . . . ▶	<b>7</b>		

### Part II Expenses. Enter expenses for business use of your home **only** on line 30.

<b>8</b> Advertising . . . . .	<b>8</b>			<b>18</b> Office expense (see instructions)	<b>18</b>		
<b>9</b> Car and truck expenses (see instructions). . . . .	<b>9</b>			<b>19</b> Pension and profit-sharing plans . . . . .	<b>19</b>		
<b>10</b> Commissions and fees . . . . .	<b>10</b>			<b>20</b> Rent or lease (see instructions):			
<b>11</b> Contract labor (see instructions)	<b>11</b>			<b>a</b> Vehicles, machinery, and equipment	<b>20a</b>		
<b>12</b> Depletion . . . . .	<b>12</b>			<b>b</b> Other business property . . . . .	<b>20b</b>		
<b>13</b> Depreciation and section 179 expense deduction (not included in Part III) (see instructions). . . . .	<b>13</b>			<b>21</b> Repairs and maintenance . . . . .	<b>21</b>		
<b>14</b> Employee benefit programs (other than on line 19) . . . . .	<b>14</b>			<b>22</b> Supplies (not included in Part III) . . . . .	<b>22</b>		
<b>15</b> Insurance (other than health)	<b>15</b>			<b>23</b> Taxes and licenses . . . . .	<b>23</b>		
<b>16</b> Interest (see instructions):				<b>24</b> Travel and meals:			
<b>a</b> Mortgage (paid to banks, etc.)	<b>16a</b>			<b>a</b> Travel . . . . .	<b>24a</b>		
<b>b</b> Other . . . . .	<b>16b</b>			<b>b</b> Deductible meals (see instructions) . . . . .	<b>24b</b>		
<b>17</b> Legal and professional services	<b>17</b>			<b>25</b> Utilities . . . . .	<b>25</b>		
<b>28</b> <b>Total expenses</b> before expenses for business use of home. Add lines 8 through 27a . . . . . ▶	<b>28</b>			<b>26</b> Wages (less employment credits) . . . . .	<b>26</b>		
<b>29</b> Tentative profit or (loss). Subtract line 28 from line 7 . . . . .	<b>29</b>			<b>27a</b> Other expenses (from line 48) . . . . .	<b>27a</b>		
<b>30</b> Expenses for business use of your home. Do not report these expenses elsewhere. Attach Form 8829 unless using the simplified method (see instructions). <b>Simplified method filers only:</b> enter the total square footage of: (a) your home: _____ and (b) the part of your home used for business: _____. Use the Simplified Method Worksheet in the instructions to figure the amount to enter on line 30 . . . . .	<b>30</b>			<b>27b</b> <b>Reserved for future use</b> . . . . .	<b>27b</b>		
<b>31</b> <b>Net profit or (loss).</b> Subtract line 30 from line 29. • If a profit, enter on both <b>Schedule 1 (Form 1040), line 12</b> (or <b>Form 1040NR, line 13</b> ) and on <b>Schedule SE, line 2.</b> (If you checked the box on line 1, see instructions). Estates and trusts, enter on <b>Form 1041, line 3.</b> • If a loss, you <b>must</b> go to line 32.	<b>31</b>						
<b>32</b> If you have a loss, check the box that describes your investment in this activity (see instructions). • If you checked 32a, enter the loss on both <b>Schedule 1 (Form 1040), line 12</b> (or <b>Form 1040NR, line 13</b> ) and on <b>Schedule SE, line 2.</b> (If you checked the box on line 1, see the line 31 instructions). Estates and trusts, enter on <b>Form 1041, line 3.</b> • If you checked 32b, you <b>must</b> attach <b>Form 6198.</b> Your loss may be limited.							
				<b>32a</b> <input type="checkbox"/> All investment is at risk.			
				<b>32b</b> <input type="checkbox"/> Some investment is not at risk.			

**Part III Cost of Goods Sold** (see instructions)

**33** Method(s) used to value closing inventory:    **a**  Cost    **b**  Lower of cost or market    **c**  Other (attach explanation)

**34** Was there any change in determining quantities, costs, or valuations between opening and closing inventory?  
If "Yes," attach explanation . . . . .  **Yes**     **No**

<b>35</b> Inventory at beginning of year. If different from last year's closing inventory, attach explanation . . . . .	<b>35</b>	
<b>36</b> Purchases less cost of items withdrawn for personal use . . . . .	<b>36</b>	
<b>37</b> Cost of labor. Do not include any amounts paid to yourself . . . . .	<b>37</b>	
<b>38</b> Materials and supplies . . . . .	<b>38</b>	
<b>39</b> Other costs . . . . .	<b>39</b>	
<b>40</b> Add lines 35 through 39 . . . . .	<b>40</b>	
<b>41</b> Inventory at end of year . . . . .	<b>41</b>	
<b>42</b> <b>Cost of goods sold.</b> Subtract line 41 from line 40. Enter the result here and on line 4 . . . . .	<b>42</b>	

**Part IV Information on Your Vehicle.** Complete this part **only** if you are claiming car or truck expenses on line 9 and are not required to file Form 4562 for this business. See the instructions for line 13 to find out if you must file Form 4562.

**43** When did you place your vehicle in service for business purposes? (month, day, year)    ▶    \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**44** Of the total number of miles you drove your vehicle during 2018, enter the number of miles you used your vehicle for:  
**a** Business \_\_\_\_\_    **b** Commuting (see instructions) \_\_\_\_\_    **c** Other \_\_\_\_\_

**45** Was your vehicle available for personal use during off-duty hours? . . . . .  **Yes**     **No**

**46** Do you (or your spouse) have another vehicle available for personal use?. . . . .  **Yes**     **No**

**47a** Do you have evidence to support your deduction? . . . . .  **Yes**     **No**

**b** If "Yes," is the evidence written? . . . . .  **Yes**     **No**

**Part V Other Expenses.** List below business expenses not included on lines 8–26 or line 30.

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<b>48</b> <b>Total other expenses.</b> Enter here and on line 27a . . . . .	<b>48</b>	

# Medical Services – Appendix R, Transfer of Assets Divisor, Home Equity Limit, and Gift Tax Exclusion for ABLE Accounts

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04/01/2020

## Transfer of Assets Divisor

Time Period	Divisor Amount
04/01/20 through 03/31/21	\$5,871.00
04/01/19 through 03/31/20	\$5,749.00
04/01/18 through 03/31/19	\$5,493.00
04/01/17 through 03/31/18	\$5,383.00
04/01/16 through 03/31/17	\$5,277.00
04/01/15 through 03/31/16	\$5,168.00
04/01/14 through 03/31/15	\$5,098.00
04/01/13 through 03/31/14	\$4,955.00
04/01/12 through 03/31/13	\$4,849.00
04/01/11 through 03/31/12	\$4,657.00
04/01/10 through 03/31/11	\$4,514.00

The divisor will be re-determined each year and any changes in the divisor will be effective on April 1.

## Home Equity Limit

Year	Limit
2020	\$595,000
2019	\$585,000
2018	\$572,000
2017	\$560,000
2016	\$552,000
2015	\$552,000
2014	\$543,000
2013	\$536,000

The home equity limit will be re-determined each year and any changes will be effective January 1.

## Gift Tax Exclusion for ABLE Accounts

Year	Limit
2018	\$15,000
2017	\$14,000

The gift tax exclusion will be re-determined each year and any changes will be effective January 1.

SSI and Quarters of Coverage Chart

<b>Long Term Care (LTC), TEFRA, Autism, Home &amp; Community Based Waiver, Assisted Living, DDS</b>	<b>Individual</b>	<b>\$2,349.00 per month</b>
<b>SSI/SPA</b>	<b>Individual Couple</b>	<b>\$783.00 \$1,175.00</b>
<b>1/3 Reduction for Living in the Household of Another</b>	<b>Individual Couple</b>	<b>\$522.00 \$783.34</b>
<b>In-Kind Support</b>	<b>Individual Couple</b>	<b>\$281.00 \$411.66</b>
<b>Living Allowance for Ineligible Spouse or Child</b>	<b>Individual</b>	<b>\$392.00</b>
<b>Substantial Gainful Activity (SGA) for Disability Substantial Gainful Activity for Blindness</b>	<b>Individual Individual</b>	<b>\$1,260.00 \$2,110.00</b>
<b>Assisted Living Facility Waiver Room and Board</b>	<b>Individual</b>	<b>\$711.00</b>
<b>Assisted Living Facility Waiver Personal Allowance</b>	<b>Individual</b>	<b>\$71.00</b>
<b>Student Earned Income Exclusion</b>	<b>Monthly Annual</b>	<b>\$1,900.00 \$7,670.00</b>
<b>Amount Needed to Earn a Qualifying Quarter: Earnings Needed for One Credit</b>	<b>Quarterly</b>	<b>\$1,410.00</b>

## Medical Services – Appendix T, Standard of Need

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01/01/14

<b>Number of Eligible Individuals</b>	<b>100% Standard</b>	<b>29% Reduced Standard</b>
1	\$ 280.00	\$ 81.00
2	\$ 560.00	\$ 162.00
3	\$ 705.00	\$ 204.00
4	\$ 850.00	\$ 247.00
5	\$ 985.00	\$ 286.00
6	\$ 1,140.00	\$ 331.00
7	\$ 1,285.00	\$ 373.00
8	\$ 1,430.00	\$ 415.00
9 or more	\$ 1,575.00	\$ 457.00

# Medical Services – Appendix U, Life Estate and Remainder Interest Tables

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01/01/14

**Table - Unisex Life Estate or Remainder Table**

Age	Life Estate	Remainder	Age	Life Estate	Remainder	Age	Life Estate	Remainder
0	.97188	.02812	37	.93026	.06974	74	.53862	.46138
1	.98988	.01012	38	.92567	.07433	75	.52149	.47851
2	.99017	.00983	39	.92083	.07917	76	.50441	.49559
3	.99008	.00992	40	.91571	.08429	77	.48742	.51258
4	.98981	.01019	41	.91030	.08970	78	.47049	.52951
5	.98938	.01062	42	.90457	.09543	79	.45357	.54643
6	.98884	.01116	43	.89855	.10145	80	.43659	.56341
7	.98822	.01178	44	.89221	.10779	81	.41967	.58033
8	.98748	.01252	45	.88558	.11442	82	.40295	.59705
9	.98663	.01337	46	.87863	.12137	83	.38642	.61358
10	.98565	.01435	47	.87137	.12863	84	.36998	.63002
11	.98453	.01547	48	.86374	.13626	85	.35359	.64641
12	.98329	.01671	49	.85578	.14422	86	.33764	.66236
13	.98198	.01802	50	.84743	.15257	87	.32262	.67738
14	.98066	.01934	51	.83674	.16126	88	.30859	.69141
15	.97937	.02063	52	.82969	.17031	89	.29526	.70474
16	.97815	.02185	53	.82028	.17972	90	.28221	.71779
17	.97700	.02300	54	.81054	.18946	91	.26955	.73045
18	.97590	.02410	55	.80046	.19954	92	.25771	.74229
19	.97480	.02520	56	.79006	.20994	93	.24692	.75308
20	.97365	.02635	57	.77931	.22069	94	.23728	.76272
21	.97245	.02755	58	.76822	.23178	95	.22887	.77113
22	.97120	.02880	59	.75675	.24325	96	.22181	.77819
23	.96986	.03014	60	.74491	.25509	97	.21550	.78450
24	.96841	.03159	61	.73267	.26733	98	.21000	.79000
25	.96678	.03322	62	.72002	.27998	99	.20486	.79514
26	.96495	.03505	63	.70696	.29304	100	.19975	.80025
27	.96290	.03710	64	.69352	.30648	101	.19532	.80468
28	.96062	.03938	65	.67970	.32030	102	.19054	.80946

## Medical Services – Appendix U, Life Estate and Remainder Interest Tables

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Age	Life Estate	Remainder	Age	Life Estate	Remainder	Age	Life Estate	Remainder
29	.95813	.04187	66	.66551	.33449	103	.18437	.81563
30	.95543	.04457	67	.65098	.343902	104	.17856	.82144
31	.95254	.04746	68	.63610	.363690	105	.16962	.83038
32	.94942	.05058	69	.62086	.37914	106	.15488	.84512
33	.94608	.05392	70	.60522	.39478	107	.13409	.86591
34	.94250	.05750	71	.58914	.41086	108	.10068	.89932
35	.93868	.06132	72	.57261	.42739	109	.04545	.95455
36	.93460	.06540	73	.55571	.44429			

Source: Section 20.2031-7 of Title 26 of the Code of Federal Regulations

01/01/14

### **Voter Registration**

The National Voter Registration Act of 1993 (P. L. 103-31) requires each state's public assistance agency to provide the customer the opportunity to complete a Voter Registration Application at any time a request for assistance is made. This requirement became effective January 1, 1996.

Voter registration is not a part of program eligibility requirements. Therefore, an application for assistance will not be denied nor will a case be closed due to failure to complete any forms in relation to voter registration. No forms or other documents related to voter registration except for the DHS-131 and Voter Registration Change of Status will be filed in the customer's case record.

### **DCO Employees will not:**

1. Seek to influence a customer's political preference or party registration;
2. Display any such political preference or party allegiance;
3. Make any statement to a customer or take any action, the purpose or effect of which is to discourage the customer from registering to vote; or
4. Make any statement to a customer or take any action, the purpose or effect of which is, to lead the customer to believe that a decision to register or not to register has any bearing on the availability of services or benefits.

### **Explanation & Offer**

Each customer must be offered an opportunity to apply to register to vote when visiting the county office for purposes of applying for assistance, recertification/reevaluation, or for reporting changes of name or address. If a customer is applying for more than one service and is interviewed by two or more Program Eligibility Specialists on the same day, the offer has to be made at least once. The County Office will put into place a procedure that will ensure that the offer has been made.

Subsequent visits to the County Office for the purpose of completing the application/ recertification process (e.g., customer returns the next day to furnish check stubs) will be considered part of the same application. Therefore, it is not necessary to make another offer for voter registration.

### **Who Can Make the Offer**

The offer can be made by any employee or volunteer. If the offer is made by someone other than the Program Eligibility Specialist, a procedure must be in place to notify the worker that the offer was made to avoid duplication of effort during the program eligibility interview.

A Voter Registration Application form must be provided to anyone who requests one. If someone is not applying for DHS services but requests a Voter Registration Application form, the worker will give

him/her the form with instructions to mail it directly to the Secretary of State's office. A declaration form will not be given in this instance, nor will it count on the daily recap report.

### **Customer Acceptance**

If a customer states she/he wishes to register to vote, she/he will be given a Voter Registration Application to complete. The voter registration application can be completed at the county office and given back to the receptionist or the customer can take it with him or her and mail directly to the designated address. Assistance in completing the form will be provided if requested. It is a local decision as to whether the Agency-Based Declaration Statement will be completed. If it is completed, a copy may be given to the customer if requested. It is a local decision as to whether the "yes" declarations will be kept in the county office. Do not mail the declaration forms to the Secretary of State's Office. The customer will be advised that a decision on his/her Voter Registration Application will be provided by the County Clerk's Office.

If there are other adult household members a Voter Registration Application may be given to the customer for the other adult(s) to complete. However, if the other adult(s) chooses not to register, a declination form is not needed.

The worker will put the agency code on the voter registration application that applies at the time it is being completed. For example, if the customer is applying for Supplemental Nutrition Assistance Program benefits at the time a voter registration application is being completed, the worker would use the SNAP code. If the customer is applying for several programs, just use one code (worker choice).

### **Telephone Interviews and Authorized Representatives**

Applicants who are interviewed by phone and indicate a desire to register to vote should be mailed a Voter Registration Application no later than the date that a determination (approval or denial) is made on the case. This applies to both initial applications and reevaluation/recertifications.

The Voter Registration Application form will be mailed to the applicant/recipient any time an authorized representative is interviewed on the customer's behalf. If a customer makes a telephone request for a Voter registration Application form, one will be mailed to his/her mailing address.

### **Access Arkansas**

Applicants who apply through Access Arkansas may apply directly online by following a link to the Secretary of State's website to register to vote.

### **SNAP/MSP Annual Review**

Mail in applicants should be mailed an Arkansas Voter Registration Application no later than the date that a determination (approval or denial) is made on the case. This applies to both reevaluation/recertifications.

### **Customer Declination**

If the customer declines to register to vote, then she/he will be asked to make the declination by checking "no" on the Agency-Based Declaration Statement. She/he should also sign and date the statement. If the customer refuses to complete the form, the DCO employee will print the customer's name on the statement, date, and make a note of "refused to sign" in the comment section. A copy of the Agency-Based Declaration Statement may be provided to the customer if requested. A daily count of the declinations must be provided to the Secretary of State's office when completing the Agency Daily Recap Reporting Form. The Agency Based Declaration Statement will be kept for 2 years in the County Office in a chronological file by month and year.

### **Change of Address or Name Change**

If a customer reports a change of address or name change, a DCO-131, Voter Registration change of Status form and a Voter Registration Application will be sent to the customer advising that the change can be reported to the County Clerk's office for voter registration purposes or that she/he can register to vote. A declaration statement will not be completed in this instance.

### **Submitting Applications**

Completed Voter Registration Applications must ensure that this timeframe is met. The customer may mail his/her application; the address is on the back of the application. An envelope is not needed. An Agency Daily Recap Reporting Form will be completed and sent with the voter registration application. This form advises the Secretary of State's Office of the number of declination and number of completed voter registration applications being submitted. A single report including all programs will be submitted. The County Office will retain a copy of the Daily Recap Reporting form for 24 months in a chronological file by month and year.

The County office must maintain a record of the number of Voter Registration applications mailed to the Secretary of State's Office each day. No later than the 10th calendar day of each month, the county will report to the DCO Field Operations, via the DHS-132, Voter Registration Application Monthly Report, the number of voter registration applications and declinations submitted to the Secretary of State's office in the prior month.

# Medical Services – Appendix W, ARChoices in Homecare and Living Choices Assisted Living Facility (ALF) Waiver Application Tracking and Release Procedures

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10/18/18

The ARChoices in Homecare and Living Choices Assisted Living Facility (ALF) Home and Community-Based Services (HCBS) waiver programs are experiencing a rapid growth rate. The increasing number of participants may exceed the maximum number of unduplicated beneficiaries that can be served during any given waiver year, as well as the maximum number of individuals that can be active on the waiver program on any given day. These are two separate counts that are monitored daily by Division of Aging, Adult and Behavioral Health Services (DAABH). Since exceeding the maximum number affects Federal funding, DAABH must implement an application tracking and release process at the time it appears that participants in either program may exceed the cap.



**NOTE:** The two programs affected, ARChoices and ALF, each have their own caps. The tracking and release procedures and, if necessary, waiting list process will be implemented separately.

DCO staff will be notified via email when the tracking and release process has been implemented or lifted for either program and of any specific changes in processing instructions at that time. The tracking and release procedures will be implemented **only** when DAABH sends notification that it appears participants may exceed the cap. Once the cap has been reached, DAABH will send notification to implement the waiting list.

When an application tracking and release procedure is implemented, ***no applicant will be denied or told they are not eligible due to unavailable slots.*** Each application will be accepted and eligibility will be determined. Medicaid eligibility in a non-HCBS waiver category will be processed and approved as normal.

The following steps require actions from the DCO County Office, DCO LTSS Unit, DAABH Central Office, and the DHS RN. In order to easily identify the action steps for each party, the party responsible for each step has been written in **bold print** and underlined.

## Tracking and Release Procedure

### DCO County Office Responsibilities

1. The **County Office** will accept the application and date stamp it on the date received.
2. The **County Office** will scan the application into ANSWER and,
  - a. if the **County Office** knows which LTSS eligibility worker it will be assigned to, they will register the application in ANSWER in the appropriate budget unit, assign the “Application Follow Up” task to the LTSS eligibility worker; and email the LTSS eligibility worker and the LTSS Local Office

# Medical Services – Appendix W, ARChoices in Homecare and Living Choices Assisted Living Facility (ALF) Waiver Application Tracking and Release Procedures

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10/17/18

Administrative Assistant (LOAA) to notify him/her that an application has been received and scanned; **or**

- b. if the **County Office** doesn't know which LTSS eligibility worker the application will be assigned to, they will email the LTSS LOAA to notify them the application was received/scanned so the LTSS LOAA can register it.

## LTSS Unit Responsibilities

1. The **LTSS LOAA** will log the application on the SharePoint site for the appropriate HCBS Application List:

- <http://dhsshare.arkansas.gov/DAAS/ARChoices/Lists/ARChoices%20Waiver%20Application/AllItems.aspx> for ARChoices; or
- <http://dhsshare.arkansas.gov/DAAS/LivingChoices/Lists/Living%20Choices%20Application/AllItems.aspx> for ALF.

The required information, as indicated by a red asterisk, will be entered by the **LTSS LOAA** on the Application List in the appropriate fields.

- Applicant's Name (*Last Name, First Name*);
- Applicant's Social Security Number (*SSN*);
- Applicant's date of birth (*DOB*);
- *Date of Application*;
- *County Office* name; and
- Eligibility worker's name (*Program Eligibility Specialist*.)

Last Name *	<input type="text"/>
First Name *	<input type="text"/>
SSN *	<input type="text"/>
DOB *	<input type="text"/>
Date of Application *	<input type="text"/>
3330 Sent	<input type="text"/>
County Office *	<input type="text"/>
Program Eligibility Specialist *	<input type="text"/>

2. The **LTSS eligibility worker** will send a referral to the DHS RN via the DHS-3330 as described in policy section [MS C-241](#) for ARChoices and [MS C-253](#) for ALF and update the Application List with the date the DHS-3330 referral was sent to the DHS RN (*3330 Sent*).
3. The **LTSS eligibility worker** will check ANSWER to confirm the application was registered in order to ensure the individual's information is sent to the Asset Verification System (AVS). If the application has not been registered, the **LTSS eligibility worker** will register the application effective the date the application was received and date stamped in the County Office.

# Medical Services – Appendix W, ARChoices in Homecare and Living Choices Assisted Living Facility (ALF) Waiver Application Tracking and Release Procedures

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10/17/18

4. Based on the information on the application, the **LTSS eligibility worker** will screen the waiver application for possible eligibility in another Medicaid category. If it appears the applicant may be eligible in another Medicaid category, the application will be referred to the appropriate DCO County Office for an eligibility determination through the normal process for possible Medicaid coverage outside of the HCBS category.

5. Financial and MRT, if applicable, eligibility for the HCBS waiver will continue to be determined. (Refer to [MS B-312](#) for ALF or [MS B-313](#) for ARChoices.) If found eligible based on the non-functional need criteria for the category, the **LTSS eligibility worker** will update the Application List by entering the date of financial eligibility determination in the “*DCO Eligibility Date*” field.

6. If the applicant is found not eligible based on non-functional need criteria for the category, then the application will be denied in ANSWER. The **LTSS eligibility worker** will send a DHS-3330 to the DHS RN advising of the denial and update the Application List by entering the date of financial eligibility determination in the “*Ineligible Date*” field. This action will remove the applicant from the Application List.

## **DHS RN /DAABH Central Office Responsibilities**

1. Upon receipt of the DHS-3330 referral, the **DHS RN** will complete the functional eligibility assessment.
2. If the applicant is determined functionally eligible, the DHS RN will receive an email notification from **DAABH Central Office** which states: “704 Completed by OLTC – Wait for further instructions to process.”
3. The **DAABH Central Office** will update the Application List by entering the date of the functional eligibility determination in the appropriate field based on the date the DHS-0704 was signed.
4. **DAABH Central Office** will monitor the Application List for eligibility and move the appropriate applicants to the Tracking and Release List.
5. **DAABH Central Office** will send an email to the **DHS RN** to obtain the eligibility date and Medicaid number.
6. Upon receipt of the email request from Central Office, the **DHS RN** will send a DHS-3330 and the DHS-0704, if available, to the LTSS eligibility worker requesting the eligibility date and Medicaid number.

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7. Upon receipt of the eligibility date and Medicaid number, the **DHS RN** will forward the email from DAABH Central Office with the eligibility date and Medicaid number entered on the blank lines in the email to the ArPath folder: [DHS.DAAS.ArPath@arkansas.gov](mailto:DHS.DAAS.ArPath@arkansas.gov).
8. **DAABH Central Office** will enter the eligibility date to the appropriate field on the Tracking and Release List to move the applicant to the Archive List.

## Waiting List Process

### **If the cap is reached, then a waiting list will be implemented.**

Once both the financial and functional eligibility dates have been entered, the Tracking and Release List will assign a wait list/slot number.

Slot numbers are not necessarily filled in sequential order when a slot becomes available.

**EXAMPLE:** Under the Living Choices waiver, the following process is followed for prioritizing available slot releases:

- a) waiver application determination date for persons inadvertently omitted from the waiver waiting list due to administrative error;
- b) waiver application determination date for persons being discharged from a nursing facility after a 90-day stay/waiver application determination date for persons residing in an approved Level II Assisted Living Facility for the past six months or longer;
- c) waiver application determination date for persons in the custody of DHS Adult Protective Services (APS); and
- d) waiver application determination for all other persons.



**NOTE:** After prioritizing, if more than one application is determined eligible on a certain date, the slot number will be determined by the date logged. If more than one has the same log date, then the slot number will be assigned alphabetically based on the applicant's last name.

At this point, the applicant must be advised that eligibility has been established, but that no waiver slots are currently available. This notice (DHS-0707) must also include the wait list slot number assigned to the individual.

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Open waiver slots will be determined twice per month – on the 1st and 15<sup>th</sup> – or if this falls on a holiday or weekend, the first business day thereafter. As slots become available, they will be filled in sequential order according to the assigned slot numbers.

**EXAMPLE:** (This example assumes only two applicants are on the waiting list.)

Ms. Jones submits an application on July 20. Her application is pending an MRT decision and verification of bank accounts.

Mr. Smith submits an application on July 22 and is determined financially and functionally eligible on August 14. His status is updated on the Tracking and Release List and he is assigned Slot #1.

Ms. Jones' financial and functional eligibility is established and updated on the Tracking and Release List on August 30. She is assigned Slot #2.

On August 15, a waiver slot is available so Mr. Smith is placed in it as he has Slot #1. As of that date, Ms. Jones' eligibility had not yet been established, so even though she had an earlier application date, Mr. Smith is placed in the slot since his eligibility was already established. Since she now has Slot #2, Ms. Jones will be placed in the next available slot.

## Approval Process

### DAABH Central Office, DHS RN, and LTSS Eligibility Worker Responsibilities

1. Once financial and functional eligibility have been established, the **DAABH Central Office** will look up the applicant's slot number on the Tracking and Release List and notify the DHS RN by email.
2. Upon receipt of the slot number from Central Office, the **DHS RN** will enter the waiting list/slot number on the DHS-3330 and send it to the LTSS eligibility worker.
3. The **LTSS eligibility worker** will complete and send the DHS-0707 to notify the applicant that eligibility has been established, but that there are currently no open slots. The DHS-0707 must include the following:
  - Applicant's waiting list/slot number; and
  - The following statement: *"You have been determined financially and functionally eligible to receive services through the \_\_\_\_\_ (ARChoices or Assisted Living Facility) Medicaid waiver program. Currently, all \_\_\_\_\_ (ARChoices or Assisted Living Facility) slots are filled, and you have been placed on the waiting list. Your slot number is \_\_\_\_\_. Once a slot becomes*

# Medical Services – Appendix W, ARChoices in Homecare and Living Choices Assisted Living Facility (ALF) Waiver Application Tracking and Release Procedures

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*available, your approval will be submitted for services to begin and you will receive notification. Once services begin, both financial and functional eligibility will be determined annually.”*

4. The **DAABH Central Office** will regularly monitor the Tracking and Release List. Open waiver program slots will be determined twice per month, on the 1st and 15<sup>th</sup> or, if this date falls on a holiday or weekend, the first business day thereafter.
5. When a slot is available, the **DAABH Central Office** will notify the appropriate DHS RN via e-mail.
6. Upon notification from Central Office, the **DHS RN** will send a DHS-3330 and the DHS-0704, if not previously sent, to the LTSS eligibility worker advising that the applicant may now be approved for services and to request a Medicaid identification number and waiver eligibility date.
7. Upon notification from DAABH that a slot is available, the **LTSS eligibility worker** will approve the application according to normal procedures.



**NOTE:** For either waiver program, ARChoices or ALF category, under the waiting list process, the waiver eligibility date is the date the County Office approves the application in ANSWER.

8. The **LTSS eligibility worker** will return the DHS-3330 to the DHS RN providing the waiver eligibility date and the Medicaid number.
9. Upon receipt of the eligibility date and Medicaid number, the **DHS RN** will forward the email from DAABH Central Office with the eligibility date and Medicaid number entered on the blank lines in the email to the ArPath folder: [DHS.DAAS.ArPath@arkansas.gov](mailto:DHS.DAAS.ArPath@arkansas.gov).
10. **DAABH Central Office** will enter the eligibility date to the appropriate field on the Tracking and Release List to move the applicant to the Archive List.
11. The applicant will be notified by the **LTSS eligibility worker** via the system generated approval process that services will begin.
12. The application will be processed under normal practices by the **DHS RN**. The provider packets (plan of care, start of care form, claim forms, etc.) will be mailed.

## MEDICAL SERVICES – APPENDIX X, REFERRALS FOR INDEPENDENT CHOICES

05/01/18

IndependentChoices is for individuals who:

1. Are 18 years of age or older and currently receive Medicaid in a category that covers personal care, or
2. Are in the ARChoices in Homecare waiver program; and
  - a. have an assessed need for personal assistance services; and
  - b. are willing to accept the responsibilities of directing their in-home services or
  - c. have a representative who can direct their care for them.

IndependentChoices allows a Medicaid recipient in need of personal care or ARChoices attendant care to hire his or her own caregiver. The participant is given an allowance based on medical need to pay the caregiver. Caregivers are often friends or family members. A spouse or anyone legally responsible for the participant (e.g., a guardian) cannot be the paid caregiver.

Medicaid categories that **do not** cover personal care are:

- Medicare Savings categories (QMB, SMB, and QI-1) – **NOTE:** Individuals enrolled in ARSeniors are eligible for IndependentChoices.
- Medically Needy categories (both Exceptional and Spend Down)
- ARKids B
- Limited Pregnant Woman (A pregnant woman whose income is at or below 209% of the federal poverty level)
- Adult Expansion Group with a Qualified Health Plan (QHP).

Individuals enrolled in all other Medicaid categories including Medically Frail individuals in the Adult Expansion Group may be eligible for IndependentChoices if the other criteria are met. Individuals who are not currently on Medicaid or are in one of the above categories should not be referred to IndependentChoices. County offices should continue to refer interested individuals who are Medicaid recipients in appropriate categories to the IndependentChoices toll-free number at **1-866-710-0456**. If the individual receives ARChoices in Homecare, direct them to their DAAS RN.

County office staff who have further questions regarding eligibility for IndependentChoices may also call the above number.

# Medical Services – Appendix Y, Work Activity Hours Chart

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02/08/2019

Use the following chart to manually determine work activity hours:

Work Activity	Work Activity Hours
Working at a job that earns you money. Report your income each month. DHS will decide your work hours based on the Arkansas minimum wage. If you do not earn enough each month before taxes are taken out of your check, you must combine this activity with others to make the 80 hours.	<ul style="list-style-type: none"> <li>• Your reported income divided by Arkansas minimum wage = work activity hours</li> </ul>
Going to school, job training, vocational, or other educational program.	<ul style="list-style-type: none"> <li>• 1 hour of instruction = 2.5 work activity hours</li> </ul>
Volunteering in your community. You can find ways to volunteer at <a href="http://www.volunteerar.org">www.volunteerar.org</a> .	<ul style="list-style-type: none"> <li>• 1 reported hour = 1 work activity hour</li> </ul>
Looking for a job on your own or going to free job search training at an Arkansas Workforce Center. You may count up to 39 total hours from these activities each month.	<ul style="list-style-type: none"> <li>• Job Search: 1 reported job contact = 3 work activity hours</li> <li>• Job Search Training: 1 reported hour = 1 work activity hour</li> </ul>
Going to a health education class. You may count up to 20 hours each year from this activity. Learn more about these classes at <a href="http://www.access.arkansas.gov">www.access.arkansas.gov</a> . Click on the Arkansas Works button.	<ul style="list-style-type: none"> <li>• 1 reported hour = 1 work activity hour</li> </ul>

# Medical Services – Appendix Z, Medicaid Program Resource Limits, Medicare Premiums, and Medicare D Benchmark

01/01/20

## Supplemental Security Income (SSI)/ SSI Related Groups

Year	Supplemental Security Income (SSI)	AABD Adult Spend Down	Pickle (COLA)	Disabled Adult Child (DAC)	Widows/Widowers and Surviving Divorced Spouses with a Disability
2020	Individual \$2000 Couple \$3000	Same as SSI	Same as SSI	Same as SSI	Same as SSI

## Long Term Services and Supports (LTSS) Group

Year	Nursing Home	Assisted Living (ALF)	ARChoices	DDS	PACE	Workers with Disabilities	TEFRA	Autism
2020	Individual \$2000 Couple \$3000	No Resource Limit	\$2000 Only Child's resources are counted	\$2000 Only Child's resources are counted				

## Family and Individuals Group (MAGI)

Year	Adult Expansion Group	Parents/Caretaker Relative	ARKids A & B	Full Pregnant Woman	Limited Pregnant Woman	Former Foster Care
2020	*N/A	*N/A	*N/A	*N/A	*N/A	*N/A

**\*MAGI Related Groups have no resource limit\***

# Medical Services – Appendix Z, Medicaid Program Resource Limits, Medicare Premiums, and Medicare D Benchmark

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01/01/20

## Non-MAGI Families Spend Down

Family Size	Pregnant Woman	Under 18 (U-18)	Unemployed Parent	AFDC Related
1	\$2000	\$2000	\$2000	\$2000
2	\$3000	\$3000	\$3000	\$3000
3	\$3100	\$3100	\$3100	\$3100
4	\$3200	\$3200	\$3200	\$3200

**\*\*NOTE: Add \$100 for each additional person\*\***

## Medicare Savings Resource Limits

Year	AR Seniors	QMB	SMB	QI-1	QDWI
2020		Individual \$7,860.00 Couple \$11,800.00			Individual \$4000 Couple \$6000

## Medicare B Premiums

Year	Limit
2020	\$144.60

## Medicare D Benchmark

Year	Limit
2020	\$32.74

01/01/14

### **PURPOSE**

Section 2651 of the Deficit Reduction Act of 1984 mandates that the Department of Human Services request and utilize IRS tax return information in determining eligibility for assistance. As a condition of receiving IRS tax return information, the Department of Human Services must establish and maintain safeguards designed to prevent unauthorized uses of the information and to protect the confidentiality of such information. This appendix specifically details the confidentiality and safeguard requirements that must be strictly followed.

Each DCO County Administrator has the responsibility of insuring that each employee is fully aware of the criminal and civil penalties for unauthorized disclosure of IRS tax return information. All information contained in this appendix must be reviewed by all staff semi-annually and each new employee must review this appendix prior to receiving and/or utilizing IRS tax return information.

Return information consists of more than an individual identity, amount and source of income, and other monetary values. Internal Revenue Code Section 6103 (b) (2), which defines return information, lists numerous items and continues with "...or any other data, received by, recorded by, furnished to, or collected by the Secretary with respect to a return or with respect to the determination of the existence, or possible existence, of liability...of any person..." "Even the existence or possible existence" of a tax liability has been interpreted (by IRS) to mean that the fact that IRS has information on an individual is considered return information. Any information showing that an IRS match occurred, reveals that IRS has information on that individual; therefore, such information is "return information".

Additionally, tax information never loses its character. That is, tax information remains tax information even after it has been verified. The major determining factor is the source of the information. If the initial source is IRS, the information is return information. If the initial source is the customer or a third party (from their records), the information is generally not return information. If a document contains return information and is verified by the customer or a third party, the information remains return information as the original source was IRS and it does not lose its character.

### **EMPLOYEE AWARENESS**

Each agency employee entitled to access IRS tax return information must be thoroughly briefed on all security procedures and instructions. Periodic reorientation sessions should be conducted to insure that all appropriate employees remain alert to security requirements regarding IRS information.

In compliance with IRS Safeguard requirements, a poster has been developed advising employees of the penalties for unauthorized disclosure. Each DCO County Administrator has the responsibility of displaying the poster so that employees are reminded of the penalties. Penalties apply even if an unauthorized disclosure is made after employment with the agency is terminated. Unauthorized disclosure by current employees will result in termination.

Employees who are entitled to access IRS tax return information must not disclose this information to any party outside the agency other than the taxpayer to whom the information relates, the taxpayer's duly appointed representative who has the explicit written authority to obtain the information, or employees of the federal agency charged with oversight of the particular program the state agency is administering.

Employees who are entitled to access IRS tax return information must not disclose this information to any other officer or employee within the agency whose official duties do not require this information to determine eligibility for, or the correct amount of, benefits under these programs.

Due to stringent IRS safeguarding and disclosure guidelines it is necessary that employees exercise care in composing notices to customers and correspondence to payers with respect to IRS tax return information. It is recommended that notices to customers do not list the IRS as the source of the information but rather should state that the agency has learned about the information through computer matching.

If the customer questions the source of the information then the source of the information may be disclosed to the customer or his/her duly appointed representative. In the case of adults (including spouses) on whom an IRS report is generated, disclosure of the source of the information will be provided only to the adult for whom the information is reported. In the case of children on whom an IRS report is generated, disclosure of the source of the information will be provided only to the child's parent or guardian. Any correspondence written or verbal between the agency and the payer should not reference IRS as the data source.

### **OFFICE SECURITY AND RECORD RETENTION**

All TEA, Food Stamp, and Medicaid case records will be kept in a locked storage area during non-working hours. Further, at no time will any IRS or BENDEX Wage report be left in open view so that unauthorized persons may gain access. IRS reports are generated under the title "State Resource" reports.

All IRS and BENDEX Wage summary reports will be maintained in the county office for one year from the report rundate and may be destroyed at that time following the procedures which follow.

### **DESTRUCTION OF IRS TAX RETURN INFORMATION**

The Tax Reform Act of 1976 requires that certain actions be taken when destroying federal tax information in order to protect its confidentiality. IRS data will be destroyed by burning or shredding.

**Burning:** The material is to be either burned in an incinerator that produces enough heat to burn the entire bundle or the bundle should be separated to insure that all pages are consumed.

**Shredding:** To make reconstruction more difficult, the paper should be inserted so that the lines of print are perpendicular to the cutting line; small amounts of shredded paper should not be allowed to accumulate in the shredder bin.

IRS data in identifiable form must never be released to private contractors for unsupervised destruction. Destruction of the data must be witnessed by an agency employee in a manner sufficient to safeguard the data from unauthorized disclosure.

Each Economic Services Supervisor will have the responsibility of maintaining a Control Log of all IRS data that is destroyed. At a minimum, the log will contain the following:

- Date of destruction
- Method of destruction
- Printout number and rundate for summary reports
- Case name and number for cases containing IRS data
- Agency personnel responsible for overseeing destruction

Since IRS data must be logged when destroyed and since Individual Case Sheets will be filed in case records, it is necessary that case records be screened for IRS data prior to destruction. If

tax return information is in the case record, then an entry to the IRS destruction log is required. To expedite the screening of cases for tax return data, enter "IRS" in the upper right corner of the face sheet of the case to alert staff that the case contains tax return information from the IRS. It is important that all offices use a consistent method to notate cases for IRS data since cases are often transferred between offices.

The Control logs will be forwarded to the Assistant Director of the Office of Program Planning and Development no later than August 15th of each year. A copy of the Control log will be retained in the county office for five complete years from the date of its submission to Central Office.

### **SAFEGUARD CONTROLS**

A control list will be maintained in each DHS county office substantiating that each employee authorized to receive and use IRS tax return information has received a copy of the IRS Confidentiality and Safeguard Procedures and has been made fully aware of the penalties for unauthorized disclosure. Each new agency employee entitled to access IRS tax return information must also be added to the control list prior to accessing the data. This list will contain, at a minimum, the name and signature of the person responsible for IRS data, the date that safeguard procedures were reviewed and the supervisor's initials. The list is subject to review by the Management & Evaluation Unit, the Program Support Specialist, the Program Support Manager, and other Central Office staff as deemed necessary. In addition, the control list will be made available for on-site inspections made by the Internal Revenue Service.

### **ON-SITE INSPECTIONS**

Annual inspections will be conducted to ascertain that safeguards are being followed. A complete record will be made of each inspection and kept on file in the DCO Office of Program Planning and Development. A complete record of the inspections will be submitted to OPPD by August 15 of each year. Any deficiencies noted as a result of an on-site inspection will require that corrective action measures be taken. These inspection records will be maintained for a period of three years or until reviewed by the Internal Revenue Service, whichever is later. An on-site inspection will include the following:

1. A review of the storage and handling of federal tax information;
2. A review of the dissemination of federal tax reports to appropriate agency staff;
3. An assessment of county office security features;

## Medical Services – IRS Safeguards Appendix

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4. Verification that all IRS tax return is maintained in a locked storage area during non-working hours or that the county office is making a good faith effort to work toward such an arrangement;
5. A review of after-hours security to insure that unauthorized access cannot be obtained by unauthorized personnel (e.g., janitorial staff);
6. A review of all IRS Control Logs;
7. Interviews with appropriate agency staff to ensure that employees are aware of the confidentiality regarding IRS data and the penalties for unauthorized disclosure;
8. Verification that each county office has displayed the poster advising of the penalties for unauthorized disclosure of IRS information; and
9. A review of county office procedures for destruction of IRS information.