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* 1. Introduction

(Eff. 09/01/17)

This chapter provides policy and procedures related to determining eligibility for the following Medicaid programs:

* Aged, Blind and Disabled (ABD)
* Medicare Savings Programs (MSP), which include:
	+ Qualified Medicare Beneficiaries(QMB),
	+ Specified Low Income Medicare Beneficiaries (SLMB),
	+ Qualifying Individuals (QI)

303.01.01 Eligibility Criteria

(Eff. 09/01/17)

To qualify for ABD or MSP Medicaid categories, an individual must meet certain eligibility criteria to include categorical, non-financial and financial requirements.

303.01.02 Categorical Requirements

(Eff. 09/01/17)

An individual must be:

* Age65 or older (refer to MPPM 102.06.01);
* Blind, as defined by SSI rules (refer to MPPM 102.06.02); *or*
* Disabled, as defined by SSI rules (refer to MPPM 102.06.02).

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| **Note:** If the Social Security Administration has not established disability, it will need to be determined before eligibility can be established (refer to MPPM 102.06.02A).Additionally, some individuals receive disability payments such as Long-Term, Veterans’ and State Disability; however, receipt of these payments does not verify that an individual meets the SSI definition of disability. |

303.01.03 Non-Financial Requirements

(Eff. 09/01/17)

To qualify for assistance, an individual must meet certain non-financial requirements listed below. (Refer to MPPM Chapter 102 for specific information on these non-financial requirements.)

* Identity MPPM 102.02
* State Residency MPPM 102.03
* Citizenship/Alienage MPPM 102.04
* Enumeration/Social Security Number MPPM 102.05
* Assignment of Rights to Third Party Medical Payments MPPM 102.07
* Applying for and Accepting other Benefits MPPM 102.08
	1. Aged, Blind and Disabled (ABD) Introduction

(Eff. 09/01/17)

Section 9402 of the Omnibus Budget Reconciliation Act of 1986 (OBRA 86) created an optional coverage group for aged, blind or disabled individuals with family income at or below 100% of the Federal Poverty Level. This provision enabled states to provide the full range of Medicaid services to elderly and disabled individuals with low income. The South Carolina Medicaid program began covering these individuals effective 10/01/89.

303.02.01 ABD Eligibility

(Eff. 09/01/17)

* To be eligible for ABD, an individual does not have to be eligible for Medicare.
* There is a general income disregard of $50.
* ABD provides full Medicaid coverage.
* ABD recipients get a Healthy Connections (Medicaid) Insurance Card.
* ABD eligible cases are approved as Payment Category 32 in MEDS.

303.02.02 ABD Retroactive Period

(Eff. 09/01/17)

The retroactive period for ABD is the three (3) calendar months before the month in which the application is filed. A separate determination must be made for each retroactive month regarding:

* Categorical eligibility
* Actual income received in each month
* Actual resources in each month

303.02.03 Early Application for ABD

(Rev. 12/01/21)

Individuals may apply for ABD up to 3 months prior to becoming eligible for Medicare or turning age 65. If the person meets all other financial and non-financial eligibility criteria for ABD, the application can be approved in the system of record up to two months prior to the Medicaid effective date.

Example: Ms. Jackson turns age 65 in January. She is not disabled. She submits her application for Medicaid in October. In November, the Eligibility Specialist determines Ms. Jackson meets all eligibility criteria and approves Ms. Jackson for Medicaid effective January 1. The QMB indicator is added to Ms. Jackson’s case effective February 1.

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| **MEDS Procedure**1. Update the information on the Household Member Detail screen, HMS06
	1. Medicare Coverage should be entered as yes and have the Medicare number.
	2. SS Claim number should be entered as yes and have the social security claim number.
	3. TPL insurance should be entered as yes.
	4. Unearned income should be entered as yes if they are receiving SSA or SSDI.
2. Verify the Medicare Coverage screen, HMS08 has the beginning date for Part A and Part B.
3. When approving the budget group after you make decision (Shift F3) go to the Medicaid Eligibility Decision screen, ELD02 and update the Medicaid Begin date to the month the recipient will be turning 65 and then modify the update. Complete the case by acting on decision (Shift F12).
 |

303.03 Qualified Medicare Beneficiaries (QMB) Introduction

(Rev. 11/01/20)

Section 303 of the Medicare Catastrophic Coverage Act of 1988 (MCCA) required the State Medicaid program to pay the premiums (Part A and/or B) and cost sharing for individuals/couples with limited resources and incomes at or below 100% of the Federal Poverty Level. However, when ABD coverage started in October 1989, the QMB group was more or less “rolled up” into the ABD group and does not exist as a separate category.

QMB-eligible beneficiaries are entitled to cost sharing benefits not otherwise available to Medicaid beneficiaries. Therefore, it is mandatory to make a separate QMB determination for full benefit Medicaid eligible beneficiaries who are also eligible for Medicare.

303.03.01 QMB Eligibility

(Eff. 09/01/17)

QMB shares many of the same eligibility requirements as ABD, with the following exceptions:

* To be eligible for QMB, a beneficiary **must** have Part A of Medicare.
* The general disregard is $20 for an individual/couple.
* The effective date of QMB eligibility is the month following the month in which the eligibility determination is completed.
* The COLA Rebudget and Application/Redetermination Disregards do not apply to QMB.

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303.03.02 Dual Eligibility

(Rev. 11/01/20)

Any individual who is eligible for a full Medicaid benefit category and receives Medicare Part A must have a separate QMB determination. If an Eligibility Specialist determines an individual is qualified for QMB, they must code the ELD02 screen in MEDS with the correct indicator.

When budgeting a case, such as when processing a review or change, the Eligibility Specialist must compare the QMB result to the indicator in MEDS. If there is a change in QMB eligibility, the ELD02 screen must be updated in MEDS to reflect the correct eligibility.

303.03.03 QMB Retroactive Period

(Eff. 09/01/17)

There is no retroactive eligibility for QMB; however, if dually eligible for ABD/QMB, ABD eligibility may be established for a retroactive period.

303.03.04 Early Application for QMB

(Eff. 09/01/21)

Individuals may apply for QMB up to 3 months prior to becoming eligible for Medicare. If the person meets all other financial and non-financial eligibility criteria for QMB, the application can be held and approved for QMB the month after Medicare starts.

303.04 Specified Low Income Medicare Beneficiaries (SLMB) Introduction

(Eff. 09/01/17)

Section 4501 of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), requires Medicaid to pay Part B premiums for SLMB.

303.04.01 SLMB Eligibility

(Rev. 04/22/22)

SLMB policies are the same as those for ABD-SC, with the following exceptions:

* To be eligible for SLMB, an individual **must** have Part A of Medicare.
* The general disregard is $20.
* SLMB pays the Part B premium only.
* SLMB recipients do not get a Healthy Connections (Medicaid) Insurance Card.
* Medicaid does not pay:
	+ Medicare coinsurance and deductibles.
	+ Any Medicaid-covered services other than the Part B premium.
* SLMB eligible cases are approved as Payment Category 52.
* The COLA Rebudget and Application/Redetermination Disregards do not apply to SLMB.

303.04.01A SLMB Plus (Dual Eligibility)

(Rev. 05/01/22)

Any individual who is eligible in a full benefit category and receives Medicare Part A must have a separate SLMB Plus determination. Eligible categories include:

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| * PCAT 10: MAO NH
 | * PCAT 32: ABD-SC
 |
| * PCAT 14: MAO GH
 | * PCAT 33: ABD-SC NH
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| * PCAT 15: MAO WV (HCBS)
 | * PCAT 40: Working Disabled
 |
| * PCAT 16: ABD SSI Pass Along
 | * PCAT 57: TEFRA
 |
| * PCAT 19: ABD SSI Disabled Adult Children Pass Along
 | * PCAT 85: OSS
 |

Approving SLMB Plus for beneficiaries eligible for full Medicaid benefits allows SCDHHS to receive the appropriate federal matching funds to pay Medicare premiums. SLMB Plus does not provide any additional coverage or benefits for the individual.

SLMB Plus policies are the same as those for SLMB (Only), with the following exceptions:

* The beneficiary must be receiving full coverage benefits to qualify
* SLMB Plus **must** be explored if the beneficiary does not meet the QMB income limit

**NOTE:** The general disregard for ABD-SC is $50.00, but the general disregard for QMB is $20.00. This difference in the disregard will disqualify some ABD-SC beneficiaries from receiving QMB coverage. These beneficiaries will receive SLMB Plus coverage.

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| **Procedure**In CGIS, SLMB coverage will be authorized separately from the full coverage category. When the beneficiary is determined to be eligible for both SLMB coverage and a full coverage category, authorize the full coverage first in the authorization dialog box. The SLMB coverage will be authorized second in the hierarchy.**NOTE:** SLMB Plus eligibility can only be determined when CGIS is the System of Record. SLMB Plus eligibility cannot be processed in MEDS.1. Add the Medicare Benefit Evidence to the Income Support Application or the Income Support Case
2. Verify Medicare Parts A and B
3. Income Support Application-
	1. Apply the Benefit Evidence to the Income Support Application
	2. Check Eligibility
	3. Select Ready for Determination
	4. Select Authorize
	5. Authorize the full coverage category first and then SLMB coverage

**NOTE:** All decisions in Cúram-CGIS must be made at the same time on the Income Support Application.1. Income Support Case-
	1. Check Eligibility
	2. Apply the Benefit Evidence to the Income Support Case
	3. Return to the previous Check Eligibility
	4. Select the List Action Button
	5. Authorize the SLMB coverage

**NOTE:** Extend the Certification Period as appropriate based on current procedures and “Reassess” all active Product Delivery Cases (PDCs) to make the full coverage and the SLMB Plus coverage align in the System of Record (SOR). 1. The SLMB+ Indicator will display as “Y” in the Individual Eligibility Tab on the Person Page.
 |

303.04.02 SLMB Retroactive Period

(Eff. 04/22/22)

The retroactive period for SLMB or SLMB+ is the three (3) calendar months before the month in which the application is filed. A separate determination must be made for each retroactive month regarding:

* Categorical eligibility
* Actual income received in each month
* Actual resources in each month

**NOTE:** SLMB Plus eligibility can only be determined when CGIS is the System of Record. SLMB Plus eligibility cannot be processed in MEDS.

303.04.03 Early Application for SLMB

(Eff. 04/22/22)

Individuals may apply for SLMB or SLMB+ up to 3 months prior to becoming eligible for Medicare. If the person meets all other financial and non-financial eligibility criteria for SLMB, the person can be approved in MEDS or Cúram-CGIS up to two months before becoming eligible for Medicare, effective the month Medicare starts.

**NOTE:** SLMB Plus eligibility can only be determined when CGIS is the System of Record. SLMB Plus eligibility cannot be processed in MEDS.

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| **Procedure**1. Update the information on the Household Member Detail screen, HMS06
	1. Medicare Coverage should be entered as yes and have the Medicare number.
	2. SS Claim number should be entered as yes and have the social security claim number.
	3. TPL insurance should be entered as yes.
	4. Unearned income should be entered as yes if they are receiving SSA or SSDI.
2. Verify the Medicare Coverage screen, HMS08 has the beginning date for Part A and Part B.
3. When approving the budget group after you make decision (Shift F3) go to the Medicaid Eligibility Decision screen, ELD02 and update the Medicaid Begin date to the month the recipient will be turning 65 and then modify the update. Complete the case by acting on decision (Shift F12).

**Procedure Cúram-CGIS**1. When an applicant is only applying for SMLB coverage,
	1. Mark yes for Benefits when submitting/entering the Income Support Application
	2. Follow the collateral call process to try to obtain the information from the applicant/beneficiary or the Authorized Representative if the information was not provided on the application.
	3. If unable to verify via collateral call, **DO NOT** deny SLMB coverage prior to receiving a response from Interfaces.
	4. Place the Tracking Form in Follow-Up for 15-days to await the return of the BENDEX data. If there is no Tracking Form, the eligibility specialist must create one.
2. When a dual eligible applicant is applying and the full coverage category is ready for approval, but the Medicare has not been verified,
	1. Delete the Medicare benefits from the Income Support Application and approve the full coverage category.
	2. Add the Medicare Benefits back to the Income Support Case once the Full benefits are approved
	3. Follow the collateral call process to try to obtain the information from the applicant/beneficiary or the Authorized Representative if the information was not provided on the application.
	4. If unable to verify via collateral call, **DO NOT** deny SLMB prior to receiving a response from Interfaces.
	5. Place the Tracking Form in Follow-Up for 15-days to await the return of the BENDEX data. If there is no Tracking Form, the eligibility specialist must create one.
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303.05 Qualifying Individuals (QI) Introduction

(Eff. 09/01/17)

Effective January 1, 1998, Section 4732 of the Balanced Budget Act of 1997 required states to pay the Medicare Part B premiums for a mandatory group of low-income Medicare beneficiaries called Qualifying Individuals, or QI. States receive an annual allocation to permit Medicaid to pay Medicare Part B premiums for a limited number of Qualifying Individuals with income above 120% and less than 135% of the Federal Poverty Level (FPL.) The amount of the allocation is capped and based on the federal allotment. QI pays the Part B premium only. QI beneficiaries do not get a Healthy Connections Medicaid Card.

There are a limited number of slots available to help applicants with their Medicare Part B premium payment before reaching the CAP. Therefore, applicants are determined eligible on a first come, first serve basis. The number of beneficiaries receiving QI will be tracked and if the limit is reached, applications received after the cap has been reached must be denied. Eligibility workers will be notified if this procedure must be implemented.

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| **MEDS Procedure**Once the enrollment cap has been reached, deny new applications with the MEDS reason code 113, “We have reached out annual enrollment limit.” |

303.05.01 QI Eligibility

(Eff. 09/01/17)

QI policies are the same as those for ABD, with the following exceptions:

* To be eligible for QI, an individual **must** have Part A of Medicare.
* The general disregard is $20.
* QI pays the Part B premium only.
* QI recipients do not get a Healthy Connections (Medicaid) Insurance Card.
* Medicaid does not pay:
	+ Medicare coinsurance and deductibles.
	+ Any Medicaid-covered services other than the Part B premium.
* QI eligible cases are approved as Payment Category 48 in MEDS.
* The COLA Rebudget and Application/Redetermination Disregards do not apply to QI.

303.05.02 QI Retroactive Period

(Rev. 08/01/19)

QI Applications approved for the month of application can receive up to three months of retroactive eligibility without a separate eligibility determination provided the beneficiary had Medicare Part A during that period and there is no reason to believe resources or income exceeded the limit. Retroactive eligibility can begin no earlier than January of the year the application is submitted. If the QI application is denied, the applicant is not eligible for any retroactive coverage.

303.05.03 Early Application for QI

(Eff. 12/01/19)

Individuals may apply for QI up to 3 months prior to becoming eligible for Medicare. If the person meets all other financial and non-financial eligibility criteria for QI, the person can be approved in MEDS up to two months before becoming eligible for Medicare, effective the month Medicare starts. Refer to the procedure below for instructions for updating a Medicare recipient in the future

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| **Procedure**1. Update the information on the Household Member Detail screen, HMS06
	1. Medicare Coverage should be entered as yes and have the Medicare number.
	2. SS Claim number should be entered as yes and have the social security claim number.
	3. TPL insurance should be entered as yes.
	4. Unearned income should be entered as yes if they are receiving SSA or SSDI.
2. Verify the Medicare Coverage screen, HMS08 has the beginning date for Part A and Part B.
3. When approving the budget group after you make decision (Shift F3) go to the Medicaid Eligibility Decision screen, ELD02 and update the Medicaid Begin date to the month the recipient will be turning 65 and then modify the update. Complete the case by acting on decision (Shift F12).
 |

* 1. General Financial Criteria

(Eff. 09/01/17)

ABD and MSPs use the following general financial eligibility criteria.

303.06.01 Individual vs. Couple Cases

(Eff. 01/01/23)

Income and resource limits differ for “individual” versus “couple” cases. It is important to determine which limits to apply. Generally, an individual case is one for a single individual or one who is separated from a spouse. Similarly, a case is considered a couple case if both spouses reside together, even if only one is applying for benefits. However, under special circumstances, there are exceptions. See below for guidelines.

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| **Procedures for Determining “Individual” vs. “Couple” Cases:**Treat the applicant/beneficiary as an “Individual”, if:* The applicant/beneficiary has never married, is divorced, or is widowed.
* The applicant/beneficiary is separated from his/her spouse. This would apply to either type of separation:
	+ Marriage breakup
	+ Separation due to illness:
		- Spouse resides with a child who is providing care for him or both.
		- Spouse resides in a Nursing Facility or Residential Care Facility.
* The spouse is in the home but is an SSI recipient.
* The applicant/beneficiary is a minor child who is not married.

**Note:** Treat the spouse applying for non-MAGI coverage and the spouse in the facility as a couple to determine eligibility in the month the spouse entered the facility. Treat the spouse applying for non-MAGI coverage as an individual for the following months.* Month of Entry into Facility = Treat as a Couple
* Month following Facility Entry Date = Treat the Community Spouse as an Individual

**Note:** A legally divorced couple who reside together are budgeted as “individuals” in the determination. **Following the month of separation, an applicant/beneficiary is treated as an individual. When budgeting, be mindful of any income and resource allocations given to the individual from the spouse residing in a facility.**Treat the Applicant(s) as a “Couple” Case, if:* The applicant(s) is a married couple (legal or common law before July 24, 2019) and are:
* Residing together AND
* Neither is an SSI recipient.

**Example 1:** John Bell applied for Medicaid on April 15, 2022. He reported that he and his wife, Sally Bell, have been separated since December 2021. John Bell is treated as an individual to determine his eligibility for Medicaid. Sally is not entered as a Household Member in CGIS.**Example 2:** John Bell was approved for Medicaid effective April 1, 2022, as an individual. He reported that his wife, Sally Bell, returned home on June 10th, 2022. John and Sally Bell are treated as a couple effective June 1, 2022, to determine his continued eligibility for Medicaid. Salley must be added to John’s Household in CGIS using the Guided Change function.**Example 3:** Erica Smith applied for Medicaid on August 20, 2022. She reported that she separated from her spouse, Harry Smith, on August 2, 2022. Erica and Harry are treated as a couple in August. In September, Erica is counted as an individual. In CGIS, use the effective date of change in Harry’s Household Member evidence to end date the evidence for August 31, 2022.**Example 4:** Erica Smith was approved for Medicaid effective September 1, 2022, as an individual on August 30th. She reported that her separated spouse returned home on September 25, 2022. Erica and Harry are treated as a couple beginning September 1, 2022. In CGIS, edit Harry’s Household Member evidence to remove the end date (8/31/2022) because Harry left on August 2, 2022, and returned on September 25, 2022.**Note:** When a previously separated spouse returns home, the returning spouse is counted, and the current beneficiary must be reassessed using the couple limits in the month that the spouse returns home. When the return of a spouse is reported, it is important that the eligibility specialist determine the date of the return. If an exact date cannot be determined, the month of the spouse's return must be established to evaluate the eligibility.* The 15-day Adverse Action rule applies when coverage must be terminated due to ineligibility. (Refer to MPPM 101.09.03)
* If the spouse is not in the System of Record as a Household Member, add the spouse into Cúram-CGIS or MEDS household. (Refer to the [Add a Household Member (Guided Change) Job Aid](https://www1.scdhhs.gov/ees/TrainingPortal_NonMAGI/) for CGIS Case; refer to Supervisor for MEDS cases)

Note: If one member of the couple is applying for MSP or ABD and the other member receives Home and Community Based Services, they are still considered a couple. |

303.06.02 Financial Requirements

(Eff. 01/01/23)

To qualify for assistance, an individual must meet certain financial requirements for each program.

**Income**

The individual or couple must have income at or below the appropriate percentage of Federal Poverty Level (FPL) as defined for each program. Refer to MPPM 103.05 for the specific income amounts.

|  |  |
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| **Program** | **Countable Income Limit** |
| ABD and QMB | Less than or equal to 100% FPL |
| SLMB | Greater than 100% and Less than or equal to 120% FPL |
| QI | Greater than 120% and Less than or equal to 135% FPL |

**Resources**

An applicant’s countable resources must be at or below the following established limits which are normally adjusted annually:

* $9,090 for an Individual
* $13,630 for a Couple

303.06.03 Income

(Eff. 09/01/17)

Income is the receipt of any assets, payments, or property in a specified period, which the client may use to meet basic needs for food or shelter. Such use may be through sale or conversion. Refer to MPPM Chapter 301 for general information regarding the income issues listed below.

* Cash vs. In-kind (**Note:** In-kind income is not countable in the eligibility determination.)
* Earned vs. Unearned
* Countable vs. Exclusions
* Verification and Documentation

303.06.03A Social Security, Railroad Retirement, and Federal Poverty Level (FPL) COLAS

(Rev. 04/22/22)

Income limits for these programs increase each year when the Federal Poverty Level increases. Typically, this is effective in March. However, Cost of Living Allowances (COLAs) for benefits such as SSA are generally effective on January 1 each year. Because these changes occur at different times, three processes/disregards related to the COLA have been developed.

**I. Annual COLA Application/Review Process** (Applies to ABD-SC, QMB, SLMB Plus, and QI)

Eligibility determinations made in January and February may use the gross benefit before the cost of living adjustment increase for applications and re-determinations. In March when the new FPL is effective, the record must be re-budgeted using the gross benefit for the current year. For ABD-SC cases, if the beneficiary is over the income limit at the annual COLA re-budget; refer to Section II, COLA Rebudget Disregard.

**II. COLA Rebudget Disregard** (Applies to ABD-SC only)

If at the annual COLA rebudget a Medicaid beneficiary loses ABD-SC Medicaid eligibility due to the increase in his or her Social Security or Railroad Retirement payment, the most recent Social Security or Railroad Retirement COLA increase received by the beneficiary may be disregarded.

**III. COLA Application/Redetermination Disregard** (Applies to ABD-SC only)

Applicants and beneficiaries over 100% of FPL at application or re-determination using the current year’s Social Security or Railroad Retirement benefits can disregard the most current COLA increase received by the applicant/beneficiary to establish eligibility if the disregard has not been given in a prior Medicaid eligibility period. A prior period is established when there is a lapse in Medicaid coverage of more than three months. If a beneficiary has maintained continuous Medicaid Eligibility, regardless of changes in category, the disregard can be given when needed.

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| **Procedure for COLA Application/Redetermination Disregard**1. Budget eligibility using current income
2. If applicant/beneficiary is eligible, approve case or continue eligibility.
3. If applicant/beneficiary is not eligible, print completed budget for the case record.
4. Complete second budget using the current Social Security and/or Railroad Retirement benefit and apply a disregard of the most current COLA increase received by the applicant/beneficiary if not given in a prior eligibility period. Enter that amount of the COLA to be being disregarded in the Budget Workbook. Print the second budget for the case record.
5. If the applicant/beneficiary is eligible, approve/continue eligibility in MEDS.
6. If the applicant/beneficiary is ineligible, deny/close case in MEDS.
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| **Example #1: Applicant applies prior to Federal Poverty Level (FPL) increase**Gloria Lane applied for ABD on January 15, 2017. Her only income is Social Security.  January 2017 - $1,041 (Received $3 COLA) January 2016 - $1,038 The income limit in January 2017 is $990. All other eligibility criteria have been met.* $1,041 – $50 (General Income Disregard) = $991
* $991 > $990

Since Ms. Lane is not eligible using her current income, use the Annual COLA Application/ Review Process. Determine her eligibility using the amount of Social Security she received prior to the last COLA. * $1,038 (SSA received in 2017) – $50 (General Income Disregard) = $988
* $988 < $990

Ms Lane is eligible for ABD.Rebudget Ms. Lane’s case for March 2017 when the FPL limits are updated. The income limit for March 2017 is $1,005.* $1,041 – $50 (General Income Disregard) = $991
* $991 < $1,005

Ms. Lane continues to be Medicaid eligible.**Example #2: Applicant applies after the FPL increase**Jamie Summers applies for ABD on March 29, 2017. Her only income is Social Security disability. Her 2017 gross benefit is $1,056. The most current COLA she received was in January 2017 in the amount of $3. All other eligibility criteria have been met.* $1,056 – $50 (General Income Disregard) = $1,006
* $1,006 > $1,005

Ms. Summers is not eligible based on her 2017 Social Security. Use her current SSA income and disregard the most current COLA to determine eligibility.* $1,056 – $3 (Disregard 2017 COLA) = $ 1,053
* $1,053 – $50 (General Income Disregard) = $1,003
* $1,003 < $1,005

Ms. Summers is eligible for ABD by disregarding the 2017 Social Security COLA. |

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303.06.03B Income Considerations

(Eff. 09/01/17)

If the applicant is an adult, consider the income of the following:

* Applicant
* Spouse, if residing in the home and not an SSI recipient
* Minor natural, adopted, or step child(ren) – for allocation purposes only

If the applicant is a child, consider the income of the following:

* Applicant
* Natural, adopted, or step parent(s) residing in the home – for deeming purposes
* Natural, adopted, or step siblings – for allocation purposes

303.06.03C Income Budgeting

(Eff. 09/01/17)

* The source and gross amount of all earned and unearned income must be verified.
* Not all income is countable.
* Income that is excluded under Federal Law must be determined.

**Allocation**

An allocation may be made for natural, adopted, or step children of the applicant/ beneficiary or spouse in the home.

* A child is someone who is neither married nor the head of a household and is:
	+ Under age 18; or
	+ Under age 22 and regularly attends school, college, or training designed to prepare him for a paying job. School attendance must be verified. Refer to [POMS 00501.020](http://policy.ssa.gov/poms.nsf/links/0500501020)
* The maximum allocation per child is determined as follows:

Couple SSI FBR – Individual SSI FBR = Maximum Allocation

* The child’s allocation is determined as follows:

Maximum Allocation – Child’s Income (Earned and Unearned) = Allocation Amount

* For ABD, QMB, SLMB and QI, the child allocation amount changes each year when the new FPL income limits become effective

**Deeming**

When the applicant is a minor child, you must consider the income of the ineligible parents to determine what portion is available to meet the child’s needs. If there are ineligible children in the home, a portion of the parent(s)’s income may be allocated to them. The parents are then allowed the same earned and unearned income exclusions as an applicant. After such exclusions, an amount equal to the SSI Federal Benefit Rate is deducted (Individual or Couple, depending on the situation). Any remaining income is considered unearned income to the applying child. Refer to MPPM 301.11 and MPPM Chapter 301 Appendix A for additional information.

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| **Procedures – Basic Income Considerations:****Adult Applicant – No Dependent Children*** Unearned Income:
* Verify the source and gross amount of all unearned income for the applicant and the spouse, if applicable.
* Total the gross income.
* Exclude any unearned income as authorized by Federal Laws (Refer to MPPM Chapter 301)
* Apply $50 general disregard (given only once in couple cases)
* Earned Income:
* See section 301.04.08 for earned income verification procedures on reported income. Verify the source and gross amount of all earned income for the applicant and the spouse, if applicable.
* Total the gross earned income.
* Exclude any income as authorized by Federal Laws.
* Apply other exclusions in the following order:
* Earned income tax credit payments
* Up to $30 of earned income in a quarter, if it is infrequent or irregular (Refer to MPPM 301.04.09.)
* Up to $400 per month, but not more than $1,690 in a calendar year, of the earned income of a blind or disabled child under 22 years of age who is attending school
* Any portion of the $50 monthly general income exclusion which has not been excluded from unearned income in that some month
* $65 of earned income in a month (given only once in couple cases)
* Earned income of disabled individuals used to pay impairment-related work expenses
* One-half of total remaining earned income in a month
* Earned income of blind individuals used to meet work expenses
* Any earned income used to fulfill an approved plan to achieve self-support

Total remaining unearned and earned income and compare to the applicable limit. |

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| **Adult Applicant – With Dependent Child**Adult* Unearned Income:
* Verify the source and gross amount of all unearned income for the applicant and the spouse, if applicable.
* Total the gross income.
* Exclude any unearned income as authorized by Federal Laws (Refer to MPPM Chapter 301.)
* Apply $50 general disregard (given only once in couple cases)
* Earned Income:
* Verify the source and gross amount of all earned income for the applicant and the spouse, if applicable.
* Total the gross earned income.
* Exclude any income as authorized by Federal Laws.
* Apply other exclusions in the following order:
* Earned income tax credit payments
* Up to $30 of earned income in a quarter if it is infrequent or irregular (Refer to MPPM 301.04.09.)
* Up to $400 per month, but not more than $1,690 in a calendar year, of the earned income of a blind or disabled child under 22 years of age who is attending school
* Any portion of the $50 monthly general income exclusion which has not been excluded from unearned income in that some month
* $65 of earned income in a month (given only once in couple cases)
* Earned income of disabled individuals used to pay impairment-related work expenses
* One-half of total remaining earned income in a month
* Earned income of blind individuals used to meet work expenses
* Any earned income used to fulfill an approved plan to achieve self-support
* Total remaining unearned and earned income.
* Subtract allocation for any ineligible child/children (See steps below.)
* Compare remainder to the appropriate income limit.

Child/Children’s Allocation* Determine the child’s income.
* Subtract from the allocation amount for a child.
* The remainder is the total allocation for the child.
* If there is more than one child, do the above for each child and total.

Subtract total allocation from the parent’s income as shown above. |

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| **Minor Child Applicant**Ineligible Parent(s)’ Allocation to Ineligible Children* Determine parent(s)’ unearned income after exclusions.
* Subtract an allocation for each ineligible child and total (Refer to steps under adult applicant with dependent child.)
* Determine parent(s)’ earned income.
* Subtract any unused allocation.

Deeming to Eligible Child* Remaining unearned income from allocation step:
* Subtract $50 general income exclusion (only given once, even if both parents are in the home and have income).
* Remainder is countable unearned income.
* Remaining earned income:
* Subtract any remaining general income disregard.
* Subtract $65 work expense exclusion.
* Subtract one-half of remaining earned income.
* Remainder is countable earned income.
* Add countable unearned and countable earned income.
* Subtract the parent(s), personal allocation (Individual SSI FBR for an Individual or a couple.)
* The remainder is the amount of income available for deeming.

Income Determination for Eligible Child* Unearned income calculation:
* Begin with the amount of income available for deeming from previous step.
* Add child’s unearned income.
* Subtract $50 general income exclusion.
* Obtain total countable unearned income.
* Earned income calculation:
* Begin with child’s gross earned income.
* Subtract $65 work expense exclusion.
* Subtract one-half of remaining income.
* Obtain net earned income.
* Subtract any Plan for Self-Support (PASS) amount.
* Obtain countable earned income.

Total countable unearned and earned income and compare to the income limit for an individual.**Note:*** Earned income is never reduced below zero.
* Any unused earned income exclusion is **never applied** to unearned income.
* Any unused portion of a monthly exclusion **cannot be carried over** for use in a subsequent month.
* The $50 general and $65 earned income exclusions are **applied only once to a couple**, even when both members have income (whether eligible or ineligible), since the couple’s earned income is combined in determining eligibility.
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303.06.04 Resources

(Eff. 09/01/17)

To be eligible, an individual’s or couple’s resources must be considered. Refer to MPPM Chapter 302, Liberal SSI Resource Policy, for general information on what a resource is, liquid vs. non-liquid resources, and resource exclusions.

303.06.04A Verification and Documentation

(Eff. 09/01/17)

Resources must be verified and documented in the case record.

* Verification is substantiation or authentication of submitted information.
* Documentation is the written record of verified information and methods used.

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| **Procedure for Verification:*** Refer to the resource chapter for acceptable forms of:
	+ Verification
	+ Rebuttal evidence
* Verify and document any alleged resources.

**(Exception:** Verification of value is not required for resources that are totally excluded, regardless of value, but ownership must be verified for excluded Homestead property and excluded automobiles.)* Verify and document any resources revealed through IEVS checks.
* Property checks are not required if ownership is not alleged.

**Note:** If each member of a couple has life insurance, each is entitled to the exclusion if the total face values for each person are below $10,000.**Example:** Mr. Brown has life insurance totaling $5,000. Mrs. Brown has $4,000 in life insurance. No cash value is counted for either. |

303.06.04B Resource Considerations

(Eff. 09/01/17)

If the applicant/beneficiary is an adult, consider the resources of the following:

* Applicant/beneficiary
* Spouse, if residing in the home and not an SSI recipient.

If the applicant/beneficiary is a child, consider the resources of the following:

* Applicant/beneficiary
* Parent(s) residing in the home – for deeming purposes.

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| **Procedure for Deeming Resources to an Eligible Child**1. Determine the countable resources of the parent. Allow all exclusions and deductions from the parent’s resources.
2. Subtract the applicable resource limit from the countable resources.
3. Deem the remaining resources to the child.
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303.07 Application Process

(Eff. 09/01/17)

303.07.01 Standard of Promptness

(Eff. 09/01/17)

Federal rules require that applications be approved or denied within certain time frames. These standards are:

* 45 days from the date the application was filed
* 90 days from the filing date in cases requiring a determination of disability or blindness

(For allowable exceptions to the Federally-mandated Standard of Promptness and applicable procedures, refer to MPPM 101.08.02.**)**

303.07.02 Application Form and Intake of Applications

(Rev. 12/01/19)

* Applications may be filed in person or by mail.
* The following applications can be used to apply for QI:
	+ The DHHS Form 3400, Healthy Connections Application, and the DHHS Form 3400-A, Additional Information for Select Medicaid Programs; and
	+ Electronic applications for Medicare Savings Programs (MSP) received from the Social Security Administration

**Note:** The DHHS Form 914, Application for Medicare part B Premium Assistance for Qualifying Individuals (QI), has been removed from general circulation, but can still be used if received by the agency. Additional information will be needed before making a final decision and can be obtained either by calling the applicant or requesting a DHHS Form 3400-A be completed.

* The application date is the date a signed application form is received at a DHHS office. (**Note:** An application form received unsigned is NOT considered an application; it MUST be returned to the applicant/authorized representative for a signature. The date the returned application form is received by a DHHS office with the required signature is the application date.)
* If an interview is needed it may be conducted either in person or by telephone.
* Any necessary verification is requested using the [DHHS Form 1233 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201233%20ME.pdf), Medicaid Eligibility Checklist, giving reasonable time for it to be returned.

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| **Procedures for Applications:****Mail-In Applications:*** Review for completeness.
* Contact the applicant/authorized representative if:
* All questions are not answered
* Clarification is needed
* If needed, conduct either a face-to-face or telephone interview.

**All Applications:*** Conduct an interview if needed.
* Whether there is an interview or not, make sure the applicant/authorized representative is advised of:
* Eligibility requirements
* Standard of Promptness
* Right to a Fair Hearing and how to request one
* The applicant’s Civil Rights
* The applicant’s responsibilities:
* Give complete and accurate information,
* Report changes in circumstances within 10 days of the change
* The requirement to repay funds received ineligibly
* Verification process
* The computer matching process (IEVS)
* The type and scope of Medicaid services, including the availability of retroactive coverage
* All appropriate pamphlets and brochures
* Evaluate the information provided by the applicant/authorized representative.
* Verification:
* Obtain verification of:
	+ - Any questionable non-financial information
		- All alleged income: See MPPM 301.04.08 for procedures for earned income verification of reported income
		- All alleged resources
	+ Verification can be requested from:
		- The applicant/authorized representative using DHHS Form 1233 ME giving:
			* A list of necessary verifications
			* A reasonable length of time to provide needed information
		- Third Parties, such as:
			* Court House records ([DHHS Form 1255 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201255%20ME.pdf))
			* Banks
				+ Asset Verification System (AVS),
				+ [DHHS Form 1253 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201253%20ME.pdf) if already in the record or if unable to verify with AVS)
			* Insurance Companies ([DHHS Form 1280 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201280%20ME.pdf))
	+ All information/verification must be
		- Documented in the case record, and
		- Evaluated using the program requirements.
	+ Budget all income and resources and apply appropriate limits.
	+ Disposition:
	+ Approval
		- Approve, if all eligibility criteria is met.
		- MEDS will generate a notice giving the effective date of eligibility.
		- Notify any other agencies or departments as needed, such as Third Party Liability regarding other insurance coverage.
	+ Denial
		- Deny, if any one eligibility factor is not met.
		- MEDS will generate a denial notice which includes:
			* Reason for denial (make sure correct code is entered into MEDS).
			* Supporting Medicaid MPPM Section reference.
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| **LIS Application from SSA*** Central Eligibility
	+ Evaluate Application
		- Send Exception Letter if the applicant is currently eligible
		- If the reported income is less than or equal to 100% FPL, pend the application for ABD (PCAT 32)
		- If the reported income is greater than 100% FPL and less than or equal to 120% FPL, pend the application for SLMB (PCAT 52)
		- If the reported income is greater than 120% FPL and less than or equal to 150% FPL, pend the application for QI (PCAT 48)
		- If the reported income is greater than 150% FPL, deny the application
	+ The DHHS Form 3400-A, Additional Information for Select Medicaid Programs, will be sent to the applicant if the application is pended in MEDS
	+ The application will be virtually printed into OnBase if the case is pended in MEDS
* Local Eligibility
	+ Applications will be placed in WLP and general workflow
	+ If the DHHS Form 3400-A is returned within 30 days, process the application
	+ If the DHHS Form 3400-A is not returned within 30 days, deny the application for failure to return information

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303.08 Annual Review for ABD, QMB, SLMB and QI

(Rev. 11/01/18)

An annual review is required for the ABD, QMB, SLMB and QI programs.

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| **Procedure for Annual Review:** 1. MEDS generates a review form based on the Next Review Date.
2. Eligibility Worker responsibilities:
* Acknowledge the receipt of the review form into MEDS.
* Compare the information on the form to the CR history:
	+ Noting any alleged changes or discrepancies
	+ Contacting PI/AR to clarify information or request any verification
	+ Ensuring Income and Resource verifications are current through such methods as:
		- Requesting verification from the PI/AR
		- Obtaining necessary information/verification from third parties through such methods as:
			* Sending forms and letters, such as,
				+ [DHHS Form 1255](http://medsweb.scdhhs.gov/EligibilityForms/FM%201255%20ME.pdf);
				+ [DHHS Form 1280](http://medsweb.scdhhs.gov/EligibilityForms/FM%201280%20ME.pdf);
				+ [DHHS Form 1212](http://medsweb.scdhhs.gov/EligibilityForms/FM%201212%20ME.pdf);
				+ [DHHS Form 1253 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201253%20ME.pdf) (If unable to verify with AVS)
				+ letter to a funeral home;
				+ Civil Service
			* Telephone contact – make sure to document the following:
				+ Date of Contact;
				+ Company/Business Name;
				+ Phone Number;
				+ Individual’s Name (and Title, if possible) that provided the verification
			* On-line Internet searches such as
				+ Asset Verification System (AVS);
				+ Property search/Verification of Car Values
		- Checking all available data matches such as IEVS; BENDEX; SDX; State Retirement; ESC Wage Match; Unemployment; CHIP; and Person Composite Service (PCS) Wage Verification
	+ Once all verifications have been obtained and documented, do budget to determine continual eligibility:
	+ If continually eligible, update MEDS information – **Note:** Date of Next Review
	+ If ineligible, begin closure actions in MEDS.
	+ Determine if the individual would be eligible in any other Payment Category. If so, take appropriate actions to change category.
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303.09 Case Examples

(Eff. 01/01/18)

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| **Example #1 – Aged Individual****Scenario:** Carl Wade, date of birth 06/24/44, applies for Medicaid. He mails a completed, signed application to the local office along with a copy of his driver’s license. It is received on July 5. He alleges his only income for the year has been $750 per month in Social Security. Alleged resources are a checking account, an irrevocable pre-need burial contract worth $6,500, and a 2010 Toyota. A $7,000 CD matured in May, was deposited into the checking account, and then used to purchase the pre-need. He has Medicare Part A and B. He was hospitalized in April and has requested retroactive coverage. The application is processed on August 10.**Analysis:** Categorical Eligibility – Aged (verified by driver’s license)Verification Needed:* Verification of SSA - BENDEX; SVES query, SSA letter
* Low Balance of Checking Account for April, May, June, and July (copies of statements, AVS or [DHHS Form 1253 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201253%20ME.pdf))
* CD – Verification of:
	+ April Balance
	+ Redemption date and amount
	+ Deposit into checking account (checking statement)
* Copy of Pre-need Contract
* Medicare Coverage (BENDEX; copy of card)

**Note:** It would be good to verify the Toyota (copy of registration). However, it is not required since one vehicle is totally excludable regardless of value.Verified Information:* BENDEX verifies:
	+ Gross SSA of $950
	+ DOB – aged so categorical criteria is met
* DHHS 1253 from the bank verifying:
	+ CD Balance of $7000 in April and it’s redemption for that amount on May 2
	+ Checking:
		- Low Balances of $200 for April; $800 in May, $150 in June, and July balance of $450.
		- Deposit of $7000 on May 2 from CD
		- Non interest bearing account
	+ Copy of Pre-need verifying it is irrevocable and was purchased on May 30.

**Budgeting:**Income* ABD: $950 – $50 = $900
* QMB: $950 – $20 = $930

Resources:* April: $200 (checking) + $7,000 (CD) = $7,200
* May: $800 (checking) only. Pre-need is irrevocable after 30 days and is not a resource. CD was deposited into the checking account and used to purchase the pre-need.
* June: $150
* July: $450 (checking)

**Disposition:** Mr. Wade is over age 65 and meets the Aged categorical requirement. For April, his income was below the limit. However, his countable resources exceeded the individual resource limit. He meets both the income and resource criteria for May, June, and July. He is denied for April for excess resources and approved for ABD effective May 1. His also meets the QMB income limit. His QMB eligibility is effective September 1 (the month after the determination is completed). |

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| **Example #2 – Applicant’s Spouse is on SSI****Scenario:** Eva Banks applied for ABD Medicaid on January 15, 2017, at her local office alleging disability. She worked until April 2016 when she was diagnosed with cancer. Her insurance lapsed effective January 1, and she will be unable to return to work. She did not request retroactive coverage. She receives a Long Term Disability check for $800 per month so she has not applied for Social Security yet. Her husband receives SSI and SSA. They have two children, ages 13 and 16. Each child receives $120 per month in SSA; the children are eligible for PHC. She has a checking account with $500, a Life Insurance policy with a face value of $5,000, savings of $800, and a 2010 Ford Taurus.**Analysis:** Categorical Eligibility – She is under age 65 and disability must be established.Verification Needed:* Disability determination
* Proof she applied for Social Security Disability
* Gross Long Term Disability Benefit (check stub or letter)
* Copy of Life Insurance policy
* January Bank statement for checking and savings
* Children’s gross Social Security benefits
* Verification husband is a SSI recipient

(**Note:** Verification of the automobile is not required since the one vehicle is totally excluded regardless of value.)Verified Information:* MAO 99 dated February 10, 2017, verifies disability onset date as October 1, 2016.
* Copies of Long Term Disability check stubs for January 2017 verify gross of $800 per month.
* Copy of Life of Georgia policy verifies FV = $5,000.
* Bank statement for January 2017 verifies:
	+ Checking account is non-interest bearing and had a low balance of $75 in January.
	+ Savings account accrues quarterly interest with the last payment in December for $2.25 and a January balance of $802.25.
* Social Security letter of February 2017 verifies she applied for disability.
* SDX of February 4, 2017 verifies husband receives SSI and SSA.
* BENDEX of February 4, 2017, verifies the two children receive $120 each in SSA benefits for 2016 and 2017 based on the father’s Social Security benefit.
* BENDEX of February 15, 2017, verifies no SSA benefits for her at this point.

**Budgeting:**Initial eligibility determination based on 2016 Income and Income Limits:* Unearned: $800 – $50 (general disregard) = $750

(**Note:** Mr. Banks’ income is excluded since he is a SSI recipient.)* Earned: $0 – $0 = $0
* Total: $750 + $0 = $750
* Allocation: Maximum allocation for 2016 is $367 per child
	+ Child A: $367 – $120 = $247
	+ Child B: $367 – $120 = $247
	+ Total Allocation $247 + $247 = $494
* Countable Income: $750 – $464= $256 which is < $990 (2016 Income Limit)

2017 Income Limit rebudget in March* Unearned: $800 – $50 (general disregard) = $750

(**Note:** Mr. Banks’ income is excluded since he is a SSI recipient.)* Earned: $0 – $0 = $0
* Total: $750 + $0 = $750
* Allocation: Maximum allocation for 2017 is $368 per child
	+ Child A: $368– $120 = $248
	+ Child B: $368– $120 = $248
	+ Total Allocation $248 + $248 = $496
* Countable Income: $750 – $496= $254 which is < $1,005 (2017 Income Limit)

Resources:* $75 + $802.25 = $877.25 which is < $7,560 (individual limit since spouse is on SSI)

**Disposition:** Ms Banks meets all of the eligibility criteria and may be approved effective January 1, 2017.**Note:** Ms. Banks must be advised to report if she begins receiving SSA. However, the eligibility worker is responsible for follow up. This may be done by checking BENDEX data, sending an SVES query, or requesting verification from Ms. Banks. |

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| **Example #3 – Aged Couple****Scenario:** Fred and Ethel Jones, dates of birth 03/14/34 and 02/25/35, apply for Medicaid. Their application is received on March 2, 2017, and retroactive coverage is requested. According to the application, Mr. Jones receives a Social Security check for $735, and his wife receives $850. They have a checking account at People’s Bank. Both have Medicare Part A and B. They state they own a mobile home, a 2009 Ford Taurus and a 2008 Ford Ranger. Both have a $10,000 life insurance policy, but the company name and policy numbers are not listed.**Analysis:** Categorical Eligibility – both are Aged**Steps for Eligibility Worker:*** Send the [DHHS Form 1233 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201233%20ME.pdf), Medicaid Eligibility Checklist, to Mr. and Mrs. Jones requesting:
	+ Copies of the Life Insurance policies (also send the [DHHS Form 1280 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201280%20ME.pdf), Verification of Life Insurance Values, for their signatures in case they are needed).
* Check BENDEX for verification of the gross SSA amounts; send a SVES query if needed
* Send a [DHHS Form 1255 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201255%20ME.pdf) Property check or perform an On-line property search
* Create individual AVS requests for Mr. and Mrs. Jones

Mr. and Mrs. Jones return to the eligibility worker their March 10th bank statement and the first page of their life insurance policies with Liberty Life. VerifiedInformation**:*** Bank Balances:
	+ AVS verifies:
		- December 2016: $1,800 balance
		- January 2017: $1,347 balance
		- February 2017: $2,680 balance
		- March 2017: $1,098 balance
* On-line property search verifies only the mobile home (homestead) and the two vehicles alleged on the application. (**Note:** It is not necessary to verify the values of the two vehicles since they are both excluded regardless of value.)
* Copy of the Life Insurance policies indicates the face value is $10,000 each, excluded
* BENDEX verify gross SSA amounts:
	+ - Mr. Jones: 2016: $733.00 2017: $735.00
		- Mrs. Jones: 2016: $848.00 2017: $850.00

**Budgeting:*** December 2016:
	+ Income:
		- $733 + $848 = $1,581 – $50 (general disregard) = $1,531. (**Note:** This exceeds the ABD limit of $1,335.)
		- SLMB Budget: $1,581 – $20 = $1,561 < SLMB limit: $1,602
	+ Resources:
		- $1,800 (Bank) which is less than the $11,090 limit.
* January 2017
	+ Income: $1,581 – $20 = $1,561 < SLMB limit: $1,602
	+ Resources: $1,347 (Bank)
* February 2017
	+ Income: $1,561 < SLMB limit: $1,602
	+ Resources: $2,680 (Bank)
* March 2017
	+ Income:
		- $735 + $850 = $1,585 – $50 (General Disregard) = $1,535 > ABD limit: $1,354
		- $1,585 – $4 (Total COLA received 2017) = $1,581 – $50 = $1,531 > ABD limit: $1,354 (**Note:** This exceeds the ABD limit)
		- $1,585 – $20 = $1,565 < SLMB limit: $1,624
	+ Resources:
		- Bank: $1,098

**Disposition:**ABD/QMB ineligible due to excess income. SLMB may be approved effective December 1, 2016. |

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| **Example #4 – Applicant is a Minor Child****Scenario:** On February 15, 2017, Ann Smith applies for Medicaid for Jesse, her disabled son. Jesse’s date of birth is 09/05/05. He receives SSA survivor benefits of $300 per month. His SSI was terminated effective February 1, 2017, due to an increase in his mother’s income. His Medicaid will end effective March 1, 2017. Ms. Smith works full-time and is on salary; her gross income is $2,300 per month. Jesse’s twin 5 yr. old brothers also live in the home. They received $175 per month each in child support. Ms. Smith alleges no resources for her son. She has a bank account valued at $2000, and one automobile. She brought verification of the SSI termination date and reason, her gross pay, and the child support.**Analysis:** The application is complete. A disability determination is not needed at this time because the SSI terminated solely due to income.**Budgeting:*** To determine how much to deem to Jesse:
	+ Income Deeming
* Allocation to brothers: $368 – $175 = $193 per child; $193 x 2 = $386
* $0 (unearned) – $386 (allocation) = $0; $2,300 – $386 (unused allocation) = $1,914
* $1,914 – $50 (general exclusion) = $1,864
* $1,864 – $65 (work expense exclusion) = $1,799
* $1,799 divided by 2 = $899.50
* $1,823 – $899.50 = $899.50
* $899.50 – $735 (SSI Federal Benefit Rate) = $164.50, which is available to Jesse
* Resource Deeming
* $2000 - $7,560 = 0 (No resource allocation to Jessie)
* Jesse’s income determination:
	+ $164.50 (deemed income) + $300 (unearned income) = $464.50
	+ $464.50 – $50 (general disregard) = $414.50 = $0 (earned income) = $414.50 < $1,005 (Individual ABD limit)

**Disposition:** May be approved effective March 1, 2017. |