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102.01 Introduction

(Eff. 10/01/05)

This chapter discusses the non-financial criteria which must be met for an individual to qualify for Medicaid and the acceptable methods which may be used to verify that the criteria are met.

102.01.01 Verification of Non-Financial Requirements

(Eff. 10/01/05)

No additional verification is necessary other than self-declaration for some eligibility factors unless information is confusing or contradictory to other information available to the South Carolina Department of Health and Human Services (SC DHHS), the Medicaid agency. Information is considered questionable when:

* There are inconsistencies in the applicant/beneficiary’s oral or written statements.
* There are inconsistencies between the applicant/beneficiary’s allegations and information from collateral contacts, documents, or prior records.
* The applicant/beneficiary or his representative is unsure of the accuracy of his own statements.

102.02 Identity

(Eff. 07/01/06)

[CFR §435.407](http://www.ecfr.gov/cgi-bin/text-idx?SID=0d5b433b4fd4f2544aa9f64e97c6c014&node=42:4.0.1.1.6.5.63.7&rgn=div8); [CFR §435.949](http://www.ecfr.gov/cgi-bin/text-idx?SID=0d5b433b4fd4f2544aa9f64e97c6c014&node=42:4.0.1.1.6.10.76.27&rgn=div8)

The identity of the applicant/beneficiary and family members must be verified. Refer to SC MPPM [102.04.02.](#MPPM_102_04_02)

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102.03 State Residency

(Rev. 04/01/16)

[CFR §435.403](http://www.ecfr.gov/cgi-bin/text-idx?SID=0d5b433b4fd4f2544aa9f64e97c6c014&node=42:4.0.1.1.6.5.63.4&rgn=div8)

SCDHHS must provide Medicaid to South Carolina residents who meet all other eligibility requirements. Several factors determine an individual’s residency, such as: age, institutional status, and capability of indicating intent. Specific situations are discussed below.

Note: An individual **cannot be denied** Medicaid due to residency for the following reasons:

* The individual has not resided in the state for a specified period.
* The individual is temporarily absent from the state and intends to return when the purpose of the absence has been accomplished, unless another state has accepted him/her as a resident for Medicaid purposes.

102.03.01 Individuals Receiving a State Supplementary Payment

(Rev. 03/01/07)

For individuals who are receiving a state supplementary payment such as state adoption assistance or foster care payment, the State of Residence is the state making the supplementary payment to the individual unless the other state is also a member of the Interstate Compact on Adoption and Medical Assistance (ICAMA). If the other state is an ICAMA member, the child is a resident of the state in which he is living. (Refer to SC MPPM 204.06)

102.03.02 Individuals Receiving a Title IV-E Payment

(Rev. 04/01/16)

For individuals who are receiving a Title IV-E foster care or adoption assistance payment, the State of Residence is the state in which the child lives.

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102.03.03 Individuals Aged 21 and Older

(Rev. 04/01/16)

Not in an Institution

The State of Residence is where the individual is living and:

* intends to reside, including without a fixed address (if not capable of stating intent, the State of residency is the State where the individual is living); or
* Has entered the state with a job commitment or seeking employment (regardless of current employment status).

In an Institution and Became Incapable of Stating Intent Before Age 21

The State of Residence is:

* The parent’s State of Residence who is applying for Medicaid on the individual's behalf. (If a legal guardian has been appointed and parental rights have been terminated, the State of Residence of the legal guardian is used instead of the parent's);
* The parent's State of Residence at the time of placement. (If a legal guardian has been appointed and parental rights have been terminated, the State of Residence of the guardian is used instead of the parent's);
* The current State of Residence of the parent or legal guardian who files the application if the individual is residing in an institution in that state. (If a legal guardian has been appointed and parental rights have been terminated, the State of Residence of the guardian is used instead of the parent's); or,
* The State of Residence of the individual or party that files an application if the individual: (1) has been abandoned by his parent(s), (2) does not have a legal guardian and (3) is residing in an institution in that state.

In an Institution and Became Incapable of Stating Intent at or After Age 21

The State of Residence is where the individual is physically present, except where another state made the placement.

Any Other Individual in an Institution

The State of Residence is where the individual is living and intends to reside.

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102.03.04 Individuals Under Age 21 (Not Receiving Title IV-E or State Supplementary Payment)

(Rev. 04/01/16)

Not in an Institution and Not Under Care and Control of Parent(s), and Capable of Stating Intent

The State of Residence is where the individual is living and:

* intends to reside including without a fixed address (if not capable of stating intent, the State of residency is the State where the individual is living); or
* Has entered the state with a job commitment or seeking employment (regardless of current employment status).

**Anyone Else Not in an Institution**

The State of Residence is where the individual is living and:

* The State where the individual resides, including without a fixed address; or
* The State where the parent or caretaker with whom the individual
	+ Intends to reside including without a fixed address (if not capable of stating intent, the State of residency is the State where the individual is living); or
	+ Has entered the state with a job commitment or seeking employment (regardless of current employment status).

**In an Institution and Under the Care and Control of Parent(s)**

The State of Residence is:

* The parent's State of Residence at the time of placement. (If a legal guardian has been appointed and parental rights have been terminated, the State of Residence of the legal guardian is used instead of the parent's);
* The current State of Residence of the parent or legal guardian who files the application if the individual is residing in an institution in that state. (If a legal guardian has been appointed and parental rights have been terminated, the State of Residence of the guardian is used instead of the parent's); or
* The State of Residence of the individual or party that files an application if the individual: (1) has been abandoned by his parent(s), (2) does not have a legal guardian and (3) is residing in an institution in that state.

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102.03.05 State Placement in an Out-of-State Institution

(Eff. 10/01/05)

If a state agency arranges for an individual to be placed in an institution in another state, the state arranging or making the placement is the individual's State of Residence. For purposes of state placement, the term “institution” also includes licensed foster care homes that provide food, shelter, and supportive services for one or more individuals unrelated to the proprietor.

These actions are not considered state placement:

* Providing basic information to individuals about another state's Medicaid program and information about healthcare services and facilities in another state
* Providing information regarding institutions in another state if the individual can indicate intent and decides to move

When a competent individual leaves the facility in which he was placed, his residence becomes the state where he is physically located.

South Carolina does not pay for placements in out-of-state nursing facilities. Individuals must qualify for Medicaid Eligibility and vendor payment in the state in which the nursing facility is located. If he later moves to South Carolina, he will apply for benefits here and meet all eligibility requirements. If he is transferred directly from one medical facility to another, the time spent in the out-of-state facility can be used to meet the 30 consecutive day requirement.

102.03.06 Individual Moving to SC Previously Eligible in Another State

(Eff. 01/01/14, Rev. 06/01/14)

If an individual who was receiving Medicaid in another state before moving to SC applies for SC Medicaid, that individual will be responsible for self-reporting his new address to SCDHHS and notifying the other state of his move to SC. Eligibility for benefits can be determined based on the applicant’s statement.

After approval, if the beneficiary appears on the PARIS report as receiving benefits in another state, contact the beneficiary to verify his/her address and document the contact in the MEDS notes screen and in OnBase. If the beneficiary can provide a copy of a closure notice from the other state, scan into OnBase and document in MEDS and OnBase. If the beneficiary continues to appear on the PARIS report for three months after the initial contact and there is not a copy of a termination notice from the other state in the record, contact the beneficiary to follow-up. Initiate closure if unable to documentation closure from the other state.

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| Note**:** The SC Eligibility Worker should include in the case record any letters/ documents or telephone contact information with the out-of-state agency to verify the eligibility status of the applicant/beneficiary. |

102.03.07 Individual Previously Eligible in SC Moving to Another State

(Eff. 10/01/05)

An individual who was a resident and eligible for Medicaid in SC but moves to another state with the intent to remain is no longer eligible to receive Medicaid benefits from SC. The SC DHHS Eligibility Worker must send a notice in a timely manner to terminate eligibility when it has been verified that a beneficiary has moved to another state with the intent to remain there permanently, or for an indefinite period. An adequate notice is required only if the individual begins to receive assistance in another state with no break in benefits.

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102.03.08 Residency Disputes

(Eff. 10/01/05)

When a Medicaid beneficiary moves from one state to another, the former state initiates the change effective the first month in which it can administratively terminate the case in accordance with timely and adequate notice regulations.

There are occasions when a beneficiary will request that his eligibility in his new State of Residence be effective sooner than the former state can administratively terminate his case. In situations such as this, the former and the new State of Residence should coordinate their efforts to ensure that the beneficiary does not receive Medicaid coverage in two states at the same time. However, neither state can deny coverage because of administrative requirements’ time constraints. Example: Mrs. Smith applies for benefits in Florida on Nov. 23 and requests that her SC Medicaid be terminated. Worker in SC terminates, and notice of closure includes a 10-day notice, so Mrs. Smith’s SC benefits do not stop until Jan. 1, 2014. Florida cannot deny coverage for her for November and December due to these administrative constraints.

If an individual is no longer a resident of a state that state is not required to pay for any services incurred in the new state once the individual has applied for Medicaid and meets the eligibility requirements in the new state. When two or more states cannot agree on residence, the state where the individual is physically located is his residence. Coordination efforts should ensure that an individual who is eligible does not experience a discontinuation of benefits.

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| Procedure:If a medical service was incurred, the SC DHHS Eligibility Worker must contact the medical provider to verify if it will bill the other state. The SC DHHS Eligibility Worker must document the medical provider’s response in the case record. If the medical provider will not bill the other state, SC Medicaid benefits must be authorized if otherwise eligible. |

102.03.09 Interstate Agreements

(Eff. 10/01/05)

SC DHHS has not entered into any interstate residency agreements. In other words, SC does not accept residency from another state for purposes of Medicaid eligibility.

102.03.10 Migrant/Seasonal Farm Workers

(Eff. 10/01/05)

An individual involved in work of a transient nature or who goes to another state seeking employment (such as a migrant worker) can choose to:

* Establish residence in the state where he is employed or seeking employment, or
* Claim one state as his domicile or State of Residence.

102.03.11 Visitors to the United States (US)

(Eff. 03/01/11)

Visitors to the United States, who enter on a visa, passport, border passes, etc., are generally not considered residents of the state and not eligible for Medicaid benefits. However, the individual can decide to stay in the US and establish residence here. If this change in status occurs, they may be eligible to receive emergency services. (Refer to [MPPM 102.04.14](#MPPM_102_04_14).)

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102.03.12 Verification

(Eff. 01/01/14)

Residency is verified based on the statement of the applicant/beneficiary unless specific information, such as a PARIS report, makes the statement questionable. Listed below are examples of documents that may be used if necessary to verify residence:

* Current driver's license or highway department identification card
* Statement from landlord who is not related to the applicant/beneficiary
* Rent/mortgage receipt
* Utility bills
* Statement from employer
* Current voter registration card

102.04 United States Citizens

(Eff. 05/01/11)

[CFR §435.949](http://www.ecfr.gov/cgi-bin/text-idx?SID=0d5b433b4fd4f2544aa9f64e97c6c014&node=42:4.0.1.1.6.10.76.27&rgn=div8)

Most United States citizens are natural-born citizens, meaning they were born in the United States or born to United States citizens overseas. Individuals born in the United States (including, in most cases, the District of Columbia, Puerto Rico, Guam, the Northern Mariana Islands, the U.S. Virgin Islands and the Panama Canal Zone before it was returned to Panama) are U.S. citizens at birth (unless born to foreign diplomatic staff), regardless of the citizenship or nationality of the parents. (Refer to [SC MPPM 102.04.19](#MPPM_102_04_19) for budgeting procedures).

102.04.01 Citizenship

(Eff. 01/01/14)

The Deficit Reduction Act (DRA) of 2005 amended the rules regarding verification of citizenship when initially applying for Medicaid or upon a beneficiary’s first annual review on or after July 1, 2006. Certain applicants and beneficiaries are exempt from verification of citizenship and identity. Refer to [SC MPPM 102.04.09](#MPPM_102_04_09).

The Federal Data Hub will be the primary means to verify citizenship. If citizenship cannot be verified through this system, the Eligibility Worker will have to utilize other methods, such as the State Verification and Exchange System (SVES). Refer to SC MPPM 102.04.05-102.04.09.

102.04.02 Identity

(Eff. 01/01/14)

The Deficit Reduction Act (DRA) of 2005 amended the rules regarding verification of identity when initially applying for Medicaid or upon a beneficiary’s first annual review on or after July 1, 2006. Certain applicants and beneficiaries are exempt from verification of citizenship and identity. Refer to [SC MPPM 102.04.09](#MPPM_102_04_09).

The Federal Data Hub will be the primary means to verify identity. If identity cannot be verified through this system, the Eligibility Worker will have to utilize other methods, such as the State Verification and Exchange System (SVES).

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102.04.03 Exemption for Non-Applicants

(Eff. 05/01/11)

The citizenship or immigration status of non-applicants (parents or other household members) is not applicable to the eligibility determination. Disclosure of citizenship or immigration status may not be requested for non-applicants.

The Systematic Alien Verification for Entitlement (SAVE) program procedures found in [MPPM 102.04.23](#MPPM_102_04_23) of this chapter must be followed if US citizenship is not alleged and immigration papers are provided.

102.04.04 Reasonable Opportunity to Prove Citizenship and/or Identity

(Eff. 11/01/17)

An applicant can be approved for Medicaid for a period of up to 90 days from the date of application. Citizenship and Identity must be verified within this period or Medicaid eligibility must be terminated. For a BG Member who has previously been approved for Medicaid for up to 90 days while awaiting verification of Citizenship and/or Identity and is re-applying, the individual cannot be approved until all verifications, including Citizenship and/or Identity, have been received.

Verification of citizenship and identity is a one-time requirement. Once citizenship and identity are verified, subsequent changes in eligibility will not require repeating the verification process. If Physical Documents are used, the Eligibility Worker must maintain verification of citizenship and identity in the permanent verification section of the case record. Refer to SC MPPM Chapter 104, Appendix C.

Infants born to Medicaid eligible mothers are permanently exempt from the citizenship and identity documentation requirements. A completed DHHS Form 1716 and/or indication in MEDS that the baby was deemed eligible is sufficient proof of citizenship and identity. For babies deemed Medicaid eligible in another state, any indication on that state’s letterhead or other official document is acceptable proof.

Citizenship and Identity must be verified through one of the following methods in the order shown:

1. Federal Data Hub SC MPPM 102.04.05
2. SVES SC MPPM 102.04.06
3. DMV web tool SC MPPM 102.04.08
4. Original Documents SC MPPM 102.04.09

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| **Procedure for Verifying Citizenship and Identity** |
| **MEDS Procedure:*** When pending an application, the Proof of Citizenship and Identity indicators and <SRC DOCUMENT> Fields for Citizenship and Identity on HMS91, HH MBR Parental/ Citizenship/Identity Detail Screen (HMS91 C&I SCREEN) must remain blank except when one of the following conditions exist:
	+ - If valid verification is already coded in the Citizenship and/or Identity fields, do not change the information
		- If the applicant presented Original Documents at the time of application, enter the appropriate coding in the field(s)
		- If the application is to be approved the same day based on assumptive eligibility or 90-day reasonable opportunity, enter “WKRVER” in the <SRC DOCUMENT> Fields.

Note**:** For all verification methods except SVES, the Eligibility Worker will be responsible for updating HMS91 C&I SCREEN and ELD01 as the information is received.* To close the member(s) for which Citizenship and/or Identity was not provided; the Eligibility Worker should access ELD00 and change the pass/fail indicator to Fail for Citizenship and/or Identity depending upon which verification was not provided.

Note**:** If the appropriate pass/fail indicators are protected, the Eligibility Worker will need to enter RC004 in the RC1 field on ELD01 to cause those fields to become updateable. The Eligibility Worker will also need to enter RC004 on the RC1 field on ELD01 to initiate a closure for a child in a protected period.* After adjusting the pass/fail indicators and removing PPED if necessary, the Eligibility Worker should call Make Decision on ELD01. Make Decision will close those members who have not provided proof of Citizenship and/or Identity with the appropriate reason codes (RC061 if proof of citizenship was not provided, RC043 if proof of identity was not provided, or RC012 if proof of citizenship nor identity were provided). If the entire budget group is being closed, the reason code(s) will appear on ELD01. If only certain members are being closed, those reason codes will appear on the individual ELD02 screens. The worker should check to ensure the correct members are closing before calling Act on Decision to complete the closure.
* If an application is approved allowing a reasonable opportunity but verification of Citizenship and/or Identity has been not provided within the 90 days and all avenues of verification have been exhausted, the budget group must be closed using Reason Code 061, You did not provide proof of citizenship; Reason Code 043, You did not provide proof of identity; or Reason Code 012, You did not provide proof of Citizenship and/or Identity.
* If an application is denied solely for failure to provide information and the applicant provides all needed verifications within 30 days from the date on the denial notice, the date of the previous application must be used to determine the effective date of Medicaid eligibility.

If the closure is for one or more individuals and not the entire budget group, go to ELD00 in MEDS and FAIL that individual(s) on Citizenship and/or Identity. The remaining budget group members will remain eligibleNote**:** Citizenship and Identity do not have to be verified if the applicant is not otherwise eligible. Refer to SC MPPM Chapter 101.09.03. |

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| **Procedure for Remote Identity Proofing (RIDP)** |
| Cúram Procedure:Verification of the identity of an individual submitting an online application is first attempted using electronic services. If the result is anything other than “Pass” the individual will be required to supply hard copy documentation using Form 1235 of identity before verification of application information can be completed.  |

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102.04.05 Verification of Citizenship and Identity by the Federal Data Hub

(Eff. 01/01/14)

Verification of Citizenship and Identity through the Federal Data Hub is an automatic process initiated during the on-line application process.

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| **Procedure for Verifying Citizenship and Identity by the Federal Data Hub** |
| Cúram Procedure:The Eligibility Worker will enter the applicant’s information into Cúram, which will then connect to the Federal Hub to verify citizenship and identity. Results will be determined automatically. If citizenship and identity are verified, continue processing the application. If citizenship and identity are not verified, the Eligibility Worker must request hard-copy verification, see SC MPPM 102.04.09.  |

102.04.06 Verification of Citizenship and Identity by SVES

(Eff. 05/01/11)

Verifying Citizenship and Identity through SVES is an automated process that begins once an Eligibility Worker locks an application in MEDS. Information about the applicant is sent to the Social Security Administration where it is matched, and a response will be returned to indicate if the Citizenship and Identity of the applicant is verified. If the information is verified, MEDS will update. If SVES is not able to verify, the Eligibility Worker will receive an alert to pursue other methods of verification.

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| **SVES Process**1. Worker locks an application in MEDS. MEDS will create a request to verify Citizenship and Identity for each Budget Group Member where the US Citizenship indicator is “Y”, and the Social Security Number does not belong to an alternate recipient.
2. MEDS will populate the HH Member Parental/Citizenship Identity Detail screen (MEDHMS91 C&I SCREEN) as follows:
	1. The Proof of Citizenship Verified Indicator will be updated to “Y” and the Citizenship Source document field will be coded SVEPEND (SVES verification is pending) if the field is currently empty or contains the following codes: NOTVER (SVES did not verify), NORSPSV (SSA did not respond), WKRVER (Worker will verify). If there is any other source code shown in the field, MEDS will not update.
	2. The Proof of Identity Verified Indicator will be updated to “Y” and the Identity Source document field will be coded SVEPEND (SVES verification is pending) if the field is currently empty or contains the following codes: NOTVER, NORSPSV, WKRVER. If there is any other source code shown in the field, MEDS will not update.
	3. The <Reasonable Opportunity Expiration Date> will be set to the Original Request Sent Date for C&I + 90 days.
3. If SVES has not received a response within seven (7) days, a second request will automatically be generated.
4. If SVES receives a response verifying Citizenship and Identity, MEDS will update HMS91 C&I SCREEN as follows:
	1. The <Proof of Citizenship Verified> indicator will be updated and the Citizenship <SRC DOCUMENT> will be coded SVESVER (Citizenship & Identity Verified by SVES) if the field is currently blank or is populated with any of the following codes: WKRVER, NOTVER, NORSPSV, SVEPEND. If there is any other source code, MEDS will not update.
	2. The <Proof of Identity Verified> indicator will be updated and the Identity <SRC DOCUMENT> will be coded SVESVER (Citizenship & Identity Verified by SVES) if the field is currently blank or is populated with any of the following codes: WKRVER, NOTVER, NORSPSV, SVEPEND. If there is any other source code, MEDS will not update.
5. If SVES receives a response that does not verify Citizenship and Identity and the individual is coded as applying and a citizen, MEDS will generate alert #265, SVES DID NOT VERIFY C&I. WORKER VERIF REQUIRED.
6. If SVES does not receive a response, MEDS will generate alert #264, NO RESPONSE TO SVES C&I VERIFICATION REQUEST.
 |

Alerts #264 and #265 should be addressed within 15 days of receipt. The Eligibility Worker must first check the SSN verification. Refer to SC MPPM 102.05.03. If the SSN is validated, the Eligibility Worker must then verify Citizenship and Identity using alternate methods.

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102.04.07 Verification of Citizenship and Identity by VCME

(Eff. 01/01/17)

The DHEC VCME (Verification of Citizenship for Medicaid Eligibility) Web tool was discontinued effective January 1, 2017.

102.04.08 Verification of Citizenship and Identity by DMV Web Tool

(Rev. 01/01/17)

The Department of Motor Vehicles (DMV) Web Tool can be used to verify citizenship and/or identity for South Carolina residents only. If the applicant/beneficiary was issued or renewed an I.D. or Driver’s License on or after June 1, 2002, a “Y” on the right-hand side of the Driver Record Summary can verify citizenship and identity.

If the applicant/beneficiary was issued or renewed a S.C. I.D. prior to June 1, 2002, the DMV match can verify identity only.

The DMV System will:

* Search by Driver’s License or I.D. Card Number
* Search by Name, Date of Birth or Location
* Search for South Carolina residents only

Once verification of citizenship and/or identity is found, the eligibility worker must print the Driver Record Summary and place it in the permanent records section of the case file and update HMS91 C&I SCREEN in MEDS.

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102.04.09 Verification of Citizenship and Identity with Physical Documents

(Rev. 01/01/17)

If verification of citizenship cannot be obtained through SVES and citizenship and/or identity is needed, the Eligibility Worker must give the applicant a [DHHS Form 1233A](http://medsweb.scdhhs.gov/EligibilityForms/FM%201233A.pdf), Proof of Citizenship and Identity.

* If the applicant is born in another state, [www.vitalchek.com](http://www.vitalchek.com/) is a resource for locating Vital Records agencies in other states. The contact information can be given to the applicant to assist them in obtaining the necessary documentation. If documents are ordered through this website, there is a charge. The applicant will be responsible for this charge.
* If prior to the end of the 90-day reasonable opportunity period the applicant requests additional time to obtain verification, the Eligibility Worker can allow the individual to remain open in MEDS.
	+ The Eligibility Worker must verify that the applicant is trying to obtain the necessary verification with a telephone call or other contact. The telephone call or other contact should be documented. The MEDS NOTES screen, DHHS Form 1221, Medicaid Contact Report, etc., may be used.
	+ The Eligibility Worker must discuss the case with her supervisor. If the supervisor agrees, then the supervisor must send a ticket through Service Manager to get approval for the extension of Medicaid benefits.
* If an individual that was approved using the 90-day reasonable opportunity is closed for failure to provide Citizenship and/or Identity and the beneficiary can provide verification within 30 days from the date on the closure notice, the beneficiary can be reopened in MEDS. If the verification is received more than 30 days after the closure, a new application is required.
* If an application (one not able to be approved using the 90-day reasonable opportunity) is denied solely for failure to provide information and the applicant provides all needed verifications, including Citizenship and Identity, within 30 days from the date on the denial notice, the date of the previous application must be used to determine the effective date of Medicaid eligibility.

If the applicant is homeless, an amnesia victim, mentally impaired, or physically incapacitated and lacks someone who can act for the individual and cannot provide evidence of U.S. citizenship or identity, the Eligibility Worker must assist the applicant to document U.S. citizenship and identity.

Applications will not be denied until all avenues of verification have been exhausted.

Copies and electronic versions of documents are allowed. If original documents are received by mail, they must be returned within 10 working days.

Primary evidence of citizenship and identity is documentary evidence of the highest reliability that conclusively establishes that the person is a U.S. citizen. Refer to Appendix A for a chart listing acceptable Primary evidence for Citizenship and Identity.

Verification of citizenship and identity is required for initial approval of Medicaid coverage.

Secondary evidence of citizenship is documentary evidence of satisfactory reliability that is used when primary evidence of citizenship is not available. Refer to Appendix B for a chart listing acceptable evidence for Citizenship. **In addition, a second document establishing identity MUST be presented.** Refer to Appendix C for the chart listing documents that may be accepted as proof of identity.

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| **Procedure for Verifying Citizenship and Identity** |
| **MEDS Procedure**: * If an applicant does not provide verification of Citizenship and/or Identity or the worker is unable to verify using SVES:
1. For an applicant required to submit documentation of Citizenship and/or Identity for the first time:
	1. If all verifications other than Citizenship and/or Identity have been provided and Citizenship and/or Identity are not questionable, approve the application for Medicaid. Refer to the MEDS procedures below.
	2. The Eligibility Worker will send a [DHHS Form 1233 A](http://medsweb.scdhhs.gov/EligibilityForms/FM%201233A.pdf), Proof of Citizenship and Identity, to the applicant, requesting the needed information. The applicant will have up to 90 days from the date the application is pended to provide verification of Citizenship and/or Identity. Enter the <Reasonable Opportunity Expiration Date> shown on HMS91 C&I SCREEN as the date by which the applicant must return verification of Citizenship and/or Identity.
	3. On ELD01 set the ACD to the <Reasonable Opportunity Expiration Date> shown on HMS91 C&I SCREEN
	4. If verification of Citizenship and/or Identity has not been provided within 90 days, the Eligibility Worker must close each member for whom citizenship and identity has not been verified.
	5. If prior to the end of the 90-day reasonable opportunity period, the applicant contacts the worker to request additional time to obtain the required verification:
		1. The Eligibility Worker must document what steps the applicant has taken to secure the requested information
		2. The Eligibility Worker must discuss the case with her supervisor
		3. If the supervisor agrees with the worker, a ticket must be sent through Service Manager requesting approval to allow Medicaid eligibility to continue. The e-mail must describe the steps the applicant is taking to obtain the verification and the reason for the delay
		4. Medical Support will review the e-mail, make a determination, and inform the supervisor.
		5. If Medical Support approves the request for an extension in Medicaid benefits, the Eligibility Worker must update ACD to 90 days from the date of the request by the applicant. If the information is not provided by that date, the case must be closed.
		6. If Medical Support does not approve the request for an extension of Medicaid benefits, eligibility must be terminated.
2. For a BG Member who has previously been approved for Medicaid for up to 90 days while awaiting verification of Citizenship and/or Identity and is re-applying, the individual cannot be approved until all verifications, including Citizenship and/or Identity, have been received.

**Cúram Procedure**:* Citizenship and Identity can be verified from either the Application Case or the Integration Case.
* The Integrated Case may be used if case is approved within ninety (90) days reasonable opportunity. If the case is processed outside of the ninety (90) day window, the Application Case should be used.
* Under the Application Case/ Integration Case, the Eligibility Worker should click on “Verifications” link.
* Next click on the “Action” icon for “Citizen Status Code” for individual needing to be verified.
* The worker would then enter the verification source into Cúram.
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102.04.10 Exceptions to Verification of Citizenship and Identity

(Eff. 05/01/11)

1. If an applicant/beneficiary is Medicare Part A or B eligible, verification of citizenship and identity is not required since Medicare has already done it.
2. If an applicant is currently SSI or Social Security Disability Income (SSDI) eligible, verification of citizenship and identity is not required since SSA has already done it.
3. This requirement does not affect the assumptive eligibility process for pregnant women. Verification of citizenship and identify must be provided within 30 days unless an Extension of Promptness is justified.
4. Verification of Citizenship and Identity is not required for Regular Foster Care, Title IV-E Foster Care, Title IV-E Adoption Assistance, and Special Needs Adoption children. Refer to MPPM 102.04.09 through 102.04.14 to determine the alien status of non-citizen children in foster care.
5. Infants born to Medicaid eligible mothers are permanently exempt from the citizenship and identity documentation requirements.

102.04.11 Foreign-Born Children

(Eff. 05/01/17)

Effective February 27, 2001, foreign-born children, including adopted children, acquire citizenship automatically if they meet the following requirements:

* The child must have at least one natural or adoptive parent who is a United States citizen (by birth or naturalization);
* The child must be under 18 years of age;
* The child must currently permanently reside in the United States in the legal and physical custody of a parent who is a United States citizen; and
* The child must be a lawful permanent resident.

If adopted, there must be a full and final adoption of the child.

Note: A stepchild is ineligible for citizenship or naturalization through the U.S. citizen stepparent, unless the stepchild is adopted, and the adoption meets certain requirements.​

The law providing citizenship is not retroactive. Individuals who are age 18 or older on February 27, 2001, do not qualify for automatic citizenship under this provision and must apply for naturalization.

Proof of citizenship is not automatically issued to eligible children. If required, the parent may apply for a certificate of citizenship with the U.S. Citizenship and Immigration Services and/or a passport with the Department of State.

102.04.12 Qualified Aliens

(Rev. 12/01/21)

For Medicaid purposes, certain aliens are referred to as “qualified aliens.” Qualified aliens are potentially eligible for full Medicaid just like US citizens.

A qualified alien is:

* A lawful permanent resident (also referred to as a “resident alien”)
* A refugee
* An alien who has had deportation withheld
* An alien granted parole for at least one year by the Bureau of Citizenship and Immigration Services (USCIS)
* An alien granted conditional entry
* A battered immigrant as defined by the USCIS
* An honorably discharged veteran and an alien on active duty in the United States armed forces, and the spouse or unmarried dependent child of such alien.

Certain qualified aliens (such as parolees, conditional entrants, battered aliens, lawful residents) who entered the United States on August 22, 1996, and later are subject to a five-year disqualification period. This means that these aliens cannot receive public benefits for the first five years he lives in the United States. During this five-year period, these aliens are eligible for emergency services only if they meet all other eligibility requirements. For applications filed on or after January 1, 2018, children and pregnant women who are lawfully present but have not met the 5-year/40 quarter requirements can be approved for full Medicaid coverage if they meet all other eligibility criteria.

In order for the applicant to be approved correctly, the eligibility specialist must submit a request in Service Manager and select Escalation Team. This request does not have to be created by a supervisor. Prior to submission, the eligibility specialist must verify that either:

* VLP has updated in Cúram that shows the applicant is a qualified alien who is subject to the 5-year bar; or
* SAVE documentation has been uploaded into OnBase that shows the applicant is a qualified alien:
	+ DHSID evidence must added for application processed in Cúram,
	+ Alien status must be entered in MEDS. The necessary changes will be made to correct the applicant’s Medicaid eligibility for full benefits.

At the end of the five-year disqualification period, eligibility for the full range of Medicaid benefits may occur if the individual has earned or can be credited with 40 quarters of wages and/or self-employment income that required payment of Social Security taxes.

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| **Procedures to Verify and Document Qualified Alien Status** |
| **Cúram Procedure**:If you’re processing eligibility in Cúram, the qualified alien status will be verified by the Hub.The Verify Lawful Presence (VLP) process will be used to verify immigration status. Refer to the [Verified Lawful Presence](https://schhs.sharepoint.com/sites/EES/Training/Curam/HCR/Job-Aids/Evidence/Verified%20Lawful%20Presence.pdf?csf=1&e=fwhVKF&cid=6c95128d-4103-4ba6-a585-3b814d4e5aba) job aid at [Training Materials Portal-MAGI](https://www1.scdhhs.gov/ees/trainingportal/) for instructions.Make sure to enter the required fields for the various document types to ensure successful verification.

| **Document Type** | **Required Field** |
| --- | --- |
| I-327 | Alien Number |
| I-551 | Alien Number, Card /Receipt Number |
| I-571 | Alien Number |
| I-766 | Alien Number, Card /Receipt Number, Document Expiration Date |
| Certificate of Citizenship | Citizenship Number |
| Naturalization Certificate | Naturalization Number |
| Machine Readable Immigrant Visa with Temporary/I-551 Language  | Alien Number, Passport Number, Country of Issuance |
| Temporary I-551 Stamp | Alien Number |
| I-94 (Arrival/Departure Record)  | I-94 Number |
| I-94 (Arrival/Departure Record) in Unexpired Foreign Passport  | I-94 Number, Passport Number, Country of Issuance, Document Expiration Date |
| Unexpired Foreign Passport | Passport Number, Country of Issuance, Document Expiration Date |
| I-20 | SEVIS ID |
| DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)  | SEVIS ID |
| Other | Alien Number, Document Description |
| Other  | I-94 Number, Document Description |

Note: Cúram will make an applicant eligible for a 90-day period while paper documentation is pending. |

If all other verification has been provided, an application can be approved for up to 90 days while verification of Alien Status and/or Identity is pending if the applicant had not previously been approved or status is not questionable.

The applicant must be asked to present verification of Alien Status and/or Identity at **application**. An application can be approved for up to 90 days while Alien Status and/or Identity verification is pending if the applicant has not previously been approved or Alien Status and/or Identity is not questionable.

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| **Procedure for Approving Application while Qualified Alien Status Pending**: |
| * + - If an applicant does not provide verification of Alien Status and/or Identity:
1. For an applicant required to submit documentation of Alien Status and/or Identity for the first time:
2. If all verifications other than Alien Status and/or Identity have been provided and Alien Status and/or Identity is not questionable, approve the application for Medicaid. Refer to the MEDS procedures below.
3. The Eligibility Worker will send a [DHHS Form 1233](http://medsweb.scdhhs.gov/EligibilityForms/FM%201233%20ME.pdf), Medicaid Eligibility Checklist, to the applicant, requesting the needed information. The applicant will have up to 90 days from the date of approval to provide verification of Alien Status and/or Identity.
4. If verification of Alien Status and/or Identity has not been provided within 90 days, the Eligibility Worker must close each member for whom Alien Status and/or Identity has not been verified.
5. For a BG Member who has previously been approved for Medicaid for 90 days while awaiting verification of Alien Status and/or Identity and is re-applying, the individual cannot be approved until all verifications, including Alien Status and/or Identity, have been received.
6. Complete a DHHS Form 1233 requesting all needed information, including Alien Status and/or Identity, and allow at least 21 days for the applicant to submit the information to allow the application to be processed within the federal standard of 45/90 days. Refer to MPPM Section 101.08.
7. If the applicant requests additional time to obtain verification, the Eligibility Worker can request an Extension of Promptness in MEDS. Refer to MPPM Section 101.08.03. The Eligibility Worker must verify that the applicant is trying to obtain the necessary verification with a telephone call or other contact. The telephone call or other contact should be documented on the MEDS NOTES screen.
* On ELD01 set the ACD to 90 Days from the Application Effective Date (AED).

Note**:** * ACD can be monitored in MEDS through alert 582
* The Eligibility Worker will be responsible for updating ELD01 as the information is received.
* If verifications are not received within 90 days, the Eligibility Worker must close the case.

Note**:** If the closure is on a child who is in a protected period, the worker will have to enter 004 in the RC1 field on ELD01. The worker will then put the appropriate reason code in the RC1 field before calling Act on Decision to close the budget group.If an application is denied solely for failure to provide information and the applicant provides all needed verifications within 30 days from the date on the denial notice, the date of the previous application must be used to determine the effective date of Medicaid eligibility.* If an application is denied solely because the individual has not provided verification of Alien Status and/or Identity and all avenues of verification have been exhausted, the application must be denied using Reason Code 061, You did not provide proof of citizenship; Reason Code 043, You did not provide proof of identity; or Reason Code 012, You did not provide proof of Citizenship and/or Identity.

If the denial is for one or more individuals and not the entire budget group, go to ELD00 in MEDS and FAIL that individual(s) on Citizenship and/or Identity. The remaining budget group members will be eligible, and an approval notice will be generated. MEDS will generate the appropriate notices.Note**:** Citizenship and Identity do not have to be verified if the applicant is not otherwise eligible. Refer to MPPM 101.09.03. |

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102.04.13 40 Qualifying Quarters of Work

(Eff. 05/01/11)

A qualifying quarter means a quarter of coverage as defined under Title II of the Social Security Act, which is worked by the alien, and/or:

* All the qualifying quarters worked by the spouse of such alien during their marriage and the alien remains married to such spouse or such spouse is deceased, and
* All the qualifying quarters worked by a natural or adoptive parent or spouse of the natural or adoptive parent of such alien while the alien was under age 18.

**Verification of Quarters of Coverage**

Most quarters of employment will be verified through Social Security using the State Verification Exchange System (SVES). Detailed instructions regarding the use of the State Verification Exchange System are found in the MEDS Users Training Manual. With certain exceptions, an alien’s work, and work by his parents and/or spouses can be combined to attain the required 40 quarters.

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| **Procedure for Verifying Quarters of Coverage** |
| For all cases, follow steps 1-3. Step 4 will vary based on whether the case is being processed in MEDS or Cúram. * + - 1. Determine who can be included in the quarter coverage count. Question the applicant/beneficiary to determine that proper relationships exist and obtain the date of birth of the applicant/beneficiary. Request Social Security Numbers for each individual included.
			2. Determine if it is possible for the applicant/beneficiary to meet the requirement. Ask how many years the applicant/beneficiary and each of the individuals to be included in the quarter coverage calculation have lived in the United States. The total number of years for all the individuals must equal at least ten (10) years (40 quarters). If the total is less than 10 years, the applicant/beneficiary cannot meet the 40 quarters coverage requirement.
			3. Determine how many years included earnings from the total in step #2. Always determine the quarters of the applicant/beneficiary first. Many applicants/ beneficiaries may have sufficient quarters on their own record, and it will not be necessary to request earnings history for other individuals. If verification of quarters for individuals other than the applicant/beneficiary is needed, a [DHHS Form 943](http://medsweb.scdhhs.gov/EligibilityForms/FM%20943.pdf), Consent for Release of Information, and SSN must be obtained from each individual other than the applicant/beneficiary or the applicant/beneficiary must obtain verification of coverage from Social Security.

**MEDS Procedure**:* + - 1. Request a quarter coverage history using the State Verification Exchange System unless it is clear from the interview that the applicant/beneficiary or applicant/beneficiary in combination with others cannot meet the 40-quarter coverage exception.

**—OR—****Cúram Procedure**: 1. Quarters of Coverage will be determined automatically under Cúram.  |

102.04.14 Undocumented and Illegal Aliens

(Eff. 05/01/11)

Undocumented and illegal aliens were never legally admitted to the United States for any period or were admitted for a limited period and did not leave the United States when the period expired. These individuals, if they meet all eligibility criteria except citizenship, are entitled to emergency services only. Undocumented and illegal aliens do not have to make a declaration of immigration status, nor does their status have to be verified. Undocumented and illegal aliens also do not have to provide proof of identity. The Eligibility Worker must accept the applicant/beneficiary’s statement if they say they have no documentation and look at emergency services only. Undocumented and Illegal Aliens are not issued a social security number and therefore are not required to provide one to be considered for emergency services.

102.04.14A Deferred Action for Childhood Arrivals (DACA)

(Eff. 04/01/17)

Deferred Action for Childhood Arrivals (DACA) allows certain individuals, who meet specific guidelines, to request consideration of deferred action from U.S. Citizenship and Immigration Services (USCIS). Individuals who receive deferred action will not be placed into removal proceedings or removed from the United States for a specified period unless terminated. DACA recipients may receive an I-766 (Employment Authorization Document annotated “C33”). Individuals eligible for DACA are not qualified immigrants. These individuals, if they meet all eligibility criteria except citizenship, are entitled to emergency services only.

**Note:** DACA recipients will have “C33” annotated on their I-766 (Employment Authorization Document), and their SAVE documents will show “System Response: DACA-Employment Authorized” and “Provision of Law Code: C33”.

102.04.15 Visitors to the United States (US)

(Eff. 05/01/11)

Visitors to the United States who enter on a visa, passport, border pass, etc. are generally not considered residents of the state and not eligible for Medicaid benefits. However, the individual can decide to stay in the US and establish residence here. If this change in status occurs, they may be eligible to receive emergency services.

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| **Procedure for Determining Non-Citizen Qualifies for Services** |
| If the applicant provides the Eligibility Worker with a copy of their passport, visa or any other form of documentation or ID, the worker should ask the individual if they have established residence in South Carolina with no intention of returning to their country. * + If the visitor indicates they plan to remain in this country, regardless of the status of their documentation, they may be eligible for emergency services if all other eligibility criteria are met.
	+ If the visitor has no intentions of remaining in this country and has not established a residence, they are not eligible for any services (including emergency services).

The applicant’s intent to remain in SC may be documented on the DHHS Form 1221 or on the MEDS NOTES screen. If the intent is unknown to the Eligibility Worker, the Eligibility Worker must attempt to contact the applicant by phone to determine their intent. If the Eligibility Worker is unable to reach the applicant by phone, assume that the applicant intends to remain in the United States and establish residency in South Carolina because the applicant has applied for emergency services.  |

102.04.16 Non-Qualified Aliens

(Eff. 05/01/11)

Non-qualified aliens include aliens who are lawfully admitted for a temporary or specified period or who were admitted for a limited period and did not leave the United States when the period expired. Non-qualified aliens, who meet all eligibility criteria except citizenship, are entitled to emergency services only. Non-qualified aliens do not have to make a declaration of immigration status, nor does their status have to be verified. Non-qualified aliens also do not have to provide proof of identity. The Eligibility Worker must accept the applicant/beneficiary’s statement if they say they have no documentation and look at emergency services only. Non-qualified aliens do not have to provide a social security number or apply for a social security number if they do not have one.

102.04.17 Ineligible Aliens

(Eff. 05/01/11)

Ineligible aliens are lawfully admitted to the United States as legal non-immigrants for a temporary or specified period. Because of the temporary nature of their admission status, ineligible aliens are not entitled to any Medicaid benefits, including emergency services, unless there is a change in status. An example of a change in status would be a visitor established residence in South Carolina and remains in the country after the expiration of a Visa.

Ineligible aliens are:

* Foreign government representatives on official business and their families and servants
* Visitors for business or pleasure including exchange visitors
* Aliens in travel status (tourists) while traveling through the US
* Crewmen on shore leave
* Treaty traders and investors and their families
* Foreign students
* International organization representatives and personnel, their families, and servants
* Temporary workers including agricultural contract workers
* Members of the foreign press, radio, film or other informational media and their families

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102.04.18 Alien Status

(Eff. 05/01/18)

The chart in SC MPPM Appendix D identifies each alien group, whether the group can receive the full range of Medicaid benefits or just emergency services, and acceptable documentation used to establish alien status. The Systematic Alien Verification for Entitlement (SAVE) program procedures must be used to validate alien documentation presented by each individual in these groups. SAVE procedures are also used to verify the date of entry to the US for lawful permanent residents, parolees, and conditional residents to determine if an individual in one of these qualified alien groups is entitled to full benefits or emergency services only.

Note**:** For battered aliens, the codes, types, and stamps in foreign passports or on the I-94 that demonstrates an approved petition, or application under one of the provisions are too numerous to describe here. If an alien claiming pending or approved status presents a code different than those listed, or if you cannot determine the class of admission from the I-551 stamp, initiate the electronic process to verify documents through VLP or SAVE, along with a copy of the document(s) presented to USCIS. Refer to MPPM 102.04.23.

Non-citizens who qualify for emergency services only cannot be denied for failure to provide proof of their immigration status, proof of identity, or for failure to provide a Social Security Number.

102.04.19 Budgeting for Children Born in the US to Non-Citizen Parents

(Eff. 05/01/11)

[CFR §435.603](http://www.ecfr.gov/cgi-bin/text-idx?SID=0d5b433b4fd4f2544aa9f64e97c6c014&node=42:4.0.1.1.6.7.67.4&rgn=div8)

A child born in the United States to a non-citizen in the group listed in SC MPPM [102.04.09](#MPPM_102_04_09) may be eligible for Medicaid. To determine eligibility for Partners for Healthy Children, PW-Infants, or Parent/Caretaker Relatives, count the needs and income, less disregards, of the non-citizen parent as well as the needs of non-citizen siblings in the budget group. However, the non-citizen parent/sibling cannot receive any Medicaid benefits.

102.04.20 Criteria for Approval of Emergency Services

(Rev. 12/01/21)

Aliens who are not entitled to full Medicaid benefits due to immigration status (refer to [MPPM 102.04.14](#MPPM_102_04_14)) may be eligible for payment of emergency services only if:

* The individual meets all other eligibility criteria for a full Medicaid coverage group such as:
	+ Categorical eligibility:
		- Aged;
		- Blind;
		- Disabled;
		- Child under age 19;
		- Pregnant woman;
		- Parent or caretaker relative with dependent child(ren); or
		- Diagnosed and found to need treatment for either breast or cervical cancer or pre-cancerous lesions (CIN II/III or atypical hyperplasia).
	+ State residency
	+ Income
	+ Resources
* The care and services needed are not related to an organ transplant procedure or routine prenatal or postpartum care.
* The alien either:
	+ Has, after sudden onset, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
		- Placing the patient’s health in serious jeopardy
		- Serious impairment to bodily functions, or
		- Serious dysfunction of any bodily organ or part;
		- Requires medical services for Labor and delivery;

**NOTE:** Individuals approved for Parent/Caretaker Relative (PCR) eligible for payment of Emergency Services only cannot be moved to Transitional Medicaid Assistance (TMA) if there is a change in earned income.

For applications filed on or after January 1, 2018, children and pregnant women who are lawfully present but have not met the 5-year/40 quarter requirements can be approved for full Medicaid coverage if they meet all other eligibility criteria. A pregnant woman will remain eligible through the end of her post-partum period.

For the applicant to be approved correctly, the eligibility specialist must submit a request in Service Manager and select Escalation Team. This request does not have to be created by a supervisor. Prior to submission, the eligibility specialist must verify that either:

* VLP has updated in Cúram that shows the applicant is a qualified alien who is subject to the 5-year bar; or
* SAVE documentation has been uploaded into OnBase that shows the applicant is a qualified alien:
	+ DHSID evidence must added for application processed in Cúram,
	+ Alien status must be entered in MEDS. The necessary changes will be made to correct the applicant’s Medicaid eligibility for full benefits.

Claims submitted for specific incident of care by a medical provider must be for services related to the treatment of at least one diagnosis with an Outpatient Level Indicator = 3 - Emergency. Services that are not directly related to the injury, illness, or delivery for a covered diagnosis are not compensated by Medicaid.

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| **Procedure for Determining Emergency Services** |
| **MEDS Procedure**:When an applicant/beneficiary is approved for emergency services the Eligibility Worker must enter “E” for Emergency Services in the Service Type field on ELD02.Individuals will be eligible for payment of Emergency Services only for up to one year from the date of approval if he or she remains categorically eligible. This does not prevent the individual from applying for and being approved for payment of services at a future date. Individuals are responsible for reporting changes and completing an annual review. If the individual loses eligibility for any reason:* Go to ELD01 in MEDS and put enter reason code 016, “You are no longer eligible for Emergency Services”
* Enter a secondary reason code to show why the individual is losing eligibility, such as 051, “Your Income is more than policy allows,” or 060, “You have no minor child in the home.”
* Before Acting on Decision, go to ELD02 to make sure the eligibility beginning and end dates are correct.
* Act on Decision to close the Budget Group.

**Note:** Non-citizens found in need of treatment for breast or cervical cancer or pre-cancerous lesions (CIN 2/3 or atypical hyperplasia), may be eligible for BCCP. If the applicant is approved, coverage will continue if eligibility criteria are met, and the beneficiary is receiving treatment. Refer to SC MPPM 501.03.03 for MEDS Procedures.**Note:** Individuals approved for Parent/Caretaker Relative (PCR) eligible for payment of Emergency Services only cannot be moved to Transitional Medicaid Assistance (TMA) if there is a change in earned income.**Cúram Procedure**:If a service is an emergency, it will be determined automatically under Cúram.**Note:** Individuals will be eligible for payment of Emergency Services only for up to one year from the date of approval if he or she remains categorically eligible. This does not prevent the individual from applying for and being approved for payment of services at a future date. |

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102.04.21 Case Processing for Aliens Eligible for Emergency Medicaid Services Only

(Rev 09/01/15)

At the point of application, the Eligibility Worker must explain to the applicant/beneficiary that because he is not a citizen or a qualified alien who is eligible for full Medicaid benefits, Medicaid may reimburse for emergency services only (including labor and delivery) if all other eligibility requirements are met. Aliens eligible for emergency services only do not receive Medicaid cards.

If a non-citizen pregnant woman applies for Medicaid, assumptive eligibility cannot be used to determine her eligibility. However, the Eligibility Worker must process the application without delay. (Refer to MPPM 101.04.02). The applicant will need to provide her due date or Estimated Date of Confinement (EDC) by supplying the information on the DHHS Form 3400, Healthy Connections Application, or the DHHS Form 3310, Statement of Pregnancy.

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| **MEDS Procedure:** * The effective date of the application is the date the signed and dated application is received.
* The Service Type field on ELD02 in MEDS **MUST** be set to “E” for Emergency Services. For Pregnant Woman, the EDC date must be keyed in MEDS.
* Individuals will be eligible for payment of Emergency Services only for one year from the date of approval if the individual continues to meet all the eligibility criteria for a category. This does not prevent the individual from applying for and being approved for payment of services at a future date.
* After the year of coverage is over, the Eligibility Worker will get alert #582, Certification Period Ended, Verify Elig. Decision. The case will soft close.
* The Eligibility Worker must close the BG.
* Infants born to a pregnant woman approved for payment of emergency services must be deemed in PCAT 12.

**Cúram Procedure**:If a service is an emergency, it will be determined automatically under Cúram. |

Based on the final determination, [DHHS Form 901](http://medsweb.scdhhs.gov/EligibilityForms/FM%20901.pdf), Notice of Approval for Payment for Emergency Services, must be completed and mailed to the applicant/beneficiary and a copy retained in the file. An alien eligible for emergency services only will not receive a Medicaid card. The applicant/beneficiary should be told to share this notification with the medical provider of the service. If the applicant/beneficiary fails to do this, the medical provider may request the Medicaid identification number by completing [DHHS Form 900](http://medsweb.scdhhs.gov/EligibilityForms/FM%20900.pdf), Request for Medicaid Information – Coverage of Emergency Services for Aliens, and forwarding it to the county Eligibility Worker.

102.04.22 Child Born to Non-Citizen Eligible for Emergency Services Only

(Eff. 05/01/11)

A child born to an individual eligible for emergency services only is deemed eligible for Medicaid for up to one year if the child remains a resident of the state. When the child reaches age one, a new application is required.

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102.04.23 Systematic Alien Verification for Entitlement (SAVE) Program

(Eff. 05/01/18)

[CFR §435.949](http://www.ecfr.gov/cgi-bin/text-idx?SID=0d5b433b4fd4f2544aa9f64e97c6c014&node=42:4.0.1.1.6.10.76.27&rgn=div8)

The SAVE program provides a way for federal, state, and county government agencies to verify the immigration status of an applicant/beneficiary. This program should be used for non-citizens in MEDS or non-citizens in Cúram whose immigration status has not been verified by the Federal Hub.

All participants in the SAVE program must verify the immigration status of all non-citizen applicants to avoid discrimination. Participants obtain immigration status information through the SAVE program’s Verification Information System (VIS). VIS is a Web-based application that queries an immigration database containing information on more than 60 million non-citizens.

The SAVE program usually returns a response to a request within a matter of seconds. It is important for the Eligibility Worker to verify that the information in the Initial Verification Results section matches what is on the immigration documentation of the applicant/beneficiary. If any discrepancies are detected, or if “Institute Additional Verification” appears in the System Response line, the Eligibility Worker must request additional verification. (Note**:** The response time for “additional verification” is usually within three federal government workdays.)

When the Eligibility Worker has received final verification, it is important that he remembers to print the case details for the record and closes the case in VIS. It helps overall system performance to close completed cases.

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| **Procedure for Accessing VIS** |
| Access the system by entering the following Web address into the address line of your Web browser: <https://save.uscis.gov/Web/>. If logging into the system for the first time, you will be required to enter your user ID and password that will be provided to you by your supervisor. After completion of the initial login, you will be prompted to change your password. Keep in mind that your new password must contain all four (4) of the following password characteristics:* Uppercase letters
* Lowercase letters
* Numbers
* Special character ($, !, #, etc.)

To ensure that you have entered the correct password, you will be prompted to re-enter the password in the ‘Re-type New Password’ field.The system is user-friendly; however, it is advisable that you take the time to visit the tutorial link found on the title navigation links bar. The tutorial is a Web-based, self-paced, role-sensitive tutorial. It is divided into lessons that focus on each major section of the navigation menu. Each lesson is comprised of topics that focus on each of the functions that can be performed in the system. |

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| **Procedure for Completing Secondary Verification** |
| In some instances, the SAVE web-based system may not provide sufficient information for a determination of immigration status or may request secondary verification. Effective May 1, 2018, all immigration status verification requests must be submitted electronically. The paper form G-845 will no longer be accepted and there will be no paper responses returned. If secondary verification is required, the Scan & Upload functionality must be used. * For cases in Cúram, the VLP service is used. Refer to the [Verified Lawful Presence (VLP)](https://schhs.sharepoint.com/sites/EES/Training/Curam/HCR/Job-Aids/Evidence/Verified%20Lawful%20Presence.pdf?csf=1&e=fwhVKF&cid=6c95128d-4103-4ba6-a585-3b814d4e5aba) Job Aid.
* For cases processed in MEDS, this functionality is incorporated into the SAVE website.
 |

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102.05 Social Security Number (SSN)

(Rev. 01/01/21)

[CFR §435.910](http://www.ecfr.gov/cgi-bin/text-idx?SID=0d5b433b4fd4f2544aa9f64e97c6c014&node=42:4.0.1.1.6.10.72.11&rgn=div8)

All individuals applying for Medicaid must furnish an SSN or apply for one if they do not have one. (Refer to SC MPPM [102.05.02](#MPPM_102_05_02) for verification requirements.) The Federal Hub is a service used exclusively to verify SSNs for Medicaid eligibility and cannot be used for any other programs within DHHS, such as BabyNet or MIAP.

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| **Exceptions to providing an SSN include:** * Undocumented aliens applying for Emergency Services Only,
* Individuals not eligible to receive an SSN,
* An individual who does not have an SSN, and may only be issued one for a valid non-work reason in accordance with 20 CFR 422.104,
* An individual who refuses to obtain an SSN for well-established religious reasons, and
* Presumptive Applicants are not required to furnish an SSN at time of presumptive application, but to receive a full eligibility determination they must provide an SSN.
 |

Enumeration is the procedure used to assign SSNs. The SSN is used to:

* Determine accuracy and/or reliability of information given by the applicant/ beneficiary (including processing the IEVS matches),
* Prevent duplicate payments, and
* Facilitate mass changes.

SSNs for non-applicants (parents or other household members) cannot be required as a condition of eligibility. The SSN of a non-applicant whose income is used to determine the eligibility of the applicant/beneficiary may be given on a voluntary basis. Eligibility workers should explain that the disclosure of the SSN might help to speed up the determination process. However, the application cannot be denied solely for the failure to provide the SSN of a parent or other household member who is not applying for benefits. (Note**:** Although SSNs for non-applicants is not a condition of eligibility, if a non-applicant whose income is considered provides their number voluntarily, it should be used for the IEVS match.)

102.05.01 Application for an SSN

(Eff. 10/01/05)

In South Carolina, three methods may be used to obtain an SSN. The methods are:

1. Completion of [SS-5](http://www.socialsecurity.gov/online/ss-5.pdf), Application for Social Security Card, at the county Medicaid eligibility office

The Eligibility Worker must assist the applicant/beneficiary in completing the SS-5 in accordance with the Social Security enumeration procedures, if requested. Once completed, the SS-5 along with original documentation of age, citizenship, and identity, must be sent to the county Social Security Administration (SSA) for processing. SSA will return the original documentation to the applicant/beneficiary. A copy of the completed SS-5 and the documentation must be filed in the case record.

1. Application at the county SSA office

An applicant/beneficiary who does not wish to relinquish the original documentation, or who is over age 17 and has never had an SSN, must be referred to the county SSA office for an interview. The Eligibility Worker must (1) assist the applicant/beneficiary in completing the SS-5, (2) obtain the signature of the applicant/beneficiary on the SS-5, and (3) enter the welfare identification number in the "NPN" box. The welfare ID is the state's identifier (420), followed by a hyphen, and the 10-digit recipient number. A diagonal line should be drawn through the number zero to distinguish it from the alpha character "O." The applicant/beneficiary takes the original SS-5 and documentation to SSA. The applicant/beneficiary must return an official receipt from SSA to meet the requirement of applying for an SSN. A copy of the receipt must be filed in the case record.

1. Enumeration at birth

This is the most common method of obtaining an SSN. The SSA provides hospitals with form SSA-2853 "A Message from Social Security" which is used for enumeration at birth. A parent may apply for an SSN for the newborn by giving permission on the birth certificate registration form for the Bureau of Vital Statistics (BVS) to provide the information to SSA. Once completed, the parent should receive the SSN within weeks. The applicant/beneficiary must furnish a copy of the SSA-2853 to the Eligibility Worker to verify that an application for an SSN has been made.

Should an applicant/beneficiary have more than one SSN or have the same SSN as another individual, he must be referred to the county SSA office to resolve the discrepancy. Through the Medicaid Eligibility Determination System (MEDS) alerts, the Eligibility Worker will be advised of beneficiaries who do not have an SSN or who have an invalid SSN.

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102.05.02 Verification

(Eff. 10/01/05)

The following documents may be used to verify the correct SSN or application for an SSN:

1. Social Security Card
2. SDX Listing
3. BENDEX System
4. Copy of the SS-5
5. Any official document that includes the SSN (for example check stubs, life insurance policies)
6. The State Verification Exchange System (SVES)
7. SSA-5028, Application for Social Security Number
8. DHHS Form 3249, Verification of Application for Social Security Number
9. SSA-2853, A Message from Social Security
10. Person Service Composite

If the applicant/beneficiary has no documentation of the SSN, but can provide the number, the Eligibility Worker should accept the number. The computer match between Social Security and MEDS will validate the number. A "V" validation code will appear on the Household Member Detail Screen and the Recipient Detail Screen showing the SSN has been validated.

If no “V” appears after the match, the Eligibility Worker must verify the correct number with the individual. Should the individual be unable to provide verification, refer him/her to the SSA to resolve the matter.

If an applicant/beneficiary has furnished an SSN, the applicant/beneficiary cannot be denied assistance while awaiting verification of the number.

102.05.03 SVES Verification of Social Security Number

(Eff. 11/01/14)

When an application is locked in MEDS, a query is generated to verify Citizenship and Identity and the Social Security Number through SVES. The response received from Social Security will indicate if the Social Security Number is verified and if Citizenship and Identity is verified. If no response is received, the worker will receive Alert #264, NO RESPONSE TO SVES C&I VERIFICATION REQUEST. If Citizenship and Identity are not verified, the Eligibility Worker will receive Alert #265, SVES DID NOT VERIFY C&I WORKER VERIF REQUIRED. The Eligibility Worker must first check to see if the Social Security Number is verified to determine what actions to take.

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| **Procedure for Verifying Social Security Number** |
| **MEDS Procedure:**1. Eligibility Worker receives Alert #264 or Alert #265.
2. Worker must check the code on SVES13, SVES SSN Validation and C&I Verification Response.
3. If the Verification Code for Citizenship/Identity Validation Response is one of the following codes, the Eligibility Worker must use other methods to verify Citizenship and Identity. Refer to SC MPPM 102.04.04.
* B – SSN is verified, No DOD, C&I not verified by SSA
* D – SSN is verified, DOD present, C&I not verified by SSA
1. If there is no verification code under Citizenship/Identity Validation Response, check the Error Condition Code and Description under the SSN Validation Response section for the reason that the Social Security Number did not verify.
2. Compare the information provided by the applicant.
	1. If the information in MEDS does not match the information provided by the applicant, make all appropriate corrections in MEDS. If the SSN, Name, Date of Birth, Sex, or Medicare Number are changed in MEDS, a new query will be generated to attempt to verify SSN, Citizenship, and Identity.
	2. If the information in MEDS matches the information provided by the applicant, contact the applicant to confirm the provided information.
		1. If the applicant provides new information, make the necessary corrections in MEDS.
		2. If the applicant confirms that the information is correct, use other methods to verify Citizenship and/or Identity. Refer to SC MPPM 102.04.04.

**Cúram Procedure**If known to the system, Social Security Number will be verified automatically in Healthy Connections Cúram. If not known, when the service becomes available, the worker may use the Person Composite Service to verify SSN. Refer to the [Social Security Number (SSN)](https://schhs.sharepoint.com/sites/EES/Training/Curam/HCR/Job-Aids/Evidence/Social%20Security%20Number.pdf?csf=1&e=nguDrQ&cid=d4a01aab-1487-48dd-8c16-1cd261446d55) job aid for specific instructions. |

102.06 Categorical Relationship

(Eff. 10/01/05)

All individuals applying for Medicaid must be categorically eligible. To be categorically eligible for Medicaid, an individual must be:

* Receiving cash assistance, such as SSI or Optional State Supplementation (OSS),
* Aged,
* Blind,
* Disabled,
* A child under age 19,
* A pregnant woman,
* An adult with a dependent child(ren), or
* Diagnosed and found to need treatment for either breast or cervical cancer or pre-cancerous lesions (CIN II/III or atypical hyperplasia).

102.06.01 Aged/Age Verification

(Rev. 09/01/20)

[CFR §435.956](http://www.ecfr.gov/cgi-bin/text-idx?SID=0d5b433b4fd4f2544aa9f64e97c6c014&node=42:4.0.1.1.6.10.76.30&rgn=div8)

[POMS GN 00302.400](https://secure.ssa.gov/apps10/poms.nsf/lnx/0200302400)

For an applicant/beneficiary to be categorically eligible as aged, he must be 65 years of age or older. An individual qualifies as aged the month he turns 65.

An individual attains a particular age on the day before of his/her date of birth. For example, an individual born on October 1, 1965, is age 65 on September 30, 2030, and meets the categorical criteria of Aged in the month of September.

102.06.01A Age Verification

(Eff. 10/01/13)

An applicant/beneficiary is allowed to self-attest his age. The Eligibility Worker will verify age using electronic sources and will request paper documentation from the applicant if age cannot be verified electronically. Paper documentation is required if the attested date of birth does not match an electronic data source.

Examples of acceptable sources of age verification are:

* Birth Certificate or other birth records
* Social Security records
* BENDEX System
* SDX Listing
* Hospital, school, or physician/clinic records
* State or Federal Census records
* Marriage License
* Religious records (Family Bible, baptismal or confirmation certificate)

102.06.02 Blindness/Disability

(Eff. 06/01/15)

To be categorically eligible as blind or disabled, the applicant/beneficiary must meet the Supplemental Security Income (SSI) definition of blindness or disability. The Social Security Administration establishes the condition of blindness or disability. In certain situations, Vocational Rehabilitation Disability Determination Service (VRDDS) may determine whether the applicant/beneficiary meets the SSA/SSI blindness or disability criteria. An applicant/beneficiary is considered categorically eligible if determined to be blind or disabled. If the applicant/beneficiary provides a Social Security Award letter indicating current receipt of SSI or Social Security Disability benefits, the applicant meets categorical eligibility, and a referral is not needed. **Do not refer an individual aged 65 or older for a disability determination.**

102.06.02A Determination of Documented Blindness/Disability Status at Application

(Rev. 04/10/22)

This process must be followed when an application for Medicaid requires that the Eligibility Worker make a blindness/disability determination. An Eligibility Worker must establish if the applicant has applied for or is receiving Social Security Disability or Supplemental Security Income (SSI).

If it is determined that an applicant does not meet other financial or non-financial eligibility requirements for a Medicaid category requiring a disability decision, refer the application for a MAGI determination.

**Exception:** All eligibility factors must be developed before a TEFRA application can be denied.

When an application is received that indicates disability, an eligibility worker must research BENDEX, SDX, SVES and OnBase to see if disability is already documented in an existing system or if there is a pending disability referral.

The following Disability Determination Process details the steps used to arrive at a disability decision. A *Disability Packet* refers to the appropriate *Disability Report* along with a DHHS Form 921 that is sent to an applicant. The table below defines what a *Disability Report* is and what should be included in a *Disability Packet* when it is originally sent, and when an update is needed.

|  |
| --- |
| **Definitions** |
| **Term** | **Adult** | **Child (Under Age 18)** |
| *Disability Report* | * DHHS Form 3218 ME
 | * DHHS Form 3218-D ME
 |
| *Disability Packet* | * Disability Cover Letter
* DHHS Form 3218 ME
* DHHS Form 921
 | * Disability Cover Letter
* DHHS Form 3218-D ME
* DHHS Form 921
 |
| *Update Disability Packet* | * DHHS Form 3218-J, Update Disability Cover Letter
* Copy of previously submitted DHHS Form 3218
* DHHS Form 3218 for updates and additions
* DHHS Form 921
 | * DHHS Form 3218-J, Update Disability Cover Letter
* Copy of previously submitted DHHS Form 3218-D
* DHHS Form 3218-D for updates and additions
* DHHS Form 921
 |

Refer to the [Reviewing Cases for Disability Determination](https://schhs.sharepoint.com/%3Ab%3A/r/sites/EES/Training/Non-MAGI%20Track/Job%20Aids/Reviewing_Cases_for_Disability_Determination.pdf?csf=1&web=1&e=URVIdZ) Job Aid for additional instructions for processing a case requiring a disability determination. Start the Disability Packet Review Checklist (found in OnBase) at application and review when evaluating if a disability determination is required.

| **Disability Determination Process** |
| --- |
| **Step** | **Action** |
| **Disability Check – Interfaces** | **STEP 1**Check BENDEX (MPPM 102.06.02B), SDX (MPPM 102.06.02C) and SVES (MPPM 102.06.02D). Refer to [**Check** **System Interfaces**](#Interface)* Has the applicant already been determined to be disabled, including all requested retroactive months?
	+ **YES** – Go to [**Process Application**](#Proc_App)
	+ **NO** – Go to [**Disability Check - OnBase**](#Dis_Chk_Step_2)
 |
| **Disability Check – OnBase** | * Is there an existing MAO99 that has not passed the diary date?
	+ **YES** – Go to [**MAO99 Return**](#MOA99_Ret)
	+ **NO** – Continue OnBase check
* Is there a pending *Disability Packet* in OnBase for the current application?
	+ **YES** – Review the *Disability Packet* for completeness

**Note:** If the *Disability Packet* is incomplete, the missing pages/information will need to be requested via DHHS Form 1233.Go to [**Process Application**](#Proc_App)* + **NO** – Go to [**Applicant Contact**](#App_Con)
 |
| **Applicant Contact** | * Review the application and create a DHHS Form 1233 to show any additional information needed to complete an eligibility determination.
* Attempt to contact the applicant by phone using the [**Disability Process Script**](#Dis_Proc_Scrpt) (MPPM 105.02.01)
	+ - * + Does the Applicant want to continue the disability process?

**YES** – Confirm the applicant’s Name, Date of Birth, Social Security Number, Address and Phone NumberGo to [**Prepare Disability Packet**](#Prep_Dis_Pak)* + - **NO** – Assess for Family Planning or other MAGI category.
* If unable to contact the applicant by phone, go to [**Prepare Disability Packet**](#Prep_Dis_Pak)
 |
| **Prepare Disability Packet** | * On the *Disability Report*, type the applicant’s Name, Date of Birth, Social Security Number, Address, Phone Number and other Identification and Contact information.

Fill in the “For DHHS Use Only” box by typing the complete Household Number and Application Date and indicate whether it is a request for an Initial or Retro Only decision and the beginning Retro month.* On the DHHS Form 921, fill in the “To Be Completed By SCDHHS” box by typing the Name, Social Security Number, Date of Birth and complete Household or Application ID number.
	+ A DHHS Form 921 is not necessary if the applicant is deceased and documentation was submitted with the date and cause of death, preferably the death summary or case notes from the hospital.
* Update the DHHS Form 1233 to add the *Disability Packet*.
* Mail the DHHS Form 1233 and *Disability Packet* to the applicant and Authorized Representative. Allow 15 days to return the required information. Reminder: When setting the follow-up date in OnBase, add an additional six (6) days to allow for scanning and task creation in Workload Pro (WLP).

**NOTE**: If the applicant is deceased, include documentation of the date and cause of death, preferably the death summary or case notes from the hospital. The death must be linked to the applicant’s underlying disability.* Begin completion of the Disability Review Checklist in OnBase. Steps should be completed until a “Stop” is reached.
* Go to [**Information Return**](#Info_Ret)
 |
| **Information Return**If no information is returned within 15 days, deny the application for Failure to Return Information.If information is returned, check Part 1 and Part 2. | **Part 1**Is the *Disability Packet* returned within 15 days?* **YES** –
	+ **Central Document Management (CDM)** – Scan the *Disability Packet* into OnBase (Document Type: MEDS-Disability Packet) with Trailing set to “YES.”

**NOTE:** Do not date stamp or make any other marks on the front of the DHHS Form 921* + **Eligibility Worker** – Go to [**Check Disability Report**](#Chk_Dis_Rep)
* **NO** – Go to [**Second Contact**](#Sec_Cont)
 |
| **Part 2**Is all other required information returned within 15 days?* **YES** – Go to [**Eligibility Check**](#Elig_Chk)
* **NO** – Go to [**Second Contact**](#Sec_Cont)
 |
| **Second Contact** | Contact the applicant and clarify that information is still missing. Send a DHHS Form 1233 requesting the completion of the missing pages and any other necessary case information (i.e., income/resources). **Note:** Because this is the second request for this information, give the applicant 10 days to return the information and put the case in Follow-Up for an additional 6 days. Go to [**Second Contact Information Return**](#Sec_Cont_Info_Ret) |
| **Second Contact Information Return** | Did the applicant return the *Disability Packet* within 10 days?* **YES** – Go to [**Information Return – Part 1**](#Info_Ret_Pt_1)
* **NO** – Deny the Non-MAGI application and assess for Family Planning or other MAGI category in MEDS.
 |
| Did the applicant return other requested information within 10 days?* **YES** – Go to [**Eligibility Check**](#Elig_Chk)
* **NO** – Deny the application for Failure to Return Information
 |
| **Check Disability Report** | Access the *Disability Packet* in OnBase. Complete the Disability Process Checklist to evaluate the packet for completeness. *Disability Report* * Is the *Disability Packet* contact information complete and legible, and did the applicant sign the *Disability Report*?
	+ **YES**: Proceed to review the DHHS Form 921

**NOTE**: A *Disability Report* is still required with a posthumous application if a Disability Determination is required for eligibility. * + **NO**:
		- Search documentation and electronic systems to verify the information.
		- Make a collateral call to the applicant/authorized representative to verify the information.
			* If the discrepancy CAN be resolved make the change in the SOR (if needed) and on *the Disability Report*. Include a note in SOR and the Documentation Template of the error found. Add an OnBase sticky note of the change to the *Disability Report*.
			* If the discrepancy CANNOT be resolved, make note of the verification needed and include on the DHHS Form 1233.

DHHS Form 921* Is the MEDS-Disability Packet contact information complete and legible and did the applicant sign the DHHS Form 921? **NOTE**: Do not date stamp or make any other marks on the front of the DHHS Form 921
	+ **YES** –
		- If all forms are complete and correct, re-index the *Disability Packet* from MEDS-Disability Packet to MEDS-Disability Application. While the re-index column is open, update the Disability Status Keyword with the dropdown value of “Pending DD Review.”
		- Ensure the MEDS-Disability Application is in VR Workflow and exit date is blank. Right click the MEDS-Disability Application, choose “History,” then “Workflow Queues.” If the MEDS-Disability Application is not in “VR Workflow” or has an Exit Date, put the MEDS-Disability Application into VR Workflow by right clicking the MEDS-Disability Application, choose “Workflow,” then “Execute,” then “Ok.” Confirm that the MEDS-Disability Application is now in VR Workflow.
		- Set the “Disability Packet sent to VR?” indicator to “No” on the Tracking Form. This shows the Disability Determinations Team has not reviewed the MEDS-Disability Application, and Vocational Rehabilitation has yet to receive the MEDS-Disability Application to make a Disability Determination.
		- Set the follow-up date on the Tracking Form for 21 days to allow the Disability Determination Team to review the *Disability Application* and send to Vocational Rehabilitation.

 **NOTE**: Be sure POA signs their name on behalf of the client, not the client’s name. Include POA document with *Disability Application* when submitting to Vocational Rehabilitation.* + **NO** –
		- A DHHS Form 921 is not necessary if the applicant is deceased and documentation was submitted with the date and cause of death, preferably the death summary or case notes from the hospital.
		- Contact the applicant by phone regarding any incomplete or illegible information in the *Disability Packet*.

 **NOTE**: If the *Disability Application* was sent to VR-Intake Workflow and the MEDS-Application Tracking Form has been pended twice for 21 days (placed in Follow-Up two times waiting for Disability Determination Team to review the packet and send to Vocational Rehabilitation), and there are no notes on the Documentation Template that the *Disability Application* was sent to VR, notify your supervisor to escalate the case and keep the task in Finish Later until a response is received.  **NOTE**: Be sure POA signs their name on behalf of the client, not the client’s name. Include POA document with the *Disability Application* when submitting to Vocational Rehabilitation. |
| **Eligibility Check** | Verify all other financial and non-financial eligibility criteria.* Does the applicant meet all other financial and non-financial criteria?
	+ **YES** – Send the case to the Follow-Up Queue for 90 days or until [**MAO99 Return**](#MOA99_Ret).
	+ **NO** – Send the case to the Follow-Up Queue for 90 days to wait for the final disability decision. Do not deny the application at this time.

**Note:** A financial denial can only be made BEFORE a *Disability Report* has been requested/received from the applicant. Once a *Disability Packet* is received/requested, the case can no longer be denied for financial reasons until the Disability Determination is received.* + - Contact the applicant
	+ Disability Determination Services at Vocational Rehabilitation will continue processing the *Disability Packet*.
 |
| **MAO99 Return** | **CDM** – Scan MAO99 into OnBase (Document Type: MEDS Form MAO99; Trailing Document – Yes)**Eligibility Worker** – Does the MAO99 establish disability?* **YES** –
	+ Does the MAO99 indicate an Adopted or Coordinated decision?
		- **YES** – Go to [**Process Application**](#Proc_App)
		- **NO** – Check BENDEX, SDX and SVES to see if the applicant filed an application for benefits with the Social Security Administration.
			* If an application with SSA was denied, determine the reason and the impact on the Medicaid decision. Go to [**Process Application**](#Proc_App)
			* If there appears to be no application for SSA benefits, contact the applicant for an explanation.
				+ If the applicant provides a reasonable explanation, go to [**Process Application**](#Proc_App)
				+ If the applicant does not provide a reasonable explanation or indicates an application was not filed, deny the application for Failure to Apply for Other Benefits
* **NO** – Assess for Family Planning or other MAGI category.
 |
| **Process Application** | Evaluate application for all eligibility criteria.Does the applicant meet all eligibility criteria?* **YES** – Approve the application for the appropriate category.
* **NO** – Assess for Family Planning or other MAGI category in MEDS.
 |

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| **System of Record** |
| Prior to processing the application, it must be determined whether the person already has eligibility in either MEDS or Cúram. The following steps apply to most situations.**Applications originating in Cúram**:* + 1. Is the applicant Medicaid eligible?
			1. Yes: Are they eligible in a full benefit category?
				1. Yes: Treat the application like a reported change, apply changes.
				2. No: Re-index to the SSI Non-Institutional Queue.

If the applicant is found eligible under the ABD category, eligibility in Cúram must be ended before approving the application in MEDS.* + - 1. No: Re-index application to SSI Non-Institutional Queue.

**Applications originating in MEDS:**Determine if the applicant is Medicaid eligible. If they are eligible in a full benefit category, the disability decision may not be needed.If the applicant is not currently eligible in a full-benefits category, assess the application for ABD.If the applicant is not eligible for ABD, assess for Family Planning and other MAGI categories in MEDS.If the person is not eligible in any full benefit Medicaid category and does not have Medicare, their information must be forwarded to the FFM. An email must be sent to SP\_FFMTransfer@scdhhs.gov. 1. Subject Line of the email: Household Number
2. Body of the email: First and Last Name

**Applications originating in Cúram (CGIS):**Determine if the applicant is Medicaid eligible. If they are eligible in a full benefit category, the disability decision may not be needed.If the applicant is not currently eligible in a full-benefits category, assess the application for ABD.If the applicant is not eligible for ABD, assess for Family Planning and other MAGI categories.If the person is not eligible in any full benefit Medicaid category and does not have Medicare, their information must be forwarded to the FFM. An email must be sent to SP\_FFMTransfer@scdhhs.gov. 1. Subject Line of the email: Household Number
2. Body of the email: First and Last Name
 |

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| **Procedure for Entering Onset Date of Disability** |
| **MEDS Procedure:*** If an Eligibility Worker can determine that the disability criteria are met without forwarding the case for a disability determination (SSA disability or current VR decision), the onset date of disability must be entered on HH Member Detail (HMS06). The onset date of disability entered would be a verified date based on BENDEX or SDX and can be found on one of the following sources:
	+ Award Letter if dated within the last 12 months
	+ MA099 if the diary date has not passed
	+ BENDEX
	+ SDX DISABILITY ONSET
	+ SVES SSA DIB ONSET
	+ SVES SSI DIB ONSET
* When a date is entered in HMS06, the system will set the standard of promptness as 45 days rather than 90 days. MEDS will then establish 45 days as the appropriate standard of promptness when the application is locked
* If the onset date has not been established, leave the Disability Onset (DO) date blank and MEDS will establish 90 days as the appropriate standard of promptness
 |

**Delayed Application Processing**

A *Disability Packet* not forwarded to Vocational Rehabilitation within 10 months of the signature on the DHHS Form 921 requires a new signed information release form. If the date is over 10 months old and a *Disability Application* HAS been sent to Vocational Rehabilitation, a new DHHS Form 921 is not needed. For an application filed posthumously or for an applicant who died after the original application, the Personal Representative of the deceased must sign the DHHS Form 921.

Check BENDEX and SDX to see if a disability decision has already been completed by the Social Security Administration. If there is no decision, contact the applicant using the Update Disability Packet script (MPPM 105.02.01A) to explain that an updated release form is required. Once contact is completed, send the Update Disability Packet to the applicant.

If the updated *Disability Packet* is not returned within 15 days, deny the application for failure to return information.

102.06.02B Check System Interface – BENDEX

(Eff. 06/01/15)

The following procedure must be used to check BENDEX.

| **Check System Interfaces – BENDEX** |
| --- |
| * From Household Member Detail (HMS06) screen use F9; or
* From the Interfaces Menu, select IEVS Action Menu, then select BENDEX Menu, then select BENDEX Information Screen (IEV11)
	1. If BENDEX record is not found, create a request
		1. Press F16 to go to BENDEX Input Form (IEV05)
		2. Enter “BDA” in Communication Code field
		3. Enter “ADD” in the Action field
		4. Press <ENTER>
		5. The request will be returned in 2 to 3 days. An alert will not be sent when the response is received, so the Eligibility Worker must check IEV11 to determine if the query request has been returned
	2. If BENDEX record is found, check the date shown in the SSA PROCESS field
		1. If the SSA PROCESS date is more than 12 months old, create a new request. Refer to the instructions in a. above
		2. If the SSA PROCESS date is within the previous 12 months, check the Payment Status Code (PSC)
			1. If PSC is CP (Current Pay), check the applicant’s age
				1. If the applicant is age 18 through age 61, check to see if the applicant is receiving on his own record

If the claim number is the applicant’s Social Security Number with an “A” suffix, the applicant is disabled, and a disability referral is not neededIf the claim number is the applicant’s Social Security Number with a “T” suffix, go to [**SDX**](#SDX)If the applicant’s claim number ends with any other suffix or uses someone else’s SSN, check Medicare eligibility on BENDEX INFORMATION page 2 (IEV02)If the applicant is currently Medicare Part A eligible, the applicant is disabled, and a disability referral is not neededIf the applicant is not Medicare Part A eligible, go to [**SDX**](#SDX)* + - * 1. If the applicant is age 62 through age 64, check to see if the applicant is receiving on his own record

If the claim number is the applicant’s Social Security Number with an “A” suffix, check Medicare eligibility on IEV02If the applicant is currently Medicare Part A eligible, the applicant is disabled, and a disability referral is not neededIf the applicant is not currently Medicare Part A eligible, go to [**SDX**](#SDX)If the claim number is the applicant’s Social Security Number with a “T” suffix, go to [**SDX**](#SDX)If the applicant’s claim number ends with any other suffix or uses someone else’s SSN, check Medicare eligibility on IEV02If the applicant is currently Medicare Part A eligible, the applicant is disabled, and a disability referral is not neededIf the applicant is not Medicare Part A eligible, go to [**SDX**](#SDX)* + - 1. If PSC is not CP, go [**SDX**](#SDX)
 |

102.06.02C Check System Interfaces – SDX

(Eff. 06/01/15)

The following procedure must be used to check SDX.

| **Check System Interfaces –** **SDX** |
| --- |
| * From Household Member Detail (HMS06) screen, press F23; or
* From the Interfaces Menu, select SDX Menu
1. If SDX record is not found, go to [**SVES**](#SVES)
2. If SDX record is found, check SSA PROC field on the SDX CLIENT INQUIRY HISTORY / RECORD PROCESSING DATA (SDX05) screen
3. If the SSA PROC field is more than 12 months old, go to [**SVES**](#SVES)
4. If the SSA PROC field is within the previous 12 months, check PSC on SDX05
5. If PSC is C01, check TRNS CD on SDX05
	* + - 1. If TRNS CD is 05, go to [**SVES**](#SVES)
				2. If TRNS CD is any other code, the applicant is disabled. If the applicant is not in Payment Category 80, create a Service Manager ticket for Interfaces to correct
6. If PSC is H80 or if PSC is blank and TRNS CD is OP or 0P, the applicant has applied for SSI, go to the [**Disability Determination Process – Disability Check – OnBase**](#Dis_Chk_Step_2)
7. If PSC is N01, N02, N04, N05 or N22 and
8. There is a row of eligibility with a PSC of C01 or E01 within the previous 12 months, the applicant is disabled based on an Adopted SSA Decision and a referral is not required (See the note below for definitions of Adopted SSA Decision Codes)
9. There is a row of eligibility with a PSC of C01 or E01, but it has been more than 12 months, go to [**SVES**](#SVES)
10. If there are any other codes, go to [**SVES**](#SVES)

Note**:** Definitions of Adopted SSA Decision CodesN01: Recipient’s countable income exceeds Title XVI payment amount and his/her State’s payment standardN02: Recipient is inmate of public institutionN04: Recipient’s non-excluded resources exceed Title XVI limitationsN05: Recipient’s gross income from self-employment exceeds Title XVI limitationsN22: Inmate of a penal institution |

102.06.02D Check System Interfaces – SVES

(Eff. 06/01/15)

The following procedure must be used to check SVES.

| **Check System Interfaces – SVES** |
| --- |
| * From the Interface Menu, select SVES Menu, then select Request Query (SVE11)
1. Enter the beneficiary’s SSN, Recipient Number, or Social Security Claim Number (if present in MEDS) in the appropriate field
2. Check the LATEST REQ DATE and RESPONSE DATE fields to determine if a request has already been sent and received.
	1. If the SSI Title XVI or SSA Title II RESPONSE DATE field contains a date that is less than 30 days old, go to c.
	2. If the SSI Title XVI or SSA Title II RESPONSE DATE field is blank or the date displayed is over 30 days, request a new SSI or SSA query. The request will be returned in 2 to 3 days
3. To request by SSN or Recipient Number
4. Enter ‘S’ in the SSI Title XVI or SSA Title II select field and
5. Type ‘Add’ in the action field and press Enter
6. To request by CAN
7. Enter ‘S’ in the SSA Title II select field
8. Enter ‘Y’ in the CAN (Y/N) field and
9. Type ‘Add’ in the action field and press Enter
10. If the SSA RESPONSE DATE field contains a date that is less than 30 days old, either because a request was made or there was already a SVES response less than 30 days old, press F19 to access the SVES SSA RESPONSE SCREEN (SVE03)
11. If the LAF CODE field is C (Current Pay), check applicant’s age
12. If age 18 through 61, determine if applicant receives benefits on his or her own record
13. If the SSCN or CAN is the applicant’s SSN with suffix A, the applicant is disabled, and a disability referral is not needed
14. If the SSCN or CAN is the applicant’s SSN with suffix T, the applicant is not disabled, and a disability referral is needed; go to the [**Disability Determination Process – Disability Check – OnBase**](#Dis_Chk_Step_2)
15. If the SSCN or CAN is the applicant’s SSN with any other suffix, check MEDICARE HI eligibility. Medicare HI is Part A Hospital Insurance
16. If the applicant is eligible for Medicare Part A, the applicant is disabled, and a disability referral is not needed
17. If the applicant is not eligible for Medicare Part A, disability cannot be determined, go to Step **3**d to check SVES SSI Response
18. If the SSCN or CAN is not the applicant’s SSN, check Medicare Part A eligibility
19. If the applicant is eligible for Medicare Part A, the applicant is disabled, and a disability referral is not needed
20. If the applicant is not eligible for Medicare Part A, disability cannot be determined, go to Step **3**d to check SVES SSI Response
21. If age 62 through 64, determine if applicant receives benefits on his or her own record
22. If the SSCN or CAN is the applicant’s SSN with suffix T, the applicant is not disabled, and a disability referral is needed; go to the [**Disability Determination Process – Disability Check – OnBase**](#Dis_Chk_Step_2)
23. If the SSCN or CAN is the applicant’s SSN with any other suffix, check Medicare Part A eligibility
24. If the applicant is eligible for Medicare Part A, the applicant is disabled, and a disability referral is not needed
25. If the applicant is not eligible for Medicare Part A, disability cannot be determined, go to Step **3**d to check SVES SSI Response
26. If the SSCN or CAN is not the applicant’s SSN, check Medicare Part A eligibility
27. If the applicant is eligible for Medicare Part A, the applicant is disabled, and a disability referral is not needed
28. If the applicant is not eligible for Medicare Part A, disability cannot be determined, go to Step **3**d to check SVES SSI Response
29. On SVE11, if the SSI RESPONSE DATE field contains a date that is less than 30 days old, either because a request was made or there was already a SVES response less than 30 days old, press PF17 to access SVES SSI Response screen (SVE01)
	1. Create a Service Manager ticket for Interfaces to have PCAT 80 eligibility established if:
		1. The beneficiary is not eligible in MEDS as Payment Category 80,
		2. PSC is C01,
		3. Has the STATE/CO South Carolina State code of 42 (42xxx) on SVES SSI RESPONSE page 3 (SVE22), and
		4. Residence address is in South Carolina
	2. Create a Service Manager ticket for Interfaces to contact SSA to request to SSA to correct the state code and have PCAT 80 eligibility established if:
		1. The beneficiary is not eligible in MEDS as Payment Category 80,
		2. PSC is C01,
		3. Does not have the STATE/CO South Carolina State code of 42 (42xxx) on SVES SSI RESPONSE page 3 (SVE22), and
		4. Residence address is in South Carolina
	3. The Eligibility Worker will need to instruct the applicant to contact a local SSA office to report a change in residency if:
		1. the applicant is eligible for SSI in another state
		2. PSC is C01,
		3. Does not have the STATE/CO South Carolina State code of 42 (42xxx) on SVES SSI RESPONSE page 3 (SVE22), and
		4. Residence address is not in South Carolina
	4. The applicant is disabled based on an Adopted SSA Decision and a disability referral is not necessary if:
		1. PSC is N01, N02, N04, N05, or N22, and
		2. On SVE02, under SSI MNTHLY ASST the most recent row is within the last year and contains a payment amount
	5. If the PSC is H80, the applicant has applied for SSI and a disability referral is needed; go to the [**Disability Determination Process – Disability Check – OnBase**](#Dis_Chk_Step_2)
30. For all other responses, or if a SVES SSI response is not found, disability cannot be established, and a disability referral is required. Go to the [**Disability Determination Process – Disability Check – OnBase**](#Dis_Chk_Step_2)
 |

102.06.02E Disability Process Script

(Rev. 08/01/15)

The Disability Process Script can be found in MPPM 105.02.01.

102.06.02F Continuing Disability Review at Annual Review

(Rev. 12/01/21)

When a case is due for annual review, the Eligibility Worker is responsible for determining if a Continuing Disability Review (CDR) must be conducted. The Eligibility Worker must research the case record for the last favorable disability decision to determine when the disability review is due.

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| **Procedures for Continuing Disability Review for Blind and Disabled Beneficiaries at Annual Review****Eligibility Worker Tasks:**Upon receipt of the annual review form:If the disability determination was based on an Adopted or Coordinated decision, the eligibility worker must check interfaces to ensure the beneficiary is still in payment status for Social Security benefits. If they are, no CDR is required. Complete the annual review assuming continued disability. If the beneficiary had Social Security benefits terminated within the last 12 months of the annual review date, as indicated by PSC codes N01, N02, N04, N05, or N22 without an Independent, disability determination, the worker should not send a CDR packet to VR and should complete the annual review, assuming continued disability.If the terminating SSA decision occurred more than 12 months prior to the annual review date or with any other PSC code, the worker must complete the identifying information and “FOR DHHS USE ONLY” sections on the DHHS Form 3218 (adult) / 3218-D (child) and DHHS Form 921 and send it to the applicant. (This is considered a new application to Disability Determination Services.) If the applicant is otherwise eligible, the case remains open until the disability decision is received.If a disability determination was previously done, the Eligibility Worker must:1. Check the case record for the MAO99 disability determination for the Diary Date or Date of Next Review:
* If the date is past due or is due within the next three (3) months, the worker must complete (type) the identifying information and the FOR DHHS USE ONLY section on the DHHS Form 3266 (adult)/3266-D (child), as well as the DHHS Only section on DHHS Form 921. This is the CDR packet. Send a completed DHHS Form 1233 for any information needed to complete the financial determination and the CDR packet to the beneficiary/Authorized Representative. Provide 15 days to return the requested information. **Reminder:** When setting the follow-up date in OnBase, add an additional six (6) days to allow for scanning and task creation in WLP.
	+ Complete the financial determination for the annual review.
		- * If all information is not received in 15 days, contact the applicant, resend the completed DHHS Form 1233 and provide 10 additional days for follow up.
	+ If otherwise eligible keep the case open until a decision is received.
* If the date is more than three (3) months in the future, no action needs to be taken regarding disability until the next annual review. Complete the annual review.

**Eligibility Worker Tasks:*** Retrieve the CDR Packet in OnBase.
* Review the documents for completeness, legibility.
	+ Follow up with beneficiary/Authorized Representative for any needed information/clarification.
* Retrieve the case file documents related to last favorable decision. This may be via OnBase, AppXtender, Appeals documents.

**Note:** AppXtender, also known as ApplicationXtender, is a database used to store documents from application files that are dated outside the storage capacity of OnBase.* Print the CDR Packet and related documents.
* **If no case file documents found related to last favorable decision, indicate this in the DHHS Only Section of Form 3266 ME/3266D-ME.**
* Give the entire CDR Packet and related documents to VR staff.

Upon receipt of the MAO99 from VR, CDM will scan the MAO99 into OnBase. **Eligibility Worker Tasks:** * Access MAO99 from OnBase.
* Complete eligibility decision based on financial determination and disability decision for continuation of benefits. If the beneficiary is no longer eligible in this payment category, assess for eligibility in MAGI categories, including Family Planning. (Keep case in MEDS.)
 |

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| **Procedures for Continuing Disability Review for TEFRA Beneficiaries at Annual Review** |
| Follow the Procedure for Disability Referral in [MPPM 102.06.02A](#MPPM_102_06_02A) for beneficiaries eligible for TEFRA. Use the DHHS Form 3266-D ME |

102.06.02G Child Aging Out of Disability Based Category

(Eff. 09/01/15)

A child eligible in a disability-based category who is age 18 at the time of annual review will require an updated disability determination. If a current determination has not been completed for the Social Security Administration, a DHHS Form 3266, Adult – Continuing Disability Review, and DHHS Form 921, Authorization to Disclose Health Information (Request for Medical Records) must be completed and submitted to Vocational Rehabilitation as part of the ex parte process.

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| **Procedure**The worker must complete (type) the identifying information and the FOR DHHS USE ONLY section on the DHHS Form 3266, as well as the DHHS Only section on DHHS Form 921. This is the CDR packet. Send a completed DHHS Form 1233 for any information needed to complete the financial determination and the CDR packet to the beneficiary/Authorized Representative. Provide 15 days to return the requested information.* Complete the financial determination for the new eligibility category.
	+ If all information is not received in 15 days (partial information), contact the applicant, resend the completed DHHS Form 1233 and provide 10 additional days for follow up.
* If otherwise eligible keep the case open until a decision is received.
 |

102.06.02H Disability Decision Overturned by an Appeal Decision or Administrative Law Judge (ALJ) Order

(Eff. 10/01/05)

When an application is denied because an applicant/beneficiary failed to meet disability criteria, and the Appeal Decision or Administrative Law Judge (ALJ) Order overturns the disability decision, the following actions should be taken:

* + Obtain a copy of the Final Administrative Decision (FAD) or ALJ Order decision for the case record;
* Verify that the applicant/beneficiary met all other eligibility requirements; and
* Establish Medicaid eligibility as of the date of the onset of disability as established by the Appeal Decision or ALJ Order, but no earlier than:
* The Medicaid application date; or
* Three (3) months before the Medicaid application date if retroactive benefits are an issue.

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| **Example:** An application dated July 2, 2004, was denied because of failure to meet the disability criteria. An FAD or ALJ Order overturned the disability decision establishing disability effective February 2004. If the applicant/beneficiary met all other criteria and requested retroactive benefits eligibility could be established effective April 2004. |

102.06.03 Child

(Eff. 10/13/13)

[CFR §435.4](http://www.ecfr.gov/cgi-bin/text-idx?SID=fa675c86400f40b47888b47b59d41b3e&node=42:4.0.1.1.6.1.53.3&rgn=div8); [CFR §435.110](http://www.ecfr.gov/cgi-bin/text-idx?SID=1b8b9ef1f90fc64f896519015ec193ff&node=se42.4.435_1110&rgn=div8); [CFR §435.952](http://www.ecfr.gov/cgi-bin/text-idx?SID=0d5b433b4fd4f2544aa9f64e97c6c014&node=42:4.0.1.1.6.10.76.28&rgn=div8)

For an applicant/beneficiary to be categorically eligible as a child, the child must be under the age of 19. A Dependent Child is a child under the age of 18 or under the age of 19 if he is a full-time student in a secondary school, which may be self-reported. Self-attestation is accepted for students, and a statement from the student’s school verifying enrollment is not necessary. The secondary school includes high school or schools with equivalent levels of vocational or technical training, such as a GED. In addition, some children with special needs or in the custody of DSS (foster care) may be categorically eligible up to age 21. (Refer to SC MPPM 206.03 for eligibility requirements of children aged 19 – 21. If a child’s age is questionable and needs to be verified, refer to SC MPPM [102.06.01](#MPPM_102_06_01) for acceptable methods.)

102.06.04 Pregnant Women

(Eff. 04/22/22)

[CFR §435.956](https://www.ecfr.gov/cgi-bin/text-idx?SID=4facac3db9573f6d5e78230add97210e&mc=true&node=se42.4.435_1956&rgn=div8)

To be eligible under this payment category, the woman must be pregnant. Pregnancy includes a 12-month period through the end of the 12th month after the end of a pregnancy.

**Verification of Pregnancy and Expected Date of Delivery**

An eligibility caseworker must accept an applicant’s self-attestation of pregnancy unless the worker has information that is not congruent with such attestation. An individual applying as a pregnant woman can self-report once per pregnancy. If there is a valid reason not to accept the self-report, the applicant must document the pregnancy and the expected date of delivery. Examples of acceptable sources of documentation include:

* Physician or clinic records;
* Statement from a certified medical professional, such as a nurse or nurse midwife; or
* Statement from any healthcare provider or clinic, including family planning services, if the statement:
* Is on letterhead,
* Is signed legibly,
* Indicates a telephone number, and
* Includes verification and the date of miscarriage, if applicable.

Pregnancy includes the 12-month postpartum period. The postpartum period begins on the date of delivery or termination of the pregnancy. The postpartum period ends on the last day of the month in which the 12th month falls. (Refer to MPPM 204.02.)

102.07 Medical Support Requirements

(Rev. 03/01/14)

Each legally able applicant/beneficiary is required to:

* + - 1. Assign to Medicaid any rights to payment for medical care from any third party;
1. Cooperate in identifying and providing information to assist in pursuing legally liable third parties, unless the individual establishes good cause for not cooperating; and
2. Cooperate in establishing paternity and in obtaining medical support and payments unless he can show good cause for not cooperating. (Note**:** Partners for Healthy Children applicants/beneficiaries, pregnant women, child(ren) applying in SSI-related coverage groups and individuals in Transitional Medicaid are exempt from cooperating in establishing paternity and obtaining medical support from the father of the unborn child or children.)

Cooperation for Medical Support Requirement purposes is defined as:

• Providing information or evidence relevant to an investigation,

• Appearing as a witness at a court or other proceeding,

• Identifying third parties and providing information, or attesting to the lack of information, under penalty of perjury, and

• Taking any other reasonable steps to assist in establishing paternity and securing medical support payments.

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102.07.01 Automatic Assignment

(Rev. 03/01/14)

South Carolina state law provides that a Medicaid beneficiary automatically assigns his rights to payment for medical care from any third party when he uses his card. By signing the application for Medicaid benefits, the applicant/beneficiary acknowledges his assignment of rights to payment of medical support.

**Note:** The Eligibility Worker must explain the assignment of rights at the time of application.

102.07.01A Non-Cooperation with Assignment Requirements

(Rev. 03/01/14)

An individual who fails to cooperate in the identification of legally liable third parties, or the recovery of reimbursement from legally liable third parties may be subject to sanction.

If the applicant/beneficiary/caretaker relative is sanctioned, the needs and income of that person is included in the eligibility determination; however, he/she is not eligible for Medicaid. The adult parent in a multi-generational PCR case is subject to sanction, but the minor parent is not.

102.07.01B Good Cause for Non-Cooperation

(Rev. 03/01/14)

No sanction is imposed for non-cooperation if an individual can show good cause for not cooperating. The following are circumstances under which it may be determined that the individual has good cause for refusing to cooperate:

* The child was conceived because of rape or incest
* Legal proceedings for adoption are pending
* Adoptive placement of child is under active consideration
* Cooperation is reasonably expected to result in physical or emotional harm to the individual seeking support or to the child

102.07.01C Verification

(Rev. 03/01/14)

Examples of acceptable documentation used to determine good cause for non-cooperation are:

* Medical, social service or law enforcement records which indicate that the child was conceived as the result of rape or incest;
* Court, medical, social services, psychological or law enforcement records which indicate that the alleged or absent parent might cause physical or emotional harm to the applicant/beneficiary or the child;
* Medical records which verify the emotional health history, present emotional and health status of the applicant/beneficiary or child;
* Court documents or other records that indicate that legal proceedings for adoption are pending;
* A written statement from a public or private agency which confirms that the individual is considering releasing the child for adoption; or
* Signed and dated statements or affidavits from individuals who know the applicant/beneficiary or child and have knowledge of the circumstances that are the basis of the good cause claim.

102.07.02 Procedures for Third-Party Data Collection

(Rev. 02/01/22)

The [DHHS Form 3230](http://medsweb.scdhhs.gov/EligibilityForms/FM%203230%20ME.pdf), Medicaid Third-Party Liability Data Collection Form, must be submitted for all beneficiaries who have health insurance coverage. At approval, review, redetermination, or ex parte determination, the Eligibility Worker must check the Medicaid application, appropriate review forms and the TPL Policy Inquiry on MMIS for any indication of health coverage. Any new policies and/or changes in the coverage or policy number (s) on file must be reported using Part II of the DHHS Form 3230 and the information added or updated in the system of record (SOR).

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| **Procedure for Third Party Data Collection:** |
| The SC DHHS 3230, copies of the beneficiary’s health insurance cards (front and back) and/or policies if available, must be forwarded by mail, email, or faxed to:South Carolina Department of Health and Human ServicesMedical Insurance Verification Services (MIVS)Post Office Box 101110Columbia, SC 29211-9804Fax: (803) 252-0870Email: MIVS@bcbssc.comIt is not necessary to complete the SC DHHS 3230 to report Medicare coverage; however, the SC DHHS 3230 should be completed for Medicare supplemental policies.Copies must be scanned into OnBase and filed in the case record.Cúram Procedure: * Go to the Insurance Affordability Case (the integrated case) of the applicant/ beneficiary
* Click on the Evidence tab. The Evidence Dashboard will display.
* Click on “All” on the Household bar under the Evidence dashboard. This will expand section to show all evidence types. Click on “Insurance”. From here, evidence may be edited or added.
 |

102.07.03 Referrals to DSS Office of Child Support Enforcement (OCSE)

(Rev. 05/01/22)

The South Carolina Department of Social Services, Integrated Child Support Services Division (ICSSD) is the organizational unit in the state that has the responsibility for administering child support enforcement under Title IV-D. ICSSD provides services to establish paternity and child support, modify child support orders, and enforce support orders. Services are available to Healthy Connections beneficiaries at no charge. Applicants may request a [DHHS Form 2700](http://medsweb.scdhhs.gov/EligibilityForms/FM%202700%20ME.pdf), Medical Support Referral, for these services by calling Healthy Connections Member Services at 1-888-549-0820.

Any applicant/beneficiary/caretaker relative can request a referral to be sent to ICSSD to:

* establish paternity,
* locate non-custodial parents,
* establish and enforce child support obligations.

Additionally, the DHHS Form 2700 is sent to a household when eligibility is established for a Cúram MAGI application containing a child with a parent living outside of the home. Cúram generates a copy of the form that is stored in OnBase.

**The completion of the DHHS Form 2700 is not a condition of eligibility.**

A DHHS Form 2700 that is completed and signed by the applicant/ beneficiary/ caretaker relative can be submitted directly to ICSSD at the address below.

South Carolina Department of Social Services

Integrated Child Support Services Division

Case Management Services

Post Office Box 1469

3150 Harden Street

Columbia, South Carolina 29202

However, if submitted to SCDHHS, the Eligibility Worker must evaluate the form to determine if the first and last name of the Absent Parent (AP) has been provided by the applicant/beneficiary/caretaker relative to allow ICSSD to properly process the referral.

|  |
| --- |
| **Providing a Paternity/Child Support Referral to ICSSD Upon Request by Applicant/ Beneficiary/ Caretaker Relative** |
| If the DHHS Form 2700 contains at least the first and last name of the Absent Parent, scan a copy into the case record in OnBase as “MEDS – Referrals”. Then, select “Medical Support Form Returned” in Cúram to generate a Medical Support Referral Form Returned task.**Working a Medical Support Referral Form Returned task:** The worker should select “Medical Support Referral Form Script” in Cúram. Then, complete the Non-Custodial Parent Details screen with the information from the returned DHHS Form 2700 located in OnBase.  |

The address and phone number for Regional Child Support Offices can be found at: <http://www.state.sc.us/dss/csed/contact.htm>

102.07.04 Health Insurance Premium Payment (HIPP) Program

(Eff. 10/01/05)

Medicaid is allowed to pay premiums for Medicaid beneficiaries to keep their private health insurance when it is cost effective to do so. The premium payment program is appropriate for Medicaid beneficiaries with chronic medical conditions requiring long-term treatment like cancer, end stage renal disease, chronic heart problems, or AIDS.

Cost effectiveness is achieved if Medicaid savings are expected to be greater than the enrollment costs, premiums, and cost sharing amounts under the plan. Medigap and Indemnity plans typically do not provide cost-effective premium opportunities.

Arrangements are made with the insurer, employer, and beneficiary to establish the proper payee, the premium amount, and frequency of payment.

Additional information can be found in Chapter 104, Appendix O.

To apply for participation in this program, please complete and mail the Health Insurance Premium Program (HIPP) referral form to:

Department of Health and Human Services

Attention: HIPP

Post Office Box 100127

Columbia, South Carolina 29202-3127

In addition, the following supporting documents must be sent with the HIPP referral form:

* Four to six months of insurance explanation of benefits,
* Copy of premium invoice or pay stub showing premium contribution.

102.08 Application for Other Benefits

(Rev. 03/01/14, Eff. 01/01/14)

As a condition of Medicaid eligibility, an applicant/beneficiary and/or his spouse must apply for and take steps to accept any other benefits to which he/she may be entitled unless he can show good cause for not doing so. Such benefits include, but are not limited to: Social Security, Unemployment Compensation, Railroad Retirement, Veterans Compensation. An applicant/beneficiary is not required to apply for benefits from other needs-based programs such as SSI, Family Independence, certain Veterans Pensions, VA Aid and Attendance. An applicant/beneficiary is not required to apply for reduced retirement benefits. (**Note:** An eligibility decision cannot be held up pending the application for other benefits. If otherwise eligible, approve the applicant for Medicaid and follow-up at the next annual review.) Pregnant Woman applicants/beneficiaries are not required to apply for other benefits they may be eligible to receive, such as Unemployment Compensation.

Good cause for failure to apply for other benefits exists if:

* The individual is unable to file for other benefits because of illness, and there is no responsible party or relative to act on his behalf; or
* The individual has previously applied for and been denied for reasons that have not changed. A copy of the denial notice or statement from the entity denying the benefit must be filed in the case record.

Outlined below are guidelines for the Eligibility Worker to determine when to refer applicants/beneficiaries to other agencies to apply for benefits to which he may be entitled. If it is determined that an applicant/beneficiary needs to apply for other benefits, the Eligibility Worker should explain that failure to apply without good cause will result in a denial/termination of Medicaid benefits. A DHHS Form 1233 must be provided to refer the applicant/beneficiary to apply for other benefits. The applicant/beneficiary must also be informed to report to the agency the status of the application within 10 days of a decision for other benefits.

If a beneficiary reports the start of benefits, rebudget the case to determine continued eligibility (if not otherwise protected.) At annual review, check electronic data sources to determine if the beneficiary is receiving income from the referred source. If the beneficiary is not receiving income from the referred source, request an explanation. If the beneficiary failed to apply for benefits, terminate eligibility.

102.08.01 Unemployment Benefits

(Rev. 05/01/18)

<http://www.sces.org/>

An individual MAY be eligible to receive unemployment benefits if he was laid off through no fault of his own or if he quit the job due to a GOOD work-related reason such as a:

* Change in the conditions of hire (**Example:** A plant closes and an individual is offered a position at another plant that would require him/her to relocate to another area.)
* Material change in working conditions (**Example:** An individual has done a certain type of work all his life but is changed to a different type of job that does not benefit him/her.

A referral for Unemployment Benefits is not required for:

* OCWI-Pregnant Woman applicants/beneficiaries;
* Retired applicants who are no longer working;
* Full-time high school or college students not available for full-time employment. For all categories except Family Planning, school attendance must be verified.

To be potentially eligible for unemployment benefits, an individual must meet three requirements under the law with respect to wages to establish a weekly benefit amount.

* An individual must have been paid wages of at least $1,092 in covered employment during the high quarter of his base period.
* An individual must have been paid a minimum of $4,455 in covered employment during his base period.
* An individual's total base period wages must equal or exceed one and one-half times the total of his high quarter wages.

The base period is the first four of the last five completed calendar quarters. This is the one-year period used to determine how much a person may be able to receive in unemployment benefits.

The base period is controlled by the effective date of a claim, not by the date the individual becomes unemployed. Using the table below, if a claim is effective during the January, February, or March of 2023 (Quarter 1), then the base period is Quarters 1, 2, and 3 from 2021 and Quarter 4 of 2020 as shown by the shaded area on the first line. This is true even if the claim is effective on March 31, 2023, the last day of the quarter. If a claim is effective during April, May, or June of 2023 (Quarter 2), the base period is Quarters 1, 2, 3, and 4 of 2021.

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| **Quarter** |
| **4** | **1** | **2** | **3** | **4** | **1** | **2** | **3** | **4** |
| OctNovDec | JanFebMar | AprilMayJune | JulyAugSept |  | JanFebMar |  | If claim’s effective date is in: |
|  | JanFebMar | AprilMayJune | JulyAugSept | OctNovDec |  | AprilMayJune |  |  |
| 2020 |  | AprilMayJune | JulyAugSept | OctNovDec | JanFebMar |  | JulyAugSept |  |
|  |  | JulyAugSept | OctNovDec | JanFebMar | AprilMayJune |  | OctNovDec |
| 2021 | 2023 |

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| **Procedure for Determining Unemployment Benefits** |
| 1. Check the application for any applicant who is currently not working nor receiving a retirement or disability benefit
2. Check SCDEW Wage Match to see if the applicant has wages. If the applicant/beneficiary has any wages, a copy of the SCDEW Wage Match screen must be printed for the record
3. Determine the base period assuming the claim effective date is in the current quarter
4. If the applicant/beneficiary has income in at least two quarters of the base period, the Eligibility Worker must determine if a referral to the South Carolina Department of Employment and Workforce (SCDEW) is appropriate. The case record must be documented to show worker’s determination and decision
5. The [DHHS Form 3301](http://medsweb.scdhhs.gov/EligibilityForms/FM%203301.doc), Unemployment Compensation Benefits Referral Worksheet, can be used to determine if a referral is appropriate and a printed copy of the form in the case record can serve as documentation
6. If the Eligibility Worker determines that the applicant/beneficiary must be referred to SCDEW, complete a DHHS Form 1233 instructing the applicant/beneficiary to apply for benefits
7. If an applicant/beneficiary indicates she was working in another state prior to moving to South Carolina, refer to DEW for an interstate unemployment claim

Note**:** Once someone is entered into MEDS, information about South Carolina wages is immediately available on SCDEW Wage Match.**Example 1:** Sarah Berry applies for Medicaid on May 15, 2023. On the application she indicates she is not currently working. Ms. Berry’s base period is January through December of last year. ESC Wage Match shows the following income: Quarter 1/2021: 1,125.52 Quarter 2/2021: 925.25 Quarter 3/2021: 1,268.85 Quarter 4/2021: 1,365.98Quarter 2/2020 is her highest quarter at $1,365.98, which is greater than $1,092.00. Her total income for the four quarters is $4,685.60, which is greater than $4,455.00; and the total is greater than 1 and one-half times the highest quarter ($1,365.98 × 1.5 = $2,048.97.) Ms. Berry is referred to SCDEW to apply for unemployment.**Example 2:** Jean Green applies for Medicaid on August 31, 2023. On the application he indicates he is not currently working. Mr. Green’s base period is April through December of last year and January through March of this year. ESC Wage Match shows the following income: Quarter 2/2021: 1,125.25 Quarter 3/2021: 512.12 Quarter 4/2021: 600.00 Quarter 1/2023: 552.36Quarter 4/2020 is Mr. Green’s highest quarter at $1,125.00, which is greater than $1,092.00. His total income is $2,789.73, which is less than $4,455.00. Mr. Green ***is not*** referred to SCDEW to apply for unemployment. |

102.08.02 Social Security Benefits

(Eff. 10/01/05)

<http://www.ssa.gov>

Disability Related SSA

Disability Benefits off the Individual’s Own Record

* Must be disabled
	+ Expected to last at least one year or result in death
	+ Cannot do prior work or adapt to other types of work due to medical condition
* Must have a work history and worked long enough and recently enough
	+ Generally, must have earned 40 work credits - 20 of the 40 must have been earned in the last 10 years. (Note: Younger workers may qualify with fewer credits as the number of credits needed is based on the age disability begins.)

Disabled Widow/Widower Drawing off Spouse’s Record

* Must be between the ages of 50 and 60
* Must meet SSA definition of disability
* Disability must have started
	+ Before spouse’s death
	+ Within seven (7) years of spouse’s death

Disabled Child

* Must meet SSA definition of disability
* Disabling impairment must have started before the child reached age 22. (Note: the child may qualify for benefits later in life although the child must be disabled prior to age 22.)

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| Example: Parent begins receiving SSA retirement benefits at age 62 and parent’s 38-year-old child disabled since birth may qualify for Disabled Child benefits at that point. |

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Spouse/Minor Children of Disabled Individual Who Receives SSA

* Spouse may qualify if:
	+ Age 62 or older, if benefits would be higher than what he would receive off his own record. Benefits are permanently reduced if he is under full retirement age, so it is not mandatory to apply for Medicaid purposes.
	+ At any age, if caring for the covered spouse’s child who is under age 16 or disabled
* Child may qualify if:
	+ Under age 18
	+ Age 18 – 19 and a full-time student in grade 12 or lower
	+ Age 18 and older, if disabled prior to age 22
* Divorced Spouse may qualify if:
	+ Married at least 10 years
	+ At least age 62
	+ Unmarried
	+ Not entitled to a higher amount under his own record or someone else’s

Survivor’s Benefits

The following individuals may qualify for benefits from a deceased individual’s Social Security record:

* Widow or Widower – full benefits at full retirement age (currently 65) or reduced benefits as early as age 60
* Disabled Widow or Widower – as early as age 50
* Widow or Widower at Any Age – if he takes care of the deceased spouse’s child who is under age 16 or disabled and receiving Social Security benefits
* Dependent Parents – age 62 or older
* Unmarried Children – if under age 18, or up to age 19 and attending high school full-time
* Children at Any Age – if disabled before age 22 and remain disabled

Note: Under certain circumstances, benefits can be paid to stepchildren, grandchildren or adopted children.

102.08.03 Veterans Benefits

(Rev. 11/01/07)

<http://www.vba.va.gov>

**Disability**

* Disabled by an injury or disease incurred or aggravated during active duty
* Must not have a dishonorable discharge

**Pension**

**Veterans** with low incomes may qualify if:

* Age 65 or older OR
* Permanently and totally disabled, unless result of willful misconduct
* Served on active duty with at least one day served during a period of war (Note**:** Minimum active-duty service requirements may vary depending on whether the service was prior to or after 1980.)
* Did not receive a dishonorable discharge

**Survivor’s Benefits**

Dependency and Indemnity Compensation (DIC)

The following individuals may qualify for benefits:

* **Surviving Spouse** – has not remarried
* **Surviving Spouse** – remarried after age 57
* **Unmarried Child** – under age 18
* **Child between ages of 18 and 23** – if attending VA-approved school
* **Low Income Parents of Deceased Veteran** – deceased veteran must have died from an illness or injury:
	+ Incurred or aggravated while on active duty or active duty for training;
	+ Incurred or aggravated in the line of duty while on inactive duty training; or
	+ Identified as a disability compensated by the Veterans Administration.

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102.09 Living Arrangements

(Eff. 10/01/05)

Living arrangement is a factor that may affect the services that an eligible individual receives. Individuals in certain living arrangements are not eligible for Medicaid.

102.09.01 Inmates of a Public Institution

(Rev. 02/01/23)

[42 C.F.R. 435.1009](https://www.gpo.gov/fdsys/pkg/CFR-2015-title42-vol4/pdf/CFR-2015-title42-vol4-sec435-1009.pdf); [42 C.F.R. 435.1010](https://www.gpo.gov/fdsys/pkg/CFR-2015-title42-vol4/pdf/CFR-2015-title42-vol4-sec435-1010.pdf)

While an Inmate of a public institution, an individual is only eligible for inpatient services. An inmate is an individual who lives in a public institution.

Definition of an Inmate

The individual under consideration must be confined involuntarily in a State or Federal prison, jail, detention facility, or other penal facility.

An individual is **not** an inmate in the following situations:

* Parole or probation,
* Home confinement,
* Voluntarily in a public institution
* Halfway house if:
	1. Residents are not precluded from working outside the facility in employment available to individuals who are not under justice system supervision,
	2. Residents can use community resources at will, and
	3. Residents can seek health care treatment in the broader community to the same or similar extent as other Medicaid enrollees in the state
	+ Note: An individual is not an inmate even if house rules limit freedom.
		- E.g., residences are closed/locked during certain hours; residents are required to report at certain time and sign in and out

Inmates may not receive Medicaid covered services, and no federal financial participation (FFP) may be claimed for services to inmates of a public institution, except when inmates are inpatients in a medical institution (discussed below). However, incarceration does not prevent an individual from being found Medicaid eligible, or from remaining enrolled in Medicaid. There are no special rules or exceptions to MAGI-based income eligibility for incarcerated individuals. An inmate must meet all categorical, financial, and non-financial criteria to be determined eligible. For example, an individual was eligible as a Parent Caretaker Relative (PCR) is incarcerated. As an inmate, that individual would no longer have a qualifying child and would lose PCR status. However, the individual may be eligible for Family Planning.

Note: If an inmate does not meet citizenship requirements and qualifies for Emergency Services only, the inmate is eligible for emergency inpatient services only. The service type indicator is C.

Special Considerations

If the inmate is receiving Social Security Retirement, Disability, or Survivors benefits, and convicted of a crime and confined to the correctional institution for more than 30 continuous days, Social Security will suspend their benefits. Similarly, Social Security must suspend benefits to individuals receiving Supplemental Security Income (SSI) payments when the person is incarcerated for at least one full calendar month. Therefore, these payments are disregarded as income. If benefits have not been suspended, notify the Social Security Administration (SSA).

**Inmate Residency**

Generally, inmates are residents of the state where they live. If an inmate is placed in an out-of-state institution, the home state remains the state of residence for purposes of Medicaid eligibility. Before release, individuals may apply for Medicaid in a different state if they intend to reside in that state after they are released.

Inmate Applications

SCDHHS has a specialty unit with a group of workers assigned to work inmate cases. The Specialty Unit Inmate Workers process all applications for the South Carolina Department of Corrections (SCDC), the Department of Juvenile Justice (DJJ) and all other inmate cases except Nursing Home applications for individuals who have been paroled. These designated workers process all eligibility for the inmate while incarcerated. Only these designated inmate workers can establish the Service Type Indicators for inmates.

* If the inmate is not paroled and enters a nursing facility, the designated Inmate Worker processes the application.

All inmate applications must be sent to:

**Mailing Address:** SC Department of Health and Human Services

 Post Office Box 211695

 Columbia, SC 29221

**Courier Address:** SC DHHS

 7499 Parklane Road, Suite 176 and Suite 180

 Columbia, SC 29223

Note**:** The DHHS Form 1282 has been designed to include the role and responsibility of the AR. A contact name and telephone number of someone at the facility for which the application was made must be provided to the Inmate Worker should there be a need to follow up on any pending information.

**Conditions for Medicaid Reimbursement (Inpatient Exception)**

* Reimbursement can be made for Medicaid covered services provided to an eligible inmate while an inpatient in an acute care hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility.
* Inpatient means a patient who receives room, board, and professional service in the institution for a 24-hour period or longer or is expected by the institution to receive room, board, and professional services in the institution for a 24-hour period or longer even if the patient does not actually stay in the institution for 24 hours.
* Reimbursement cannot be made for services provided at any of the above institutions including clinics and physicians when provided to an inmate on an outpatient basis.
* Reimbursement cannot be made for services provided on the greater premises of the prison grounds where security is ultimately maintained by the governmental unit.

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| **Procedure for Processing an Inmate Application:** |
| * The Specialty Unit Inmate Worker checks MEDS to determine if the inmate is currently eligible.
* The worker attaches the “I” indicator or (“C” indicator if eligible for Emergency Services only) in the first full month that an individual is both eligible and an inmate.
* If not already eligible, the worker enters the application in MEDS.
* On HMS04 (Primary Individual Screen), the worker must enter the Sponsor Code of 4010 (Richland County SCDC), 0000 (Richland County Miscellaneous Correctional Facility) or 4013 (Richland County DJJ). The sponsor code is a designation given to each facility to capture Medicaid work.
* On HMS04, enter “40” (Richland County Code) as the applicant’s county, regardless of which facility the inmate is in.
* On HMS04 (Primary Individual Screen) the worker must enter the address of the correctional facility in the Residence Address and enter the mailing address as:

South Carolina Department of CorrectionsCOA Attn: Medical4542 Broad River RoadColumbia SC 2910* All correspondence must be sent to the mailing address listed on HMS04 (Primary Individual Screen). Note**:** For DJJ detainees, the HMS05 (Authorized Representative) screen is completed.
* The Inmate Reason for Application on HMS04 must be “Y”.
* On HMS06, the Living Arrangement of CORF (Correctional Facility) must be entered.
* Note: For DJJ detainees, category ‘88’ must be entered in the CAT1 field on the HMS07 (Household Members) screen.
* If an application is withdrawn due to worker error, the inmate worker should ALWAYS enter “W” at the WITHDRAW APPLICATION (W/C/N) prompt on HMS04. This will not generate a notice unnecessarily.
* Once the application is locked in MEDS, the worker will proceed to ELD00 to determine eligibility for the inmate.
* The worker will ensure that the Sponsor Code on ELD00 (Medicaid Eligibility Decision) is 4010 (Richland County SCDC), 0000 (Richland County Miscellaneous Correctional Facility) or 4013 (Richland County DJJ).
* Set the next review date on ELD01 for one (1) year from the current date. The inmate cases will be reviewed annually as long as the individual is incarcerated.
* Do not set an anticipated closure date.
* The Specialty Unit Inmate Worker will ensure that the appropriate indicator is entered on the ELD02 screen in SERVICE TYPE. Enter an “I” for Inmate and a “C” for a non-citizen Inmate.
* The Specialty Unit Inmate Worker must enter/update the Service Type on ELD02 before AOD (pf24) even if the BG is being denied.
* Do not change the eligibility date to a date prior to July 1, 2004, nor submit corrections to change the eligibility. The Helpdesk will be notified not to key MEDS corrections if the Benefits Code = I, or C and the request is to add eligibility prior to July 1, 2004.
* Do not establish eligibility for an inmate in categories 48, 50, 52, 56, or 90. The only acceptable category for a DJJ Inmate is 88.
* MMIS will edit claims to ensure only in-patient claims are paid.

**Cúram Procedure:*** Reduce benefits by adding the “I” indicator for full months the individual is both incarcerated and eligible.
	+ If a beneficiary who is currently eligible for benefits becomes incarcerated, the reduced benefits should begin on the first day of the month after the beneficiary became incarcerated.
	+ If an individual who does not have current eligibility applies for and becomes eligible for benefits while incarcerated, the reduced benefits should begin on the first day of the first full month that the applicant was both incarcerated and eligible.
	+ When an individual applies prior to incarceration and is found eligible after he/she is incarcerated, he/she can receive full benefits prior to incarceration and reduced benefits starting the first full month of incarceration.
* See Job Aid:
	+ MAGI: [Processing Incarceration Evidence and Inmate Applications](https://schhs.sharepoint.com/sites/EES/Training/Curam/HCR/Job-Aids/Evidence/Processing%20Incarceration%20Evidence%20and%20Inmate%20Applications.pdf?csf=1&e=MB7hlk&cid=77004982-1991-4c2d-8c6d-f211abe8c4ef)
	+ CGIS: [Process\_Incarcerated\_Members\_JA.pdf](https://schhs.sharepoint.com/%3Ab%3A/r/sites/EES/Training/Curam/CGIS/Job%20Aids/Process_Incarcerated_Members_JA.pdf?csf=1&web=1&e=aDhs42)
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| **Procedure when an Inmate is Released** |
| **MEDS Procedure**:* If the incarcerated beneficiary with reduced benefits is released at any time during the month, the benefits will be regained on the first day of the month that the beneficiary is released.
	+ The worker removes the “I” or “C” indicator, so the individual’s benefits are no longer limited to inpatient services.

**Cúram Procedure:*** If the incarcerated beneficiary with reduced benefits is released at any time during the month, the benefits will be regained on the first day of the month that the beneficiary is released.
	+ The worker removes the “I” or “C” indicator.
* The worker encourages the individual to report any change of circumstance after release.
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102.09.02 In a Public Institution

(Rev. 04/01/16)

The following facilities are public institutions. Refer to each section to determine the proper treatment of residents for Medicaid benefits.

Institution for Mental Diseases

An institution for mental diseases is a hospital, nursing facility or other institution of more than 16 beds that primarily engages in providing diagnosis and treatment or care of individuals with mental diseases.

Individuals under age 22 may receive Medicaid while in an institution for mental diseases if they are receiving psychiatric services and are otherwise eligible for Medicaid.

Individuals between the ages of 22 and 65 are not eligible to receive any Medicaid benefits while residing in an institution for mental diseases.

Individuals aged 65 and older who are Medicaid eligible and have Medicare coverage may receive Medicaid benefits while residing in an institution for mental diseases. This includes psychiatric long term care facilities such as Tucker Center or Dowdy Gardner, and other Department of Mental Health facilities providing inpatient psychiatric care.

**Publicly Owned or Operated Detention Facilities, Forestry Camps, or Facilities Operated Primarily** **for the Detention of Children Found to Be Delinquent**

These facilities are not childcare institutions; therefore, their residents are not eligible to receive Medicaid benefits. If the facility is privately owned and/or operated, residents may be eligible for Medicaid if they are otherwise eligible.

**Residential Facilities on the Grounds of, or Adjacent to, a** **Large Public Institution**

Residential facilities located on the grounds of, or immediately adjacent to, a large public institution or multiple purpose complexes are public institutions; therefore, residents are not eligible to receive Medicaid benefits.

The Department of Juvenile Justice owns and operates a group home immediately adjacent to its primary secure facility. The group home is licensed as a childcare facility and residents may receive Medicaid benefits if they are otherwise eligible.

Correctional or Holding Facilities

These are facilities for individuals who are prisoners who have been arrested or detained pending disposition of charges, or who are held under court order as material witnesses or juveniles. (Refer to MPPM 102.09.01.)

102.09.03 Not In a Public Institution

(Eff. 10/01/05)

Because the following facilities are not public institutions, residents may receive Medicaid benefits, if they are otherwise eligible.

Medical Institution

A medical institution:

* Is organized to provide medical care, including nursing and convalescent care;
* Has necessary professional personnel, equipment, and facilities to manage the medical, nursing and other health needs of patients on a continuing basis in accordance with accepted standards;
* Is authorized under state law to provide medical care; and
* Is staffed by professional personnel who are responsible to the institution for professional medical and nursing services.

Intermediate Care Facility for the Intellectually Disabled

This is a facility that provides active treatment for individuals with intellectual disabilities.

Publicly Operated Community Residence

A publicly operated community residence:

* Is publicly operated;
* Serves and was designed or charged to serve 16 or fewer residents; and
* Provides some services beyond food and shelter such as social services, help with personal living activities or training in socialization and life skills.

**Exception:** If a facility meets these criteria but is on the grounds of, or adjacent to, a large public institutionor is a correctional or holding facility, the facility is a public institution and residents are not eligible for Medicaid.

**Childcare Institution**

A childcare institution serves children who receive Title IV-E or regular foster care payments. For a child to be eligible, the institution must be:

* Licensed by the state;
* A non-profit private childcare institution regardless of size; or
* A public childcare institution that accommodates 25 or fewer children.

Public Educational or Vocational Training Institution

Individuals attend these facilities to obtain an education or vocational training. Examples of such facilities are John de la Howe School, Will Lou Gray Opportunity School, and School for the Deaf and Blind. Children attending these facilities may receive Medicaid if they are eligible in their home living arrangement.

Temporary Arrangement While Awaiting Permanent Placement

Individuals may be temporarily placed in a public institution while they are awaiting placement in a living arrangement appropriate to their needs. The individual may be eligible for Medicaid if:

* He is in a Medicaid-reimbursable living arrangement;
* Arrangements for appropriate placement have been made for him/her to enter a Medicaid-eligible living arrangement; and
* He is otherwise eligible for Medicaid.

102.10 Marital Status

(Eff. 08/01/19)

[CFR §435.603](http://www.ecfr.gov/cgi-bin/text-idx?SID=0d5b433b4fd4f2544aa9f64e97c6c014&node=42:4.0.1.1.6.7.67.4&rgn=div8)

When resource and income limits and treatment of resources and income are affected by marital status, the following rules and definitions apply:

* South Carolina recognizes both legal and common law marriages.
* Effective November 20, 2014. South Carolina recognizes same-sex marriage.
* Common Law Marriage
	+ South Carolina does not recognize common-law marriages established on or after July 25, 2019.
	+ Refer to the Procedure Box below for information concerning Common Law Marriage.
* Separation
	+ In some programs, separated couples are considered individuals when determining eligibility. In these cases, treat them as individuals effective the month after the separation begins. (Refer to program-specific chapters for information on how to treat separated spouses.)
* Legally Divorced Individuals Who Reside Together
	+ Occasionally, individuals who are legally divorced will reside together for various reasons such as illness.
	+ If they agree that they do not present themselves as married, they are not considered married for Medicaid purposes.

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| **Procedure for Evaluating Marital Status** |
| **NOTE:** South Carolina does not recognize common-law marriages established on or after July 25, 2019.**Common Law Marriage – Considerations and Treatment*** If they consider themselves common law and the above applies, accept their statements, and consider them as married.
* If they agree they are not married at common law, and there is no evidence to the contrary, do not consider them as married.
* If they disagree, or there is evidence to the contrary, refer to [POMS SI 00501.152](http://policy.ssa.gov/poms.nsf/lnx/0500501152%21opendocument) for further instructions.

**Separated Spouses*** The separation is considered the month following the month the separation began.
* If the separation is questionable, obtain corroborating verification such as:
	+ Landlord statements
	+ Utility bills
	+ Collateral statements from two non-relatives, to include their address and phone numbers
	+ Refer to SC MPPM 304.08 for specific instructions for Nursing Home, Waivered Services, and General Hospital.

**Legally Divorced Individuals Who Reside Together*** Request a copy of the divorce decree.
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Appendix A Primary Evidence of Citizenship and Identity

(Eff. 01/01/14)

1. A U.S. passport, including a U.S. Passport Card issued by the Department of State, without regard to any expiration date if such passport or Card was issued without limitation.
2. A Certificate of Naturalization.
3. A Certificate of U.S. Citizenship.
4. A valid State-issued driver's license if the State issuing the license requires proof of U.S. citizenship or obtains and verifies a social security number from the applicant who is a citizen before issuing such license.
5. Documentary evidence issued by a Federally recognized Indian Tribe, as published in the [Federal Register by the Bureau of Indian Affairs](http://www.gpo.gov/fdsys/pkg/FR-2012-08-10/pdf/2012-19588.pdf) within the U.S. Department of the Interior, and including Tribes located in a State that has an international border, which –
	1. Identifies the Federally recognized Indian Tribe that issued the document;
	2. Identifies the individual by name; and
	3. Confirms the individual’s membership, enrollment, or affiliation with the Tribe.

Acceptable documents include, but are not limited to:

* + A Tribal enrollment card;
	+ A Certificate of Degree of Indian Blood;
	+ A Tribal census document;
	+ Documents on Tribal letterhead, issued under the signature of the appropriate Tribal official, that meet the requirements of paragraph (a)(5)(i) of this section.

Appendix B Evidence of Citizenship

(Eff. 01/01/14)

**Acceptable Documents
Must be accompanied by Proof of Identity (Appendix C)**

1. A U.S. public birth certificate showing birth in:
	* one of the 50 States,
	* the District of Columbia,
	* Puerto Rico (if born on or after January 13, 1941),
	* Guam,
	* the Virgin Islands of the U.S. (on or after January 17, 1917),
	* American Samoa,
	* Swain's Island, or
	* the Commonwealth of the Northern Mariana Islands (CNMI) (after November 4, 1986 (CNMI local time)).

The birth record document may be issued by the State, Commonwealth, Territory, or local jurisdiction. If the document shows the individual was born in Puerto Rico, the Virgin Islands of the U.S., or the CNMI before these areas became part of the U.S., the individual may be a collectively naturalized citizen.

1. A match with the Department of Health and Environmental Control, Bureau of Vital Statistics
2. A Certification of Report of Birth, issued to U.S. citizens who were born outside the U.S.
3. A Report of Birth Abroad of a U.S. Citizen.
4. A Certification of birth.
5. A U.S. Citizen I.D. card.
6. A Northern Marianas Identification Card, issued to a collectively naturalized citizen, who was born in the CNMI before November 4, 1986.
7. A final adoption decree showing the child's name and U.S. place of birth, or if an adoption is not final, a Statement from a State-approved adoption agency that shows the child's name and U.S. place of birth.
8. Evidence of U.S. Civil Service employment before June 1, 1976.
9. U.S. Military Record showing a U.S. place of birth.
10. A data match with the Systematic Alien Verification for Entitlements (SAVE) Program or any other process established by the Department of Homeland Security to verify that an individual is a citizen.
11. Documentation that a child meets the requirements of section 101 of the Child Citizenship Act of 2000 (8 U.S.C. 1431).
12. Medical records, including, but not limited to, hospital, clinic, or doctor records or admission papers from a nursing facility, skilled care facility, or other institution that indicate a U.S. place of birth.
13. Life, health, or other insurance record that indicates a U.S. place of birth.
14. Official religious record recorded in the U.S. showing that the birth occurred in the U.S
15. School records, including pre-school, Head Start and daycare, showing the child’s name and U.S. place of birth.
16. Federal or State census record showing U.S. citizenship or a U.S. place of birth.
17. If the applicant does not have one of the documents listed above, he or she may submit an affidavit signed by another individual under penalty of perjury who can reasonably attest to the applicant’s citizenship, and that contains the applicant’s name, date of birth, and place of U.S. birth. The affidavit does not have to be notarized.

Appendix C Evidence of Identity

(Eff. 01/01/14)

1. The following will be accepted as proof of identity, provided such document has a photograph or other identifying information including, but not limited to, name, age, sex, race, height, weight, eye color, or address:
	* Driver's license issued by a State or Territory (does not include driver’s license issued by a Canadian government authority).
	* School identification card.
	* U.S. military card or draft record.
	* Identification card issued by the Federal, State, or local government.
	* Military dependent's identification card.
	* U.S. Coast Guard Merchant Mariner card.
2. For children under age 19, a clinic, doctor, hospital, or school record, including preschool or day care records.
3. Two documents containing consistent information that corroborates an applicant’s identity. Such documents include, but are not limited to:
	* employer identification cards,
	* high school and college diplomas (including high school equivalency diplomas),
	* marriage certificates,
	* divorce decrees, and
	* property deeds or titles.
4. Finding of identity from a Federal or State governmental agency. The agency may accept as proof of identity a finding of identity from a federal agency or another State agency, including but not limited to a public assistance, law enforcement, internal revenue or tax bureau, or corrections agency, if the agency has verified and certified the identity of the individual.
5. A finding of identity by the South Carolina Department of Social Services (DSS).
6. If the applicant does not have any document specified above and identity verified by an appropriate agency as defined in 4 or 5, the applicant may submit an affidavit signed, under penalty of perjury, by another person who can reasonably attest to the applicant’s identity. Such affidavit must contain the applicant’s name and other identifying information establishing identity, as describe in paragraph (c)(1) of this section. The affidavit does not have to be notarized.

Appendix D Alien Status Chart

(Rev. 08/01/22)

For applications filed on or after January 1, 2018, children and pregnant women who are lawfully present but have not met the 5-year/40 quarter requirements can be approved for full Medicaid coverage if they meet all other eligibility criteria.

| **MEDICAID TREATMENT OF NON-CITIZENS** |
| --- |
| **VERIFICATION DOCUMENTATION** | **ALIEN STATUS** | ELIGIBILITY STATUS |
| * **I-551** (Alien Registration Receipt Card) commonly referred to as the “green card”
* **Foreign passport** stamped with an un-expired temporary I-551 stamp
* **I-94** annotated stamped with a temporary I-551 stamp (for recent arrivals or aliens who have applied for a replacement I-551)
 | LAWFULLY ADMITTEDFOR PERMANENTRESIDENCE (LPR) | Eligible for full Medicaid benefits if entered the US before August 22, 1996.If admitted August 22, 1996, or after, ineligible for full Medicaid benefits for 5 years from the date they entered the country or obtained qualified status, whichever is later. Eligible for emergency services only during the disqualification period.Eligible for full Medicaid benefits after the 5-year disqualification period **IF** they have 40 quarters of income that required payment of Social Security taxes.  |
| * **I-94** stamped showing admission under section 207 of the INA and date of entry to the United States
* **I-688B** (Employment Authorization Card) annotated 274a.12(a)(3)
* **I-766** (Employment Authorization Document) annotated “A3”
* **I-571** (Refugee Travel Document) **I-551** (Alien Registration Receipt Card) with a status code of RE6, RE7, RE8, or RE9.
 | **REFUGEE** | 5-Year Disqualification period does not apply.Can qualify for full benefits up to 7 years if meets all requirements for any Medicaid category.After 7 years, must meet citizenship requirements (40 work quarters) to establish eligibility.If they do not meet Medicaid categorical requirements, then they are eligible for full benefits for 12 months beginning with the month of entry. (Refer to MPPM Chapter 503) |
| * **I-94** stamped showing grant of asylum under section 208 of the INA and date of entry
* **A grant letter** from the Asylum Office of the USCIS
* **I-688B** (Employment Authorization Card) annotated “274a.12(a)(5)”
* **I-766** (Employment Authorization Document) annotated “A5”
* **Court order** of an immigration judge showing asylum granted under section 208 of the INA
 | **ASYLEE** | 5-Year disqualification period does not apply.Can qualify for full benefits up to 7 years if meets all requirements for any Medicaid category.After 7 years, must meet citizenship requirements (40 work quarters) to establish eligibility.If they do not meet categorical requirements, then they are eligible for full benefits for 12 months beginning with the month of entry. (Refer to MPPM Chapter 503) |
| * **Order** of an immigration judge showing deportation withheld under section 243(h) of INA as in effect prior to April 1, 1997, or removal withheld under Sec. 241(b)(3) of the INA and date of grant
* **I-688B** (Employment Authorization Card) annotated 274a.12(a)910)
* **I-766** (Employment Authorization Document) annotated “A10”
 | **DEPORTATION****WITHHELD** | 5-Year disqualification period does not apply.Eligible for any Medicaid category if they meet all other eligibility criteria. |
| * **I-94** annotated with stamp showing grant of parole under 212(d)(5) and a date showing granting of parole for at least one year
 | **PAROLEE**(Refer to **IRAQI /AFGHAN SPECIAL IMMIGRANTS** for Special Immigrant Parolees with an I-94 form showing SQ or SI Parole)(Refer to **UKRAINIAN HUMANITARIAN PAROLEE**) | Eligible for full Medicaid benefits if entered the US prior to August 22, 1996If admitted August 22, 1996, or after, ineligible for full Medicaid benefits for 5 years from the date they entered the country or obtained qualified status, whichever is later. Eligible for emergency services only during the disqualification periodEligible for full Medicaid benefits after the 5-year disqualification period **IF** they have 40 quarters of income that required payment of Social Security taxes. |
| * **I-94** with stamp showing admission under 203(a)(7) of the INA, refugee-conditional entry
* **I-688B** (Employment Authorization Card) annotated 274a.12(a)(3)
* **I-766** (Employment Authorization Document) annotated “A3”
 | **CONDITIONAL ENTRANT** | Eligible for full Medicaid benefits if entered the US prior to August 22, 1996If admitted August 22, 1996, or after, ineligible for full Medicaid benefits for 5 years from the date they entered the country or obtained qualified status, whichever is later. Eligible for emergency services only during the disqualification period.Eligible for full Medicaid benefits after the 5-year disqualification period **IF** they have 40 quarters of income that required payment of Social Security taxes. |
| * **Green Form DD-2** marked “ACTIVE”

OR* **Current orders** showing the individual is on full-time duty in the US Army, Navy, Air Force, Marine Corps, or Coast Guard (Reserves are not considered active duty.)
 | **ACTIVE-DUTY MILITARY****Includes spouse and unmarried dependent children under 21** | 5-Year disqualification period does not apply.Eligible for any Medicaid category if they meet all other eligibility criteria. |
| * **DD-214** indicating honorable discharge,

OR* **Discharge papers** indicating honorable discharge
 | VETERAN**Includes spouse and unmarried dependent children under 21** | Eligible5-Year disqualification period does not apply. |
| * **I-551** (Alien Registration Receipt Card) with the code CU6, CU7, or CH6
* **Foreign passport** stamped with an unexpired temporary I-551 stamp with the code CU6 or CU7
* **I-94** stamped with an unexpired temporary I-551 stamp with the code CU6 or CU7
* **I-94** with stamp showing parole as “Cuban/Haitian Entrant” under Section 212(d)(5) or the INA.
 | **CUBAN/HAITIAN ENTRANT** | 5-Year disqualification period does not apply.Can qualify for full benefits up to 7 years if meets all requirements for any Medicaid category.After 7 years, must meet citizenship requirements (40 work quarters) to establish eligibility.If they do not meet categorical requirements, then they are eligible for full benefits for 12 months beginning with the month of entry. (Refer to MPPM Chapter 503) |
| * **I-551** with code AM6, AM7, or AM8
* **Foreign passport** stamped with an unexpired temporary I-551 stamp with the code AM1, AM2, or AM3
* **I-94** stamped with an unexpired temporary I-551 stamp with the code AM1, AM2, or AM3
 | **AMERASIAN IMMIGRANTS** | 5-Year disqualification period does not apply.Can qualify for full benefits up to 7 years if meets all requirements for any Medicaid category.After 7 years, must meet citizenship requirements (40 work quarters) to establish eligibility.If they do not meet categorical requirements, then they are eligible for full benefits for 12 months beginning with the month of entry. (Refer to MPPM Chapter 503) |
| * **Iraqi or Afghan passport** with an immigrant visa stamp noting that the individual has been admitted under IV (Immigrant Visa)

**Category SI1 or SQ1**-Principal Applicant Iraqi Special Immigrant**Category SI2 or SQ2**-Spouse of Principal Applicant Iraqi/Afghan Special Immigrant**Category SI3 or SQ3**-Unmarried child under 21 years of age of Iraqi/Afghan Special Immigrant* **DHS Form I-551** (green card) showing Iraqi or Afghan nationality (or Iraqi or Afghan passport), with an IV (immigrant visa) code of:

**SI6 or SQ6-** Principal Applicant Iraqi Special Immigrant**SI7 or SQ7**- Spouse of Principal Applicant Iraqi/Afghan Special Immigrant**SI9 or SQ9**- Unmarried child under 21 years of age of Iraqi/Afghan Special Immigrant* **I-94** form showing SQ or SI Parole (per section 602(B)(1) AAPA/Sec 1059(a) NDAA 2006) with a **SQ4** or **SQ5** Class of Admission code
 | **IRAQI /AFGHAN SPECIAL IMMIGRANTS****Includes spouse and unmarried children under 21 years of Age** | 5-year disqualification period does not apply.Can qualify for full benefits up to 7 years if meets all requirements for any Medicaid category.After 7 years, must meet citizenship requirements (40 work quarters) to establish eligibility.If they do not meet Medicaid categorical requirements, then they are eligible for full benefits for 12 months beginning with the month of entry. (Refer to MPPM Chapter 503)Note**:** The date of eligibility for benefits of the Iraqi/Afghan Special Immigrant is the date the immigrant was admitted to the U.S. as an Iraqi or Afghan Special Immigrant, not the date of application for benefits and services. |
| * **Form I-94** noting humanitarian parole (per INA section 212(d)(5) or 8 U.S.C. §1182(d)(5))
* **Foreign passport** with DHS/CBP admission stamp noting “DT”
* **Foreign passport** with DHS/CBP admission stamp noting Uniting for Ukraine or “U4U”
* **Foreign passport** with DHS/CBP admission stamp noting Ukrainian Humanitarian Parolee or “UHP”
* **Form I-765** Employment Authorization Document (EAD) receipt notice with code C11
* **Form I-766** Employment Authorization Document (EAD) with the code C11
 | **UKRAINIAN HUMANITARIAN PAROLEE** | Ukrainian nationals who enter the United States as parolees on or between February 24, 2022, and September 30, 2023, are eligible for Medicaid or CHIP to the same extent as refugees.Eligibility for full benefits can begin no earlier than **June 1, 2022.** Prior to this date, eligibility is limited to Emergency Services Only.Five-year disqualification period does not apply. These Ukrainian parolees are considered “qualified non-citizens” for purposes of Medicaid and CHIP eligibility since they are eligible for the same benefits as refugees. If Ukrainian parolees do not meet the eligibility criteria for a full Medicaid benefit, evaluate for Refugee. Ukrainian nationals who are paroled into the U.S. after September 30, 2023, and are the spouse or child of a parolee described above, or who is the parent, legal guardian, or primary caregiver of a parolee described above who is determined to be an unaccompanied child will also be eligible for Medicaid and CHIP to the same extent as refugees. Eligible parolees can also include individuals other than Ukrainian nationals (i.e., individuals who are stateless or have another nationality) who last habitually resided in Ukraine. |
| * **I-797** indicating filing under one of the provisions listed below and approval of the petition or a finding that a prima facie case has been established.
* **Case Type: I-130** petition approved
* **Case Type: I-360** petition approved
* **I-551** with one of the following COA codes stamped on the lower left side of the back of a pink card demonstrates approval of a petition under C.3.j.(1)3. Above: IB1-IB3, IB6-IB8, B11, B12, B16, B17, B20-B29, B31-B33, B36-B38, BX1-BX3, or BX6-BX8
* **Order** from an immigration judge (EOIR) or the Board of Immigration Appeals granting suspension of deportation or cancellation of removal under VAWA (EOIR) Form 42B or an order from an immigration judge (EOIR) or Board of Immigration
 | **BATTERED ALIEN****Includes battered alien’s child and parent of a battered alien child** | Eligible if entered the US prior to August 22, 1996If admitted August 22, 1996, or after, ineligible for 5 years from the date they entered the country or obtained qualified status, whichever is later.Eligible after the 5-year disqualification period **IF** they have 40 quarters of income that required payment of Social Security taxes. |
| * **I-94** arrival/departure record,
* **I-94** arrival/departure record and foreign passport, or
* **I-766** Employment Authorization Document.
 | **Compact of Free Association (COFA) Migrants**COFA is an agreement between the United States and the three Pacific Island sovereign states of Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau—known as Freely Associated States. | **For coverage in December 2020 or after:**5-Year disqualification period does not apply.Eligible for any Medicaid category if they meet all other eligibility criteria.**For coverage before December 2020:*** Pregnant women and children are eligible for full Medicaid coverage,
* Medicaid coverage for other COFA migrants is limited to Emergency Services only
 |

| **ALIEN GROUPS LISTED BELOW ARE INELIGIBLE FOR ANY SERVICES****(Including Emergency Services)** |
| --- |
| Foreign StudentsVisitorsTouristsForeign government representatives on official business and their families and servantsCrewmen on shore leaveInternational organization representatives and their families and servantsTemporary workers (individuals allowed entry temporarily for employment purposes)Members of the foreign press, radio, film, etc., and their familiesShort-term parolees | Visa, Passports or Form I-766ORForm I-94, Arrival/Departure Record annotated with A to MORForm I-688, Temporary Resident Card annotated with Section 210 or 245AORForm I-688 A and B, Employment Authorization CardORForm I-185, Canadian Border Crossing CardORForm I-186, Mexican Border Crossing CardORForm SW 434, Mexican Border Visitor’s PermitORForm I-95-A, Crewman’s Landing Permit |