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304.01 Introduction to Nursing Home, and Home and Community Based Services

(Eff. 09/01/17)

The South Carolina Medicaid program sponsors the payment of long-term care for individuals who reside in certain licensed and certified medical facilities. Such facilities include:

* Skilled Nursing Facilities (SNF) and Intermediate Care Facilities (ICF)
* Swing Beds
* Intermediate Care Facilities for the Intellectually Disabled (ICF/ID)

The Medicaid program also pays for special services to individuals who participate in Home and Community Based Services (HCBS) waivers and a Program for All Inclusive Care of the Elderly (PACE). Refer to Appendix H for a comparison of the different waivers. Refer to Appendix H for a comparison of the different programs. These programs include:

* Community Long-Term Care
  + Community Choices (formerly known as Elderly and Disabled)
  + HIV/AIDS
  + Ventilator (VENT)
* Department of Disability and Special Needs
  + Head and Spinal Cord Injury (HASCI)
  + Intellectual Disability/Related Disabilities (ID/RD)
* Program of All Inclusive Care of the Elderly (PACE)
* Department of Mental Health
* Psychiatric Residential Treatment Facility (PRTF)

This chapter includes policies and procedures used to determine Medicaid eligibility for institutionalized individuals. For Medicaid purposes, an institutionalized individual is one who resides in a medical institution (nursing home) or receives home and community based services. The same eligibility requirements apply to both the Nursing Home (NH) and the Home and Community Based Services (HCBS) programs. The difference is that individuals who need nursing home care but choose to stay at home rather than in an institution, can receive special services through a waiver to help them remain in their home.

To qualify for the Medicaid coverage discussed in this chapter, an individual must meet categorical eligibility. Normally that means he must be aged, blind, or disabled. If the individual is eligible for full Medicaid benefits under another category that has different categorical eligibility requirements, he may still qualify for payment of Nursing Home or HCBS services if all other criteria discussed in this chapter are met and he remains Medicaid eligible.

Most individuals who qualify for Medicaid sponsorship in a long-term facility must contribute toward the cost of care. Individuals who qualify for HCBS with an Income Trust may be required to contribute toward the cost of the services they receive.

If an individual is not Medicaid eligible before he/she enters a medical institution or a waiver program, he/she must receive such services or a combination of such services for 30 consecutive days before he/she can be considered institutionalized.

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304.02 Application Form

(Eff. 10/01/13)

Generally, [Form 3401](https://www.scdhhs.gov/sites/default/files/3401_HealthyConnections_Inst_OSS.pdf), Application for Nursing Home, Residential or In-Home Care OR DHHS [Form 3400](https://www.scdhhs.gov/sites/default/files/Form%203400%20Application.pdf), Healthy Connections Application, AND DHHS Form [3400-B](https://www.scdhhs.gov/sites/default/files/FM3400-B-HealthyConnectionsAddendumForInstitutionalWaiver.pdf), Additional Information for Nursing Home and In-Home Care, are used to obtain information needed to determine eligibility under the institutional categories.

304.02.01 SSI or Other Medicaid Beneficiaries Applying for Nursing Home or Home and Community Based Services

(Rev. 08/01/19)

The DHHS Form [3401](http://medsweb.scdhhs.gov/EligibilityForms/FM%203401.pdf) OR the DHHS Form [3400](https://www.scdhhs.gov/sites/default/files/Form%203400%20Application.pdf) with the DHHS Form [3400-B](https://www.scdhhs.gov/sites/default/files/FM3400-B-HealthyConnectionsAddendumForInstitutionalWaiver.pdf) are:

* **NOT required** when the SSI recipient:
  + Enters a nursing facility and the SSI payment is expected to continue
  + Enters a Home and Community Based Services waiver program
* **Required** when the SSI recipient:
  + Enters a nursing home and the SSI payment will not continue (such as a dual SSI/SSA recipient)

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| **Supplemental Security Income Recipients**   * SSI recipients who enter a facility and have their SSI benefits terminated will be required to file a Medicaid application. * Dual eligibles (recipients of both Retirement, Survivors, and Disability Insurance (RSDI) and SSI benefits) who enter a facility permanently (more than 90 calendar days) and whose RSDI benefit is greater than $50 will usually have their SSI benefits terminated. Therefore, a Medicaid application will be required * Dual eligibles entering a facility temporarily (less than 90 calendar days) usually continue to qualify for SSI. A Medicaid application is not required * Dual eligibles (recipients of both Retirement, Survivors, and Disability Insurance (RSDI) and SSI benefits) who enter a facility permanently (more than 90 calendar days) and whose RSDI benefit is less than $50 will usually continue to receive SSI benefits. A Medicaid application is not required * The Payment category should be changed to 54 for the period during which the individual is both in a nursing facility and SSI eligible | | |
| **SSI only** | | |
|  | **Expected Length of Stay** | |
| **Less than 90 days in the facility** | **90 days or more in the facility** |
| * No application required * Change PCAT 80 to PCAT 54 at approval * Sign and send 181 | * No application required * Change PCAT 80 to PCAT 54 at approval * Sign and send 181 |
| **SSI and another source of income** | | |
|  | **Expected Length of Stay** | |
| **Less than 90 days in the facility** | **90 days or more in the facility** |
| Other income less than or equal to $50 | * No application required * Change PCAT 80 to PCAT 54 at approval * Sign and send 181 | * No application required * Change PCAT 80 to PCAT 54 at approval * Sign and send 181 |
| Other income greater than $50 | * No application required * Change PCAT 80 to PCAT 54 at approval * Sign and send 181 | * Application required * No look-back while SSI eligible * After 90 days in facility, SSI should close   + Verify closure date in MEDS * If SSI terminates prior to approving application   + Conduct modified look-back (MPPM 304.09.02C) from date SSI was terminated (end of the month in which 90th day falls/1st month with no SSI eligibility) to decision date * If approved prior to 90th day   + No look-back needed for decision * For all, change from PCAT 80 to PCAT 10 at decision |

Other Medicaid beneficiaries applying for Nursing Home or Home and Community Based Services waiver program are not required to complete a separate application, but a DHHS Form [3400-B](https://www.scdhhs.gov/sites/default/files/FM3400-B-HealthyConnectionsAddendumForInstitutionalWaiver.pdf) should be completed to collect the information necessary to conduct the look-back period for transfers. The documentation contained in the beneficiary’s case record must be considered when conducting the look-back. A DHHS Form 1233 must be sent to the beneficiary requesting any additional information.

For Nursing Home or Home and Community Based Services (HCBS) applicants who are current Medicaid beneficiaries in the Aged, Blind and Disabled Category (ABD), the DHHS Form 3400-B may be used to expedite the look-back process. The completed form must be submitted by the applicant before an eligibility determination can be made. If the DHHS Form 3400-B indicates that no transfers were made by the applicant below Fair Market Value, request bank statement for the current month and for the three months prior to the request and complete a property check. However, if the completed form reveals that a possible transfer has been made, current policy is to be used to determine the nature of the transfer(s) and whether it/they are sanctionable or meet any exclusions that prevent any impact on eligibility. See **APPENDIX I** **Look-back Procedures for ABD Applicants** for current procedures.

Refer to MPPM [304.29](#MPPM_304_28) for case record requirements.

304.02.02 Requests for Additional Information

(Rev. 07/01/23)

The DHHS Form [1233](http://medsweb.scdhhs.gov/EligibilityForms/FM1233-ME.pdf), Medicaid Eligibility Checklist is used to request additional information from applicant/beneficiaries or Authorized Representatives. For LTC and OSS applications, the eligibility worker must attempt a contact by phone to discuss the required information before mailing the request to the individual and ask any questions that may prevent a second request for information. The date, time and outcome of the contact attempt must be documented in MEDS and OnBase.

Refer to MPPM 101.07.02 if the applicant responds to a request for information.

304.03 Categorical Eligibility Criteria

(Rev. 06/01/08)

To qualify for Medicaid as an institutionalized patient, an individual must meet allof the following categorical requirements:

1. Reside in a medical facility, be an inpatient in a hospital, participate in a Home and Community Based Services waiver program, or a combination of the three, for at least 30 consecutive days. Count the date of admission as the first day.
   * The nursing facility must be a licensed and certified Title XIX facility, such as:
     + Skilled Nursing Facilities (SNF) and Intermediate Care Facilities (ICF)
     + Swing Beds
     + Intermediate Care Facilities for the Intellectually Disabled (ICF/ID)
   * Home and Community Based Service waiver programs such as:
     + Community Long Term Care
       - Elderly and Disabled
       - HIV/AIDS
       - VENT
       - SC Choice
     + Department of Disability and Special Needs
       - Head and Spinal Cord Injury (HASCI)
       - Intellectual Disability/Related Disabilities (ID/RD)
     + Department of Mental Health
       - Psychiatric Residential Treatment Facility (PRTF)
   * Program of All Inclusive Care of the Elderly (PACE)
   * Other Qualifying Admissions:
     + Inpatient Hospital
     + Health South Rehabilitation Center

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| **Exceptions to 30-day rule:**   * Individual is already Medicaid-eligible in another category. * Individual dies before the 30-day period expires – it is assumed he/she would have remained in the facility for 30 days. |

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| **Example #1:** Mr. Glen entered Gentle Shepherd Hospital on April 1 and transferred to XYZ Nursing Home on April 25. His wife applies for Nursing Home assistance on May 10 since he is still there. His 30 days were met May 1. If eligible, he may establish eligibility as early as April 1.  **Example #2:** Mrs. Brown is an ABD recipient. She was in Sisters of Hope Nursing Home for three weeks and applies for nursing home coverage to assist with the bill. Although she was not a resident for 30 days, she was already Medicaid-eligible in another category. If all other criteria are met, she may qualify for a vendor payment to the nursing home.  **Example #3:** James Brooks applied for Nursing Home assistance for his father, Jim Brooks. Mr. Brooks entered Caring Hearts Nursing Facility on June 10 and died June 28. If all other criteria are met, he may establish eligibility for June. It is assumed he would have remained in the nursing home for 30 days had he lived.  **Example #4:** Martha Smith entered the local hospital on May 3. She transferred to Yoder’s Nursing Home on May 18 and was discharged home on June 10. She met the 30 consecutive day criteria in a combination of the two settings. |

1. Meet a Level of Care as certified by Community Long Term Care or its designee
   * The individual must meet one of these Levels of Care:
     + Intermediate or Skilled Nursing Care
     + Intermediate Care for the Intellectually Disabled
     + Hospital Level of Care (at risk for hospitalization for HIV/AIDS waiver)
   * Determination is required before a vendor payment may be authorized.

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| **Important Notes**:     * If Medicare is sponsoring the admission to the nursing home, the individual meets a Skilled Level of Care. CLTC certification is not required until Medicare sponsorship terminates. * For General Hospital, the Level of Care is presumed. |

1. Must not be subject to a penalty for a transfer of assets

Assets are evaluated for a period prior to the month of application to determine:

* + If the applicant and/or his/her spouse transferred any property or assets
  + The value received for any property transfers
  + If a penalty should be imposed for any transfers for less than Fair Market Value (FMV). For transfers occurring before February 8, 2006, refer to MPPM [304.08](#MPPM_304_08). For transfers occurring on or after February 8, 2006, refer to MPPM [304.09](#MPPM_304_09).

Refer to MPPM [304.08.02C](#MPPM_304_08_03C) for the look-back period for applications received prior to February 8, 2006. For applications received on or after February 8, 2006, refer to MPPM [304.09.02C](#MPPM_304_09_02C).

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| **Exception:** There is no penalty for a transfer of assets under the General Hospital category. However, if an individual transfers from the hospital to a nursing home or seeks to participate in a HCBS waiver, a penalty may affect continued eligibility under the other category. |

1. Must be Aged, Blind, or Disabled (based on SSI criteria), unless the individual is already eligible for Medicaid in another category.

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304.04 Non-Financial Eligibility Criteria

(Rev. 04/01/11)

To qualify for assistance in this category, the individual must meet certain non-financial requirements. (Refer to MPPM Chapter 102 for specific information on the following.)

* 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

304.05 Financial Eligibility Criteria

(Eff. 10/01/05)

The individual must meet certain income and resource criteria in order to be eligible. Financial eligibility requirements are based on SSI policy. This chapter covers the requirements specific to this category. (Refer to MPPM Chapter 301 for general income information and to MPPM Chapter 302 for general resource information.)

304.05.01 Income

(Rev. 10/01/10)

Current income must be verified at the time of application, re-budget, or annual review.

Income Limits

Institutionalized individuals must meet a special income limit known as the Medicaid Cap.

* The Medicaid Cap is equal to 300 percent of the current SSI Federal Benefit Rate (FBR) for an individual.
* The individual’s gross monthly income must be at or below the Medicaid Cap.
* If the income exceeds the Medicaid Cap, an Income Trust may be established in Nursing Home and Home and Community Based Services cases. (Refer to MPPM [304.19](#MPPM_304_19))

Only the institutionalized individual’s income is counted in the eligibility determination. If the individual has a community spouse and the individual agrees to provide a spousal allocation, the community spouse’s income must be verified and considered to calculate the allocation.

304.05.01A Budgeting DDSN Work Therapy Wages

(Eff. 06/01/18)

The Department of Disabilities and Special Needs (DDSN) will report wages earned by individuals who reside is a DDSN facility and participate in a work therapy program as part of the plan of care. Individuals participating in work therapy are allowed a deduction of $100.00 per month for personal needs. DDSN will use the DHHS Form 181 to communicate and verify the amount of gross income earned by each Medicaid beneficiary in the section labeled, “This Box for DDSN Therapy Wages Only.” DDSN will report the following actions and the effective date: Start, Significant Change, and Stop.



Eligibility workers will budget or rebudget recurring income based on the reported wages using the instructions below.

**Start**

When **Start** is checked on the DHHS Form 181 from DDSN, this indicates this is the first month in which the beneficiary received work therapy earnings. Budget the case using the amount of work therapy earnings shown and increase the Personal Needs Allowance to $100.00. The DHHS Form 181 must be filled out and returned to DDSN even if recurring income does not change after including the work therapy earnings in the budget. The form should be sent back to DDSN by the last day of the month it was received.

**Significant Change**

When **Significant Change** is checked on the DHHS Form 181 from DDSN, this indicates that there is a difference of $50.00 of more between the amount of the beneficiary’s current work therapy wages and the amount previously budgeted. Rebudget the case using the amount of work therapy earnings shown. The DHHS Form 181 must be filled out and returned to DDSN even if recurring income does not change after including the work therapy earnings in the budget. The form should be sent back to DDSN by the last day of the month it was received.

**Stop**

When **Stop** is checked on the DHHS Form 181 from DDSN, this indicates that the beneficiary no longer participates in work therapy. Rebudget the case to remove the work therapy earnings and reduce the Personal Needs Allowance to $30.00. The DHHS Form 181 must be filled out and returned to DDSN even if recurring income does not change after removing the work therapy earnings and reducing the Personal Needs Allowance in the budget. The form should be sent back to DDSN by the last day of the month it was received.

304.05.02 Resources

(Eff. 01/01/23)

Current resources must be verified at application and annual review.

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| **Exception:** Verification of current resources is not required for SSI recipients who are:  • Entering a nursing home and who will continue to receive an SSI payment (that is, SSI is the only income); or  • Entering a Home and Community Based Services waiver program. |

Resource Limits

The institutionalized individual must have countable resources equal to or below $2,000. Allowable deductions include resource allocations under the Spousal Impoverishment Provision discussed later in this chapter.

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| **Exception:**  If an individual’s countable income is below the ABD limit, he/she may have up to $9,090 in countable resources and still qualify for a Nursing Home vendor payment. |

If married, the resources of both the institutionalized individual and the community spouse are considered in the initial eligibility determination.

304.05.02A Reducing Excess Resources

(Eff. 07/01/23)

The following policy applies to any institutional eligibility decision made on or after July 1, 2023.

If an applicant applying for Nursing Home is over the resource limit after the eligibility specialist determines the individual is otherwise eligible, the eligibility specialist must determine if the applicant can reduce the countable resources below the limit within 90 days. The eligibility specialist must talk to the applicant during the application process to explain any remaining options for reducing excess resources. The eligibility specialist will use the following process to calculate a Reasonable Expectation Reduction Period. The decision considers the individual’s countable gross monthly income and the Average Private Pay Rate.

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| **Procedure**   * Average Private Pay Rate per Month – Countable Income = Net Cost per Month * Gross Countable Resources – Resource Limit = Excess Countable Resources * Excess Countable Resources ÷ Net Cost per Month = Reasonable Expectation Reduction Period   The applicant has until the end of the third month to demonstrate they have reduced the countable resources.  **Examples**   1. John is applying for Nursing Home. His financials are as follows:  * Income: $1,500   + $8,797.11- $1,500 = $7,297.11 * Resources: $18,000   + $18,000 - $2,000 = $16,000   + $16,000 ÷ $7,297.11 = 2.19 Months   There is a reasonable expectation that John’s resources may be under the limit within the next three months. His application will remain pending   1. Alfie is applying for HCBS. His financials are as follows:  * Income: $2,000   + $8,797.11 - $2,000 = $6,797.11 * Resources: $27,000   + $27,000 - $2,000 = $25,000   + $25,000 ÷ $6,797.11 = 3.67 Months   There is NOT a reasonable expectation that Alfie’s resources may be under the limit within the next three months. His application is denied for Excess Resources.   1. Anna Leigh is applying for Nursing Home. Her financials are as follows:  * Income: $925   + $8,797.11 - $925 = $7,872.11 * Resources: $30,000   + $30,000 - $9,090 = $22,128   + $22,128 ÷ $7,872.11 = 2.81 Months   There is a reasonable expectation that Anna Leigh’s resources may be under the limit within the next three months. Her application will remain pending |

* If the Reasonable Expectation Reduction Period is greater than three months, deny the application for excess resources
* If the Reasonable Expectation Reduction Period is less than or equal to three months, leave the application in pending status. The applicant has until the end of the third month to show they have reduced the countable resources
  + The eligibility specialist must contact the applicant to let them know they are over the resource limit and to discuss any remaining options available for reducing the value within 90 days
  + The applicant will be required to contact the agency within 90 days to report if they are under the limit
    - If the applicant reports that they are over the limit, deny the application for excess resources
    - If the applicant reports they are under the limit, the eligibility specialist must verify the current value of the resources
      * If countable value is under the limit, determine eligibility
      * If countable value is over the limit, deny for excess resources
  + If the applicant fails to contact the agency, the application is denied for excess resources.

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304.05.03 Homestead Property

(Eff. 01/01/23)

For applications filed before January 1, 2006, homestead property is excluded regardless of value with intent to return home and is not subject to the home equity requirement as long as there is no break in institutionalization (Refer to MPPM 302.14.01). No break in institutionalization occurs if a beneficiary remains in an institutional setting and does not have to file a new application for long-term care services to re-establish eligibility.

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| **Example 1:** Mr. Jones is in the nursing home but is then admitted to the hospital. He stays for two months and remains Medicaid eligible. He subsequently returns to the nursing home. No break occurred because he was in an institutional setting and does not require a new application to re-establish eligibility for long-term care services. (If Mr. Jones were an Income Trust case, a break in institutionalization has occurred because he would lose Medicaid eligibility while in the hospital and would require an application to re-establish eligibility.)  **Example 2:** Mr. Jones is due for annual review, but his authorized representative (AR) does not return information needed to complete the redetermination. Mr. Jones’ case is closed, but he remains in the nursing home. Forty days after the date on the closure notice, the AR returns the information. A break in institutionalization has occurred, and Mr. Jones’ is subject to the home equity requirement because a new application is required to re-establish Mr. Jones’ eligibility for long-term care services. |

The Deficit Reduction Act of 2005 changes the way homestead property is evaluated for individuals applying for long-term care services effective with applications received on or after January 1, 2006. Homestead property for applicants whose spouse, child under age 21, or a child who is blind or disabled lawfully resides in the home is excluded regardless of equity value. The statement of the applicant/beneficiary or authorized representative is adequate verification of an individual lawfully residing in the home. Otherwise, individuals with an equity interest in their home over $688,000 are not eligible for vendor payment or other long-term care services, but may be eligible for MAO-NH, Payment Category 10, or other Medicaid category if all other eligibility criteria are met. (Refer to MPPM 101.04.01.) An applicant may seek to reduce his or her equity value by taking out a loan on the home including reverse mortgage arrangements. Verify the arrangements and the amount of funds the individual receives. The equity value does not decrease until the client actually receives the money from the loan. Any amount of funds received from a loan is an available resource when received. Any such arrangements must be done under a written contractual agreement. Chapter 104, Appendix HH contains additional information about reverse mortgages.

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| **Procedure for Applications Received After January 1, 2006**   1. If an applicant indicates homestead property, complete a DHHS Form 1255 ME, Verification of Real and Personal Property, and obtain the current assessed value of the property. 2. If the applicant has a spouse, a child under age 21, or a child who is blind or disabled that lawfully lives in the home, exclude the value of the home regardless of value, and continue with the eligibility determination. 3. If the applicant does not meet the criteria in step 2, and the assessed value is equal to or less than $688,000, exclude the property, and continue with the eligibility determination. 4. If the applicant does not meet the criteria in step 2, and the assessed value exceeds $688,000, request verification of any mortgages, liens, judgments, or other encumbrances that may reduce the equity value of the property. 5. Subtract the reductions from the assessed value of the property. If the remaining equity value is equal to or less than $688,000, continue with the eligibility determination. If the remaining equity value exceeds $688,000, deny for long-term care services. 6. Determine Medicaid eligibility. |

Refer to MPPM Chapter 304 [Appendix G](#Appendix_G) for a flowchart detailing the procedure for the Home Equity requirement.

304.06 Level of Care

(Eff. 07/01/17)

A Level of Care (LOC) is a determination of medical necessity for care. A qualified individual must meet either an Intermediate or Skilled level of care designation.

304.06.01 Level of Care Certification

(Rev. 09/01/17)

Community Long Term Care (CLTC) or its designee must certify the individual’s level of care before Medicaid can pay for long-term care services. The eligibility worker is notified of the findings in writing. The DHHS Form 185, Level of Care Certification Letter, issued by CLTC, or the DHHS Form 210, Resident Case Mix Classification Change, issued by a nursing facility, is used for notification on nursing home applicants/ beneficiaries. The DHHS Form 118/118A, Client Status Document, is used to notify the eligibility worker when the individual is a HCBS applicant/beneficiary.

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| Procedure – Certification of Level of Care  Either Community Long Term Care or its designee certifies the medical necessity. The chart below indicates who provides the level of care certification.     |  |  | | --- | --- | | **Facility Placement / HCBS** | **Certifier** | | Facility Placement | | | Nursing Home placement | Community Long Term Care (CLTC) | | Intermediate Care Facility for the Intellectually Disabled (ICF/ID) | Department of Disabilities and Special Needs (DDSN) | | **Home and Community Based Services** | | | Community Choice Waiver | CLTC | | HIV/AIDS Waiver | CLTC | | Ventilator Waiver | CLTC | | Head and Spinal Cord Injury (HASCI) Waiver | DDSN | | Intellectual Disability and Related Disabilities (ID/RD) Waiver | DDSN | | Program of All Inclusive Care of the Elderly (PACE)Palmetto SeniorCare | Program of All Inclusive Care of the Elderly (PACE)   * Palmetto SeniorCare | |

At the time of application, a level of care must be requested. Use the [DHHS Form 1231 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201231%20ME.pdf), Request for Level of Care. The DHHS Form 1231 is always sent to the certifying agency at the time of application, regardless of when the level of care needs to be determined.

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| Procedure to Request Level of Care  The applicant’s location determines where the DHHS Form 1231 ME is sent   | **Applicant’s Location** | **Send DHHS Form 1231 ME to** | **Level of Care is Certified by** | | --- | --- | --- | | Hospital | Hospital and CLTC | CLTC | | Nursing Facility | Nursing Facility and CLTC | CLTC | | ICF/ID | DDSN | DDSN | | Community |  |  | | * Waiting for Nursing Home placement | CLTC | CLTC | | * Applying for CLTC services | CLTC | CLTC | | * Applying for ID/RD, HASCI, or PDD waiver | DDSN | DDSN | | * Applying for a Program of All Inclusive Care of the Elderly (PACE) | PACE Provider  (Only in Richland, Lexington, and Orangeburg Counties) | PACE Provider | |

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304.06.02 When a Level of Care is Required

(Eff. 08/01/07)

A level of care certification, or re-certification, is required under the following circumstances:

1. **Nursing Home Assistance**

* Before a Medicaid-sponsored admission
* Before a vendor payment may be authorized
  + - If an applicant enters or resides in a nursing facility within 30 days of the effective date shown on the DHHS Form 185, Level of Care Certification Letter, the certification remains valid as long as the applicant remains at the facility.

1. A new LOC certification **IS** **NOT** required at the time of approval as long as the individual did not leave the facility after the date of entry for any reason.

**NOTE:** If a LOC is required by the nursing facility for billing purposes, the facility is responsible for obtaining the updated certification.

1. A new LOC certification is required at the time of approval if the individual left the facility for any reason, including a hospital stay.

**Exception:** If an applicant transfers directly from one nursing facility to another nursing facility, a new LOC is not required.

* Before a re-admission, if the vendor payment has terminated
* A time-limited LOC certification expires and the vendor payment needs to continue
* When a patient transfers from a:
  + Department of Mental Health (DMH) IMD facility to a non-DMH long-term care facility
  + Department of Disabilities and Special Needs ICF/ID facility to a non-DDSN long-term care facility

A Medicaid level of care determination is not requiredwhile Medicare is paying for the admission. The level of care is presumed to be skilled during the period of Medicare sponsorship. The DHHS Form 1231, Request for Level of Care, must be sent at the time of application, with a notation the applicant will initially enter the facility under Medicare sponsorship. **(Note:** At the end of this period, a level of care is required for potential continuing benefits. This includes when a patient returns to a facility from a hospital after a bed hold expires.) A [DHHS 3229-B ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%203229-B.pdf), Notice of Cost of Care for Medicare Sponsorship in a Nursing Home, is used to advise the applicant/beneficiary or the authorized representative of both the cost of care and the need for a certified level of care when Medicare Sponsorship ends.

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| **Example #1:** Mr. Jones was a Medicaid patient at Caring Hearts Nursing Home before going into the hospital. He was in the hospital for 15 days. A new level of care is required before Medicaid will pay for the re-admission.  **Example #2:** Jane Sons enters Sisters of Hope Nursing Home. She meets all the financial eligibility criteria for Medicaid. The facility has requested payment but the eligibility worker has not received a certified level of care. A payment cannot be authorized until one is received.  **Example #3:** Cindy Bouknight is a Medicaid patient at the Babcock Center’s Wire Road ICF/ID facility. She has an accident and must be transferred to the skilled care floor at Sisters of Hope Nursing Home. A level of care certification is required before payment may be authorized.  **Example #4:** Stella King entered Regional Medical Center on March 5. She transferred to Caring Hearts Nursing Home under Medicare on March 10. She applied for Medicaid to assist with her bills there. The nursing home submitted a [DHHS Form 181](http://medsweb.scdhhs.gov/EligibilityForms/FM%20181.pdf), Notice of Admission, Authorization, and Change of Status for Long Term Care, for coverage. Her Medicare eligibility ends effective May 1. CLTC assessed her at an Intermediate level of care. Caring Hearts submitted a DHHS Form 181 with a copy of the level of care certification requesting vendor payment effective May 1. All other eligibility criteria were met in March. The eligibility worker approved the case effective March 1. A level of care was not required for the March 10 admission because an individual must meet a Skilled level of care before Medicare will sponsor an admission at a nursing facility. |

1. **Home and Community Based Services Waiver**

A level of care must be certified before an individual may be approved to enter the waiver program.

1. **General Hospital**

A level of care certification is not required. The hospital’s Utilization Review Board completes a treatment plan to justify continued hospitalization, therefore a level of care is presumed.

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304.06.03 Client Status Document

(Rev. 09/01/12)

The DHHS Form 118/118-A/188-B, Client Status Document (CSD), is the primary tool used by CLTC/DDSN/PRTF Alternative CHANCE to communicate information to the Medicaid eligibility worker. Some of its uses are for:

* CLTC/DDSN/PRTF Alternative CHANCE to notify the eligibility worker that an applicant/beneficiary meets level of care;
* CLTC/DDSN/PRTF Alternative CHANCE to notify the eligibility worker that a beneficiary has requested waiver services and the look-back needs to be developed; and
* Eligibility worker to notify CLTC/DDSN/PRTF Alternative CHANCE of information regarding the applicant/beneficiary, such as:
  + Financially eligibility
  + Needs to meet the 30 consecutive day requirement
  + Ineligibility

Do not forward the CSD to CLTC/DDSN/PRTF Alternative CHANCE until it is determined if all eligibility factors are met with the exception of the 30 consecutive day criteria. It is extremely important to complete the CSD accurately for a new beneficiary before returning it to CLTC/DDSN/PRTF Alternative CHANCE. CLTC/DDSN/PRTF Alternative CHANCE enters the applicant/beneficiary into the waiver and authorizes and starts waiver services for individuals based on the information provided on the CSD.

The appropriate completion of the CSD varies, depending on the individual’s category of assistance. For instructions on completing a CSD sent by CLTC, refer to MPPM 304.06.04; for a CSD sent by DDSN, refer to MPPM 304.06.05; for a CSD sent by PACE, refer to MPPM 304.06.06; and for a CSD sent by PRTF Alternative CHANCE Project Director, refer to MPPM 304.06.07.

304.06.04 Client Status Document From CLTC

(Rev. 10/01/13)

**A. SSI Recipient Enters Waiver**

When an SSI recipient enters the waiver, CLTC would enroll the recipient in the waiver and authorize services. A look-back for transfer of assets is not required. In MEDS, the category will remain 80.

**B. Already Medicaid Eligible, But Without SSI, Beneficiary Enters Waiver**

When a beneficiary who is already eligible for Medicaid in a category other than SSI enters the waiver, CLTC sends a CSD to the eligibility worker who maintains the open record with a message **“CLIENT ENTERING WAIVER. CHECK FOR ANY TRANSFER OF RESOURCES WITHIN THE PAST 60 MONTHS.”** This message is printed directly below the address of the CLTC and eligibility office. The local eligibility office will complete a DHHS Form 1233 ME, Medicaid Eligibility Checklist, and send to the beneficiary requesting the DHHS Form [3400-B](https://www.scdhhs.gov/sites/default/files/FM3400-B-HealthyConnectionsAddendumForInstitutionalWaiver.pdf), Additional Information for Nursing Home and In-Home Care, and other information necessary to complete a look-back for transfer of assets. The eligibility worker completes the look back and returns the CSD to CLTC with appropriate transfer information. If a transfer has occurred, a DHHS Form 932, Notice of Denial of Waiver Services or Nursing Home Care, must be sent to the beneficiary.

If the beneficiary’s Medicaid category is to be changed by the eligibility worker from the original category to a category 15, this must be notated on the CSD.

Until the look back has been completed, CLTC does not enter the applicant/beneficiary into the waiver.

**C. All Others, Subject to Medicaid Cap**

Individuals who are not currently eligible for Medicaid may be eligible if their income is measured against the Medicaid Cap or if an Income Trust is established. When an individual requests to enter one of the home and community based waivers, CLTC will complete a telephone assessment. If it appears the applicant may meet level of care, a CSD will be sent to the local eligibility office. The eligibility worker must make contact using the information contained on the CSD to initiate the eligibility process.

When the eligibility worker completes the eligibility determination, the worker returns the properly annotated CSD with the correct eligibility information to CLTC. Please note the eligibility worker must check all boxes that apply in the Medicaid Eligibility Status section. If the applicant can be approved for another category of assistance, such as ABD, the eligibility worker can approve the application for Medicaid, and check all boxes that apply in the Medicaid Eligibility Status section of the CSD. If the beneficiary is not eligible for the waiver because of a transfer, a DHHS Form 932 must be sent to the beneficiary.

Once CLTC receives the CSD indicating the applicant will be Medicaid eligible, a formal level of care assessment will be completed. If the applicant meets level of care, CLTC will begin services and notify the eligibility worker concerning the date of entry into the waiver.

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| **Important:**  The eligibility worker must determine that the applicant meets all eligibility criteria except for the 30 consecutive day requirement before the Client Status Document (CSD) is returned to CLTC. Once CLTC returns the CSD showing the date the applicant entered the waiver and the 30 consecutive day requirement has been met, the applicant can be approved for Medicaid. |

304.06.05 Client Status Document From DDSN

(Rev. 10/01/13)

**A. SSI Recipient Enters Waiver**

When an SSI recipient enters the waiver, DDSN would enroll the recipient in the waiver and authorize services. A look-back for transfer of assets is not required. In MEDS, the category will remain 80.

**B. Already Medicaid Eligible, But Without SSI, Beneficiary Enters Waiver**

If the beneficiary is already Medicaid eligible, the action taken will depend upon the category.

1. If the beneficiary receives Medicaid in a category where his eligibility is established as an individual (such as TEFRA, ABD,) the DDSN sponsored eligibility worker will complete a DHHS Form 1233 ME, and send to the beneficiary requesting the DHHS Form 3400-B and other information necessary to complete a look-back for transfer of assets. The open Medicaid case must be requested from the Local Eligibility Processing office that has the case record. **A new application is not required.** Once the look-back for transfer of assets has been completed, the DDSN sponsored eligibility worker will return the DHHS Form 118-A to DDSN with the appropriate transfer information.
2. If the beneficiary receives Medicaid in a category where his eligibility is established as part of a budget group (such as Healthy Connections Plans for Children Under Age 19 or Low Income Families), the DDSN sponsored worker will complete a DHHS Form 1233 ME, and send to the beneficiary requesting the DHHS Form 3400-B and other information necessary to complete a look-back transfer of assets. **A new application is not required.** Once the look-back for transfer of assets has been completed, the DDSN sponsored eligibility worker will return the DHHS Form 118-A to DDSN with the appropriate transfer information.

Until the look-back is completed, DDSN does not enter the applicant/beneficiary in the waiver. The DDSN sponsored eligibility worker will keep and maintain the case. If the beneficiary is not eligible for the waiver because of a transfer, the case record should be returned to the LEP office and a DHHS Form 932 must be sent to the beneficiary.

**C. All Others, Subject to Medicaid Cap**

Individuals who are not currently eligible for Medicaid may be eligible if their income is measured against the Medicaid Cap or if an Income Trust is established. When an individual requests to enter one of the DDSN waivers, a CSD is sent to the regional DDSN sponsored eligibility worker. The sponsored worker will contact the family to obtain an application. Occasionally an individual may come into the local eligibility office to file an application for a DDSN waiver. Assistance should be provided to complete the application, and the application forwarded to the regional DDSN sponsored worker for processing.

When the DDSN sponsored eligibility worker completes the eligibility determination, the worker returns the properly annotated CSD with the correct eligibility information to DDSN. Please note the worker must check all boxes that apply in Section II, Medicaid Eligibility Status.

In this situation, DDSN does not enter the applicant/beneficiary into the waiver or authorize waiver services until the DDSN sponsored eligibility worker returns the CSD to DDSN stating the applicant meets all eligibility criteria except for the level of care and 30 consecutive day requirement. If the applicant can be approved for another category of assistance, such as ABD, the eligibility worker can approve the application for Medicaid, and check all boxes that apply in Section II of the CSD. If the beneficiary is not eligible for the waiver because of a transfer, a DHHS Form 932 must be sent to the beneficiary.

Once the applicant enters the waiver, DDSN notifies the DDSN sponsored eligibility worker in writing of date of entry into the waiver and level of care by completing Section III of the CSD. If the DHHS Form 118-A is returned indicating the applicant did not meet the 30 consecutive day requirement, the application must be denied.

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| **Important:**  The eligibility worker must determine that the applicant meets all eligibility criteria except for the level of care and the 30 consecutive day requirement before the Client Status Document (CSD) is returned to DDSN. Until DDSN returns the CSD with Section III completed showing the level of care and the date the applicant entered the waiver, the application cannot be approved for category 15. Once the 30 consecutive day requirement has been the met, the applicant can be approved for Medicaid. |

304.06.06 Client Status Document for PACE

(Rev. 10/01/13)

**A. SSI Recipient Enters PACE**

When an SSI recipient enters the PACE, PACE would enroll the recipient and authorize services. A look-back for transfer of assets is not required. In MEDS, the category will remain 80.

**B. Already Medicaid Eligible, But Without SSI, Beneficiary Enters PACE**

When a beneficiary who is already eligible for Medicaid in a category other than SSI enters the program, PACE sends a CSD to the eligibility worker with a message **“CLIENT ENTERING PACE. CHECK FOR ANY TRANSFER OF RESOURCES WITHIN THE PAST 60 MONTHS.”** This message is printed directly below the address of the PACE and eligibility office. The eligibility worker will complete a DHHS Form 1233 ME, and send to the beneficiary requesting the DHHS Form [3400-B](https://www.scdhhs.gov/sites/default/files/FM3400-B-HealthyConnectionsAddendumForInstitutionalWaiver.pdf) and other information necessary to complete a look-back for transfer of assets. Once the look back for transfer of assets has been completed, the eligibility worker will return the CSD to PACE with appropriate transfer information. If the beneficiary’s Medicaid category is to be changed by the eligibility worker from the original category to a category 15, this must be notated on the CSD.

Until the look back has been completed; PACE does not enter the applicant/beneficiary into the program. If the beneficiary is not eligible for the waiver because of a transfer, a DHHS Form 932 must be sent to the beneficiary.

**C. All Others, Subject to Medicaid Cap**

Individuals who are not currently eligible for Medicaid may be eligible if their income is measured against the Medicaid Cap or if an Income Trust is established. When an individual requests to be in the program, PACE refers the individual to a local eligibility office to apply. PACE sends a CSD to the eligibility office when the level of care is determined.

When the eligibility worker completes the eligibility determination, the worker returns the properly annotated CSD with the correct eligibility information. Please note the eligibility worker must check all boxes that apply in the Medicaid Eligibility Status section. If the applicant can be approved for another category of assistance, such as ABD, the eligibility worker can approve the application for Medicaid, and check all boxes that apply in the Medicaid Eligibility Status section of the CSD.

PACE does not enter the beneficiary into the waiver or authorize waiver services until the eligibility worker returns the CSD to PACE stating that the eligibility determination has been completed and the beneficiary is eligible except for meeting the 30 consecutive day requirement. If the beneficiary is not eligible for the waiver because of a transfer, a DHHS Form 932 must be sent to the beneficiary.

Once applicant enters the program, PACE notifies the eligibility worker in writing of date of entry.

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| **Important:**  The eligibility worker must determine that the applicant meets all eligibility criteria except for the 30 consecutive day requirement before the Client Status Document (CSD) is returned to PACE. Once PACE returns the CSD showing the date the applicant entered the waiver and the 30 consecutive day requirement has been the met, the applicant can be approved for Medicaid. |

304.06.07 Client Status Document for the Psychiatric Residential Treatment Facility (PRTF) Waiver

(Rev. 07/01/15)

The Psychiatric Residential Treatment Facility (PRTF) Waiver is for children ages 4 through 18 (under age 19) who meet the criteria for a Residential Treatment Facility.

**A. SSI Recipient Enters Waiver**

When an SSI recipient enters the waiver, the SCDHHS PRTF Waiver Project Director would enroll the recipient in the waiver and authorize services. A look-back for transfer of assets is not required. In MEDS, the category will remain 80.

**B. Already Medicaid Eligible, But Without SSI, Beneficiary Enters Waiver**

* The SCDHHS PRTF Waiver Project Director will inform the beneficiary that a look-back for transfer of assets is required.
* The SCDHHS PRTF Waiver Project Director will complete the DHHS Form 118-B indicating the DHHS Form [3400-B](https://www.scdhhs.gov/sites/default/files/FM3400-B-HealthyConnectionsAddendumForInstitutionalWaiver.pdf) was given to client to fill out, and fax the DHHS Form 118-B to the local eligibility office at 803-741-9475.
* The SCDHHS PRTF Waiver Project Director will use the contact information on the DHHS Form 118-B for further/ongoing contact with the eligibility office.
* The local eligibility office will complete a DHHS Form 1233 ME; and send to the beneficiary requesting the DHHS Form [3400-B](https://www.scdhhs.gov/sites/default/files/FM3400-B-HealthyConnectionsAddendumForInstitutionalWaiver.pdf) and other information necessary to complete a look-back.

The specific action taken by the local eligibility office will depend upon the category under which the beneficiary is receiving Medicaid.

1. If the beneficiary receives Medicaid in a category where his eligibility is established as part of a budget group (such Partners for Healthy Children (PHC)), the eligibility worker will contact the family to obtain the information needed to conduct the look-back using the DHHS Form 3400-B. **A new application is not required.** Once the look-back has been completed, the eligibility worker will return the DHHS Form 118-B to the SCDHHS PRTF Waiver Project Director with the appropriate transfer information.

Until the look-back is completed, the SCDHHS PRTF Waiver Project Director does not enter the applicant/beneficiary into the waiver. If there is no transfer of assets, the SCDHHS PRTF Waiver Project Director can enroll the beneficiary into the waiver. There is no 30-day wait because the beneficiary is Medicaid eligible.

1. If the beneficiary receives Medicaid in category where his eligibility is established as an individual (such as TEFRA, Aged, Blind or Disabled) the eligibility worker will contact the family to obtain the information needed to conduct the look-back using the DHHS Form [3400-B](https://www.scdhhs.gov/sites/default/files/FM3400-B-HealthyConnectionsAddendumForInstitutionalWaiver.pdf). **A new application is not required.** Once the look-back for transfer of assets has been completed, the eligibility worker will return the DHHS Form 118-B to the SCDHHS PRTF Waiver Project Director with the appropriate transfer information.

Until the look-back is completed, the SCDHHS PRTF Waiver Project Director does not enter the applicant/beneficiary into the waiver. If there is no transfer of assets, the SCDHHS PRTF Waiver Project Director can enroll the beneficiary into the waiver. There is no 30-day wait because the beneficiary is Medicaid eligible.

If the beneficiary is not eligible for the waiver because of a transfer, a DHHS Form 932 must be sent to the beneficiary.

**C. All Others not already Medicaid Eligible**

When a request is made to enter the PRTF waiver, the SCDHHS PRTF Waiver Project Director will refer the individual to the local eligibility office to apply. The SCDHHS PRTF Waiver Project Director will complete the DHHS Form 118-B indicating the following forms were given to the family: DHHS Form 3400, Healthy Connections Application; and DHHS Form [3400-B](https://www.scdhhs.gov/sites/default/files/FM3400-B-HealthyConnectionsAddendumForInstitutionalWaiver.pdf). The SCDHHS PRTF Waiver Project Director will then fax the DHHS Form 118-B to the local eligibility office at 803-741-9475. The local eligibility office will complete a DHHS Form 1233 ME; and send to the beneficiary requesting the DHHS Form 3400, DHHS Form 3400-B, and other information necessary to complete a look-back.

Medicaid eligibility for the family should first be considered. Process the application to determine if the family is eligible for Partners for Healthy Children (PHC) or Parent/ Caretaker Relative (PCR). If the family is eligible, approve the family for Medicaid in MEDS. If there have been no sanctionable transfers by the child, return the Client Status Document indicating the child is currently Medicaid eligible and that the look back has been completed.

If the child does not qualify for Medicaid as part of the family, the worker must process the application to determine if the child would be eligible as an individual. For the family members that do not qualify for Medicaid, send a DHHS Form 3229-A, Notice of Approval/Denial for Medical Assistance/Optional Supplementation, to deny those applicants. Do not take action in MEDS to deny the Budget Group until a final determination is made on the child applying for PRTF.

Determine if the child would qualify as an individual for one of the Healthy Connections Plans for Children Under Age 19 groups. If eligible, indicate on the DHHS Form 118-B that the child has been determined financially eligible; except for the level of care (LOC), but his/her case cannot be certified until the 30 consecutive day requirement is met, and return the CSD to the SCDHHS PRTF Waiver Project Director.

When the SCDHHS PRTF Waiver Project Director receives the DHHS Form 118-B, a Level of Care will be completed. If the child meets the PRTF Level of Care, when a waiver slot is available, the SCDHHS PRTF Waiver Project Director will enter the child into the waiver and notify the Medicaid eligibility worker in writing of date of entry into waiver and verify the PRTF level of care. If the child must meet the 30 consecutive day requirement, once the 30 days has been met, approve the application back to the first day of the month in which the 30-day period began.

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| **Important:**  If the child must qualify as an individual, the eligibility worker must determine that the applicant meets all eligibility criteria except for the 30 consecutive day requirement before the DHHS Form 118-B is returned to the SCDHHS PRTF Waiver Project Director. Once the SCDHHS PRTF Waiver Project Director returns the DHHS Form 118-B showing the date the applicant entered the waiver and the 30 consecutive day requirement has been the met, the applicant can be approved for Medicaid. |

304.07 Standard of Promptness

(Rev. 07/01/23)

The standard of promptness for processing applications for institutional programs is 45 days unless a disability determination is required. For applications requiring a disability determination, the standard of promptness is 90 days.

For Nursing Home and Home and Community Based Service cases, the standard of promptness may exceed to 45/90 days if:

* The eligibility determination is complete AND
* The individual meets all other eligibility criteria but a bed and/or slot is not available.

While the applicant is waiting to enter a nursing facility or waiver slot, the application should remain in pending status.

|  |
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| **Nursing Home Pending Approval**   * Determine the individual’s eligibility for Nursing Home. The applicant must meet all other financial and non-financial criteria, and be waiting for admission into a Nursing Home   + Send a [CGIS717—Cover Letter-NH-Notification to Enter Nursing Facility](https://medsweb.scdhhs.gov/EligibilityForms/CGIS717_Cover%20Letter_NH_Notification%20to%20Enter%20Nursing%20Facility.pdf)—to the applicant     - * The applicant has 90 days to be admitted to a nursing facility. (If processing the application in MEDS, manually complete the CGIS717 and mail to the applicant.)       * Set the follow-up date in OnBase to 95 days to allow for mailing, scanning, and task creation         + If the applicant is admitted:   The facility sends a completed DHHS Form 181 to DHHS indicating the date of admission  The Eligibility Specialist will determine the Cost of Care, approve the application, and send the DHHS Form 181 to the facility.   * + If a DHHS Form 181 admitting the applicant is not received from the facility within 90 days, the ES will check OnBase to confirm a form has not been received, and will deny the application as appropriate |

304.07.01 Arranging for Alternate Placement

(Eff. 04/01/06)

When a Medicaid sponsored patient in a nursing facility or ICF/ID is awaiting placement due to a change in level of care and the individual no longer needs long term care, benefits continue for a maximum of 30 days while the individual is seeking alternate placement. If alternate placement is found within the 30 days and is refused by the individual or responsible party, the Medicaid payment will terminate immediately. Otherwise, payment will stop at the end of the 30-day period.

304.08 Transfer of Assets Prior to February 8, 2006

(Rev. 01/01/10)

MPPM 304.08 and the appropriate subsections regarding transfers that have occurred prior to February 8, 2006 have been moved to MPPM Chapter 304, Appendix J.

304.09 Transfer of Assets on or after February 8, 2006

(Eff. 06/01/06)

The Deficit Reduction Act of 2005 amended the rules regarding the transfer of assets for less than fair market value. Applications taken on or after February 8, 2006 must be evaluated under old and new policy (Refer to MPPM [304.08](#MPPM_304_08) for policy on transfers prior to February 8, 2006). Transfers occurring on or after February 8, 2006 must be evaluated under the new rules only.

304.09.01 Definitions that Apply to Transfer of Assets and Trusts

(Eff. 11/01/14)

The following definitions apply, as appropriate, to both transfer of assets and trusts.

| **TERM** | **Definition** |
| --- | --- |
| Assets | All income and resources of the individual and his/her spouse. This includes income and resources to which the individual or his/her spouse is entitled to but does not receive because of any action by the individual or his/her spouse or anyone authorized to act in their behalf (such as a Power of Attorney).  *Examples of actions that would cause income or resources not to be received:*   * Irrevocably waiving pension income; * Waiving an inheritance (including an elective share); * Not accepting injury settlements; * Diverting tort settlements into a trust (Structured Settlements); * Refusing to take legal action to obtain a court-ordered payment; and * Gifting portion(s) of the outstanding principal of a promissory note. |
| Income | Same definition as SSI. (Refer to Chapter 301 on Income for discussion.) |
| Individual | * The individual applying for (applicant) or receiving (beneficiary) Medicaid; * The applicant/beneficiary’s spouse who is acting on his/her behalf; * A person (including a court or administrative body) acting at the direction of the individual or his/her spouse; or * A person with legal authority (including a court or administrative body) to act in place of the applicant/beneficiary or his/her spouse. |
| Resources | Same definition as SSI except for the home exclusion. (Refer to MPPM Chapter 302 on Resources for discussion. MPPM [304.05.03](#MPPM_304_05_03) for information on the Homestead exclusion.) |
| Spouse | A person who is considered legally married to the individual. |

The following definitions apply to transfer of assets.

| **TERM** | **Definition** |
| --- | --- |
| Fair Market Value (FMV) | The amount the resource can be expected to sell for on the open market in the area in which the property is located. If a resource sells for more than the value assigned to it, the FMV is equal to the sale price. |
| Institutionalized individual | An individual who is:   * An inpatient in a nursing facility or hospital swing bed; * An inpatient in a medical facility for whom payment is based on a nursing facility level of care; and * An individual participating in a Home and Community Based Services waiver program. |
| Non-institutionalized individual | An individual who is living in the community and not participating in a waiver program. |
| Uncompensated value | The difference between the FMV at the time of transfer (less any encumbrances) and the amount received for the asset. |
| Valuable consideration | What the individual receives in exchange for his/her right or interest in an asset. The object, service, or benefit received must have a value to the individual that is equal to or greater than the value of the transferred asset. |

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304.09.02 Transfer of Assets for Less than Fair Market Value

(Rev. 10/01/06)

Many times, an individual may transfer assets to another person. If an asset is transferred and the individual does not receive the full value for it, it is assumed he did so with the intention of becoming Medicaid-eligible. If an institutionalized individual or his/her spouse transfers an asset for less than Fair Market Value, it may affect eligibility for services. If all the other Medicaid eligibility criteria are met, he/she may receive Medicaid but coverage for certain Medicaid services is denied. These services include:

* Vendor payment to a nursing facility
* Swing Bed
* Home and Community Based (Waiver) Services

Denial of the coverage is known as a **penalty**. The transfer resulting in the penalty is also known as a **sanctionable** **transfer or a penalty-liable transfer.**

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| Procedure – Penalty-Liable Transfer  If an individual or his/her spouse has a penalty-liable transfer but meets all of other eligibility criteria, the eligibility worker must follow the guidelines below.   * For Nursing Home Assistance:   + Deny or terminate the vendor payment (room and board payment.) Use DHHS Form 932,   + The Medicaid Card is authorized or continued. * For Home and Community Based Services (HCBS) or other Waiver service:   + If an individual is applying for or receiving HCBS:     - Determine if the individual qualifies for Medicaid under any other category,     - Notify CLTC/DDSN to deny or terminate services (DHHS Form 118 or DHHS Form 118A).   + If an individual is already Medicaid eligible under another payment category, such as ABD, continue Medicaid, and notify CLTC/DDSN to deny or terminate services. |

304.09.02A Effective Date of Transfer of Assets Policy

(Eff. 06/01/06)

The transfer of assets provisions apply to all transfers made on or after February 8, 2006.

304.09.02B Individuals Affected by Transfer of Assets Provisions

(Eff. 06/01/06)

These provisions apply when assets have been transferred for less than Fair Market Value by any of the following:

* Institutionalized individual
* Community spouse
* Anyone acting in place of, on behalf of, or at the direction of the institutionalized individual or community spouse, such as:
  + A parent or guardian
  + Court or administrative body
  + Power of Attorney
  + Conservator

304.09.02C Look-Back Date/Period

(Rev. 08/01/20)

When an individual applies for Medicaid coverage for nursing home or HCBS, a look-back must be conducted to determine if there has been a transfer of assets. If a transfer has occurred, the eligibility worker must determine if a penalty applies.

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| **Note:** For any SSI recipients entering a nursing facility or a Home and Community Based Services waiver program, a look back is NOT required. A modified look-back must be conducted for those individuals applying for institutional coverage who do not currently receive SSI but were SSI eligible in the past. The modified look-back period would begin the month the SSI was terminated. |

The look-back period is 60 months prior to the date:

* An institutionalized individual was institutionalized, and has applied for medical assistance for long term care coverage, or
* A non-institutionalized individual applies for medical assistance for long-term care coverage.

The look-back date is the earliest date on which a penalty can be assessed.

Transfers of assets for less than Fair Market Value are:

* Subject to penalty if the transfer took place on or after the look-back date, or
* Not subject to penalty if the transfer took place prior to the look-back date.

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| **Procedure – Conducting a Look-back**  **Property Check**   * Must be completed to verify no real property was transferred in the look-back period (60 months prior to the date of application). * May be completed online or by sending a [DHHS Form 1255 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201255%20ME.pdf), Verification of Real and personal property if online information is not available. * The property check must be completed for:   + County of residence, and   + Other counties where the individual and/or spouse:     - In-state       * Alleges current or previous property ownership, and/or       * Resided for long periods in their adulthood.     - Out-of-state       * Alleges current ownership of property, and/or       * Alleges previous ownership of property within the past five years. Send a DHHS Form 1255 but do not wait for the return of the form to determine eligibility. * If the applicant/beneficiary (or spouse) indicates receiving an inheritance within five (5) years prior to the application date, obtain the name of the deceased person, when and where the person’s estate was probated, what type of resource was involved, and complete a probate court check.   **Asset Verification System - Balance Increase**  The worker must examine the AVS response for evidence that a transfer may have occurred.   * Account increase(s) that exceed $5000.00 within the lookback period, the worker must request verification of where the money came from.   Example: Bank statement for the month of the account increase, deposit slip, copy of a cancelled check, etc.   * Account increase(s) that are below $5000.00 but exceeds the applicant / beneficiary’s income by $1200.00 (or the couples’ combined income by $2400.00), the worker must obtain a verbal or written statement from the applicant / beneficiary or AR / legal representative.   **Example:** Jane Doe applied for Nursing Home Medicaid on December 31, 2015. Her SSA benefit of $1800.00 is deposited into her Bank of America account each month. An AVS search was completed for the 5-year look-back period. The AVS response is as follows:   |  |  | | --- | --- | | **Month/Year** | **Balance** | | 05/2015 | 1.24 | | 06/2015 | 8.82 | | 07/2015 | 7.77 | | 08/2015 | 19872.69 | | 09/2015 | 17229.53 | | 10/2015 | 15060.22 | | 11/2015 | 11589.29 | | 12/2015 | 9294.30 | | 01/2016 | 8649.08 | | 02/2016 | 6130.45 | | 03/2016 | 4517.53 | | 04/2016 | 3441.58 | | 05/2016 | 2619.44 | | 06/2016 | 1898.54 | | 07/2016 | 300.20 | | 08/2016 | 16.46 | | 09/2016 | 9.13 | | 10/2016 | 0.90 |   Jane Doe’s total monthly SSA net income is $1800.00 + $1200 = $3000.00. During the look-back period, the account balance increased from $7.77 in July 2015 to $19,842.69 in Aug. 2015. The funds were then spent gradually from Aug. 2015 through July 2016. The account increase was over $5000 in the look-back period. The worker should request verification of where the money came from. However, because the funds were spent gradually over time and never decreased by more $1200 of the applicant’s income, verification of how the money was spent is not required.  **Bank / Financial Account – Balance Increase**  The worker must examine the bank / financial account statement(s) for evidence that a transfer may have occurred. For instance:   * Account increase(s) that exceed $5000 within the look-back period should provide the information needed to determine where the money came from.   + If the information on the statement does not provide enough evidence to determine if a transfer occurred, the worker must request additional verification. * Account increase(s) that are below $5000 but exceeds the applicant / beneficiary’s income by $1200 (or the couples’ combined income by $2400.00), the worker must obtain a verbal or written statement from the applicant / beneficiary or AR / legal representative if the source of the deposit is not indicated on the statement.   Reminder: If account statement(s) are provided, the worker must review the statement(s) to determine if there are any sources of income that are not reported on the application. Such as, consistent deposits made to the account weekly, bi-weekly, monthly, semi-annually, annually, etc.  **Asset Verification System – Balance Decrease:**   * For month to month balance decrease(s) that are less than or equal to the monthly income, no additional information is needed * For month to month balance decrease(s) that exceed the monthly income by $1200 for an individual ($2400 for a couple) or less: * Request a verbal explanation to verify whether a transfer of assets occurred. If unable to obtain a verbal explanation, a statement should be requested via Form 1233. * Document the explanation in the appropriate systems. * Do not ask for bank statements, cancelled checks, or other paper verification * If a reasonable explanation is not provided, the account balance decrease(s) must be counted as a transfer of assets * Continue with the eligibility determination * For month to month balance decrease(s) that exceed the applicant/beneficiary’s income by more than $1200 (or $2400 for a couple): * Request written verification such as bank statement(s), receipts, cancelled checks and/or statement(s) from the provider(s) of services. * If documentation is not provided, the account balance decrease(s) must be counted as a transfer of assets   **Example 1:** A Nursing Home application was submitted for Jane Doe in December 2016. Her SSA benefit of $1300 (net) and pension of $550 (net) is deposited into her Wells Fargo checking account each month. The AVS response is as follows:   |  |  | | --- | --- | | **Month / Year** | **Balance** | | 12/2015 | $19,872.69 | | 01/2016 | $17,229.53 | | 02/2016 | $15,060.22 | | 03/2016 | $11,589.29 | | 04/2016 | $9294.30 | | 05/2016 | $6130.45 | | 06/2016 | $4517.53 | | 07/2016 | $3441.53 | | 08/2016 | $1898.54 | | 09/2016 | $300.20 | | 10/2016 | $16.46 | | 11/2016 | $9.13 | | 12/2016 | $0.00 |   Jane Doe’s total monthly net income is $1850.00 + $1200 = $3050.00. The account balance from Feb. to March 2016 decreased by $3470.93 and the account balance from April to May 2016 decreased by $3163.85, exceeding the applicant’s income by more than $1200. The eligibility worker should:   * Send Form 1233 to request verification of how money was spent from Feb. to May 2016 and from April to May 2016 by providing bank statement(s), receipts, cancelled checks, statement from person or provider that provided services, etc.   **Bank/Financial Account Statement(s) – Balance Decrease:**  For total monthly withdrawals or payments that exceed the applicant/beneficiary’s monthly income by $1200 (or $2400 for a couple) or less:   * Obtain a verbal or written explanation to verify whether a transfer of assets occurred. * Document the explanation in the appropriate systems * Do not ask for additional cancelled checks or other paper verification. * If a reasonable explanation is not provided, the payment or withdrawal must be counted as a transfer of assets. * Continue with the eligibility determination   For total monthly withdrawals or payments that exceed the applicant/beneficiary’s monthly income by more than $1200 (or $2400 for a couple):   * Request verification to determine if a sanctionable transfer occurred. * If the requested information does not provide sufficient verification to determine if a sanctionable transfer occurred, request additional verification   Example: Receipts, cancelled checks, statement from the provider(s) of services, etc.   * If documentation is not provided, the payment or withdrawal must be counted as a transfer of assets.   **Examples of verification(s) of payments or withdrawals that are not considered a sanctionable transfer of assets** include but are not limited to home repairs, doctor / hospital bills, other bills, church donations, adult personal care/sitter fees.  **Examples payments or withdrawals that need to be clarified** as they could be considered a sanctionable transfer of assets, include but are not limited to giving gifts or money to children or grandchildren, purchasing an annuity, receiving a promissory note, or property agreement.  Note: Annuities, property agreements, or promissory notes must be submitted to the Division of Policy and Process via a Service Manager ticket. |
| **For New Applications**  Determine if the applicant has included any bank statements with the application. If the current month and the three months prior to the month of application are included, evaluate for any potential transfers. An AVS request is created but it is not necessary to wait for the responses to be returned unless a potential transfer is indicated. If no statements are included with the application, do not request the statements from the applicant. Create an Asset Verification System (AVS) request for the 60-month look-back period. Adjust the dates as necessary based on any history that may already be in record. |
| **For Current or Past Beneficiaries**  If the beneficiary is currently eligible or has been eligible in an SSI-related category which required a resource determination, a 60-month look-back for bank accounts must still be conducted.   * Base the time of the look-back on the date of the request/application for HCBS or nursing home services * Identify and use what bank/financial information is already available in the case history.   + Verify the current account balance by collateral call or by creating a request through the Asset Verification System (AVS). Do not ask for bank statements from the applicant * Conduct a property search * Evaluate other resources * Contact the applicant to clarify any potential transfers and request documentation if needed * Complete the look-back  |  | | --- | | **Effective on or after March 13, 2017**  Current Medicaid beneficiaries in the Aged, Blind and Disabled category evaluated by CLTC for Home and Community Based Services (HCBS) on or after March 13, 2017, must complete a redetermination and look-back before being. A DHHS Form 3400-B must be submitted and the record assessed for any potential transfers before approving the beneficiary for enrollment by CLTC into HCBS.  For ABD beneficiaries enrolled by CLTC before March 13, 2017, the expedited process defined in Chapter 304 [Appendix I](#Appendix_I) can be used. | |  | |
| **Example 1:**  A Medicaid beneficiary has been continuously eligible for more than 60 months (was eligible prior to the 5-yr look-back period), and is currently eligible:   * Review the available bank statements from the case history * Verify the current balance by collateral call   + If unable to verify by collateral call, create an AVS request * Evaluate other resources * Conduct a property search * Contact the applicant to clarify any potential transfers and request documentation if needed * Complete the look back   **Example 2:**  A Medicaid beneficiary was eligible 60 months ago, is currently eligible but lost eligibility for a brief period due to a change in income   * Review available bank statements from the case history * Verify the current balance by collateral call   + If unable to verify by collateral call, create an AVS request * Conduct the property search * Evaluate other resources * Contact the applicant to clarify any potential transfers and request documentation if needed * Complete the look-back   **Example 3:**  A Medicaid beneficiary is currently eligible and has been eligible for the last three (3) years.   * Review the available back statements in the case record * Verify the current balance by collateral call   + If unable to verify by collateral call, create an AVS request * Complete a property search * Evaluate other resources * Contact the applicant to clarify any potential transfers and request documentation if needed * Conduct the look back |
| **Procedure – Conducting a Look-back for a Child**  Use the following guidelines to conduct a look-back for a transfer of assets for a child applying for any institutional service (waiver or nursing home):  Is the child currently eligible for Medicaid?   1. If “Yes”, does the case record show any assets in the name of the child? 2. If “Yes”, does the record show any possible transfers in the look-back period? Does the DHHS 3400-B allege any transfers in the look-back period months?    * 1. If “Yes”, verify the details of the possible transfer, and calculate the transfer penalty if appropriate.      2. If “No”, conduct a property search in the child’s name. If no property found, look-back is completed. 3. If “No”, conduct a property search in the child’s name. If no property found, look-back is completed. 4. If “No”, does the application allege any assets in the name of the child? 5. If “Yes”, does the application show any possible transfers in the look-back period?    * 1. If “Yes”, verify the details of the possible transfer, and calculate the transfer penalty if appropriate.      2. If “No”, conduct a property search in the child’s name. If no property found, look-back is completed 6. If “No”, conduct a property search in the child’s name. If no property found, look-back is completed. |
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304.09.02D Penalty Period – Important Points

(Rev. 12/01/21)

**Maximum Penalty Period** – There is no maximum penalty period. (Refer to MPPM [304.09.05](#MPPM_304_09_05) for computation of penalty period.)

**Beginning Date of Penalty Period** – For transfers occurring on or after February 8, 2006, the beginning date of the penalty period is the later of:

* The first day of the month in which the asset was transferred, or
* The date on which the individual is eligible for medical assistance for long term care and would otherwise be receiving a vendor payment if not for the application of the penalty period. In other words, the penalty begins when the individual would have been eligible for a vendor payment if there had been no transfer.

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| Procedure **Nursing Home**  For initial applications, the start date of the transfer penalty is determined as the date the individual would have been authorized for vendor payment but for the application of the penalty period.  **Example:** Jack Bristow applied for Nursing Home coverage on March 12. He entered Vaughn Acres Nursing Home on April 23. It is determined there was a transfer that will result in a six (6) month penalty period. Mr. Bristow meets all other eligibility criteria. The penalty period for Mr. Bristow will begin April 23, the date he could have been authorized for a vendor payment but for the imposition of the penalty period, and he could be potentially eligible for Nursing Home or other long-term care services after October 23. |
| **Home and Community Based Services**  An application for Home and Community Based Services (HCBS) can trigger the start of a transfer penalty period.  The Eligibility Specialist will process the Waiver application up to the point of a financial determination. The Eligibility Specialist must:   * Complete a budget workbook   + Confirm that the applicant meets all the financial criteria but for the having a sanctionable transfer.   + Calculate the penalty period using the current date as the effective date of the transfer to determine the length of the penalty.   + Upload the budget workbook into Onbase. * Check the System of Record   + In MEDS,     - Make sure all information is correct and up to date     - Do not deny the application   + In Cúram     - Update all evidence     - Complete Check Eligibility     - Do not authorize the denial decision * Submit a Service Manager ticket for case assignment to an EEMS Policy Technician who will work with CLTC to impose the penalty. Refer to the **Service Manager Instructions** below * Update the Documentation Template   + Ensure it is thoroughly completed   + Action summary should include:     - Case is financially cleared but for a transfer penalty     - Service Manager Ticket has been submitted for the case to be completed by the Policy Team and no one should touch. Include the Service Manager ticket number * Send case to follow-up in OnBase for 30 days. (Prevents case from coming back into workflow) * Put in **Not Finished** in WLP. * Will not take any action in Phoenix. The Policy Technician will complete the necessary actions in Phoenix.  |  | | --- | | **Service Manager Instructions**  Eligibility Specialists will use the following temporary procedure to submit a ticket in Service Manager:  Under the ***EEMS Category***, select the ***Phoenix and CLTC Corrections*** offering.  Answer the following questions:   * Specialist preferred contact number * Applicant/Beneficiary Name * Spouse’s name (if applicable) * Date of Birth * Medicaid ID   Other Identifiers such as the HH#, CGIS ID#, or Phoenix ID# if known should be added in the appropriate box separated with commas.  From the Select a Category for this Ticket drop down select: ***CLTC Correction issue.***  In the *Provide Any Additional Details box* add: **Waiver Applicant with a Transfer Penalty.**  Select Save to complete the ticket submission. | |
| **Penalty Period for Transfers Occurring After Approval** If a transfer occurs after an individual has been approved for Nursing Home or HCBS, the start date for the transfer penalty is determined as the first day of the month in which the transfer occurred. Because a beneficiary eligible for HCBS is already receiving waiver services, the start of penalty period is triggered. Once the penalty period is completed, the individual can be approved for institution services if he applies. |

The penalty period cannot overlap with the term of a prior penalty period.

**Multiple Transfers**

* If the individual made multiple transfers for less than Fair Market Value during the look-back period, and the transfers occurred in the same or different months, the transferred amounts are added together.

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| Example 1: Janice Wilkes applies for Medicaid in June. In February, she transferred $10,000 to each of her three grandchildren.  The transferred amount is calculated as follows:  $10,000 + $10,000 + $10,000 = $30,000  **Example 2:** Summer Blake applies for Medicaid on June 1. Last September, she gave $10,000 to her granddaughter. In October, she transferred property worth $15,000 to her grandson.  The transferred amount is calculated as follows:  $10,000 + $15,000 = $25,000  **Example 3:** Calvin Hobbs applies for Medicaid on December 15. In April, he transferred $30,000 to his son. In July, he transferred $35,000 to his daughter.  The transferred amount is calculated as follows:  $30,000 + $35,000 = $65,000 |

304.09.02E Transfers by a Spouse

(Eff. 06/01/06)

If the institutionalized individual is being penalized due to a transfer by the community spouse, and the community spouse becomes institutionalized and applies for Medicaid, the penalty must be apportioned between both spouses.

If one member of the couple should leave the facility or die, the remaining portion of the penalty must be served by the remaining institutionalized spouse.

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304.09.02F Transfers of Jointly Held Assets

(Eff. 06/01/06)

Jointly held assets may also be transferred. Such transfers may be subject to a penalty.

An asset held by an individual jointly with another person is considered to be transferred by the individual when any action is taken to reduce or eliminate the individual’s ownership or control of the asset by the individual or the other owner(s).

The individual is not penalized for the transfer if the other person can prove that the institutionalized individual:

* Has no ownership interest, or
* Has only partial interest in the asset, and the part removed is the amount owned by the other person.

Joint bank accounts are the most common type of bank account and jointly-held asset. Adding another person’s name on an account or asset as a joint owner may not necessarily constitute a transfer of asset. There is **no transfer** if the account or asset may still be considered to belong to the individual.

| WHEN A TRANSFER OF A JOINTLY-HELD ASSET OCCURS | |
| --- | --- |
| Situation | Date of Transfer |
| Other person withdraws funds. | Date of withdrawal |
| Other person removes an asset. | Date of removal |
| Placing the other person’s name on the account limits the individual’s right to sell or dispose of the property. | Date name was placed on the account or asset |

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| **Examples - No Transfer of Asset**  **Example 1:** Jason Young added his son’s name to his bank account as a precaution should he be unable to handle his account for some reason. Richard Young makes no deposits to the account from his own money. The only withdrawals he makes are for his father’s benefit.  **Example 2:** Rachel Silver and her daughter, Joan Sox, had a jointly-held account. The account was closed three months ago for $25,000 and the money was placed in an account in Joan’s name only. Rachel states the money was not hers, and her name was only on the account in case her daughter became ill and money was needed for her young children. Joan provides verification that the bank account was established from funds transferred from her personal account. |

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| **Example - Transfer of Asset**  Rick Snow added his daughter Lela’s name to his bank account last year. Two months ago, Lela withdrew $15,000 to buy a swimming pool for her family. Rick is a nursing home patient, and Lela is applying for Medicaid to cover his bills. A transfer of asset took place the date the money was withdrawn. It was not used for Rick’s benefit. |

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304.09.02G Transfers and Lifetime Rights to Property

(Rev. 12/01/07)

An individual with a life estate interest has the right to use property and obtain income from the property during his/her lifetime. An individual may receive a life estate interest through a will (for example, a husband wills the home to his wife during her lifetime and it passes to his children upon her death).

Sometimes an individual will transfer the ownership of rights to property to someone else but retain a life estate interest for himself/herself. Although the individual has the right to use the property and obtain income from it, he/she transferred the ownership interest. The value of the transfer is the difference between the value of the property and the value of the individual’s life estate interest in the property. The value of the life estate is calculated using the age of the individual at the time the transfer was done, rather than the date of the Medicaid application.

A transfer of a life estate is sanctionable, and the uncompensated value is calculated using the age of the individual at the time the transfer occurred.

The tables used to establish the value of the life estate are found in Chapter 302 Appendix F.

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| Example 1: Last month, Paul Taylor, age 80, transferred his homestead to his son for $5 love and affection, and retained a life estate. The property is valued at $100,000.  To determine the uncompensated value:  $100,000 x .43659 = $43,659 (life estate value)  $100,000 - $5 (amount rec’d.) - $43,659 (life estate value) = $56,336 (uncompensated amount)  **Example 2:** At the time of his death in 2000, Jane Eyre’s husband left her lifetime rights to the farm then valued at $150,000. She is now applying for nursing home care, and it is discovered she transferred her life estate interest to her son last month. She is currently age 95 and the property has increased in value to $250,000.  To determine the uncompensated value:  $250,000 x .22887 = 57217.50 (uncompensated value of the life estate at the time of transfer) |

The purchase of a life estate in another individual’s home on or after February 8, 2006 is a transfer of asset unless the purchaser resides in the home for at least 12 consecutive months after the date of purchase. Do not deduct vacations, overnight visits, and hospital stays from the one-year period as long as the home continued to be the individual’s legal residence. Count the entire purchase price as an uncompensated transfer if the purchaser resides in the home for any period less than one year. Determine the sanction period based on the purchase price.

In addition to the above requirement, the purchaser must not pay more than fair market value for the life estate. Any amount paid above fair market value is considered a transfer and should be penalized according to the transfer policy.

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| **Procedure**   * Verify the life estate purchase   + Copy of deed   + County tax records * Verify the Fair Market Value (FMV) of the property. The county tax assessed value may be used * Verify the purchase price and calculate the fair market price of the life estate. Any amount over the fair market value of the life estate is considered a transfer * Verify that the individual purchasing the life estate lived in the home for at least 12 consecutive months after the date of purchase. Acceptable forms of verification include:   + Old postmarked mail received at the address   + Bills such as electric or telephone in her name   + Statements from at least two persons who indicate the individual lived in the home for at least 12 consecutive months after the date of purchase |

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304.09.02H Transfer of Assets in Month of Receipt

(Rev. 10/01/06)

Assets transferred in the month of receipt are subject to penalty under the transfer of assets provision, even though the asset may not be a countable resource in the month of receipt.

Examples:

* Cash proceeds of a loan, home equity loan, or reverse mortgage
* An inheritance

304.09.02I Transfer of Income

(Rev. 03/01/12)

Income is considered an asset for transfer purposes. If an individual gives away or assigns income to another person, the gift or assignment can be considered a transfer of assets for less than fair market value,

When a single lump sum is transferred, such as an annual rent payment, the penalty period is calculated using the value of the lump sum. If the transfer of several payments has taken place, the total of the payments are added together and the penalty period is calculated based on the total.

If the transfer was a stream of income, determine the value of the stream of income by multiplying the life expectancy of the individual at the time of the transfer by the annual amount of income that would have otherwise been received.

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| **Procedure**   1. Calculate the annual amount of the stream of income 2. Determine the individual’s life expectancy using the Life Expectancy table located in Appendix A 3. Multiply the individual life expectancy by the annual amount of the income stream 4. If a transfer occurred, refer to MPPM [304.09.05](#MPPM_304_09_05) to calculate the transfer penalty   **Example:** Mr. George Wildcat, age 60, receives a royalty check for $100 each month. He transfers his right to receive this income to his nephew on May 6, 2013. He applies for Nursing Home Medicaid on January 21, 2015.   1. $100.00 x 12 = 1200.00 2. The life expectancy table indicates a 60 year old male has a life expectancy of 19.07 years 3. $1200.00 x 19.07 = $22,884.00   The value of the transfer is $22,884.00. |

304.09.03 Exceptions to the Penalty

(Rev. 04/01/07)

Resources excluded under SSI policy (except for the home) are not subject to the transfer of assets penalty. However, assets that are excluded by Medicaid but not by SSI are subject to the transfer of assets penalty.

If there has been a transfer of assets, no penalty is imposed if:

1. The asset transferred was a home, and title to the home was transferred to:

• The spouse of the institutionalized individual;

• A child who:

* + Is under age 21, or
  + Meets the Supplemental Security Income (SSI) definition of blindness or disability (may be at any age); or
  + Was residing in the home:

– For at least two years immediately before the individual became institutionalized; **and**

– Who provided care which delayed institutionalization.

• A sibling of the individual who:

* + Has an equity interest in the home; **and**
  + Was residing in the home for at least one year immediately before the date the individual became institutionalized.

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| Procedure – Home is Transferred to a Child  The following must be verified:   * Relationship (Examples of verification: birth certificate, adoption papers, family Bible) * Criteria for not imposing penalty   + Age, if under 21   + Blindness or disability   + Length of residence   + Doctor’s statement verifying the child’s care delayed the need for institutionalization.   **Procedure – Home is Transferred to a Sibling**  The following must be verified:   * Relationship * Sibling’s equitable interest * Length of time sibling has resided in the home |

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| **Example:** Mr. Brownlee applied for Medicaid through the Nursing Home program. It was discovered that he transferred his home to his daughter one year before he applied for Medicaid. The home was valued at $250,000. The daughter explained that Mr. Brownlee wanted her to have the home because she had lived with him and cared for him since he had a stroke six years ago so that he would not have to be placed into a nursing home. She said she had occasionally hired a sitter to stay with him while she ran errands; but, for the most part, she had cared for him herself for the past six years. Now that his health had deteriorated to the point that she was no longer able to provide the care he needed, she has placed him in a nursing home.  **Treatment:** No penalty is imposed for this transfer of assets if the daughter can provide the following sources of verification:   * Verification of her relationship to Mr. Brownlee   + Birth certificate   + Family Bible * Verification that she lived at the same address as her father for at least two years immediately before he was institutionalized. Acceptable forms of verification include:   + Old postmarked mail received at the address   + Bills such as electric or telephone in her name   + Statements from at least two persons who know she stayed at the same address and provided for her father’s care. * Verification from her father’s doctor stating that the care she provided delayed institutionalization. |

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1. The assets were transferred:

* To the individual's spouse or to another person for the sole benefit of the spouse; or
* From the individual's spouse to another person for the sole benefit of the individual's spouse;
* To an individual’s child or to a trust established solely for the benefit of the individual’s child. The child MUST be blind or totally and permanently disabled as defined by SSI.
* To a trust established solely for the benefit of an individual under age 65 who is disabled as defined by SSI.

A transfer is considered to be "for the sole benefit of" a spouse, disabled child or individual under age 65 under the following circumstances:

* The transfer is arranged in such a way that no individual except the spouse, child or individual under age 65 can benefit from the assets transferred in any way at the time of transfer or in the future.
* The trust may provide for reasonable compensation for a trustee to manage the trust.
* If a secondary beneficiary is named to receive the asset, or whatever is left, at the individual's death as long as:
  + The state Medicaid agency is:

– Named as the primary beneficiary of the asset, and

– Receives up to the amount paid by Medicaid; and

* + The other designated beneficiary is only to receive any remaining amounts after the obligation to Medicaid is satisfied.

1. The individual can show that he/she intended to dispose of the assets either at Fair Market Value or for other valuable consideration.
2. The individual can show that he/she transferred the assets exclusively for a purpose other than to qualify for Medicaid.

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| **Procedure**  If the individual indicates the transfer was made for a reason other than to qualify for Medicaid:   * Request a written statement from the individual outlining the circumstances of the transfer. The statement should at least include the following:   + A listing of all transferred assets;   + The reason(s) for the asset transfer;   + To whom the assets were transferred;   + Compensation received for the asset;   + The financial condition of the applicant at the time of the transfer; * A statement from the individual’s physician detailing the health status of the applicant at the time of the transfer. * Request the names and addresses of all principals involved including attorneys, realtors, or any individuals having knowledge of the circumstances surrounding the transaction; * Request collaborative statements from anyone having supporting evidence that the transfer occurred exclusively for reasons other than to qualify for services; and * After the county has reviewed the information, forward all material to the Division of Policy and Planning for a decision. |

1. All assets transferred for less than Fair Market Value have been returned to the individual.
2. The individual can show that the transfer occurred because of exploitation.

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| Procedure – Verification of Exploitation  Refer the applicant or authorized representative to DSS Adult Protective Services. Require verification that the exploitation has been reported to the Solicitor for prosecution. |

1. A transfer that does not meet one of the above six exceptions and for which a denial of vendor payment or Home and Community Based Services has occurred may have the penalty waived if it is determined that the denial of eligibility would cause an *undue hardship*. Undue hardship is defined as depriving the applicant/beneficiary of medical care that would result in the individual’s health or life being endangered, or that would result in the individual being deprived of food, clothing, shelter, or other necessities of life. The applicant/beneficiary, an authorized representative, or a nursing facility with the consent of the applicant/beneficiary or his authorized representative may make a request for a waiver of the penalty. Refer to MPPM 304.09.04 for the waiver of transfer penalty procedure.

304.09.04 Waiver of Transfer Penalty Procedure and 30-Day Hold

(Eff. 04/01/07)

Within thirty (30) days of an applicant/beneficiary receiving the [DHHS Form 932](http://medsweb.scdhhs.gov/EligibilityForms/FM%20932.pdf), Notice of Denial of Waiver Services or Nursing Home Care, indicating that a vendor payment or eligibility for HCBS services has been denied due to the imposition of a transfer penalty, the individual, the individual's spouse or authorized representative, or the institution where the individual resides (with the individual's consent) may submit a written request for a waiver of the penalty period based on a claim of undue hardship.

It must be demonstrated that all other possible exceptions to the imposition of the transfer penalty has been explored, including return of the asset to the applicant/ beneficiary.

The eligibility worker must obtain the following verifications:

* + Letter from a physician certifying that the applicant/beneficiary is at risk of death or permanent disability without the institutional care; AND
  + Letter from CLTC either denying or terminating services; OR
  + Letter from the nursing home either:
  + Refusing to admit the patient, or
  + Threatening discharge of the patient.

Send the letters, a copy of the DHHS Form 932, and other documentation to the DHHS Division of Policy and Planning in the Division of Policy and Planning for evaluation.

While an application for waiver of the penalty period is pending for an individual currently residing in a nursing facility, a payment may be made to the facility for up to 30 days from the date the request is made if the individual meets all other eligibility criteria. The nursing facility may request an earlier date, but in no event will the start date occur after the date of the request.

The DHHS Form 3229-C, Request for Waiver of Transfer Penalty, is used by the Medicaid eligibility worker to:

* Notify applicants/beneficiaries the dates that have been approved for the bed hold and any recurring income to be paid to the facility, and/or
* Notify the applicant/beneficiary if the request for the waiver of transfer penalty has been approved or denied.

If a request for a waiver of the penalty period is denied, the applicant/beneficiary may request a fair hearing. Refer to MPPM 101.12.11.

304.09.05 Calculating the Penalty Period

(Eff. 01/01/21)

The preferred method for calculating the penalty period is to use the eligibility budgeting workbook in effect at the time of the eligibility decision. The result is the period during which the individual would be ineligible for certain Medicaid services. (Refer to MPPM [304.09.07](#MPPM_304_09_07).)

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| Procedure to Calculate the Penalty Period Using the Eligibility Workbook   * Determine the uncompensated value of the transferred asset(s).   + Fair Market Value – amount received = amount transferred   + Amount transferred – amount of legal encumbrance (such as a mortgage or lien) = uncompensated value  1. Total the uncompensated value of all assets transferred by the individual and/or his or her community spouse. 2. Enter the Effective Date of Transfer (refer to MPPM 304.09.02D, Beginning Date of Penalty Period) and the Amount of Transfer into the Transfer Penalty Calculator on the NH-HCBS tab in the eligibility workbook in effect at the time of the decision. 3. The results will display the length of the penalty period, the end date of the penalty period, and the first date the individual may be able to qualify for services.  |  |  |  | | --- | --- | --- | | **Transfer Penalty Calculator** | |  | | Effective Date of Transfer | Amount of Transfer |  | | 1/1/2021 | 25,000.00 |  | |  |  |  | | Length of Transfer Penalty | End of Penalty Period | Date of Vendor Payment Eligibility | | **0 years, 3 months, 3 days** | **4/3/2021** | **4/4/2021** | |
| Procedure to Manually Calculate the Penalty Period  Note: The manual method shown below is included to demonstrate the steps used to determine the penalty. Using the manual method may produce slight differences in the length and end dates of the penalty period due to Excel being able to determine the length of the penalty period with more precision and account for the actual number of days in each month.   * Determine the uncompensated value of the transferred asset(s).   + Fair Market Value – amount received = amount transferred   + Amount transferred – amount of legal encumbrance (such as a mortgage or lien) = uncompensated value * Total the uncompensated value of all assets transferred by the individual and/or his or her community spouse. * Divide by the state’s most current average private pay nursing home rate (Refer to MPPM 103.07A). **Do not** use the average pay rate that was in effect at the time the transfer occurred. * **Do Not** round answer down to the nearest whole number. * Multiply the fractional amount of the month by 30 days to determine the partial month penalty period.  |  |  | | --- | --- | | Uncompensated Amount | = Length of Penalty Period | | Current Average Nursing Home Private Pay Rate |   The result is the period the individual would be ineligible for certain Medicaid services.  **Example:** Alton Gray transferred $10,000. The penalty period is calculated as follows:  $10,000 ÷ $8,104.52 = 1.23 (round to two places)  .23 x 30 = 6 (round down to whole day)  Length of penalty period is 1 month, 6 days |

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| **Example 1**  Sam Mills applied for Nursing Home Assistance on March 27, 2021. He meets level of care and all other eligibility criteria and entered the facility on April 1, 2021. On April 12, 2019, he gave his grandson Rick $10,000. On April 17, 2019, he gave his granddaughter Jean $10,000. On April 28, 2019, he gave his daughter Laura $15,000.   |  |  |  | | --- | --- | --- | | **Transfer Penalty Calculator** | |  | | Effective Date of Transfer | Amount of Transfer |  | | 3/1/2021 | 147,358.45 |  | | Length of Transfer Penalty | End of Penalty Period | Date of Vendor Payment Eligibility | | **0 years, 4 months, 9 days** | **7/9/2021** | **7/10/2021** |   **Example 2**  Susie Moss gave her grandson an acre of land (FMV $28,000) on February 19, 2019. On May 3, 2019, she gave her granddaughter $25,000. She applies for Nursing Home assistance on June 30, 2021. She meets level of care and all other eligibility criteria and entered the facility on July 15, 2021.   |  |  |  | | --- | --- | --- | | **Transfer Penalty Calculator** | |  | | Effective Date of Transfer | Amount of Transfer |  | | 7/15/2021 | 53,000.00 |  | | Length of Transfer Penalty | End of Penalty Period | Date of Vendor Payment Eligibility | | **0 years, 6 months, 14 days** | **1/28/2022** | **1/29/2022** |   **Example 3**  John Slick transferred $25,000 to his son on February 22, 2019. He meets level of care and all other eligibility criteria and entered Acres Nursing Facility on March 10, 2021. The transfer penalty is calculated as follows:   |  |  |  | | --- | --- | --- | | **Transfer Penalty Calculator** | |  | | Effective Date of Transfer | Amount of Transfer |  | | 3/10/2021 | 25,000.00 |  | | Length of Transfer Penalty | End of Penalty Period | Date of Vendor Payment Eligibility | | **0 years, 3 months, 1 days** | **6/10/2021** | **6/11/2021** |   **Note:** Although the vendor payment cannot be authorized, the applicant may be eligible for MAO-NH, Payment Category 10, or other Medicaid category if all other eligibility criteria are met. Refer to MPPM 101.04.01.  **Example 4**  Frank Purvis was approved for Nursing Home Medicaid effective June 12, 2009. In May 2021 while reviewing the case, his eligibility worker discovers that Mr. Purvis transferred homestead property to his daughter on October 20, 2020. The property is valued at $135,000. The transfer penalty is calculated as follows:   |  |  |  | | --- | --- | --- | | **Transfer Penalty Calculator** | |  | | Effective Date of Transfer | Amount of Transfer |  | | 10/1/2020 | 135,000.00 |  | | Length of Transfer Penalty | End of Penalty Period | Date of Vendor Payment Eligibility | | **1 years, 4 months, 18 days** | **2/18/2022** | **2/19/2022** |   **Note:** The eligibility worker will terminate vendor payment as soon as possible, giving the appropriate notice. An overpayment summary must be completed for any vendor payments made to the facility during the penalty period. The beneficiary’s Medicaid eligibility is not affected. |

304.09.06 Notification of Penalty

(Rev. 04/01/07)

If an applicant/beneficiary or the community spouse has transferred assets for less than Fair Market Value and the transfer is penalty-liable, the eligibility worker must notify the applicant/beneficiary or authorized representative using a [DHHS Form 932](http://medsweb.scdhhs.gov/EligibilityForms/FM%20932.pdf), Notice of Denial of Waiver Services or Nursing Home Care for Medicaid Beneficiaries.

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| Procedure – Notification of Penalty  The written notification of penalty must include the following information:   * Item transferred; * Value of the penalty; * Beginning date of the penalty; * Length of the penalty period; and * Services that will not be covered by Medicaid during the penalty period:   + Vendor payment to a nursing facility, and/or   + Community Long-Term Care services.   **Note:** The notification must be issued even if the individual is already eligible under an “at home” coverage group such as SSI, ABD. A copy of the DHHS Form 932 must be forwarded to CLTC/DDSN if the individual is an applicant for or beneficiary of home and community based services. |

304.09.07 Medicaid Benefits during Penalty Period

(Rev. 04/01/07)

An individual residing in a nursing facility while he/she is awaiting the expiration of a transfer of assets penalty, may receive Medicaid benefits to pay for non-institutional services provided, if:

* The level of care has been certified, and/or
* All other eligibility criteria (financial and non-financial) are met.

304.09.08 Annuities

(Rev. 04/01/07)

Refer to MPPM [304.12](#MPPM_304_12) for policy concerning annuities.

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304.10 Obtaining Other Assets/Elective Share

(Eff. 06/01/06)

If a benefit is available to an applicant/beneficiary, he/she must make an effort to obtain the benefit or asset. Failure to do so may result in a transfer of assets.

One such asset relates to the claiming of an **elective share** from a spouse’s estate. The South Carolina Probate Code gives a surviving spouse the right to claim an “elective share” of the deceased spouse’s estate.

The Elective Share is one-third of the estate remaining after deductions for:

* Funeral expenses,
* Administrative expenses, and
* Enforceable claims (SC Code Ann.62-2-201 and –202).

The right to an Elective Share usually becomes an issue when:

* The surviving spouse inherits nothing, or
* The surviving spouse receives only a small inheritance.

In these types of cases, the surviving spouse can demand his/her elective share of 1/3 of the estate. The surviving spouse must claim the elective share by the later of these two dates:

* Within 8 months of the decedent’s death; or
* Within 6 months of the time the decedent’s will is probated.

An individual applying for Medicaid sponsorship of nursing facility services or Home and Community Based Services **must** claim the elective share. Failure to do so will be considered a transfer of assets.

* If the surviving spouse received no inheritance and did not claim the elective share; the value of the transfer is 1/3 of the estate, after expenses
* If the surviving spouse inherited an amount less than the elective share, the value of the transfer is 1/3 of the estate, after deductions for expenses, minus the amount actually received

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| Procedure – Elective Share and Calculating the Penalty Period   1. **Determine the Elective Share Value**  * Determine the total value of the decedent’s estate. * Deduct the following expenses:   + Funeral expenses   + Administrative expenses   + Enforceable claims filed against the estate * Divide the remainder by 3; this amount represents the value of the elective share to which the surviving spouse is entitled.  1. **Determine the Amount Transferred**  * Take the value of the elective share. * Subtract the value of any of the decedent’s property passing to the surviving spouse. * The difference is the amount transferred.  1. **Determine the Penalty Period**  * The amount transferred is then divided by the monthly average private pay rate to determine the number of months to which the penalty applies.   For purposes of the transfer penalty, the transfer is deemed to have occurred on the last day that the surviving spouse could have claimed the elective share.  **Example:** The husband is in a nursing facility as a Medicaid beneficiary. His wife dies on January 1, leaving him nothing in her will. Her will is probated on February 1, but the husband fails to make a claim against her estate. The estate consists of real property and certificates of deposit with a total value of $105,000. Expenses and claims against the estate total $27,000, leaving a “net” estate subject to the elective share provisions of $78,000.  **Treatment:** The husband is entitled to receive 1/3 of this net estate as his elective share ($26,000.) The last day on which he could have claimed the elective share was August 31 (that is, within 8 months from the date of her death, since this date is later than 6 months from the date the will was probated.) His failure to claim the $26,000 to which he is entitled is treated as a transfer of resources on August 31.  **Note:** If the cost of obtaining the asset is greater than the value of the asset, the individual is not required to pursue it. |

304.11 Promissory Notes

(Rev. 02/01/22)

A promissory note is a written, unconditional promise by one party to pay a specified sum of money to another party. It may be:

* Payable:
  + At a specified time
  + On a specified schedule
  + On demand
* Given in return for goods, money loaned, or services rendered
* Negotiable or non-negotiable

Negotiable Notes

* May be sold or transferred, and
* Value is a countable resource.

Non-Negotiable Notes

* May not be sold or transferred under any circumstances.
* May not be considered a transfer of an asset for less than Fair Market Value if:
  + It is actuarially sound – that is, expected to be paid back during the holder’s lifetime (refer to MPPM [304.11.01](#MPPM_304_17_01))
  + It requires monthly payments that fully amortize it over the life of the loan
    - Equal payments with no balloon payment at the end
    - Payments include both interest and principal
    - Reasonable rate of interest
    - May NOT be self-canceling or conditional

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| Procedure – Promissory Notes  All Promissory Notes must be submitted for evaluation. Refer to the [Service Manager Ticket Submission Guide](https://gcc02.safelinks.protection.outlook.com/ap/b-59584e83/?url=https%3A%2F%2Fschhs.sharepoint.com%2F%3Ab%3A%2Fr%2Fsites%2FEES%2FTraining%2FService%2520Manager%2FService%2520Manager%2520Ticket%2520Submission%2520Guide.pdf%3Fcsf%3D1%26web%3D1%26e%3DDHOO8D&data=04%7C01%7CCOVINGJ%40scdhhs.gov%7C3040a6d257514d2e09bc08d9e0db442e%7C4584344887c24911a7e21079f0f4aac3%7C0%7C0%7C637788054768975231%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000&sdata=YYohw3saNIbmBOMcCEmwJ1LWC8SWqOsokQe8W%2B6IleA%3D&reserved=0) for instructions. |

304.11.01 Actuarially Sound Notes

(Eff. 06/01/06)

Like an annuity, the non-negotiable note must be actuarially sound. The expected return on the note must be proportionate with a reasonable estimate of the life expectancy of the owner of the note (that is, it is expected to be paid off within the owner’s lifetime). If the note is NOTactuarially sound, it is considered a transfer of assets for less than Fair Market Value and the transfer of assets penalty applies. (Refer to MPPM 304.11.03.)

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| Procedure – Determining if Non-Negotiable Note is Actuarially Sound   * Use the Life Expectancy Table found in MPPM Chapter [Appendix A](#Appendix_A). Life expectancy is based on the individual’s age at the time the promissory note was executed (the date signed), NOT the date of the Medicaid application. * The average number of years of expected life remaining on the table for the owner’s age must be equal to or less than the number of years stated in the note to be paid. * If the individual is not expected to live long enough to receive full payment on the note:   + Fair market value was not received, and   + The transfer penalty is applied. |

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304.11.02 Transfer of Assets Related to Promissory Notes

(Eff. 01/01/21)

For notes created on or after February 8, 2006, the transfer penalty begins the later of the first day of the month in which the asset was transferred, or the date on which the individual is eligible for medical assistance for long term care and would otherwise be receiving institutional level care (vendor payment) if not for the application of the penalty period (Refer to MPPM [304.09.02D](#MPPM_304_09_02D).)

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| **Procedure – Promissory Notes and Calculating Transfer of Assets Penalty Period for notes created on or after February 8, 2006**   * If the promissory note, loan, or mortgage does not meet the criteria listed in MPPM 304.11, determine the outstanding balance due as of the date of application. * Divide the uncompensated value by the average private pay nursing facility rate in the state. (Refer to MPPM Chapter 304 [Appendix D](#Appendix_D).) Follow the procedure for calculating a transfer penalty as shown in MPPM 304.09.05.   **Example #1**  Mr. Jones is 89 years old. He applies for assistance on March 1, 2021. He sold his home and surrounding property for $150,000. He holds the note, which is to be paid off in 30 years at 4% interest. The note is non-negotiable; therefore, it must be determined if the note meets the test of being actuarially sound. The note was signed, and payments began March 1, 2020, when he was age 88. The note is not actuarially sound because the length of time for payments through the note is 30 years, and Mr. Jones' life expectancy at the time the note was executed was 4.26 years. Therefore, Mr. Jones is not considered to have received Fair Market Value based on the projected return and the transfer of assets penalty is applied.  To calculate the transfer of assets penalty:   * Determine the balance due on the note on the date of application,   March 1, 2021: $147,358.45.   * Enter the date of application and the balance due into the Transfer Penalty Calculator.  |  |  |  | | --- | --- | --- | | **Transfer Penalty Calculator** | |  | | Effective Date of Transfer | Amount of Transfer |  | | 3/1/2021 | 147,358.45 |  | | Length of Transfer Penalty | End of Penalty Period | Date of Vendor Payment Eligibility | | **1 years, 6 months, 4 days** | **9/4/2022** | **9/5/2022** |   **Treatment:** The penalty period is 18 months and 27 days (1 year, 6 months, 4 days): March 1, 2021 through September 4, 2022. The vendor payment may not be authorized earlier than September 5, 2022. Medicaid may be approved if otherwise eligible.  **Example #2:** Mr. Smith 3is 50 years old. He sells a piece of property valued at $10,000. On September 1, 2020, he signs the mortgage and payments begin that day. The mortgage is non-negotiable and will be paid off in 25 years. According to the Life Expectancy Table, Mr. Smith is expected to live 27.13 years.  **Treatment:** Since the mortgage will be paid off in 25 years, the note is considered actuarially sound.  Note: If it is determined that a transfer of assets did not occur and the mortgage is actuarially sound, the scheduled loan payments, including the interest, are counted as income in the month received in the eligibility and post-eligibility steps. The loan payments will be counted as income according to the schedule stated in the mortgage. |

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304.11.03 Default on Payments

(Eff. 06/01/06)

As long as the requirements in MPPM [304.11.01](#MPPM_304_17_01) are met and payments are made, no transfer has occurred. Should the borrower default on his/her payments, the owner of the note must take legal action to foreclose on the note. The owner must provide documentation of the action being taken. If the owner fails to take any action to foreclose on the note, he/she is considered to have transferred assets equal to the remaining value of the note. The effective date of this transfer is the date the payments stopped.

304.11.04 Forgiving Principal Portions of Promissory Notes

(Eff. 06/01/06)

Forgiving Principal Portions of Promissory Notes

If a promissory note was approved by the Eligibility, Enrollment, & Member Services, it has been determined the note:

* + - * Is actuarially sound; AND
      * Was established to create a stream of income; AND
      * Is fully amortized over the life of the note.

If the owner of the note later gifts a portion of the principal balance of the note, Medicaid cannot forgive the owner of the note for gifting the principal balance of the note. The monthly payments he/she gifted would still be counted as income to the beneficiary. This means the gift will not change the final payment or principal balance of the note.

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| **Example:** Mrs. Smith is a Medicaid beneficiary. She established an actuarially sound non-negotiable promissory note prior to becoming eligible. The terms of the note state she is to receive $325 per month for a period of 5 years (60 months running from November 2004 through October 2009). At annual review, it is discovered that she “gifted” $5,000 of the principal balance to her daughter.  **Treatment:** The $325 remains countable income each month for the term of the original note ($325 per month through October 2009). |

304.12 Annuities

(Eff. 06/01/06)

Annuities are generally purchased from a financial institution such as a bank or insurance company. The purchaser/annuitant is promised regular payments of income in certain amounts in exchange for the money paid to the financial institution.

304.12.01 Periodic Payments

(Eff. 06/01/06)

Payments from an annuity usually continue for a fixed period (such as 10 years) or as long as the annuitant or other designated beneficiary lives. These payments create an ongoing income stream for the individual.

The annuity may or may not include a remainder clause under which the financial institution converts and pays the remainder of the annuity in a lump sum to a designated beneficiary in the event the annuitant dies before the payout is completed.

304.12.02 Purpose of Annuity

(Rev. 02/01/22)

**Policy for Annuities before February 8, 2006:**

Annuities are generally purchased to provide a source of income for retirement. However, they are occasionally used as a mechanism to shelter assets. The following determinations must be made to decide if the transfer of assets penalty applies to an individual who has purchased an annuity.

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| **Procedure to Determine Purpose of Annuity**  It is considered to be a creation of a stream of income if:   * It was purchased as part of a retirement plan and regular payments were made while employed; or * It was purchased with a lump sum and is actuarially sound.   It is considered a transfer of assets for less than Fair Market Value if it is not actuarially sound. |

The ultimate purpose of an annuity must be determined to in order to distinguish an annuity purchased as part of a retirement plan from those used to shelter assets. To be considered valid, the annuity must be actuarially sound.

If the individual is not reasonably expected to live longer than the guarantee period of the annuity, the individual will not receive fair market value for the annuity based on the projected return; in this case, the annuity is not “actuarially sound” and a transfer of assets for less than fair market value has taken place.

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| Procedure – Determining if Annuity is Actuarially Sound  To make this determination, use the Life Expectancy Table found in [Appendix A](#Appendix_A) of this chapter.  **Example:** A 65-year-old male purchases a $10,000 annuity to be paid over the course of 10 years. According to the tables, his life expectancy is 15.52 years. Therefore, the annuity is actuarially sound. |

The average remaining life expectancy for the individual must coincide with the life of the annuity. If the individual is not reasonably expected to live longer than the guaranteed period of the annuity, the individual is not considered to receive Fair Market Value for the annuity based on the projected return and the penalty is applied.

Policy for Annuities on or after February 8, 2006

The Deficit Reduction Act of 2005 made many changes concerning annuities created on or after February 8, 2006.

* At application and review, applicants/beneficiaries must disclose to the agency the existence of any annuities held by the applicant/beneficiary or the community spouse;
* The purchase of an annuity may be treated as a disposal of an asset for less than fair market value unless the SC Department of Health and Human Services (SCDHHS) is named as the primary remainder beneficiary for at least the total amount paid by Medicaid for long-term care services, or is named as such a beneficiary after the community spouse and/or minor or disabled child;
* SCDHHS must inform the issuer of the annuity of the requirement that the agency be named as the primary remainder beneficiary, and the responsibility of the issuer to inform the agency of any change in the amount of income or principal withdrawn from the annuity; and
* An annuity may be treated as a disposal of assets for less than fair market value unless it is irrevocable and non-assignable, actuarially sound, and provide for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments.
* An annuity that is revocable and assignable must be considered as a countable resource, and not a transfer of assets. If the annuity is revocable, the resource value is the amount that the purchaser would receive if the annuity is canceled. If the annuity is assignable, the resource value is the amount the annuity can be sold for on the secondary market. A secondary market is an informal market where existing financial instruments, such as mortgages and annuities, are bought and sold.

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| **Procedure to Determine Purpose of Annuity**  An annuity purchased by an applicant/beneficiary or a community spouse is not considered a transfer if it is:   * Purchased with the proceeds from certain retirement accounts, such as a Roth IRA * The annuity is:   + Irrevocable and non-assignable;   + Is actuarially sound; and   + Provides for equal payments during the term of the annuity with no deferred or balloon payments |

An annuity is now considered part of an estate that is subject to estate recovery unless the annuity is issued by a financial institution or other business that sells annuities in the state as part of its regular business.

A copy of the annuity must be submitted for evaluation. Refer to the [Service Manager Ticket Submission Guide](https://gcc02.safelinks.protection.outlook.com/ap/b-59584e83/?url=https%3A%2F%2Fschhs.sharepoint.com%2F%3Ab%3A%2Fr%2Fsites%2FEES%2FTraining%2FService%2520Manager%2FService%2520Manager%2520Ticket%2520Submission%2520Guide.pdf%3Fcsf%3D1%26web%3D1%26e%3DDHOO8D&data=04%7C01%7CFAULKLAR%40scdhhs.gov%7C4bbd0a082a11424f3c5008d9e047762b%7C4584344887c24911a7e21079f0f4aac3%7C0%7C0%7C637787419799260907%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000&sdata=yGgpbEZ4xgQXTiUdioDT2NNeCH2Y8mPlKtiYD4YtKA4%3D&reserved=0) for instructions.

Changes in payments or withdrawals from the annuity must be reported to the Division of Policy and Planning.

304.12.03 Transfer penalty

(Eff. 06/01/06)

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| **Procedure to Calculate an Annuity Penalty Period**   * + Divide the purchase price of the annuity by the number of payout years. This equals the annual rate.   + Using the Life Expectancy Table, determine the number of years the individual is expected to live. Subtract the number of years from the number of payout years.   + Multiply the difference by the annual rate. This is the uncompensated value.   + Divide the uncompensated value by the average private pay rate in the state. This is the number of months from the date of purchase of the annuity that the individual is penalty liable.  |  | | --- | | * + Purchase Price ÷ Payout Years = Annual Rate   + Payout Years – Life Expectancy = Difference   + Difference X Annual Rate = Uncompensated Value   + Uncompensated Value ÷ Average Private Pay Rate = Penalty Period |   **Example:**  An 80-year-old man purchases an annuity for $10,000 to be paid within 10 years.   * The purchase price ($10,000) is divided by the number of payout years (10) to get the annual rate of $1,000. ($10,000 ÷ 10 = $1,000) * The number of payout years (10) minus the life expectancy years (7.16) equals 2.84. (10 – 7.16 = 2.84) * 2.84 x annual rate of $1,000 = $2,840, which is the uncompensated value. * The uncompensated value is divided by the average private pay rate in the state to determine the number of penalty months (refer to MPPM Chapter 304 [Appendix D](#Appendix_D)). |

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304.13 Spousal Impoverishment Provisions

(Eff. 06/01/06)

Institutionalized individuals who have a spouse in the community are allowed to give a portion of their income and resources to the community spouse. This applies regardless of whether the individual is receiving services:

* In a nursing home, or
* Through a Home and Community Based Services waiver program.

304.13.01 Definitions

(Rev. 12/01/07)

For purposes of spousal impoverishment, the following definitions apply:

Community Spouse – A community spouse of an institutionalized individual resides in a community setting (such as a home, residential care facility, assisted living facility). The spouse of a nursing home patient who receives Home and Community Based Services is considered a community spouse for the purposes of the income provisions of spousal impoverishment.

If a couple is separated, the community spouse must be considered as long as they are not legally divorced.

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| **Note:** According to spousal impoverishment provisions, the community spouse may reside at home or with a relative, or in a residential care facility. The community spouse may be a legal or a common-law spouse.  If the couple is separated, but not legally divorced, the community spouse must be considered. (Refer to MPPM 304.14.01) |

Family Member – A family member may be a minor or dependent child, a dependent parent, and/or a dependent sibling who resides with the community spouse.

Institutionalized Individual – An institutionalized individual resides in a medical institution or receives Home and Community Based Services.

304.14 Spousal Impoverishment and Resources

(Eff. 05/01/21)

At the initial eligibility determination, the resources of both the institutional and community spouse must be considered. The procedure to consider the resources is given below.

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| **Procedure to Consider Spousal Resources**  The [DHHS Form 929](http://medsweb.scdhhs.gov/EligibilityForms/FM%20929.pdf), Community Spouse Worksheet, is used to calculate the couple’s total resources and the spousal share.   * Apply all exclusions to both spouses. * Total the couple’s countable resources. * Subtract the spouse’s share of $66,480. * After the spousal share is subtracted from the couple’s total countable resources, the remainder must meet the individual resource limit. The individual resource limit is $2,000 (or $7,970 if the individual can qualify under ABD criteria.)   **Example #1:** Jean Hill applies for her husband Tom who is entering Caring Hearts Nursing Home. Tom’s income is $1,000 per month in Social Security. Their combined countable resources total $67,996. Mrs. Hill may keep $66,480. The remainder of $1,516 is less than the individual limit, so the resource limit is met.  **Example #2:** Max Golden applies for his wife Jane who is entering a nursing home. Her only income is her SSA of $650 per month. Their combined countable assets total $69,415. Since $69,415 - $66,480 = $2,935, which exceeds the $2,000 individual resource limit, and Mrs. Golden’s income is less than the individual ABD income limit, the larger ABD resource limit may be applied.  **Example #3:** Sam Piper is in a nursing home, and his wife has applied. Sam’s total income is $1,400 per month. Their combined resources total $75,520. Since $75,520 – $66,480 = $9,040 which exceeds the individual resource limit, Mr. Piper would be ineligible due to excess resources. |

If eligibility is established, the spousal share must be separated from the institutionalized spouse’s resources within 30 days of the case’s approval. This may be accomplished by:

* Having jointly-owned assets transferred into the community spouse’s name only, or
* Transferring resources from the institutionalized spouse’s name to the community spouse’s name.

**Note:** If the institutionalized individual fails to transfer the assets to the community spouse within 30 days and no court order exists, the institutionalized individual becomes ineligible for Medicaid beginning the month following the month in which the 30-day period ends.

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| **Procedure – Separation of the Spousal Share**  Verification of the separation of the spousal share must be documented in the case record.  The eligibility worker **must**:   * Advise the beneficiary/authorized representative that:   + The spousal share must be separated within 30 days, AND   + Verification of the separation must be submitted to the Medicaid office. * Place the case into follow-up for 30 days to ensure appropriate action is taken. * Send a 10-day notice and initiate closure procedures if the resources are not separated or verification is not returned.   **Example:** Steve Cohen is approved for nursing home assistance on June 1. He has a community spouse, Eve. Their countable assets are as follows:   |  |  |  | | --- | --- | --- | | **Countable Asset** | **Owner(s)** | **Value** | | Money Market account | Steve & Eve | $20,000 | | CD | Eve | $5,000 | | CD | Steve | $5,000 | | CD | Steve & Eve | $10,000 | | Checking account | Steve | $200 | | Checking account | Eve | $800 | | Life Insurance - FV $10,000 | Steve | $500 | | Life Insurance - FV $8,000 | Eve | $100 |   Eve’s spousal share must be separated within 30 days (by July 1) for Steve to remain eligible. The eligibility worker sets up a tickler file. The Cohen’s close the jointly-owned Money Market account and deposit the money into a new Money Market account in Eve’s name only. Their jointly-owned CD and Steve’s CD both mature in July. They cash them in and open a new CD in Eve’s name with the proceeds of $15,550. They provide all verifications to the eligibility worker on June 25.  The case record must have verifications of the following:   * Closing date and balance of the joint Money Market account (such as a closing statement or letter from the bank) * Opening date and balance of the new Money Market account and owner’s name * Closing date and proceeds of the two CDs * Opening date and amount of the new CD and owner’s name   **Note:** If the eligibility worker had not received verification of the transactions; on July 1, the eligibility worker would have sent a 10-day notice of closure. |

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When an institutionalized individual loses eligibility and re-applies:

* If he/she remained institutionalized, the community spouse’s resources are not considered at re-application.
* If he/she was not institutionalized during any of the ineligible months, the community spouse’s resources are considered at re-application.

304.14.01 Separated Spouses

(Eff. 08/01/15)

If a person who is separated, but not divorced, applies for an institutional program, the eligibility worker MUST contact the community spouse and obtain resource information.

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| **Procedure – Separated Spouses Who Are Not Divorced**  The eligibility worker is to obtain asset information and evaluate the information as though the couple were not separated.  The eligibility worker must use the following guidelines to decide how to proceed with the eligibility determination. These guidelines apply **regardless of the length of separation.**  **If the community spouse receives SSI, the eligibility worker must:**   * Document receipt of SSI in the case record (SDX, copy of letter); AND * Count only the assets of the institutionalized spouse.   **If the community spouse is currently ABD, SLMB or OSS eligible, the eligibility worker must:**   * Review the existing case record; * Contact the community spouse to:   + Complete the [DHHS Form 3295](http://medsweb.scdhhs.gov/EligibilityForms/FM%203295.pdf), Request for Additional Information – Separated Spouse. Before sending the DHHS Form 3295 to the spouse, fill in the names of the individuals and the Household number.   + Collect current asset information,   + Request the appropriate bank statements and other necessary information     - Verification of the community spouse’s income is not required unless a spousal allocation is being budgeted. Do not give a spousal allocation if unable to verify the community spouse’s income     - If the community spouse returns the necessary information, complete normal spousal impoverishment budgeting     - If the community spouse refuses to provide the necessary information or fails to respond, treat the institutionalized spouse as an individual   **If the community spouse’s whereabouts are known, the eligibility worker must:**   * Request information/verification of the spouse’s resources using the [DHHS Form 3295](http://medsweb.scdhhs.gov/EligibilityForms/FM%203295.pdf), Request for Additional Information – Separated Spouse, and [DHHS Form 1233](http://medsweb.scdhhs.gov/EligibilityForms/FM%201233%20ME.pdf), Medicaid Eligibility Checklist, UNLESS good cause is alleged. * Attempt to contact the spouse to obtain the information:   + Document all efforts to obtain the information in OnBase or MEDS notes. This may include:     - Copies of correspondence,     - Returned mail,     - Documentation of telephone or face-to-face conversations * If requested information is not returned, assume the Community Spouse refuses to cooperate and only count the assets of the institutionalized spouse. * If the requested information is returned, evaluate as a couple.   **If the spouse refuses to cooperate, the eligibility worker must:**   * Document all attempts to obtain the verification and/or contact in the case record. * Count only the assets of the institutionalized spouse.   **If good cause is alleged, the eligibility worker must** obtain a written or verbal statement from the applicant/authorized representative detailing the reasons for good cause not to contact the separated spouse.  **If the applicant/authorized representative is unable to obtain the information, the eligibility worker must:**   * Attempt to contact the spouse to obtain the information:   + Document all efforts to obtain the information in OnBase or MEDS notes. This may include:     - Copies of correspondence,     - Returned mail,     - Documentation of telephone or face-to-face conversations   **If the community spouse’s whereabouts are unknown, the eligibility worker must:**   * Document all attempts to locate the community spouse, through such processes as:   + Telephone directory listing,   + Real and personal property searches,   + CHIP, or   + Online people and reverse number look-up searches via Internet. * If unable to locate, only count the assets of the institutionalized spouse. |

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304.14.02 Undue Hardship

(Eff. 10/01/13)

Undue hardship may exist if a denial of eligibility would:

* Result in a Medicaid facility refusing to admit or threatening to discharge an individual, or
* Result in the individual being placed in a life-threatening situation.

A community spouse refusal to make resources available to the institutionalized spouse, may result in an undue hardship.

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| Procedure – Community Spouse and Undue Hardship  The eligibility worker must:   * Document the community spouse’s refusal to cooperate. * Obtain verification/documentation that:   + Either     - The facility is either refusing to admit or is threatening to discharge the applicant/beneficiary, or     - Community Long Term Care is denying or terminating services AND * There is a life-threatening situation (such as an individual would have no care)   + The facility is either refusing to admit or is threatening to discharge the applicant/ beneficiary, OR   + Community Long Term Care is denying or terminating services * Make a local decision based on the verification/documentation received. |

* 1. Budgeting Income and Resources Under Spousal Impoverishment Provisions

(Eff. 06/01/06)

Determining the amount to be allocated to the community spouse is a two-step process. The Electronic Budgeting Workbook or the [DHHS Form 1296-A ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201296-A%20ME.pdf), Medical Assistance Only (MAO) Institutional Worksheet, is used for budgeting. The [DHHS Form 929](http://medsweb.scdhhs.gov/EligibilityForms/FM%20929.pdf), Community Spouse Resource Worksheet, may also be used to budget resources.

304.15.01 Eligibility

(Eff. 06/01/06)

The first step is to determine if the institutionalized individual is income eligible. Only the institutionalized spouse’s income is considered in this step. However, the resources of both the institutionalized and the community spouse must be considered.

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| Procedure – Step One - Eligibility  **Income –** Consider only the income of the institutionalized spouse in this step.  **Resources –** Consider the resources of both the institutionalized spouse and the community spouse at these times: (1) initial eligibility determination, and (2) at the beginning of the first continuous period of institutionalization. |

304.15.02 Post-Eligibility

(Rev. 05/01/07)

If the institutionalized individual is eligible, the post-eligibility step is next. In this step, the eligibility worker must determine:

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| Procedure – Step Two – Post-Eligibility  The eligibility worker must determine:   * How much income and resources the institutionalized individual keeps, * How much income and resources are allocated to the community spouse, and * How much the institutionalized individual must contribute toward the cost of his/her care after allowable deductions (that is, recurring income).   **Note:** Only the income and resources that the institutionalized individual actually makes available to the community spouse will be allowed as a deduction from his/her income or resources. |

304.15.02A Income Allocation

(Eff. 01/01/23)

In the post-eligibility step, the deductions from gross income are made in the order shown below. The remaining income must be applied to the institutionalized individual’s cost of care (that is, recurring income).

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| **Personal Needs Allowance** | * $100 – Work Therapy Allowance – if the institutionalized individual participates in a work therapy program as a part of the plan of care; or * $30 – Standard Allowance – if the institutionalized individual does not participate in a work therapy program. * $2,742 – Waiver Allowance – for individuals participating in a HCBS waiver |
| **Note:** Individuals receive the $30 personal needs allowance from countable income in addition to any excluded income such as VA Aid and Attendance or the $90 reduced VA pension. | |

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| **Court Ordered Guardianship Fees** | * The lesser of 10% of gross income or $25 for court ordered guardianship fees |

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| **Community Spouse Income Allowance** | * Institutionalized spouse **must** choose to give the allocation; and * The amount must not exceed $3,715.50 per month. |
| **Procedure to Determine the Amount of the Community Spouse Income Allowance**   * Determine the community spouse’s gross income. * Subtract this amount from $3,715.50. * The difference is the maximum allocation amount.   **Note:** A lower amount may be allocated if the community spouse wishes to maintain or establish eligibility for SSI benefits or Medicaid under another payment category such as ABD. The institutionalized individual must actually make the income available to the community spouse in order for it to be deducted. The spouse of a nursing home patient who receives Home and Community Based Services is considered a community spouse for the purposes of the income provisions of spousal impoverishment.  **Procedure – Amount of Community Spouse Allocation Questioned**    If the community spouse disagrees with the amount allocated or needs a higher amount to maintain him/her, the eligibility worker should inform the spouse of his/her right to appeal (Fair Hearing).  The community spouse must justify the need for the additional amount due to exceptional circumstances or significant financial duress. A higher amount can only be allowed if it is ordered through an appeal. | |

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| **Allowance for Other Dependent Family Members** | * Institutionalized spouse **must** choose to give the allocation * May include minor children or dependent adults of the institutionalized or community spouse. A dependent adult is an adult family member (such as a mother, father, child, brother, sister) living in the home who depends on the applicant/beneficiary or community spouse for meeting physical, medical, or financial needs. * A signed statement completed by the applicant/beneficiary or authorized representative indicating the relationship of the dependent adult and the nature of the dependency is acceptable verification to provide the allowance. |
| Procedure to Determine the Amount of Income Allowances for Other Dependent Family Members  Dependent(s) residing with Community Spouse   * Determine the gross income of each family member. * Subtract the total gross income of each family member from $3,715.50. * One-third of the remaining amount is each family member’s income allowance. * Add each family member’s income allowance together to determine the total family income allowance. * This is the amount allowed for allocation to family members.   **Dependent(s) residing with someone other than the Community Spouse**   * Determine the gross monthly income of all dependents living together * Compare the gross income of all dependents living together to the TANF/FI Need Standard (PCR Income Limit, refer to MPPM 103.03) for a family of the appropriate size. For example, 2 dependents would use PCR Income Limit for 2. * If gross monthly income is equal to or greater than the standard, no allocation is made. * If gross monthly income is less than the standard, subtract the income from the standard. The resulting figure is the allocation to the dependents.   **NOTE:** The institutionalized individual must actually make the income available to the family in order for it to be deducted. | |

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| **Health Insurance Premiums**  **Note:**  Does not include Medicare Parts A and B  Refer to the next table for Medicare Part D | * Must only be paid by or for the Medicaid beneficiary out of the beneficiary’s funds. * May only be deducted the month the premium is due or the month after. (See table below) * Must be verified. * Convert premiums paid at a frequency other than monthly to a monthly amount. |
| **Procedure – Health Insurance Premiums**  Acceptable forms of verification include:   * Premium notice * Copy of cancelled check * Bank statement verifying draft  |  |  | | --- | --- | | **When Premium is reported** | **Effective Date of Change** | | Month premium due/paid | Recurring Income may be rebudgeted effective the month the premium is due/paid | | Month after premium due/paid | Recurring Income may be rebudgeted effective the month the premium is due/paid | | Two or more Months after premium due/paid | Recurring Income may be rebudgeted effective the month the premium is reported to the agency | | **Reminder:**   * Regardless when the rebudget is being completed, the effective date is based on when the information was reported to DHHS * If the amount a beneficiary must pay goes up once the rebudget is completed, adequate and advance notice must be given before the change becomes effective unless the beneficiary waives the 15-day notice requirement * For premiums paid at a frequency other than monthly, average the premium to determine a monthly amount for the Cost of Care calculation | |   **Example 1:** Joe’s income is $300 and he reports on June 2nd that his quarterly insurance premium of $450 is due on June 30. He has no other deductions other than his personal needs allowance.  Health Insurance: $450.00 (Quarterly Premium)  ÷ 3  $150.00 (Monthly Average)  Cost of Care: $300.00 (Gross Income)  – $30.00 (Personal Needs)  – $150.00 (Health Insurance Premium)  $120.00 (Cost of Care)  **Example 2:** Alice’s income is $500 and she reports on September 10 that her monthly insurance premium changed in June from $100 per month to $150 per month. She has no other deductions except for her personal needs allowance.  June, July, August recurring income: $500 - $30 = $470, then $470 - $100 = $370  September recurring income: $500 - $30 = $470, then: $470 - $150 = $320 | |

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| **Health Insurance Premiums – Medicare Part D, Drug Coverage** | * For individuals approved for Nursing Home coverage who are not already Medicaid eligible, subtract the Medicare Part D Benchmark from the verified Part D premium being paid by the individual and allow the remainder as a Health Insurance Premium deduction from countable income. * For individuals receiving Medicaid who are then approved for Nursing Home coverage, the adjustment for the Medicare Part D Benchmark has already been applied. Allow the Medicare Part D premium being paid by the beneficiary as a Health Insurance Premium deduction from countable income. * At COLA or Annual Review, the adjustment for the Medicare Part D Benchmark has already been applied. Allow the Medicare Part D premium being paid by the beneficiary as a Health Insurance Premium deduction from countable income. * Refer to MPPM 103.07 for the current Medicare Part D Premium Benchmark for South Carolina |
| **Procedure – Health Insurance Premiums**  Verify the Part D Medicare premium   * Is the individual currently Medicaid eligible?   + If Yes, the benchmark adjustment has already been applied. Allow the premium being paid as a Health Insurance Premium deduction in the cost of care calculation   + If No, subtract the benchmark from the premium being paid and allow the remainder as a Health Insurance Premium deduction in the cost of care calculation   **Example:** John Allen is admitted to Happy Trails Nursing Facility on June 23 and approved for Medicaid. He currently has Medicare Part D and pays a $42.82 premium per month.  42.82 (Medicare Part D Premium)  – 37.84 (2023 Part D Benchmark)  $4.98 (Health Insurance Premium deduction)  **Example:** Alice Kramer was approved for Medicaid coverage last year. She has now been admitted to Green’s Awesome Care Nursing Facility on May 12 and approved for coverage. She currently has Medicare Part D and pays a $12.93 premium per month. Allow $12.93 as a Health Insurance Premium deduction in the cost of care calculation. | |

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| **Home Maintenance Allowance** | * A maximum of six months is allowed.   + A physician **must** certify the individual is expected to return home within six months of admission to an institutional setting.   + The first full calendar month following the month of admission to a hospital or nursing facility begins the six-month count. * Given for actual expenses, not to exceed the maximum SSI payment level for an individual. May be given even if someone continues to reside in the home.   + Examples of expenses that are allowed include:     - Rent or Mortgage     - Home owners or renters insurance     - Utilities     - Basic Cable, Internet or Satellite TV service   + Examples of expenses that are not allowed include:     - Premium Cable or Satellite TV services and channels     - Special telephone features, such as call waiting * Expenses can be documented using a written or verbal statement from the individual. The statement must show:   + The type of payment; (for example: mortgage, electricity, water and sewer, trash pickup, cable, phone)   + To whom the payment is made; and   + The amount paid. * A copy of the actual bill is not required unless the person appears to be paying for extra or premium services |
| **Note:**   * A request for the Home Maintenance Allowance can be made at any time during the six-month period. The allowance can be budgeted retroactively to when the applicant entered the facility * The deduction is applied when determining the amount of recurring income, the individual is responsible for paying to a facility * The time an individual is in a hospital counts toward the maximum six-month period. For example, if the individual is in the hospital for two months and then enters a nursing facility, the home maintenance allowance can only be applied for up to four months | |

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| **Protected Income** | Allowable for the month of admission from or discharge to a community setting |
| * Income is protected if the individual was in a community setting at any point during the month of admission to a nursing facility * Examples of a community setting are the person’s home, the home of another person, an assisted living facility or a community residential care facility * A hospital admission is considered an institutional setting   **EXCEPTION:** Income Trust Cases. Income is not protected for individuals with an Income Trust. | |

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| **Cost of Pre-Eligibility Non-Covered Medical Expenses** | * The nursing facility may deduct pre-eligibility non-covered medical expenses. These are expenses:   + Recognized by State or Federal law as medical expenses;   + Not covered by Medicaid, Medicare, or other third-party payers; and   + Incurred by an individual before becoming eligible for Medicaid |
| **Note:** Deductions for non-covered medical expenses cannot exceed a beneficiary’s monthly recurring income and cannot be made if the beneficiary has zero ($0) reported monthly income. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty is limited to zero. | |

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| **Cost of Post Eligibility Non-Covered Medical Expenses** | * The nursing facility may deduct post-eligibility non-covered medical expenses. These are expenses:   + Recognized by State or Federal law as medical expenses;   + Not covered by Medicaid, Medicare, or other third-party payers (Refer to [Appendix B](#Appendix_B)); and   + Incurred by an individual currently Medicaid eligible in a Nursing Home |
| **Note:** Deductions for non-covered medical expenses cannot exceed a beneficiary’s monthly recurring income and cannot be made if the beneficiary has zero ($0) reported monthly income. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty is limited to zero. | |

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304.15.02B Resource Allocation

(Eff. 05/01/21)

The community spouse of an institutionalized individual can retain a portion of the couple’s countable resources.

If an applicant is separated but not divorced, the resources of the community spouse are still considered. Contact with the spouse must be made. The eligibility specialist must document the case record if the community spouse refuses to cooperate with the applicant or authorized representative. If the whereabouts of the spouse is unknown, the eligibility specialist must attempt to locate the spouse and fully document this in the case record. Procedures for this are discussed earlier in this chapter.

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| Procedure – Determining Resources and the Spousal Resource Allocation   * Determine the total value of the couple’s combined countable resources. * Deduct the community spouse’s share, not to exceed $66,480, at both:   + The point of the initial eligibility determination, **and**   + The beginning of first continuous period of institutionalization. * The remaining resources are considered to be the institutionalized individual’s and the eligibility worker **must compare** this amount to the resource limit ($2,000 or $7,970 if ABD eligible) at both:   + The point of the initial eligibility determination, **and**   + The beginning of first continuous period of institutionalization.   **Note:**   * The community spouse’s share of the countable resources must be separated from the institutionalized spouse’s share **within 30 days** of certification for Medicaid. * Verification of the change of ownership must be submitted to the eligibility worker and filed in the case record. * If the institutionalized individual fails to transfer the assets to the community spouse within 30 days and no court order is involved, the institutionalized individual becomes ineligible for Medicaid beginning the month following the month in which the 30-day period ends.   + The community spouse can request an extension if the change in ownership cannot be completed within 30 days for reasons outside the control of the spouse. * The eligibility specialist must place the case into follow-up for 30 days to ensure appropriate action is taken. |

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| **Procedure – Amount of Community Spouse Allocation Questioned**    The eligibility specialist must inform the spouse of his/her right to appeal if the community spouse disagrees with the amount allocated or needs a higher amount to maintain his/her living arrangements.  The community spouse must justify the need for the additional amount due to exceptional circumstances or significant financial duress. A higher amount can only be allowed if it is ordered through an appeal. |

304.15.02C Changes in Community Spouse’s Resources after Approval

(Eff. 06/01/06)

Once the institutionalized spouse is certified eligible for Medicaid, the following DO NOT affect eligibility:

* An increase in the community spouse’s resources, and
* A transfer by the community spouse for less than Fair Market Value.

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| **Note:** If the community spouse needs institutionalization later, such a transfer may affect his/her own eligibility. |

304.15.03 Prenuptial Agreement

(Eff. 06/01/06)

The existence of a prenuptial agreement has no effect on the treatment of income or resources under Spousal Impoverishment provisions. The resources owned by both spouses must be combined regardless of any State laws relating to community property or the division of marital property. This includes a prenuptial agreement covering the division of assets in the event of divorce.

304.15.04 Resource Assessment

(Eff. 06/01/06)

In some cases, a couple may request an assessment of their resources **before** they apply for assistance. An assessment is a snapshot of the couple’s countable resources in the month of institutionalization.

An assessment is separate from an application for Medicaid.

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| **Procedure – Resource Assessment Requested by Individuals**  The [DHHS Form 3228 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%203228%20ME.pdf), Assessment Questionnaire for Medicaid Institutional Programs, is used to collect information.  The assessment must be completed in the following manner:   * Verification of all the countable resources must be provided. * Written notice must be given to spouses advising them of:   + The couple’s total countable resources, and   + The maximum community spouse share of $66,480. * A copy of the assessment and the notice must be kept on file in the event an application is made later.   The [DHHS Form 3227 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%203227%20ME.pdf), Notice of Resource Assessments, is used to advise individuals of the outcome. |

304.16 30-Consecutive Day Requirement

(Rev. 01/01/21)

To qualify for Medicaid for Nursing Home or Home and Community Based Services, an individual must:

* Reside for 30 consecutive days or more in a medical facility, in-state or out-of-state, such as:
  + Nursing Home or
  + Hospital
* Receive Home and Community Based Services for 30 consecutive days or more.
* Meet the 30 consecutive day criteria through a combination of the above.
* Count the date of admission or the date services begins as the first day.

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| **Exceptions:**   1. An individual who is Medicaid-eligible prior to entering a medical facility or a Home and Community Based Services waiver program does not have to meet the 30-day criteria. 2. If an individual dies before the 30 days are met, it is assumed he or she would have continued to receive services for 30 consecutive days or longer. |

304.16.01 Effective Date of Eligibility

(Eff. 06/01/06)

If the individual meets the 30 consecutive day requirement and is otherwise eligible, the beginning date of eligibility is the first day of the month in which he/she became institutionalized in a medical facility, or a combination of medical facilities, or receiving Home and Community Based Services.

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| **Example #1:** Lillie Smith enters the hospital after an accident on May 10. On May 29, she is transferred to Caring Hearts Nursing Home until she is able to return home on June 29. Ms. Smith was in the hospital 19 days. However, she went directly to the nursing home where she spent 31 days. She met the 30 consecutive day criteria on June 9 through a combination of hospital and nursing home days. If otherwise eligible, she may qualify for Medicaid effective May 1.  **Example #2:** Jamie Green is a SSI recipient who enters a nursing home on July 15 after breaking his hip. He returns home on August 1. He was only in the facility for 18 days. Since he was already Medicaid-eligible, he may qualify for assistance without having been institutionalized for 30 consecutive days.  **Example #3:** Jean Mills entered the nursing home on June 6 and died on June 14. It is assumed she would have remained in the facility for 30 consecutive days if she had lived. Therefore, if otherwise eligible, her benefits are effective June 1. |

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304.16.02 Moving from a Medical Facility to Home and Community Based Services

(Eff. 06/01/06)

A Medicaid applicant/beneficiary who: (1) is in a nursing home, (2) has met the 30 consecutive day requirement, and (3) wishes to enter a Home and Community Based Services waiver program, does NOT have to meet the 30 consecutive day requirement again if he/she enters the waiver program within 10 calendar days of discharge from a nursing home.

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| **Note:** If the break in service from the date of discharge from the nursing home to the date of enrollment in the waiver will exceed 10 calendar days, prior approval to exempt the 30 consecutive day requirement must be obtained from the State DHHS Community Long Term Care Office. |

304.16.03 Moving from Home and Community Based Services to a Medical Facility

(Eff.05/01/23)

For any Medicaid applicant/beneficiary who is approved and enrolled in Home and Community Based Services and then enters a Nursing Home with no break in service, the Eligibility Specialist should follow the guidelines for the Ex Parte process (MPPM 101.08.06). Do not complete an additional look-back or request a new application or addendum.

**Note:** A DHHS Form 1277, Statement of Intent to Return, may be needed when moving from HCBS to NH coverage. See MPPM 302.14.01 to determine if the home can remain excluded without an Intent to Return.

304.17 Permit Days

(Eff. 06/01/06)

Because nursing facility beds are sometimes limited, some Medicaid applicants have difficulty locating a facility willing to accept a Medicaid patient. In instances when an individual has been determined to be Medicaid-eligible and is residing in a Medicaid certified facility, the eligibility worker should approve the application; notify the individual; and complete the [DHHS Form 181](http://medsweb.scdhhs.gov/EligibilityForms/FM%20181.pdf), Notice of Admission, Authorization, and Change of Status for Long Term Care. Whether the nursing facility accepts the vendor payment becomes a matter between the nursing facility and the patient’s family.

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| Procedure Prior to Approving an Application and Completing the DHHS Form 181  The eligibility worker is required to determine that the applicant/beneficiary meets all financial and non-financial eligibility criteria, including level of care, prior to approving the application and completing the DHHS Form 181. |

304.18 Vendor Payment

(Eff. 06/01/06)

Medicaid sponsored individuals in a nursing home actually receive two distinct services. They receive a Medicaid Insurance Card for assistance with medical services such as prescription medicines, physician’s visits, and hospitalizations. Secondly, they receive a vendor payment, or room and board assistance. Generally, the individual must contribute toward his/her cost of care. The individual’s contribution to his/her cost of care is referred to as the recurring income. Medicaid’s contribution is referred to as the vendor payment.

304.18.01 Recurring Income Used to Determine Vendor Payment

(Eff. 01/01/23)

When individuals apply for Medicaid to assist with payment of institutional care, the financial eligibility determination is a two-step process.

1. The first step determines whether Medicaid eligibility requirements are met.
2. If eligible, the second step determines the amount of available income that must be contributed toward the cost of care. This is called the monthly recurring income.

The monthly recurring income amount is determined by the eligibility worker and reported to the medical provider on the [DHHS Form 181](http://medsweb.scdhhs.gov/EligibilityForms/FM%20181.pdf), Notice of Admission, Authorization, and Change of Status for Long-Term Care.

To calculate the cost of care, the eligibility worker must determine the individual’s gross countable income, and then deduct allowable expenses. The eligibility worker is responsible for making all of the deductions except the non-covered medical expenses. That deduction is the responsibility of the nursing facility.

Allowable deductions for nursing home patients who have not established an Income Trust include the following:

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| **Personal Needs Allowance** | * $100 – Work Therapy Allowance – if the institutionalized individual participates in a work therapy program as a part of the plan of care; or * $30 – Standard Allowance – if the institutionalized individual does not participate in a work therapy program. * $2,742 – Waiver Allowance – for individuals participating in a HCBS waiver |
| **Note:** Individuals receive the $30 personal needs allowance from countable income in addition to any excluded income such as VA Aid and Attendance or the $90 reduced VA pension. | |

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| **Court Ordered Guardianship Fees** | * The lesser of 10% of gross income or $25 for court ordered guardianship fees |

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| **Community Spouse Income Allowance** | * Institutionalized spouse **must** choose to give; and * The amount must not exceed $3,715.50 per month. |
| **Procedure to Determine the Amount of the Community Spouse Income Allowance**   * Determine the community spouse’s gross income. * Subtract this amount from $3,715.50. * The difference is the maximum allocation amount.   **Note:** A lower amount may be allocated if the community spouse wishes to maintain or establish eligibility for SSI benefits or Medicaid under another payment category such as ABD. The institutionalized individual must actually make the income available to the community spouse in order for it to be deducted. The spouse of a nursing home patient who receives Home and Community Based Services is considered a community spouse for the purposes of the income provisions of spousal impoverishment.  **Procedure – Amount of Community Spouse Allocation Questioned**    If the community spouse disagrees with the amount allocated or needs a higher amount to maintain him/her, the eligibility worker should inform the spouse of his/her right to appeal (Fair Hearing).  The community spouse must justify the need for the additional amount due to exceptional circumstances or significant financial duress. A higher amount can only be allowed if it is ordered through an appeal. | |

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| **Allowance for Other Dependent Family Members** | * Institutionalized spouse **must** choose to give the allocation * May include minor children or dependent adults of the institutionalized or community spouse. A dependent adult is an adult family member (such as a mother, father, child, brother, sister) living in the home who depends on the applicant/beneficiary or community spouse for meeting physical, medical, or financial needs. * A signed statement completed by the applicant/beneficiary or authorized representative indicating the relationship of the dependent adult and the nature of the dependency is acceptable verification to provide the allowance. |
| Procedure to Determine the Amount of Income Allowances for Other Dependent Family Members  Dependent(s) residing with Community Spouse   * Determine the gross income of each family member. * Subtract the total gross income of each family member from $3,715.50. * One-third of the remaining amount is each family member’s income allowance. * Add each family member’s income allowance together to determine the total family income allowance. * This is the amount allowed for allocation to family members.   **Dependent(s) residing with someone other than the Community Spouse**   * Determine the gross monthly income of all dependents living together * Compare the gross income of all dependents living together to the TANF/FI Need Standard (PCR Income Limit, refer to MPPM 103.03) for a family of the appropriate size. For example, 2 dependents would use PCR Income Limit for 2. * If gross monthly income is equal to or greater than the standard, no allocation is made. * If gross monthly income is less than the standard, subtract the income from the standard. The resulting figure is the allocation to the dependents.   **NOTE:** The institutionalized individual must actually make the income available to the family in order for it to be deducted. | |

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| **Health Insurance Premiums**  **Note:**  Does not include Medicare Parts A and B  Refer to the next table for Medicare Part D | * Must only be paid by or for the Medicaid beneficiary out of the beneficiary’s funds. * May only be deducted the month the premium is due or the month after. (See table below) * Must be verified. * Convert premiums paid at a frequency other than monthly to a monthly amount. |
| **Procedure – Health Insurance Premiums**  Acceptable forms of verification include:   * Premium notice * Copy of cancelled check * Bank statement verifying draft  |  |  | | --- | --- | | **When Premium is reported** | **Effective Date of Change** | | Month premium due/paid | Recurring Income may be rebudgeted effective the month the premium is due/paid | | Month after premium due/paid | Recurring Income may be rebudgeted effective the month the premium is due/paid | | Two or more Months after premium due/paid | Recurring Income may be rebudgeted effective the month the premium is reported to the agency | | **Reminder:**   * Regardless when the rebudget is being completed, the effective date is based on when the information was reported to DHHS * If the amount a beneficiary must pay goes up once the rebudget is completed, adequate and advance notice must be given before the change becomes effective unless the beneficiary waives the 15-day notice requirement * For premiums paid at a frequency other than monthly, average the premium to determine a monthly amount for the Cost of Care calculation | |   **Example 1:** Joe’s income is $300 and he reports on June 2nd that his quarterly insurance premium of $450 is due on June 30. He has no other deductions other than his personal needs allowance.  Health Insurance: $450.00 (Quarterly Premium)  ÷ 3  $150.00 (Monthly Average)  Cost of Care: $300.00 (Gross Income)  – $30.00 (Personal Needs)  – $150.00 (Health Insurance Premium)  $120.00 (Cost of Care)  **Example 2:** Alice’s income is $500 and she reports on September 10 that her monthly insurance premium changed in June from $100 per month to $150 per month. She has no other deductions except for her personal needs allowance.  June, July, August recurring income: $500 - $30 = $470, then $470 - $100 = $370  September recurring income: $500 - $30 = $470, then: $470 - $150 = $320 | |

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| **Health Insurance Premiums – Medicare Part D, Drug Coverage** | * For individuals approved for Nursing Home coverage who are not already Medicaid eligible, subtract the Medicare Part D Benchmark from the verified Part D premium being paid by the individual and allow the remainder as a Health Insurance Premium deduction from countable income. * For individuals receiving Medicaid who are then approved for Nursing Home coverage, the adjustment for the Medicare Part D Benchmark has already been applied. Allow the Medicare Part D premium being paid by the beneficiary as a Health Insurance Premium deduction from countable income. * At COLA or Annual Review, the adjustment for the Medicare Part D Benchmark has already been applied. Allow the Medicare Part D premium being paid by the beneficiary as a Health Insurance Premium deduction from countable income. * Refer to MPPM 103.07 for the current Medicare Part D Premium Benchmark for South Carolina |
| **Procedure – Health Insurance Premiums**  Verify the Part D Medicare premium   * Is the individual currently Medicaid eligible?   + If Yes, the benchmark adjustment has already been applied. Allow the premium being paid as a Health Insurance Premium deduction in the cost of care calculation   + If No, subtract the benchmark from the premium being paid and allow the remainder as a Health Insurance Premium deduction in the cost of care calculation   **Example:** John Allen is admitted to Happy Trails Nursing Facility on June 23 and approved for Medicaid. He currently has Medicare Part D and pays a $42.82 premium per month.  42.82 (Medicare Part D Premium)  – 37.84 (2021 Part D Benchmark)  $4.98 (Health Insurance Premium deduction)  **Example:** Alice Kramer was approved for Medicaid coverage last year. She has now been admitted to Green’s Awesome Care Nursing Facility on May 12 and approved for coverage. She currently has Medicare Part D and pays a $12.93 premium per month. Allow $12.93 as a Health Insurance Premium deduction in the cost of care calculation. | |

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| **Home Maintenance Allowance** | * A maximum of six months is allowed.   + A physician **must** certify the individual is expected to return home within six months of admission to an institutional setting.   + The first full calendar month following the month of admission to a hospital or nursing facility begins the six-month count. * Given for actual expenses, not to exceed the maximum SSI payment level for an individual. May be given even if someone continues to reside in the home.   + Examples of expenses that are allowed include:     - Rent or Mortgage     - Home owners or renters insurance     - Utilities     - Basic Cable, Internet or Satellite TV service   + Examples of expenses that are not allowed include:     - Premium Cable or Satellite TV services and channels     - Special telephone features, such as call waiting * Expenses can be documented using a written or verbal statement from the individual. The statement must show:   + The type of payment; (for example: mortgage, electricity, water and sewer, trash pickup, cable, phone)   + To whom the payment is made; and   + The amount paid. * A copy of the actual bill is not required unless the person appears to be paying for extra or premium services |
| **Note:**   * A request for the Home Maintenance Allowance can be made at any time during the six-month period. * The deduction is applied when determining the amount of recurring income the individual is responsible for paying to a facility. * The time an individual is in a hospital counts toward the maximum six-month period. For example, if the individual is in the hospital for two months and then enters a nursing facility, the home maintenance allowance can only be applied for up to four months. | |

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| **Protected Income** | Allowable for the month of admission from or discharge to a community setting |
| * Income is protected if the individual was in a community setting at any point during the month of admission to a nursing facility * Examples of a community setting are the person’s home, the home of another person, an assisted living facility or a community residential care facility. * A hospital admission is considered an institutional setting.   **EXCEPTION:** Income Trust Cases. Income is not protected for individuals with an Income Trust. | |

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| **Cost of Pre-Eligibility Non-Covered Medical Expenses** | * The nursing facility may deduct pre-eligibility non-covered medical expenses. These are expenses:   + Recognized by State or Federal law as medical expenses;   + Not covered by Medicaid, Medicare, or other third-party payers; and   + Incurred by an individual before becoming eligible for Medicaid |
| **Note:** Deductions for non-covered medical expenses cannot exceed a beneficiary’s monthly recurring income and cannot be made if the beneficiary has zero ($0) reported monthly income. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty is limited to zero. | |

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| **Cost of Post Eligibility Non-Covered Medical Expenses** | * The nursing facility may deduct post-eligibility non-covered medical expenses. These are expenses:   + Recognized by State or Federal law as medical expenses;   + Not covered by Medicaid, Medicare, or other third-party payers (Refer to [Appendix B](#Appendix_B)); and   + Incurred by an individual currently Medicaid eligible in a Nursing Home |
| **Note:** Deductions for non-covered medical expenses cannot exceed a beneficiary’s monthly recurring income and cannot be made if the beneficiary has zero ($0) reported monthly income. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty is limited to zero. | |

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304.18.02 Protected Income

(Eff. 01/01/12)

An individual is not responsible for paying toward his/her cost of care during the calendar month of admission from, or discharge to, a non-institutional living arrangement. Income is protected the month of admission to a nursing home if the individual was in a non-institutional setting (home or Community Residential Care Facility) anytime during that same month. Institutional living arrangements would be a hospital, rehabilitation center, or a nursing home. If the individual goes from home to hospital to nursing home within the same month, the income would be protected since the individual was in the home during the month of admission to the nursing home.

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| **Exception:** Income is not protected in either the month of admission or the month of discharge in Income Trust cases. |

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| **Example #1:** Joe Green enters Caring Hearts Nursing Home directly from home on May 15 and does not have an Income Trust. His income his protected for May. He must begin paying his recurring income effective June.  **Example #2:** Susan Blackwell entered the local hospital on May 15 and was transferred to Sisters of Charity Nursing Home on June 8. Her income is below the Medicaid Cap. Susan must begin paying her recurring income effective June. Her month of admission is May.  **Example #3:** Alonzo Evening entered Georgetown Medical Hospital on March 9 from home. He was transferred to Hoya Nursing Home on March 22. His income is below the Medicaid Cap. His income is protected for the month of March, and he must begin paying recurring income in April.  **Example #4:** Steve Norris entered Jamestown Nursing Center on June 14 from home. He established eligibility by executing an Income Trust. He must begin paying his recurring income effective June. |

It is the provider's responsibility to collect recurring income amounts from the Medicaid eligible recipient and/or responsible party. There is nothing to prevent the nursing facility from collecting recurring income a month in advance.

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| **Procedure to Calculate Recurring Income When an Applicant/Beneficiary in a Nursing Facility Has Not Established an Income Trust**  Use the [DHHS Form 1296-A ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201296-A%20ME.pdf), Medical Assistance Only (MAO) Institutional Budget Sheet, to reflect the following calculations:   * Determine gross countable monthly income. * Subtract allowable deductions in the following order: * Personal needs allowance * Community spouse income allocation * Child allocation (regardless of whether living with the community spouse) * Home maintenance allowance * Health insurance premiums (other than Medicare) for the beneficiary only * Enter the remaining amount on the [DHHS Form 181](http://medsweb.scdhhs.gov/EligibilityForms/FM%20181.pdf). The institutionalized individual must contribute this amount toward his/her cost of care/recurring income.   **Note:** The nursing facility is responsible for deducting any non-covered medical expenses. |
| **Example #1:** Jill Smalls, a widow, entered a skilled nursing home on May 20 from home. Her gross income is $800 per month SSA. She is paying $50 per month in premiums for health insurance coverage.  Month of May: $800 Countable gross income  -$30 Personal needs allowance  -$50 Health insurance premium  $720  -$800 Protected income for May  $0 Recurring income for May  Month of June: $800 Countable gross income  -$30 Personal needs allowance  -$50 Health insurance premium  $720 Recurring income for June  **Example #2:** Henry Jones entered the hospital on June 25 and transferred to a skilled nursing home on July 8. His income is $900 per month SSA and $300 from a pension. He and his community spouse have health insurance coverage through his former employer and pays $75 per month, but his portion of the premium is $50. His wife’s only income is $500 in SSA.  Month of July: $1,200 Social Security + Pension  -$30 Personal needs allowance  -$50 Health insurance premium  $1,120  - $2,341 Spousal allocation ($2,931 – $500)  $0 Recurring income for July, |

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304.18.03 Medicaid Eligibility and Vendor Payment

(Eff. 01/01/23)

An individual residing in a nursing facility awaiting the expiration of a transfer of assets penalty or whose home equity is over $688,000 may receive Medicaid benefits for payment of non-institutional services if:

* The level of care has been certified, and/or
* All other eligibility criteria (financial and non-financial) are met.

304.19 Income Trust

(Rev. 07/01/15)

The Omnibus Budget Reconciliation Act of 1993 (OBRA 93) provides that certain individuals whose income exceeds the Medicaid Cap may be able to qualify for Medicaid using an income trust. Income trusts are commonly called "Miller" trusts. The intent of the legislation is to enable individuals who need institutional care to qualify for Medicaid even if the state does not have a spend down (Medically Needy) program.

304.19.01 Who May Be Covered Under this Provision

(Eff. 06/01/06)

Individuals who may be covered under this provision are individuals who:

* Reside in nursing facilities or receive Home and Community Based Services; and,
* Meet all eligibility requirements with the exception of their income exceeding the Medicaid Cap. There is no upward income limit for Income Trusts.

Example: The individual could place a monthly income of $3,000 in the Income Trust account each month, and this amount would not cause him/her to be ineligible.

304.19.02 Income Trust Requirements

(Rev. 04/01/10)

An institutionalized individual who meets all eligibility requirements except income may establish an Income Trust with his/her monthly income.

An Income Trust may be exempt from the transfer of assets policy if the following apply:

* The single State Medicaid agency must be named as a beneficiary of the trust.
  + The applicant is the primary beneficiary.
  + The Medicaid agency is the secondary beneficiary.
  + Other beneficiaries may be named but may not receive any money until Medicaid has been repaid in full.
* If funds remain in the Income Trust account at the time of the individual’s death, it is required that:
  + The trust reimburses the Medicaid agency for expenses paid on the individual’s behalf.

304.19.03 Explanations and Forms to Give at Intake

At application, if the stated income exceeds the Medicaid Cap, the LTC worker must explain to the applicant or authorized representative that the income exceeds the allowable limit and the only way to qualify for Medicaid is to set up an Income Trust. The LTC worker must also give the applicant or authorized representative copies of all of the following:

* DHHS Form 905, Income Trust Agreement Form
* DHHS Form 906, Management of the Income Trust
* DHHS Form 925, Income Trust Notice to Beneficiary

**Note:** The applicant should also be advised that the earliest possible beginning date of eligibility may be the first day of the month in which the trust document is executed.

304.19.04 Establishing an Income Trust

(Eff. 07/01/15)

* To establish an Income Trust, the applicant/beneficiary or their **legal** representative must:
  + Properly complete and execute (sign) an Income Trust Document. The earliest possible date of eligibility is the first day of the month the trust document is properly executed.
    - A DHHS Form 905 Income Trust document must be given to the applicant/beneficiary or the authorized representative immediately when the need to establish an Income Trust is identified.
    - The applicant/beneficiary must appoint a trustee to handle the Income Trust. The applicant/beneficiary may not act as his/her own trustee.
    - The Schedule A must list any income that is assigned to the Income Trust. All income listed on the Schedule A must be placed in the trust.
  + Designate or establish a separately identifiable account to work in connection with the Income Trust.
    - The account may be a regular checking account.
    - It must have both the applicant and trustee’s names on it.
    - Only the applicant/beneficiary’s income that is assigned to the Income Trust on the Schedule A can be deposited into the account.
    - Only certain withdrawals are allowed (ref MPPM 304.19.06A and 304.19.06B
    - The account used for this purpose must be documented on the documentation tool and on the Income Trust document.
  + Place the income in the account for any month that eligibility is needed and provide verification. The income does not initially have to be placed in the account the month of receipt but must be deposited before the case can be approved.

**Note:** If an individual deposits only a portion of his/her income from a specific source, the Schedule A must specify how much of the income is to be placed in the trust.

**Example:** If Ms. Jones receives $1,800 per month from her pension but only places $1,700 in the trust, the Schedule A must specify $1,700 of her pension.

304.19.04A Who Can Sign the Trust Document?

(Eff. 07/01/15)

The applicant/beneficiary must sign the trust document. The applicant/beneficiary may sign with a mark if properly witnessed by two persons. If the applicant/beneficiary is unable to sign, only their legal representative can sign on their behalf. A legal representative may be a Power of Attorney, conservator, or legal guardian. If there is no legal representative, the Income Trust cannot be executed until one is appointed. The earliest possible date of coverage is the date the Income Trust is executed.

If a legal representative signs, copy of the legal paperwork must be in the case file.

**NOTE**: The Power of Attorney must be for financial purposes. A health care only power of attorney is not acceptable.

304.19.04B Review of the Income Trust

(Eff. 07/01/15)

The executed Income Trust document must be reviewed to ensure it has been executed properly and that the language meets the requirements. The document must be submitted to the Division of Policy & Planning for review via Service Manager Ticket. To submit the ticket, the LTC worker must select the following:

Group: Medicaid Eligibility

Category: Medicaid Policy

Category Option: Income Trust Approval

Assignment: Beverly Ashford

If the language of the trust meets the requirements and has been properly executed, a memorandum will uploaded into OnBase approving the trust and giving the effective date.

If the language of the trust does not meet the requirements and/or the trust is not properly executed, it will be returned to the applicant/beneficiary for correction along with a letter detailing the needed corrections and allowing 15 days for corrections to be returned. A copy of the letter will be uploaded into OnBase.

If the corrections are returned, they will be reviewed for accuracy. A memorandum will be uploaded giving the effective date of approval.

If the corrections are not returned, a memorandum denying the application will be uploaded into OnBase.

The LTC Worker will use the information to complete the eligibility determination.

304.19.04C Death of an Applicant

(Eff. 07/01/15)

If an applicant passes away during the application process

* The LTC worker must ensure the case is thoroughly documented and all documentation uploaded into OnBase.
* Request the LTC Coordinator to submit a Service Manager Ticket as an Income Trust Policy to have the case evaluated.

Group: Medicaid Eligibility

Category: Income Trust Policy

Category Option: Income Trust Policy

Assignment: Ticket Pool

* EEMS will respond with guidance.

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304.19.05 Funding the Income Trust

(Rev. 03/01/19)

**Only** income may be placed into the Income Trust. Placing other assets into the Income Trust changes the terms of the trust. It is then subject to the same treatment as other trusts. Any other assets placed into the trust must remain there, a transfer of assets penalty may result.

A transfer of assets penalty:

* May be assessed when an asset is transferred from one person to another for less than its Fair Market Value.
* Results in the individual being ineligible for Medicaid to pay for either:
  + Nursing Home Vendor Payment
  + Home and Community Based Services

The account must be funded before the application can be approved. Income may be:

* Directly Deposited
* Counter Deposit
* Direct Transfer from another account

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| **LTC Intake worker responsibilities at Application**  If it is determined an Income Trust is needed when the application is filed, the LTC Intake Team worker must:   * Provide all explanations as indicated in MPPM 304.19.02. * Provide all appropriate Income Trust paperwork   + DHHS Form 905   + DHHS Form 906   + DHHS Form 925 * Complete a DHHS 1233 ME if necessary, requesting the Income Trust and any additional information needed to complete the application. * Send case to follow-up to await the return of information.   **LTC worker responsibilities When the Need for an Income Trust is Determined Later in the Application Process**  When it is determined that the income exceeds the Medicaid CAP, the LTC Intake Team worker or Assessment/Processing Team worker must immediately:   * Complete a DHHS 1233 ME, providing all appropriate Income Trust paperwork   + DHHS Form 905   + DHHS Form 906   + DHHS Form 925 * Request Income Trust and verification of separately identifiable account be returned within 10 days. * Send case to follow-up to await return of the information.   **LTC worker responsibilities When the Need for an Income Trust is Determined at Annual Review**  When it is determined that the income exceeds the Medicaid CAP, the LTC Review Team worker or Assessment/Process Team worker must immediately:   * If discovered prior to or during a collateral call with the beneficiary/authorized representative, use Income Trust Script to explain the Income Trust provision and what is needed to establish one. * If income has been verified, rebudget the case with the new income. * Complete a DHHS 1233 ME, providing all appropriate Income Trust paperwork   + DHHS Form 905   + DHHS Form 906   + DHHS Form 925 * Request Income Trust and verification of separately identifiable account and any other needed verifications be returned within 15 days. * Send case to follow-up pending receipt of information.   **LTC worker responsibilities When the Need for an Income Trust is Determined at Reported change**  When it is determined that the income exceeds the Medicaid CAP, the LTC Change Team worker or Assessment/Processing Team worker must immediately:   * If discovered prior to or during a collateral call with the beneficiary/authorized representative, use Income Trust Script to explain the Income Trust provision and what is needed to establish one. * If income has been verified, rebudget the case with the new income. * Complete a DHHS 1233 ME, providing all appropriate Income Trust paperwork   + DHHS Form 905   + DHHS Form 906   + DHHS Form 925 * Request Income Trust and verification of separately identifiable account and any other needed verifications be returned within 15 days. * Send case to follow-up pending receipt of information. |

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| **Procedure Before Establishing Eligibility**  The LTC worker MUST verify:   * The bank account has been established or designated, and * The money is in the trust for any month that eligibility is needed.   **Note:** It is not necessary at initial approval that the income be placed in the trust the month it is received. However, it must have been placed in the trust prior to the case being approved.  **Example #1:** Cheri is seeking eligibility for June. The case is not completed until August. The LTC worker obtains bank statements verifying the income for June and July was not placed into the trust until August. Provided all other criteria were met, eligibility can be established effective June.  **Example #2:** Susan Doe applies on March 20 for her mother who just entered Caring Hearts Nursing Home. Her mother’s income exceeds the Medicaid Cap so she establishes an Income Trust to qualify. The trust document was signed on March 22. Susan opened a bank account on March 30 and places all her mother’s income in the account beginning April, including the amount received in March. The LTC worker is ready to complete the case on May 3. The LTC worker must have verification of the trust account and the amount in the account. Eligibility may be established effective March.  **Example #3:** John Black entered a nursing home on April 7. His income exceeds the Medicaid Cap. His son applied for Medicaid on April 15 and signed an Income Trust document on April 18. The LTC worker verifies the account was set up and the income for May and June deposited in June. April’s income was not placed in the trust. Eligibility may be established effective May. Mr. Black is not eligible for April because the income received outside the trust exceeded the limit.  **Budgeting Reminders**  In the eligibility determination process, the Income Trust account is NOT a countable resource to be listed on the Electronic Budget Workbook when determining eligibility.  Any income not included on the Income Trust Schedule A which is not placed in the trust must be counted and compared to the Medicaid Cap.  Any income placed in the Income Trust is NOT counted toward the Medicaid Cap.   |  | | --- | | **Example #1:** An applicant/beneficiary has $3,000 gross monthly income: $2,500 in Retirement and $500 in SSA. All income is listed on the Schedule A and deposited into the Income Trust account. Therefore, it is **not** counted as income and compared with the Medicaid Cap in the eligibility determination.  **Example #2:** Only the $500 SSA check is listed on Schedule A and deposited into the account. The $2,500 Retirement check is neither listed nor placed in the trust. Therefore, the $2,500 Retirement check is counted as income and must be compared to the Medicaid Cap to determine income eligibility. | |

304.19.06 Income Eligibility

(Eff. 06/01/06)

The income determination for institutional Income Trust individuals is a two-step process.

**Step One - Eligibility**

Compare the gross countable income against the Medicaid Cap using the Electronic Medicaid Budgeting Workbook If the income exceeds the Medicaid Cap, the applicant or beneficiary may establish an Income Trust.

**Step Two – Post-Eligibility**

If an applicant/beneficiary establishes an Income Trust, determine the cost of care by using the Electronic Medicaid Budgeting Workbook The procedure for this step is listed below.

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| **Procedure – Income Determination**  **Step One: Eligibility**   * Use the Electronic Medicaid Budgeting Workbook. * Enter all Budget Group Information on the BG Info Tab. * On the NH\_HCBS Tab, Income Trust will display in red letters below the Countable Income Computation when gross income exceeds the Medicaid Cap. * Verify what income is being placed in to the trust (refer to Schedule A and bank deposits)   + Exclude any income placed into the trust.   + Count any income received outside of the Income Trust toward the Medicaid Cap.   **Note:** If the money received outside the trust is listed on the Income Trust Schedule A, the terms of the trust are changed, and eligibility may be affected.   * Exclude any income placed into the Trust.   **Step Two: Post-Eligibility:**   * All of the individual's total countable gross income is considered in the post-eligibility step, regardless if placed in the trust or not. * On the IT Tab of the Electronic Budget workbook, enter the amounts of income placed in the trust and received outside the trust in the appropriate Budget (Nursing Facility or Waiver.  | **Nursing Home** | **Waiver** | | --- | --- | | * Subtract any allowable deductions (Refer to MPPM [304.19.06A](#MPPM_304_19_06A) | * Subtract any allowable deductions (Refer to MPPM [304.19.06B](#MPPM_304_19_06B) | | * On Line 11, choose the appropriate facility from the drop down box | * Any remaining income the Cost of Care for Waiver Services. | | * Line 12 will reflect any amounts that must remain in the Trust each month, if any. |  | | * Line 13 is the Recurring Income. |  | |

**304.19.06A Allowable Deductions for Nursing Home**

(Eff. 01/01/23)

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| **Personal Needs Allowance** | * $100 – Work Therapy Allowance – if the institutionalized individual participates in a work therapy program as a part of the plan of care; or * $30 – Standard Allowance – if the institutionalized individual does not participate in a work therapy program. |
| **Note:** Individuals receive the $30 personal needs allowance from countable income in addition to any excluded income such as VA Aid and Attendance or the $90 reduced VA pension. | |

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| **Court Ordered Guardianship Fees** | * The lesser of 10% of gross income or $25 for court ordered guardianship fees |

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| **Income Trust Specific** | * $10 Trustee Fee to manage the trust (Note: A higher amount must be approved by the SC Department of Health and Human Services) * Actual Bank Charges up to a maximum $20 per month if charged by the bank for the account used for the trust * Payment of Federal and/or State Income taxes   + Must be owed by the Income Trust, not the individual.   + Copy of the tax return must be provided.   + Allowed only once per calendar year. |

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| **Community Spouse Income Allowance** | * Institutionalized spouse **must** choose to give; and * The amount must not exceed $3,715.50 per month. |
| **Procedure to Determine the Amount of the Community Spouse Income Allowance**   * Determine the community spouse’s gross income. * Subtract this amount from $3,715.50. * The difference is the maximum allocation amount.   **Note:** A lower amount may be allocated if the community spouse wishes to maintain or establish eligibility for SSI benefits or Medicaid under another payment category such as ABD. The institutionalized individual must actually make the income available to the community spouse in order for it to be deducted. The spouse of a nursing home patient who receives Home and Community Based Services is considered a community spouse for the purposes of the income provisions of spousal impoverishment.  **Procedure – Amount of Community Spouse Allocation Questioned**  If the community spouse disagrees with the amount allocated or needs a higher amount to maintain him/her, the eligibility worker should inform the spouse of his/her right to appeal (Fair Hearing).  The community spouse must justify the need for the additional amount due to exceptional circumstances or significant financial duress. A higher amount can only be allowed if it is ordered through an appeal. | |

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| **Allowance for Other Dependent Family Members** | * Institutionalized spouse **must** choose to give the allocation * May include minor children or dependent adults of the institutionalized or community spouse. A dependent adult is an adult family member (such as a mother, father, child, brother, sister) living in the home who depends on the applicant/beneficiary or community spouse for meeting physical, medical, or financial needs. * A signed statement completed by the applicant/beneficiary or authorized representative indicating the relationship of the dependent adult and the nature of the dependency is acceptable verification to provide the allowance. |
| **Procedure to Determine the Amount of Income Allowances for Other Dependent Family Members**  **Dependent(s) residing with Community Spouse**   * Determine the gross income of each family member. * Subtract the total gross income of each family member from $3,715.50. * One-third of the remaining amount is each family member’s income allowance. * Add each family member’s income allowance together to determine the total family income allowance. * This is the amount allowed for allocation to family members.   **Dependent(s) residing with someone other than the Community Spouse**   * Determine the gross monthly income of all dependents living together * Compare the gross income of all dependents living together to the TANF/FI Need Standard (PCR Income Limit, refer to MPPM 103.03) for a family of the appropriate size. For example, 2 dependents would use PCR Income Limit for 2. * If gross monthly income is equal to or greater than the standard, no allocation is made. * If gross monthly income is less than the standard, subtract the income from the standard. The resulting figure is the allocation to the dependents.   **NOTE:** The institutionalized individual must actually make the income available to the family in order for it to be deducted. | |

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| **Health Insurance Premiums**  **Note:**  Does not include Medicare Parts A and B  Refer to the next table for Medicare Part D | * Must only be paid by or for the Medicaid beneficiary out of the beneficiary’s funds. * May only be deducted the month the premium is due or the month after. (See table below) * Must be verified. * Convert premiums paid at a frequency other than monthly to a monthly amount. |
| **Procedure – Health Insurance Premiums**  Acceptable forms of verification include:   * Premium notice * Copy of cancelled check * Bank statement verifying draft  |  |  | | --- | --- | | **When Premium is reported** | **Effective Date of Change** | | Month premium due/paid | Recurring Income may be rebudgeted effective the month the premium is due/paid | | Month after premium due/paid | Recurring Income may be rebudgeted effective the month the premium is due/paid | | Two or more Months after premium due/paid | Recurring Income may be rebudgeted effective the month the premium is reported to the agency | | **Reminder:**   * Regardless when the rebudget is being completed, the effective date is based on when the information was reported to DHHS * If the amount a beneficiary must pay goes up once the rebudget is completed, adequate and advance notice must be given before the change becomes effective unless the beneficiary waives the 15-day notice requirement * For premiums paid at a frequency other than monthly, average the premium to determine a monthly amount for the Cost of Care calculation | |   **Example 1:** Joe’s income is $300 and he reports on June 2nd that his quarterly insurance premium of $450 is due on June 30. He has no other deductions other than his personal needs allowance.  Health Insurance: $450.00 (Quarterly Premium)  ÷ 3  $150.00 (Monthly Average)  Cost of Care: $300.00 (Gross Income)  – $30.00 (Personal Needs)  – $150.00 (Health Insurance Premium)  $120.00 (Cost of Care)  **Example 2:** Alice’s income is $500 and she reports on September 10 that her monthly insurance premium changed in June from $100 per month to $150 per month. She has no other deductions except for her personal needs allowance.  June, July, August recurring income: $500 - $30 = $470, then $470 - $100 = $370  September recurring income: $500 - $30 = $470, then: $470 - $150 = $320 | |

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| **Health Insurance Premiums – Medicare Part D, Drug Coverage** | * For individuals approved for Nursing Home coverage who are not already Medicaid eligible, subtract the Medicare Part D Benchmark from the verified Part D premium being paid by the individual and allow the remainder as a Health Insurance Premium deduction from countable income. * For individuals receiving Medicaid who are then approved for Nursing Home coverage, the adjustment for the Medicare Part D Benchmark has already been applied. Allow the Medicare Part D premium being paid by the beneficiary as a Health Insurance Premium deduction from countable income. * At COLA or Annual Review, the adjustment for the Medicare Part D Benchmark has already been applied. Allow the Medicare Part D premium being paid by the beneficiary as a Health Insurance Premium deduction from countable income. * Refer to MPPM 103.07 for the current Medicare Part D Premium Benchmark for South Carolina |
| **Procedure – Health Insurance Premiums**  Verify the Part D Medicare premium   * Is the individual currently Medicaid eligible?   + If Yes, the benchmark adjustment has already been applied. Allow the premium being paid as a Health Insurance Premium deduction in the cost of care calculation   + If No, subtract the benchmark from the premium being paid and allow the remainder as a Health Insurance Premium deduction in the cost of care calculation   **Example:** John Allen is admitted to Happy Trails Nursing Facility on June 23 and approved for Medicaid. He currently has Medicare Part D and pays a $42.82 premium per month.  42.82 (Medicare Part D Premium)  – 37.84 (2021 Part D Benchmark)  $4.98 (Health Insurance Premium deduction)  **Example:** Alice Kramer was approved for Medicaid coverage last year. She has now been admitted to Green’s Awesome Care Nursing Facility on May 12 and approved for coverage. She currently has Medicare Part D and pays a $12.93 premium per month. Allow $12.93 as a Health Insurance Premium deduction in the cost of care calculation. | |

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| **Home Maintenance Allowance** | * A maximum of six months is allowed.   + A physician **must** certify the individual is expected to return home within six months of admission to an institutional setting.   + The first full calendar month following the month of admission to a hospital or nursing facility begins the six-month count. * Given for actual expenses, not to exceed the maximum SSI payment level for an individual. May be given even if someone continues to reside in the home.   + Examples of expenses that are allowed include:     - Rent or Mortgage     - Home owners or renters insurance     - Utilities     - Basic Cable, Internet or Satellite TV service   + Examples of expenses that are not allowed include:     - Premium Cable or Satellite TV services and channels     - Special telephone features, such as call waiting * Expenses can be documented using a written or verbal statement from the individual. The statement must show:   + The type of payment; (for example: mortgage, electricity, water and sewer, trash pickup, cable, phone)   + To whom the payment is made; and   + The amount paid. * A copy of the actual bill is not required unless the person appears to be paying for extra or premium services |
| **Note:**   * A request for the Home Maintenance Allowance can be made at any time during the six-month period. * The deduction is applied when determining the amount of recurring income the individual is responsible for paying to a facility. * The time an individual is in a hospital counts toward the maximum six month period. | |

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| **Protected Income** | Income is not protected for the month of admission from or discharge to a community setting for individuals with an Income Trust. |

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| **Cost of Pre-Eligibility Non-Covered Medical Expenses** | * The nursing facility may deduct pre-eligibility non-covered medical expenses. These are expenses:   + Recognized by State or Federal law as medical expenses;   + Not covered by Medicaid, Medicare, or other third-party payers; and   + Incurred by an individual before becoming eligible for Medicaid |
| **Note:** Deductions for non-covered medical expenses cannot exceed a beneficiary’s monthly recurring income and cannot be made if the beneficiary has zero ($0) reported monthly income. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty is limited to zero. | |

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| **Cost of Post Eligibility Non-Covered Medical Expenses** | * The nursing facility may deduct post-eligibility non-covered medical expenses. These are expenses:   + Recognized by State or Federal law as medical expenses;   + Not covered by Medicaid, Medicare, or other third-party payers (Refer to [Appendix B](#Appendix_B)); and   + Incurred by an individual currently Medicaid eligible in a Nursing Home |
| **Note:** Deductions for non-covered medical expenses cannot exceed a beneficiary’s monthly recurring income and cannot be made if the beneficiary has zero ($0) reported monthly income. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty is limited to zero. | |

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| **Procedure – Computing Allowable Deductions for Individuals in Nursing Home Facilities**   * Use the Electronic Budgeting Workbook or the [DHHS Form 1729 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201729%20ME.pdf), Income Trust Budget Worksheet. * Combine any income received outside the trust with any income placed in the trust. * Subtract any allowable deductions   + Appropriate Personal Needs Allowance   + $10 Trustee Fee   + Court ordered guardianship fees (lesser of 10% of gross income, or $25)   + Actual Bank Service Charges, up to $20 per month   + Federal or State Income Tax payment (once per calendar year, IF the trust owes the taxes – not the individual.)   + Family Maintenance Allowance, if any   + Health insurance premium (for individual only)   + Home Maintenance Allowance, if any   + Medical Expenses not subject to third-party payment such (for individual only). These adjustments are made by the nursing facility as part of billing     - Pre-Eligibility Expenses     - Post Eligibility Expenses   **Note:** In Income Trust Cases, income is NOT protected in the months of entry and discharge. The recipient must contribute recurring income. The nursing home may pro-rate the actual payment based on the number of days the individual was a patient.   * Compare the remainder to the facility’s average monthly Medicaid payment rate (Refer to [Appendix D](#Appendix_D) of this chapter.)   + If the remainder is less than or equal to the monthly rate:     - The remainder is the cost of care, and     - No money will be left in the trust.   + If the remainder is greater than the monthly rate:     - The cost of care is equal to the monthly rate, and     - Any additional income must be left to accumulate in the trust.   **Note:** If these funds are used for any other purpose, they may be considered a Transfer of Assets or Countable Income.   * Enter a Y as the Income Trust indicator on MEDS screen ELD02.   A copy of the budget calculations must be given to the trustee. If using the Budgeting Workbook, for an initial approval, provide a copy of the following tabs: BG Info, NH-HCBS, IT. At each subsequent review, provide a copy of the BG Info and IT tabs. |

**304.19.06B Allowable Deductions for Home and Community Based Services**

(Eff. 01/01/23)

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| **Personal Needs Allowance** | * $2,742 – Waiver Allowance – Individuals participating in a HCBS waiver receive a Personal Needs Allowance equal to the Medicaid Cap |

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| **Court Ordered Guardianship Fees** | * The lesser of 10% of gross income or $25 for court ordered guardianship fees |

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| **Income Trust Specific** | * $10 Trustee Fee to manage the trust (Note: A higher amount must be approved by the SC Department of Health and Human Services) * Actual Bank Charges up to a maximum $20 per month if charged by the bank for the account used for the trust * Payment of Federal and/or State Income taxes   + Must be owed by the Income Trust, not the individual.   + Copy of the tax return must be provided.   + Allowed only once per calendar year. |

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| **Community Spouse Income Allowance** | * Institutionalized spouse **must** choose to give; and * The amount must not exceed $3,715.50 per month. |
| **Procedure to Determine the Amount of the Community Spouse Income Allowance**   * Determine the community spouse’s gross income. * Subtract this amount from $3,715.50. * The difference is the maximum allocation amount.   **Procedure – Amount of Community Spouse Allocation Questioned**    If the community spouse disagrees with the amount allocated or needs a higher amount to maintain him/her, the eligibility worker should inform the spouse of his/her right to appeal (Fair Hearing).  The community spouse must justify the need for the additional amount due to exceptional circumstances or significant financial duress. A higher amount can only be allowed if it is ordered through an appeal. | |

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| **Allowance for Other Dependent Family Members** | * Institutionalized spouse **must** choose to give the allocation * May include minor children or dependent adults of the institutionalized or community spouse. A dependent adult is an adult family member (such as a mother, father, child, brother, sister) living in the home who depends on the applicant/beneficiary or community spouse for meeting physical, medical, or financial needs. * A signed statement completed by the applicant/beneficiary or authorized representative indicating the relationship of the dependent adult and the nature of the dependency is acceptable verification to provide the allowance. |
| **Procedure to Determine the Amount of Income Allowances for Other Dependent Family Members**  **Dependent(s) residing with Community Spouse**   * Determine the gross income of each family member. * Subtract the total gross income of each family member from $3,715.50. * One-third of the remaining amount is each family member’s income allowance. * Add each family member’s income allowance together to determine the total family income allowance. * This is the amount allowed for allocation to family members.   **Dependent(s) residing with someone other than the Community Spouse**   * Determine the gross monthly income of all dependents living together * Compare the gross income of all dependents living together to the TANF/FI Need Standard (PCR Income Limit, refer to MPPM 103.03) for a family of the appropriate size. For example, 2 dependents would use PCR Income Limit for 2. * If gross monthly income is equal to or greater than the standard, no allocation is made. * If gross monthly income is less than the standard, subtract the income from the standard. The resulting figure is the allocation to the dependents.   **NOTE:** The institutionalized individual must actually make the income available to the family in order for it to be deducted. | |

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| **Health Insurance Premiums**  **Note:**  Does not include Medicare Parts A and B  Refer to the next table for Medicare Part D | * Must only be paid by or for the Medicaid beneficiary out of the beneficiary’s funds. * May only be deducted the month the premium is due or the month after. (See table below) * Must be verified. * Convert premiums paid at a frequency other than monthly to a monthly amount. |
| **Procedure – Health Insurance Premiums**  Acceptable forms of verification include:   * Premium notice * Copy of cancelled check * Bank statement verifying draft  |  |  | | --- | --- | | **When Premium is reported** | **Effective Date of Change** | | Month premium due/paid | Recurring Income may be rebudgeted effective the month the premium is due/paid | | Month after premium due/paid | Recurring Income may be rebudgeted effective the month the premium is due/paid | | Two or more Months after premium due/paid | Recurring Income may be rebudgeted effective the month the premium is reported to the agency | | **Reminder:**   * Regardless when the rebudget is being completed, the effective date is based on when the information was reported to DHHS * If the amount a beneficiary must pay goes up once the rebudget is completed, adequate and advance notice must be given before the change becomes effective unless the beneficiary waives the 15-day notice requirement * For premiums paid at a frequency other than monthly, average the premium to determine a monthly amount for the Cost of Care calculation | |   **Example 1:** Joe’s income is $300 and he reports on June 2nd that his quarterly insurance premium of $450 is due on June 30. He has no other deductions other than his personal needs allowance.  Health Insurance: $450.00 (Quarterly Premium)  ÷ 3  $150.00 (Monthly Average)  Cost of Care: $300.00 (Gross Income)  – $30.00 (Personal Needs)  – $150.00 (Health Insurance Premium)  $120.00 (Cost of Care)  **Example 2:** Alice’s income is $500 and she reports on September 10 that her monthly insurance premium changed in June from $100 per month to $150 per month. She has no other deductions except for her personal needs allowance.  June, July, August recurring income: $500 - $30 = $470, then $470 - $100 = $370  September recurring income: $500 - $30 = $470, then: $470 - $150 = $320 | |

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| **Health Insurance Premiums – Medicare Part D, Drug Coverage** | * For individuals approved for Nursing Home coverage who are not already Medicaid eligible, subtract the Medicare Part D Benchmark from the verified Part D premium being paid by the individual and allow the remainder as a Health Insurance Premium deduction from countable income. * For individuals receiving Medicaid who are then approved for Nursing Home coverage, the adjustment for the Medicare Part D Benchmark has already been applied. Allow the Medicare Part D premium being paid by the beneficiary as a Health Insurance Premium deduction from countable income. * At COLA or Annual Review, the adjustment for the Medicare Part D Benchmark has already been applied. Allow the Medicare Part D premium being paid by the beneficiary as a Health Insurance Premium deduction from countable income. * Refer to MPPM 103.07 for the current Medicare Part D Premium Benchmark for South Carolina |
| **Procedure – Health Insurance Premiums**  Verify the Part D Medicare premium   * Is the individual currently Medicaid eligible?   + If Yes, the benchmark adjustment has already been applied. Allow the premium being paid as a Health Insurance Premium deduction in the cost of care calculation   + If No, subtract the benchmark from the premium being paid and allow the remainder as a Health Insurance Premium deduction in the cost of care calculation   **Example:** John Allen is admitted to Happy Trails Nursing Facility on June 23 and approved for Medicaid. He currently has Medicare Part D and pays a $42.82 premium per month.  42.82 (Medicare Part D Premium)  – 37.84 (2021 Part D Benchmark)  $4.98 (Health Insurance Premium deduction)  **Example:** Alice Kramer was approved for Medicaid coverage last year. She has now been admitted to Green’s Awesome Care Nursing Facility on May 12 and approved for coverage. She currently has Medicare Part D and pays a $12.93 premium per month. Allow $12.93 as a Health Insurance Premium deduction in the cost of care calculation. | |

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| **Cost of Post Eligibility Non-Covered Medical Expenses** | * The nursing facility may deduct post-eligibility non-covered medical expenses. These are expenses:   + Recognized by State or Federal law as medical expenses;   + Not covered by Medicaid, Medicare, or other third-party payers (Refer to [Appendix B](#Appendix_B)); and   + Incurred by an individual currently Medicaid eligible |
| **Note:** Deductions for non-covered medical expenses cannot exceed a beneficiary’s monthly recurring income and cannot be made if the beneficiary has zero ($0) reported monthly income. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty is limited to zero. | |

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| **Procedure Computing Allowable Deductions for Individuals Receiving Home and Community Based Services**   * Use the [DHHS Form 1729 ME](http://medsweb.clemson.edu/EligibilityForms/FM%201729%20ME.pdf), Income Trust Budget Worksheet, or the IT tab in the Budget Workbook. * Combine any income received outside the trust with any income placed in the trust. * Subtract any allowable deductions   + Waiver Allowance (equal to the Medicaid Cap)   + $10 Trustee Fee   + Court ordered guardianship fees (lesser of 10% of gross income, or $25)   + Actual bank service charges up to $20 per month   + Federal or State Income Tax payment (once per calendar year, IF the trust owes the taxes – not the individual.)   + Family Maintenance Allowance, if any   + Medical Expenses not subject to third-party payment (for the applicant/beneficiary only)     - Health insurance premiums     - Non-covered post eligibility medical expenses (Refer to [Appendix B](http://medsweb.scdhhs.gov/mppm/HTML/Section300/Chapter%20304%20%20NH-HCBS-GH.htm#Appendix_B) of this chapter.)   + The remainder of the income is the cost of care.     - Enter the amount on the [DHHS Form 3229 ME](http://medsweb.clemson.edu/EligibilityForms/FM%203229%20ME.pdf), Notice of Cost of Care, as the amount that will be billed for the waiver services. * Enter a Y in the Income Trust indicator field on MEDS screen ELD02.   **Example:** Mr. Lee Brown applies for Home and Community Based Services. He receives Social Security benefits of $1,349 and a Union Retirement check in the amount of $2,219 per month. He pays a health insurance premium of $185 per month. He establishes an income trust and opens the trust bank account. Upon approval, he has been accepted into the Palmetto SeniorCare a PACE. Mr. Brown is a widow and lives with his daughter at night.  **Treatment:** The LTC worker should use the electronic budgeting workbook or DHHS Form 1729 ME, Income Trust Budget Worksheet, to calculate the maximum cost of care. (**Note:** Be sure to use the side for Waiver Participants.) A copy of the DHHS Form 1729 ME must be given to the trustee.  **Gross monthly income $3,568**  Deductions:  Waiver Allowance $2,742  Trust Administration Fee + 10  Health Insurance Premium + 185  **Total Deductions $2,937**  Gross Income $3,568  Total Deductions - 2,937  **Payable Monthly Recurring Income $631**  **A copy of the DHHS Form 3229 must be emailed to the Division of Accounting to inform them of approval and the beneficiary’s recurring income.** |

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304.19.07 Billing for Home and Community Based Services Waiver Program Participants

(Eff. 07/01/15)

* Upon approval, the LTC worker will forward a copy of the DHHS Form 3229 to the Division of Accounting when a beneficiary has a recurring income (cost of care).
* State DHHS, Division of Accounting is responsible for billing the trustee for the recurring income (cost of care).
* The trustee must pay on a monthly basis for the Home and Community Based Services the beneficiary receives.
* Eligibility Enrollment and Member Services (EEMS) will reconcile the actual amount of Medicaid funds expended to the cost of care at the time the trust is dissolved.

**Failure to Pay for Services**

If the trustee fails to make monthly payments for the Home and Community Based Services received, the Principal Beneficiary (the client) will be required to change the trustee.

If the Principal Beneficiary refuses to change the trustee, Home and Community Based Services and Medicaid benefits will be terminated.

Refer to MPPM 304.19.10 regarding non-compliance.

304.19.08 Annual Accounting

(Eff. 06/01/06)

Annually, the trustee must provide an accounting of the Income Trust and its activity to the eligibility worker. This must include verification of:

* All income placed in the trust,
* All funds distributed from the trust,
* The purpose of all funds that were distributed, and
* The total amount of funds remaining in the trust, if applicable.

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| **Procedures for Conducting an Annual Accounting:**  **First annual accounting after approval:**   1. Examine all budget workbooks beginning with the effective month of eligibility forward. 2. Determine how much, if any, funds were to remain in the Income Trust. 3. Examine the statements for the Income Trust account that were submitted with the review form.    1. Deposits – Do the sources and amounts deposited match the income that is assigned to the trust?    2. Withdrawals       1. Are the withdrawals for allowable expenses?       2. If not, what things are being withdrawn? Obtain additional statements, if needed.    3. Balance – Does the balance reflect what should have been left in the account according to the budget workbooks?       1. If the balance is less than what it should be, contact the trustee to discuss.       2. If unable to reach the trustee by telephone, send DHHS 1233 requesting additional statements to determine if the trust is in compliance.    4. If the trust is not in compliance, refer to MPPM 304.19.10    5. Document the annual accounting on the Budget workbook and send a copy to the trustee.   **Annual Accounting Year 2 and after:**   1. Examine all budget workbooks beginning with the last accounting. 2. Determine how much, if any, funds were to remain in the Income Trust. 3. Examine the statements for the Income Trust account that were submitted with the review form.    1. Deposits – Do the sources and amounts deposited match the income that is assigned to the trust?    2. Withdrawals       1. Are the withdrawals for allowable expenses?       2. If not, what things are being withdrawn? Obtain additional statements, if needed.    3. Balance – Does the balance reflect what should have been left in the account according to the budget workbooks?       1. If the balance is less than what it should be, contact the trustee to discuss.       2. If unable to reach the trustee by telephone, send DHHS 1233 requesting additional statements to determine if the trust is in compliance.    4. If the trust is not in compliance, refer to MPPM 304.19.10    5. Document the annual accounting on the Budget workbook and send a copy to the trustee. |

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304.19.09 Trust Modification: Trustee or Bank Account Change

(Eff. 06/01/06)

Eligibility, Enrollment and Member Services (EEMS) must approve all Income Trust modifications.

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| **Procedure – Income Trust Modifications**  A change of Trustee requires that the LTC worker   * Provide all explanations as indicated in MPPM 304.19.02. * Provide all appropriate Income Trust paperwork   + DHHS Form 905   + DHHS Form 906   + DHHS Form 925   Complete a DHHS 1233 ME if necessary, requesting the Income Trust document any additional information needed to complete the application.  The new Income Trust document must be reviewed and approved (refer to MPPM 304.19.04B  A change in Bank Account information requires that the eligibility worker:   * Verify any change made and file the documentation in the case record. |

304.19.10 Non-Compliance with Terms of the Income Trust

(Eff. 06/01/06)

Several things may result in non-compliance with terms of the Income Trust, such as:

* Failure to place income listed on the Income Trust Schedule A into the Income Trust (Either the Schedule A included in the DHHS Form 905 or a separate [DHHS Form 3270](http://medsweb.scdhhs.gov/EligibilityForms/FM%203270%20ME.pdf))
* Failure to pay the cost of care for Nursing Home or Waiver Services
* Funds from the Income Trust distributed for expenses other than those allowed on the Income Trust Worksheet of the Budget Workbook.
* Failure to maintain a separately identifiable account

The LTC worker may become aware of possible non-compliance in several ways:

* The LTC worker may discover problems while conducting the annual accounting.
* A nursing home or the Division of Accounting may advise the LTC worker of non-payment.

When non-compliance is detected or reported, the LTC worker must:

* Staff the case with the LTC Coordinator
* Contact the Applicant/Trustee to advise them that the trust is not in compliance.
* Explain what steps are needed to bring the trust into compliance. For example:
  + Placing the correct income into the trust
  + Amending the Schedule A
  + Bringing payments up to date.
* Explain if the trust is not brought into compliance, Medicaid will be terminated unless a new trustee is named.
* Give an time frame of 15 days to verify the trust has been brought into compliance
* If the trust is not brought into compliance, contact the applicant to discuss. Send a DHHS 1233 ME requesting new trustee be appointed and verification of the designated account. Attach the Income Trust forms. Give a time frame to 10 days for return.
* If a new trustee is not appointed, the case must be closed.

304.19.11 Death of Income Trust Principal Beneficiary

(Eff. 06/01/06)

If the Principal Beneficiary of an income trust dies, the Division of Policy & Planning must dissolve the trust.

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| **Procedure to Dissolve the Income Trust Upon the Death of the Principal Beneficiary**  If a Principal Beneficiary dies and the Income Trust case is closed, the following steps must be taken:   * The LTC worker must submit a Service Manager ticket to refer the Income Trust for dissolution. Refer to MPPM 304.19.14 |

304.19.12 Income Trust Dissolution

(Rev. 07/01/15)

An Income Trust may need to be dissolved for a number of reasons, (such as, death of beneficiary, non-compliance, income falls below the Medicaid Cap, and termination of case).

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| **Procedure to Dissolve an Income Trust**  If an Income Trust needs to be dissolved for any reason, the LTC worker must:   * Initiate a Service Manager Ticket to Medical Support   Group: Medicaid Eligibility  Category: For Medicaid Policy  Category Option: Income Trust Dissolution  Assignment: Beverly Ashford   * Explain the reason for the dissolution (such as discharged from nursing facility); and * Give dates of eligibility under Income Trust   Medical Support will:   * For Nursing Home Cases:   + Pull claims for the associated time frame   + Determine how much money is due the agency under the terms of the Income Trust.   + Send a certified letter to the trustee notifying them:     - The trust has been dissolved     - Of any amounts due to the agency under the terms of the Income Trust and how to remit payment.     - That the account may be closed. * For Waiver cases:   + Pull claims for the associated time frame   + Determine how much money is due the agency under the terms of the Income Trust   + Advise the Division of Accounting of the amount of claims paid. If the beneficiary has paid the agency more than amount that Medicaid has paid, a refund will be issued for the difference.   + Send a certified letter to the trustee, copying Estate Recovery, advising the trustee that the dissolution of the trust has been completed and the account may be closed.   If the Income Trust is dissolved because the beneficiary’s income has fallen below the Medicaid Cap, any funds remaining in the account after the trust is dissolved becomes a countable resource. |

304.19.13 Income Trust and Transfer Penalties

When an applicant/beneficiary with an Income Trust is subject to a penalty due to a transfer of assets, funds must remain in the Income Trust and cannot be used to pay the facility. This must be explained to the applicant/beneficiary. If all eligibility criteria are met, except for the penalty period, the application may be approved for the month eligibility established **only** so the penalty may start. The case must then be closed. A new application will be needed when the penalty period is over.

NOTE: If the penalty period expired while the application is pending, a new application will not be required. The worker should:

* Approve in MEDS effective the month vendor payment will begin.
* Submit a Service Manager Ticket for a MEDS correction to add the initial month of eligibility.

304.19.14 Income Trust Identification/Set up Flow

(Eff. 07/01/15)

| **Need for Income Trust Identified during Application** | | |
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|  | **Application Intake**  **(Green Team) Worker** | * Identifies the need to establish an Income Trust through stated and/or verified income.   + If stated income is within $200 of Medicaid cap, the Income Trust should be pursued. * If the Income Trust document has been submitted with the application:   + Reviews the document for accuracy.     - If accurately completed and signed, approves document     - If incomplete or incorrectly signed, returns to the applicant/trustee for correction. * If telephone interview is conducted, explains   + Why and Income Trust is needed   + General information about the Income Trust Packet,   + Management of the Income Trust account.   **NOTE**: If it is near the end of the month, see if the documents can be emailed or faxed in an effort to have it completed by the end of the month. |
|  | **Assessment/Process (Purple Team) Worker** | * When information is received, reviews Income Trust or corrected Income Trust for accuracy. * If incomplete or incorrectly signed,   + Attempt to contact via telephone to discuss necessary corrections.   + Returns document to the applicant/trustee for corrections. * If accurately completed and signed, approves the document. * Proceeds with eligibility determination. |

**Eligibility Determination Reminders With Income Trust:**

* Must have verification of Separately Identifiable Account
* Account must be funded for any months for which Medicaid eligibility is needed. That is, income for that month must run through the account.
* Income is NOT protected for the month of entry.

| **Need for Income Trust Identified at Annual Review** | | |
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|  | **Review Team**  **(Blue Team) Worker** | * During review, current stated and/or verified income indicates the need to establish an Income Trust through stated and/or verified income. * If successful in collateral call with the beneficiary/authorized representative, explains:   + Why and Income Trust is needed   + General information about the Income Trust Packet,   + Management of the Income Trust account. * Sends 1233 checklist with the Income Trust packet requesting return within 15 days. * Rebudgets case if income has been verified * Sends to follow-up awaiting return of the Income Trust document and account. |
|  | **Assessment/Process (Purple Team) Worker** | * When information is received, reviews Income Trust or corrected Income Trust for accuracy. * If incomplete or incorrectly signed,   + Attempt to contact via telephone to discuss necessary corrections.   + Returns document to the applicant/trustee for corrections. * If accurately completed and signed, approves the document. * Proceeds with eligibility determination. When information is received, reviews Income Trust or corrected Income Trust for accuracy. * If incomplete or incorrectly signed,   + Attempt to contact via telephone to discuss necessary corrections.   + Returns document to the applicant/trustee for corrections. * If accurately completed and signed, approves the document. * Ensures separately identifiable account has been set up and funded. * Completes eligibility determination and rebudgets case if not previously completed. |

304.20 Other Trusts

(Eff. 06/01/06)

In the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), Congress provided that certain trusts must be exempt from a Transfer of Assets penalty. These trusts are generally called:

* Special Needs Trusts (Refer to MPPM 302.30.06.)
* Pooled Trusts (Refer to MPPM 302.30.07.)

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| Procedure  The trusts discussed in this section must be submitted for evaluation. Refer to the [Service Manager Ticket Submission Guide](https://gcc02.safelinks.protection.outlook.com/ap/b-59584e83/?url=https%3A%2F%2Fschhs.sharepoint.com%2F%3Ab%3A%2Fr%2Fsites%2FEES%2FTraining%2FService%2520Manager%2FService%2520Manager%2520Ticket%2520Submission%2520Guide.pdf%3Fcsf%3D1%26web%3D1%26e%3DDHOO8D&data=04%7C01%7CFAULKLAR%40scdhhs.gov%7C4bbd0a082a11424f3c5008d9e047762b%7C4584344887c24911a7e21079f0f4aac3%7C0%7C0%7C637787419799260907%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000&sdata=yGgpbEZ4xgQXTiUdioDT2NNeCH2Y8mPlKtiYD4YtKA4%3D&reserved=0) for instructions. |

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304.20.01 Undue Hardships and Trusts

(Eff. 02/01/09)

Undue hardship exists when the application of trust provisions or the post eligibility cost of care determination would deprive the individual of:

* Medical care such that his/her health or life would be endangered; OR
* Food, clothing, shelter, or other necessities of life.

The eligibility worker must obtain a letter from the applicant/beneficiary or his/her authorized representative claiming an undue hardship exists and verifications to substantiate the claim. Such verifications include, but are not limited to the following:

* Letter from a physician certifying that the applicant/beneficiary’s health or life may result in the individual being placed in a life-threatening situation.

===AND===

* + Verification that services are not available through a Medicaid Provider; **AND/OR**
  + Verification of necessary medical expenses not otherwise covered; **AND/OR**
  + Verification of necessary household expenses not being paid (e.g.; mortgage, utilities).

For nursing home and waiver service applicants/recipients, the eligibility worker must obtain the above verifications as well as the verifications listed below:

* Letter from CLTC/DDSN/PACE
  + Denying or terminating services OR
  + Verifying the inability to provide this service to the extent necessary through the waiver;

===OR===

* Letter from the nursing home either:
  + Refusing to admit the patient, or
  + Threatening discharge of the patient.

Send the letters and other documentation to the DHHS Division of Policy and Planning for evaluation to determine if undue hardship exists.

304.21 Bed Hold Policy

(Eff. 06/01/06)

Medicaid may continue to make a vendor payment to a nursing facility in the following instances and within the specified limitations:

* For up to 10 days, if an individual is in a hospital. An individual may be in the hospital 10 full days, returning to the facility on the 11th day.
* For an absence of up to 18 days per fiscal year for a de-institutionalization program, not to exceed nine days at any one time.
* For up to 30 consecutive days for the purpose of participating in an approved rehabilitation program.
* For up to 96 days each fiscal year for individuals who reside in Intermediate Care Facilities for the Intellectually Disabled (each period of leave is for a maximum of eight days and may be two 16-consecutive days if authorized by a physician).
* A one-time 30-day consecutive leave per admission is allowed for discharge planning and permanent placement to a home environment. The attending physician must prescribe this leave as a vital part of the discharge planning activity. A leave of absence exceeding the allowed days requires a discharge from the facility.

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| Note: The majority of the bed holds the eligibility worker will work with are 10-day bed holds for hospital admissions. The chart below indicates the steps to take when an individual transfers from a nursing facility to a hospital. |

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| **Upon Admission to a Hospital** | | |
| **What the Nursing Facility Should Do** | **What the Eligibility Worker MUST Do** | |
| Send a [DHHS Form 181](http://medsweb.scdhhs.gov/EligibilityForms/FM%20181.pdf) to advise the eligibility worker of the hospital admission date. Ideally, this should be done within a few days of the individual’s admission. | Set up a tickler file to count the 10 days. | |
| **When the 10 Days are Up** | | |
| **What the Nursing Facility Should Do** | **What the Eligibility Worker MUST Do** | |
| Send a DHHS Form 181 to notify the eligibility worker of either:  • The re-admission date (if Medicare is paying for the re-admission, this should be verified); or  • The individual’s inability to return to the facility and the vendor payment termination date. | If a DHHS Form 181 is not received from the nursing facility:   * Contact the nursing facility and/or hospital to verify the individual’s location.   If individual is re-admitted to the nursing facility within the 10 days:   * Document the case record; no other action is needed.   If individual remains hospitalized:   * Generate a DHHS Form 181 to terminate the vendor payment, * Send a notice to the authorized representative notifying him/her of the termination, and * Ex parte to General Hospital (or another payment category, if applicable).   If individual is not eligible for Medicaid in another payment category:   * Begin closure action for Medicaid. |

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| **Example #1:** Jennifer Ward is a patient at Sisters of Charity Nursing Home. She is transferred to the local hospital on March 5 suffering from pneumonia. The nursing home sent a [DHHS Form 181](http://medsweb.scdhhs.gov/EligibilityForms/FM%20181.pdf) to the county Medicaid eligibility office on March 6 notifying them of the change. The eligibility worker marked her calendar for follow up on March 15. On March 10, the county Medicaid eligibility office received a DHHS Form 181 verifying Ms. Ward was readmitted to the nursing facility at the same level of care. No further action was needed.  **Example #2:** On April 5, the county Medicaid eligibility office received a DHHS Form 181 from Caring Hearts notifying them that Davis Mathews was transferred to the local hospital on April 2. On April 13, the eligibility worker contacted the nursing home, verified Mr. Mathews remained hospitalized, and that the DHHS Form 181 had been mailed terminating the vendor payment. On April 20, the eligibility worker verified Mr. Mathews was still in the hospital and was expected to remain there indefinitely. Mr. Mathews did not have an income trust so the eligibility worker changed the payment category to General Hospital.  **Example #3:** Same scenario as Example #2 except that Mr. Mathews qualified for Nursing Home by establishing an Income Trust. The eligibility worker initiated closure of his Medicaid because the General Hospital has no Income Trust provision. |

304.22 Medicare/Co-Insurance

(Rev. 07/01/07)

Under certain conditions, Medicare Part A may cover an individual’s costs in a nursing facility for a short period. After a qualifying hospital stay, Medicare pays in full for services during the first 20 days of skilled care for a spell of illness. Beginning with the 21st day, only a portion of the cost is covered. Coverage may be available for up to 100 days if all the Medicare criteria are met.

If an individual is eligible for both Medicare Part A and Medicaid, the Medicaid program is not responsible for the co-insurance amount due from the 21st day up to the 100th day (maximum of 80 days). However, the individual must meet all eligibility criteria for nursing home, and is still responsible for contributing his/her recurring income during that time. The [DHHS Form 3229-B](http://medsweb.scdhhs.gov/EligibilityForms/FM%203229-B.pdf), Notice of Cost of Care for Medicare Sponsorship in a Nursing Home, is used to notify the beneficiary or authorized representative of the cost of care.

When Medicare sponsorship is terminated, an assessment for Medicaid Level of Care will be conducted. Generally, the nursing facility initiates this process for individuals whose Medicare coverage is ending.

304.23 DHHS Form 181 (Notice of Admission, Authorization and Change of Status for Long-Term Care)

(Eff. 01/01/10)

The [DHHS Form 181](http://medsweb.scdhhs.gov/EligibilityForms/FM%20181.pdf), Notice of Admission, Authorization, and Change of Status for Long-Term Care, is the form used by nursing facilities to bill Medicaid for a vendor payment. Eligibility workers and nursing facilities use it to communicate information about:

* + - * Approvals
      * Changes such as:
  + Transfers to another facility
  + Admissions to or re-admissions from a hospital
  + Level of Care changes
  + Increases or decreases in recurring income
* Terminations due to such things as:
  + Death of beneficiary
  + Expiration of bed hold
* Medicare-sponsored admissions
* Medicare terminations
* Denials
  + If an applicant/beneficiary is denied for Medicaid or Vendor payment eligibility, one of the following reasons must be shown on the DHHS Form 181:
    - You failed to meet financial eligibility
    - You failed to meet non-financial eligibility
    - Vendor Payment denied, eligible for Medicaid card only

(Refer to the [Processing LTC Form 181/MSCs Types](https://schhs.sharepoint.com/:b:/r/sites/EES/Training/Non-MAGI%20Track/Job%20Aids/LTC%20Processing%20181s.pdf?csf=1&web=1&e=D75eeH) job aid and [Appendix C](#Appendix_C) for detailed instructions on completing the DHHS Form 181.)

304.23.01 Initiation of DHHS Form 181

(Eff. 06/01/06)

Generally, the provider initiates the DHHS Form 181 by completing Sections I and II. However, if the eligibility worker becomes aware of a change, the eligibility worker initiates the DHHS Form 181 and forwards it to the appropriate nursing facility.

304.23.02 Signature Requirements

(Eff. 06/01/06)

The eligibility worker **must** sign and date the form for each of these actions:

* New admissions under either Medicare or Medicaid
* Income changes
* Discharges that affect recurring income

A signature is **not required** for routine Level of Care changes or most termination actions.

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304.24 Program for All-inclusive Care for the Elderly (PACE)

(Eff. 11/01/07)

A Program for All-inclusive Care for the Elderly (PACE) is a federal Medicaid and Medicare capitated program for beneficiaries age 55 and older who meet a Nursing Facility Level of Care. Using an interdisciplinary team approach, PACE coordinates and provides all needed preventative, primary, acute and long-term care services to enable participants to continue living in their homes or with family. The following chart compares the HCBS waivers and PACE program.

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|  | **HCBS** | **PACE** |
| **Plan of Care** | Case Manager | Interdisciplinary Team |
| **Appeals and Hearings** | Medicaid | Medicaid and Medicare |
| **Focus of Care** | Home | Center |
| **Payment Source** | Fee for Service | Capitated Payment |
| **Estate Recovery** | Required | Not Required |
| **Age Limit** | Varies by Waiver | 55 and Older |
| **Services** | Established by waiver | All-inclusive |
| **Service Area** | Statewide | County Specific |

Since PACE provides all-inclusive care, beneficiaries who participate in the program receive all care through the PACE provider and providers with whom they have contracted. Special procedures are in place for beneficiaries who require nursing home or residential care placement. Refer to the following sections for the procedures.

304.24.01 PACE Participant Enters a Nursing Home

(Eff. 11/01/07)

If a PACE participant is placed in a nursing home under PACE sponsorship or resided in a nursing home under PACE sponsorship, the beneficiary is responsible for paying any recurring income directly to PACE.

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| **Procedure**   1. PACE staff will complete Section I of the DHHS Form 181, with the exception of parts eight (8) and nine (9) and forward to the Medicaid eligibility worker. 2. The Medicaid eligibility worker will determine recurring income in the same manner as for any nursing home beneficiary and complete Section III, Item 12-C as appropriate. 3. Retain the white copy for the case record. The pink and canary copies will be returned to the PACE social worker for their use. |

If an SSI eligible PACE beneficiary enters a nursing facility, PACE will be responsible for notifying Social Security to have the SSI payment recalculated.

Although the PACE participant is in a nursing facility, the Medicaid category will not change. The beneficiary remains in original category. Also if the beneficiary is placed in a nursing facility in another county, the case will remain in the original county and not be transferred.

304.24.02 PACE Participant Enters a Residential Care Facility

(Eff. 01/01/15)

If a PACE participant is placed in a Residential Care Facility (RCF) under PACE sponsorship, or resides in a RCF under PACE sponsorship, the beneficiary will become responsible for paying appropriate income directly to PACE. The PACE program will be responsible for calculating the amount the participant will pay using the following procedure.

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| **Procedure**   * From all unearned income, except for SSI, subtract $20 General Disregard. * From any earned income   + Subtract any of the remaining $20 General Disregard not used in the above step   + Subtract $65 from the remaining Earned Income   + Subtract ½ of the remaining Earned Income * Add the Unearned and Earned Income * Subtract $65 for the beneficiary’s Personal Needs * The remainder is the PACE participant’s liability |

Although the PACE participant is in a RCF, the case will continue to be a PACE case. Do not change the Medicaid category to Optional State Supplement (OSS). Also if the beneficiary is placed in a RCF in another county, the case will remain in the original county and not be transferred.

304.24.03 PACE Participant Terminated from Program

(Eff. 11/01/07)

When a PACE participant is terminated from the program, the termination will always occur at midnight the last day of the month. PACE will notify the appropriate Medicaid office and appropriate action should be taken.

Terminations occur when the beneficiary dies, move out of the service area, become Medicaid ineligible, there is failure to cooperate with the service plan, or at the beneficiary’s request. If a beneficiary is terminated from PACE because the family chose to place the beneficiary in a nursing home or in a regular waiver, the case can be changed. It will be necessary to coordinate the change between PACE and the nursing home or CLTC to avoid interruption of Medicaid coverage.

304.25 Denial of Payment for New Admissions (DPNA)

(Eff. 06/01/06)

When the Department of Health and Environmental Control (DHEC) finds deficiencies with a nursing facility, DHEC may recommend a DPNA to the Centers for Medicare and Medicaid (CMS). The nursing facility is aware the recommendation has been made. Generally, the facility is given a time frame for corrective action. DHEC will visit the facility again to determine if the deficiencies have been cleared up. If the corrective action has been taken, DHEC will recommend that CMS rescind the DPNA. CMS must rescind the DPNA before payment can be made.

E-mail notifications are sent to eligibility staff statewide when DPNA sanctions are applied and rescinded.

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| Procedure – Denial of Payment for New Admissions  If an applicant/beneficiary is in a facility under a DPNA, the eligibility worker must verify if the admission date and requested date for vendor payment on the [DHHS Form 181](http://medsweb.scdhhs.gov/EligibilityForms/FM%20181.pdf) is prior to the effective date of the DPNA sanction. The effective date of the sanction must be documented in the case record.  If the admission is prior to the DPNA effective date and all other eligibility criteria are met, the case may be certified and the DHHS Form 181 authorized.  If the admission is on or after the DPNA effective date, the DHHS Form 181 cannot be authorized unless the eligibility worker has been notified the DPNA was rescinded.  The eligibility worker must determine if the applicant is Medicaid-eligible under another payment category.   * If eligible under another category, the eligibility worker must:   + Approve under the other payment category and   + Deny the vendor payment. * If not eligible under another category and all other eligibility criteria are met for PC 10:   + Extend the standard of promptness to the 90th day (refer to MPPM [304.07.01](#MPPM_304_15_01)) for a bed slot to become available.   + After the 90th day, deny the application if the DPNA has not been rescinded. * If the DPNA is rescinded within 45 days of the date on the denial notice **and** the facility or family requests it, the eligibility worker must:   + Determine eligibility using the same application, and   + File a copy of the e-mail verifying the DPNA was rescinded in the case record. |

304.26 Miscellaneous Facts about Nursing Facilities

(Eff. 06/01/06)

Eligibility workers are frequently asked questions about the following issues regarding nursing facilities.

304.26.01 Private vs. Semi-Private Rooms

(Eff. 06/01/06)

Private rooms are not a covered service under Medicaid. The difference between the private and semi-private room rates may not be billed to Medicaid. If the family requests a private room, the facility may charge the patient or responsible party the difference.

* The Medicaid beneficiary cannot be charged more than any other resident is charged.
* The charge is usually the difference between the customary private and semi-private room rates.

304.26.02 Solicitation of Contributions from Medicaid Beneficiaries by Providers of Long-Term Care Services

(Eff. 06/01/06)

Medicaid policy prohibits providers from directly soliciting contributions, donations, or gifts from Medicaid long-term care beneficiaries or their relatives.

304.26.03 Sitters

(Eff. 06/01/06)

Medicaid beneficiaries may have sitters; however, the sitters:

* May not provide services reimbursable under the Medicaid program, and
* Cannot perform duties that are part of the total nursing needs provided by an employee of the facility.

304.26.04 Condition of Admission

(Eff. 06/01/06)

A nursing facility must not require a third-party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require an individual who has legal access to a beneficiary's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the beneficiary's income or resources.

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304.26.05 Continuing Care Retirement Communities (CCRCs)

(Eff. 06/01/06)

**Continuing Care Retirement Community (CCRC):** sometimes referred to as a “life care community,” the service is the provision of multiple residential options all in one location. Residential options typically include independent living arrangements, assisted living, and skilled nursing care. Usually, a contract is required that obtains a financial commitment from the aging person in return for assurances that the appropriate level of care will be provided when needed. The SC Department of Consumer Affairs licenses CCRC’s in this state. A list of licensed facilities can be found at [www.scconsumer.gov](http://www.scconsumer.gov/licensing/ccrc/directory.htm).

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| **Treatment of Entrance Fees of Individuals Residing in Continuing Care Retirement Communities (CCRCs) and applies for Long-term Care:**  Entrance fees for CCRCs or life care communities are considered to be countable resources to the applicant, to the extent that:   * The individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient. * The individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the CCRC or life care community contract and leaves the community; and * The entrance fee does not confer an ownership interest in the CCRC or life care community. |

304.27 Estate Recovery

(Rev. 12/01/21)

In August of 1993, Congress passed a law that requires states to recover amounts that Medicaid has paid for certain beneficiaries. In South Carolina, the Estate Recovery program went into effect on 07/01/94. The state will recover amounts paid by Medicaid for services received on 07/01/94 or later.

Estate Recovery applies to the following beneficiaries:

* A person who was 55 years of age or older and received medical assistance consisting of:
  + Nursing facility services,
  + Home and community based services, and
  + Hospital and prescription drug services provided to individuals in nursing facilities or receiving Home and Community Based Services paid by Medicaid. **Exception:** A Program of All Inclusive Care of the Elderly (PACE Program) such as Palmetto SeniorCare is not subject to estate recovery provisions;
* A person of any age who was:
  + An inpatient in
    - A nursing facility,
    - An intermediate care facility for the Intellectually Disabled, or
    - A long-term care facility at the time of death.
  + Required to pay most of his/her monthly income to the facility toward the cost of care.

Applicants/Beneficiaries must be informed about the Estate Recovery provisions when applying for services subject to recovery. The DHHS Estate Recovery Brochure 24116 must be given to the applicant/beneficiary. A CLTC or DDSN case manager must complete a [DHHS Form 1296 ER](http://medsweb.scdhhs.gov/EligibilityForms/FM%201296%20ER.pdf), Estate Recovery Notification, for Medicaid beneficiaries that do not require a separate application (such as SSI recipients), and forward the original to:

Mail: SCDHHS

Attn: Medicaid Estate Recovery

Post Office Box 100127

Columbia, SC 29202-3127

The state files a claim with the probate court against the beneficiary's estate to recover amounts paid by Medicaid for the deceased beneficiary's medical care. No recovery will be made as long as there is:

* A surviving spouse,
* A minor child (under age 21), or
* A disabled child, as defined according to SSI criteria.

In addition, no recovery will be made for beneficiaries who died before 07/01/94, and recovery may be waived if it would cause undue hardship to a surviving family member.

Questions about Medicaid Estate Recovery should be directed to:

Department of Health and Human Services

Attn: Medicaid Estate Recovery

Post Office Box 100127

Columbia, SC 29202

Phone 1-888-289-0709, option 5, option 3

Fax (803) 462-2579

|  |
| --- |
| **Procedure – Beneficiary Who Meets the Estate Recovery Criteria Dies**  The eligibility worker must:   * Complete the [DHHS Form 238](http://medsweb.scdhhs.gov/EligibilityForms/FM%20238.pdf), Medicaid Estate Recovery Notification of Death. * Attach copies of the following to the DHHS Form 238:   + Form 3401, Application for Nursing Home, Residential or In-Home Care OR DHHS Form 3400, Healthy Connections Application for Medicaid and/or Affordable Health Coverage AND DHHS Form 3400-B, Additional Information for Select Medicaid Programs   + [DHHS Form 1253 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201253%20ME.pdf), Request for Financial Investigation   + Asset Verification System (AVS) responses   + [DHHS Form 1255 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201255%20ME.pdf), Verification of Real and Personal Property   + Any other pertinent financial documents * Forward all of the above to the State DHHS Medicaid Estate Recovery Department.   Mail: SCDHHS  Attn: Medicaid Estate Recovery  Post Office Box 100127  Columbia, S C 29202-3127  Staff in Medicaid Estate Recovery may share information with the Medicaid eligibility staff when they receive information regarding news of beneficiaries’ deaths from other sources.  It is the responsibility of the eligibility specialist to ensure that eligibility has been terminated and the appropriate documents have been forwarded to Medicaid Estate Recovery. |

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304.28 Basic Application Process for Nursing Home and Home and Community Based Service Cases

(Eff. 04/22/22)

**Application Received/Intake**

The DHHS Form 3401, Application for Nursing Home, Residential or In-Home Care, OR the DHHS Form 3400, Healthy Connections Application, and the DHHS 3400-B, Additional Information for Nursing Home and In-Home Care, are used to collect necessary information for the institutional programs. The DHHS Form 3400 Espanol and DHHS Form 3400-B Espanol may be used when an individual’s primary language is Spanish.

When an application for an institutional program is received, the LTC eligibility specialist will attempt to call the applicant/authorized representative and use the Long-Term Care Application Script to confirm and verify the provided information and to explain what else may be required.

Prior to placing the call, the LTC eligibility specialist will:

* Ensure the case is entered and locked in MEDS or submitted in Cúram-CGIS
* Review the information submitted on the application
* Review case history
* Conduct any available data matches and online property searches

During the call, the LTC eligibility specialist will:

* Use the Long-Term Care Application Script to:
  + Ask relevant questions needed to determine eligibility
  + Discuss any discrepancies between information reported on the application, case history, and found via data matches and online searches.
  + Share information about the eligibility process including Income Trust when needed.
* Explain what verifications are needed and why
* Describe the interaction with the nursing home and Community Long Term Care
* Relay the Rights and Responsibilities
* Utilize three-way calls to assist applicant/authorized representative in obtaining as many verifications as possible.
* Send a DHHS Form 1233 requesting any additional information needed from the applicant/authorized representative.

If attempts to complete the call are unsuccessful, the LTC eligibility specialist must

* Ensure all necessary information is gathered to include:
  + Any unanswered questions
  + Any discrepancies found on the application or between the current and any past applications
* Complete a manual DHHS Form 1233, Medicaid Eligibility Checklist, and mail the form to the applicant and any active Authorized Representatives. The following information must be included:
  + Information about the eligibility process, including Income Trust when needed.
  + What verifications are needed and why
  + Rights and Responsibilities

**Processing**

The LTC eligibility specialist must:

* Have case pended in MEDS or submitted in Cúram-CGIS within 4 working days of receipt
* Ensures all third-party verifications are requested/received. Examples include:
  + Level of Care
  + Property search (online searches or [DHHS Form 1255](http://medsweb.scdhhs.gov/EligibilityForms/FM%201255%20ME.pdf), Verification of Real and Personal Property)
  + Bank Forms
    - Asset Verification System (AVS) Bank responses,
    - [DHHS Form 1253](http://medsweb.scdhhs.gov/EligibilityForms/FM%201253%20ME.pdf), Request for Financial Verification (Only if unable to verify with AVS)
  + Insurance Cash Values ([DHHS Form 1280](http://medsweb.scdhhs.gov/EligibilityForms/FM%201280%20ME.pdf), Verification of Life Insurance Values)
  + Income requests: VA, Railroad, or Civil Service for example
  + Performs Data Matching on Computer system and follows up on any lead or verified information
    - Bendex
    - SDX
    - ESC
    - State Retirement
* Assesses all the verifications provided by the applicant/AR and obtained from Third Parties and
  + Determines
    - If any clarification is needed
    - There are any discrepancies between reported and verified information
    - Contacts appropriate party to clarify
  + Policy
    - Applies all financial and non-financial policy to the specific situation
    - Requests clarifications from supervisor or trainer as needed

**Determination**

* Financial Determination
  + Applies all income and resource exclusions
  + For Income Trust cases,
    - Ensures Income Trust document has been completed, reviewed, and approved.
    - Ensures separately identifiable account has been designated or opened and Income assigned to it has been deposited for month coverage is needed.
  + Budget countable income and resources using the Electronic Budget Workbook for cases when manual eligibility is used
  + If eligible, determine recurring income
* Non-Financial Determination
  + Ensure all non-financial criteria has been met
    - Categorical (aged, blind, disabled)
    - Common Non-financial (citizenship, residency, enumeration, identity)
    - Level of Care
    - 30 consecutive days
* If case is not eligible for institutional due to non-financial criteria such as level of care or not entering a facility, be sure to look at eligibility under other categories such as ABD-SC or SLMB.
* Approve or deny application in the System of Record. Change to appropriate payment category, if necessary. An application that requires both a level of care and disability determination cannot be denied by the eligibility worker until both decisions have been received.
* If case is eligible, take the following actions:
  + Approve in the System of Record
  + Authorize the [DHHS Form 181](http://medsweb.scdhhs.gov/EligibilityForms/FM%20181.pdf), Notice of Admission, Authorization and Change of Status for Long Term Care
  + For MEDS cases, manually complete the [DHHS Form 3229 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%203229%20ME.pdf), Notice of Cost of Care, notifying the beneficiary/authorized representative of the recurring income.
  + For CGIS cases, if the automated notices are correct, allow the notices to be sent by the system. If the automated notices are incorrect, suppress the notices and send a manual [DHHS Form 3229](http://medsweb.scdhhs.gov/EligibilityForms/FM%203229%20ME.pdf)

**NOTE:** When authorizing the Long-Term Care (LTC) coverage in the System of Record (SOR), the eligibility specialist must ensure that all coverage for which the applicant/beneficiary qualifies has been authorized. This includes QMB and SLMB Plus. For example: If the beneficiary meets the eligibility criteria for LTC and SLMB or QMB, authorize both the LTC coverage and the SLMB or QMB coverage in Cúram-CGIS.

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

304.29 Case Record Requirements

(Rev. 01/01/19)

| **Element** | | **Nursing Home:**  **No SSI/SSI Terminating** | **Nursing Home:**  **Receiving SSI** | **HCBS:**  **Non-SSI Recipient** | **HCBS:**  **SSI Recipient** |
| --- | --- | --- | --- | --- | --- |
| OR | DHHS Form 3401Application | Required | Not Required | Required | Not Required |
| DHHS Form 3400 Application and  DHHS Form 3400-B | Required | Not Required | Required | Not Required |
| Look-back | | Required | Not Required\*\*  (See Note) | Required | Not Required |
| Verification of  Current Income | | Required | Required | Required | Not Required |
| Verification of  Current Resources | | Required | Not Required | Required | Not Required |
| DHHS Form 181 | | Required | Required | N/A | N/A |
| DHHS Form 185  Level of Care | | Required | Required | N/A | N/A |
| DHHS Form 118/118A  Client Status Document | | N/A | N/A | Required | Not Required |
| MEDS  Payment Category | | 10, 33 | 54 | 15, 32 | 80 |
| Other | | N/A | N/A | N/A | CLTC enters Recipient Special Program (RSP) code into MMIS |

**\*\*Note:** If the applicant once received SSI, but is no longer eligible for SSI, a look-back must be conducted for the period between the last month of SSI eligibility and the month of application.

If an applicant is Medicaid eligible (not SSI), the current case record must be examined to determine what resource information is available for completion of the look-back for a transfer of resources. A request for additional documentation should only be made if the information is incomplete, or if there is an indication a transfer may have occurred and further verification is required. If the case record contains bank information for the look-back period and the balances have remained consistent, no further information should be needed. A routine property check must be conducted to verify current ownership and to determine if a transfer occurred. Routine system checks should also be completed.

For an applicant who was Medicaid eligible (not SSI) at anytime during the look-back period, use the available information in the case record to conduct the look-back, and request documentation for the time not covered by the record.

|  |
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| **Example:**  Joe Green has received ABD for the past five years. He has made a referral to CLTC for HCBS and the DHHS Form 118 is sent to the local eligibility office to request a look-back for a transfer of assets. The eligibility worker examines the case record and determines that Mr. Green has a checking account that has been consistent for the entire period, and homestead property. When Mr. Green returns the DHHS Form 3400-B, there is no indication any transfers have occurred.   * A property check is completed and verifies:   + Mr. Green still owns the homestead property   + The value of his homestead is under $603,000.   + He owns no other property   + He did not transfer any property during the look-back period * The file contains bank information from each year in the look-back period. His balances have been consistent during that time. There is no indication of a transfer so additional information is not requested from Mr. Green. * The eligibility worker returns the DHHS Form 118 to CLTC indicating the look-back has been completed. |

304.30 Annual Review Procedures

304.30.01 Nursing Home

(Rev. 11/01/18)

* + - 1. Annual re-determinations are required.
      2. MEDS generates a review form based on the Date of Next Review.
      3. Eligibility Worker Responsibilities:
* Acknowledge the receipt of the review form into MEDS
* Comparing 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
  + Obtain current verification of all Income and Resources 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:
        + Asset Verification (AVS) request for bank accounts;
        + [DHHS Form 1253 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201253%20ME.pdf), Request for Financial Verification (Only if unable to verify with AVS);
        + [DHHS Form 1255 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201255%20ME.pdf), Verification of Real and Person Property;
        + [DHHS Form1280 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201280%20ME.pdf), Verification of Life Insurance Values;
        + [DHHS Form 1212 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201212%20ME.pdf), Request for Verification of Veterans Information;
        + 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 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 – Important: Next Review Date
    - If there is a change in recurring income, advise the PI/AR and facility of the change
      * DHHS Form 181
      * Cost of Care Letter ([DHHS Form 3229 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%203229%20ME.pdf)) to advise the facility and the PI/AR of the new amount
  + If ineligible
    - Begin closure actions in MEDS
    - Send a [DHHS Form 181](http://medsweb.scdhhs.gov/EligibilityForms/FM%20181.pdf) to the facility
  + Determines if the individual would be eligible in any other Payment Category. If so, take appropriate actions to change category.

304.30.02 Home and Community Based Services

(Rev. 11/01/18)

* + - 1. Annual re-determinations are required.
      2. MEDS generates a review form based on the Date of Next Review.
      3. Eligibility Worker Responsibilities:
* Acknowledge the receipt of the review form into MEDS
* Comparing 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
  + Obtain current verification of all Income and Resources 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:
        + Asset Verification (AVS) request for bank accounts;
        + [DHHS Form 1253 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201253%20ME.pdf), Request for Financial Verification (Only if unable to verify with AVS);
        + [DHHS Form 1255 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201255%20ME.pdf), Verification of Real and Person Property;
        + [DHHS Form1280 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201280%20ME.pdf), Verification of Life Insurance Values;
        + [DHHS Form 1212 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201212%20ME.pdf), Request for Verification of Veterans Information;
        + 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 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—Important: Next Review Date
    - For Income Trust Cases: if there is a change in recurring income,
      * Advise the PI/AR by sending Cost of Care Letter ([DHHS Form 3229 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%203229%20ME.pdf))
      * Send a copy of the DHHS Form 3229 ME and [DHHS Form 1729 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201729%20ME.pdf), Income Trust Budget sheet to the Bureau of Eligibility and Program Oversight.
  + If ineligible, begin closure actions in MEDS.
  + Determines if the individual would be eligible in any other Payment Category. If so, take appropriate actions to change category.

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304.31 Introduction to General Hospital

(Eff. 06/01/06)

An individual of any age who is hospitalized for an extended period of 30 consecutive days or more may be eligible for Medicaid benefits if he/she meets all of the financial and non-financial criteria. This category of assistance is similar to the Nursing Home category of assistance.

304.31.01 General Hospital vs. Nursing Home Assistance

(Rev. 05/01/09)

|  | General Hospital | Nursing Home Assistance |
| --- | --- | --- |
| Countable Income | Countable income must be at or below the Medicaid Cap; no Income Trust provisions. | If countable income exceeds the Medicaid Cap, eligibility may be established using Income Trust provisions. |
| Level of Care | Level of Care is presumed; no certification required. | Level of Care  certification required |
| Look-back for Transfers | Look-back  not required | Look-back  required |
| Recurring Income  (Cost of Care) | No recurring income or Cost of Care determination required. | Cost of Care determination is required. |
| Spousal Income | No spousal income allocation | Possible income allocation to a community spouse |
| Spousal Resource | Resources of both spouses are considered, even if separated. | Resources of both spouses are considered, even if separated. |
| Transfer of Assets | No penalty for transfer of assets for less than Fair Market Value. | Penalty applied if there is a transfer of assets for less than Fair Market Value. |

304.31.02 Non-Financial Eligibility Criteria

(Eff. 06/01/06)

To qualify for assistance in this category, the individual must meet certain non-financial requirements. (Refer to MPPM Chapter 102 for specific information on the following criteria.)

* Identity MPPM 102.02
* State Residency MPPM 102.03
* Citizenship/Alienage MPPM 102.04
* Enumeration/Social Security Number MPPM 102.05
* Applying for and Accepting other Benefits MPPM 102.08
* Assignment of Rights to Medical Support MPPM 102.07

304.31.03 Categorical Eligibility Criteria

(Rev. 07/01/09)

To qualify categorically under the General Hospital Category, an individual must:

* Reside in a licensed and certified Title XIX Acute Care Medical Facility
  + The admission must be 30 consecutive days or longer, beginning with the date of admission. The 30 days may be spent in:
    - A hospital
    - A combination of Hospital, nursing facility, and/or home and community-based services waiver
  + If the 30-day requirement is met and otherwise eligible, eligibility may be established effective the month of admission.

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| **Exceptions to 30-day requirement**   * Death prior to completion of the 30 days * Eligibility in another payment category (such as ABD) |

* Meet a Level of care – presumed because the hospital’s Utilization Review Board completes a treatment plan to justify the stay.
* Be Aged, Blind, or Disabled
* Children under age 19 are treated as part of the family for the first 30 days. Beginning on the 31st day, the child is considered an individual.

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| **Example #1:** Sarah Phillips was admitted to the hospital on January 6 and was discharged on February 28. The 30-day requirement was met.  **Example #2:** A General Hospital application was filed for Jimmy Wood. Mr. Wood was admitted to Memorial Hospital on March 10 after breaking his hip. He was transferred to Manor Care Nursing Home under Medicare for therapy on March 31. On April 13, he was discharged home from Manor Care. The 30-day requirement was met in the combined admissions.  **Example #3:** Hannah Green was admitted to County Hospital on April 3 and passed away on April 22, while still a patient. The General Hospital category may still be considered as it is assumed that she would have remained in the hospital for 30 days had she lived.  **Example #4:** The DHHS Medicaid office received a General Hospital application on Stan Smart. Mr. Smart was a patient at Doctor’s Hospital from February 20 until his discharge home on March 20. He did not meet the 30-day criteria, so eligibility could not be established under the General Hospital category. The eligibility worker must determine if he may qualify under another payment category.  **Note:** In all of the above examples, the categorical eligibility of each of the applicants was established (that is, the individuals are aged or have been determined to be blind or disabled). |

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304.31.04 Financial Criteria

(Eff. 06/01/06)

**Income Limit** – Income must be equal to or below the Medicaid Cap (three times the SSI Federal Benefit Rate). The Income Trust provision does not apply in a General Hospital situation. If the individual’s income exceeds the Medicaid Cap limit, he/she is not eligible under this category. (Refer to MPPM 103.07.)

**Resource Limit** – Countable resources must be equal to or below $2,000 for an individual after the spousal resource policy is applied, if applicable.

If there is a spouse, the eligibility worker must consider the resources of both the applicant and the community spouse. The total value of the applicant’s and the ineligible spouse’s resources must be determined. The ineligible spouse is allowed to keep a maximum of $66,480 of the couple’s countable resources. This is known as the spousal share. The remainder of the total countable resources must be considered available to the applicant. (Refer to MPPM [304.15.02B](#MPPM_304_09_02B).)

Liberalized income and resource policy applies.

304.31.05 Continued Eligibility

(Rev. 07/01/10)

General Hospital cases must be closely monitored to determine continued hospitalization as eligibility ends with the month of discharge. Also, while hospitalized, the beneficiary’s monthly income may be retained into subsequent months resulting in excess resource accumulation.

|  |
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| **Procedure – Continued Hospitalization**  The eligibility worker must set up a tickler file to check these cases a minimum of every three months to verify the individual remains hospitalized. At the end of the hospitalization, appropriate action must be taken to either ex parte to another payment category or initiate a closure action. MEDS sends alert 604 to remind the eligibility worker to verify continuing hospitalization. |

A complete eligibility review must be completed every 12 months. The cases must be re-budgeted if changes occur during the 12-month period. **Exception:** A child approved for General Hospital remains eligible throughout their continuous period of eligibility, for up to one year.

304.31.06 Basic Application Process

304.31.06A Receipt of Application/Intake

(Rev. 07/01/15)

DHHS Form 3401, Application for Nursing Home, Residential or In-Home Care, OR DHHS Form 3400, Healthy Connections Application, AND DHHS Form 3400-B, Additional Information for Select Medicaid Programs, are used to collect necessary information.

An application may be received in person or by mail. There is no requirement for a face-to-face interview although one may be beneficial in this type case.

* If a face-to-face interview is conducted, either the applicant or the authorized representative is interviewed.
  + During the interview, the eligibility worker
    - Asks relevant questions needed to determine eligibility
    - Shares information about the eligibility process
      * What verifications are needed and why
      * Rights and Responsibilities
      * If there is no face-to-face interview, the eligibility worker must:
  + Ensure all necessary information is gathered to include:
    - Contact applicant/AR if there are
      * Any unanswered questions
      * Any discrepancies found on the application or between the current and any past applications
  + Share information about the eligibility process
    - What verifications are needed and why
    - Rights and Responsibilities
    - Standard of Promptness – 45 days; 90 if disability determination is required

304.31.06B Processing of Application

(Eff. 09/01/16)

The eligibility worker must:

* Pend the case in MEDS within 3 working days of receipt
* Ensure all third party verifications are requested. Examples include:
  + Property search (on line or [DHHS Form 1255 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201255%20ME.pdf), Verification of Real and Personal Property)
  + Bank forms
    - Asset Verification System (AVS) request for bank accounts
    - [DHHS Form 1253 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201253%20ME.pdf), Request for Financial Verification (Only if unable to verify with AVS)
  + Insurance cash values ([DHHS Form 1280 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201280%20ME.pdf), Verification of Life Insurance Values)
  + Income requests: Such as VA ([DHHS Form 1212 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201212%20ME.pdf)), Railroad, Civil Service
  + Perform data matching on computer system and follows up on any lead or verified information
    - Bendex
    - SDX
    - ESC
    - State Retirement
* Assess all the verifications provided by the applicant/Authorized Representative and obtained from Third Parties and
  + Determine
    - If any clarification is needed
    - There are any discrepancies between reported and verified information
    - Contact appropriate party to clarify
  + Policy
    - Apply all financial and non-financial policy to the specific situation
    - Request clarifications from supervisor or trainer as needed

304.31.06C Determination of Eligibility/Ineligibility

(Eff. 10/01/13)

* Financial Determination
  + Applies all income and resource exclusions
  + Budgets countable income and resources ([Should](http://medsweb.scdhhs.gov/EligibilityForms/FM%201296-A%20ME.pdf) use the workbook.)
* Non-Financial Determination
  + Ensures that all of the non-financial criteria has been met
    - Categorical (aged, blind, disabled)
    - Common Non-financial (citizenship, residency, enumeration, identity)
    - Level of Care
    - 30 consecutive days
* If the case is not eligible for some reason, be sure to look at eligibility under other categories such as ABD or SLMB.
* Approve or deny application in MEDS. Change to appropriate payment category, if necessary.

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304.31.06D Continued Eligibility

(Rev. 09/01/16)

The eligibility worker must put the case in follow-up for no more than 90 days to verify the individual remains hospitalized. At the end of the hospitalization, appropriate action must be taken to ex parte to another payment category or to initiate a closure action.

304.32 Palmetto Coordinated System of Care (PCSC) Waiver

(Eff. 11/01/20)

Effective August 1, 2020, South Carolina Healthy Connections received CMS approval for a 1915(c) waiver for children and youth up to age 21 with significant behavioral health challenges who would otherwise receive treatment for psychiatric conditions in inpatient settings. The Palmetto Coordinated System of Care (PCSC) Waiver provides home and community-based services for these children and youth. The Specialty Unit will process the applications for individuals who need these services.

**Application**

* Instructions are given to families of children and youth in need of PCSC services to apply for Medicaid, including a letter, “[Healthy Connections Medicaid Application Instructions](http://medsweb.scdhhs.gov/EligibilityForms/PCSC-Parent-Letter_New-to-Medicaid.pdf).”
* The individual must be 21 years old or under
* The individual must be Medicaid eligible in a full benefit category.
* Individuals not currently Medicaid eligible may apply using [Form 3400, Healthy Connections Medicaid Application](http://medsweb.scdhhs.gov/EligibilityForms/Form3405_Single%20Person_HH.pdf) if they are applying as part of a family.
  + Flag applications as “Applying for PCSC Waiver” as found in Step 1 of the application
  + Individuals not currently Medicaid eligible may apply as an individual using Form 3405, Healthy Connections Medicaid Application - Single Person Household, if only the child who needs PCSC waiver services is applying.
  + Flag applications as “Applying for PCSC Waiver.”

**Scanning and Indexing**

* Applications flagged as “Applying for PCSC Waiver” must be scanned and indexed as the claim type, “PCSC”.

**Procedures for Processing PCSC Applications**

**See job aid:** [Palmetto Coordinated System of Care (PCSC) Job Aid](https://schhs.sharepoint.com/:b:/r/sites/EES/Training/Curam/HCR/Job-Aids/Palmetto%20Coordinated%20System%20of%20Care%20(PCSC)%20Waiver%20Job%20Aid.pdf?csf=1&web=1&e=kOtjNr)

APPENDIX A Life Expectancy Table

(Eff. 10/01/05)

| **LIFE EXPECTANCY TABLE** | | | |
| --- | --- | --- | --- |
| **MALES** | | **FEMALES** | |
| **Age** | **Average Number**  **of Years of Life**  **Remaining** | **Age** | **Average Number**  **of Years of Life**  **Remaining** |
| 0  10  20  30  40  50  60  61  62  63  64  65  66  67  68  69  70  71  72  73  74  75  76  77  78  79  80  81  82  83  84  85  86  87  88  89  90  100  110 | 73.26  64.03  54.41  45.14  35.94  27.13  19.07  18.33  17.60  16.89  16.19  15.52  14.86  14.23  13.61  13.00  12.41  11.82  11.24  10.67  10.12  9.58  9.06  8.56  8.07  7.61  7.16  6.72  6.31  5.92  5.55  5.20  4.86  4.55  4.26  3.98  3.73  2.05  1.14 | 0  10  20  30  40  50  60  61  62  63  64  65  66  67  68  69  70  71  72  73  74  75  76  77  78  79  80  81  82  83  84  85  86  87  88  89  90  100  110 | 79.26  69.93  60.13  50.43  40.86  31.61  22.99  22.18  21.38  20.60  19.82  19.06  18.31  17.58  16.85  16.14  15.44  14.85  14.06  13.40  12.74  12.09  11.46  10.85  10.25  9.67  9.11  8.57  8.04  7.54  7.05  6.59  6.15  5.74  5.34  4.97  4.63  2.39  1.22 |

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APPENDIX B Non-Covered Medical Expenses and Allowable Deductions

(Eff. 10/01/15)

1. Prescription drugs above the four (4) prescriptions-per-month limit, not to exceed $54.00 per additional prescription per month.

1. Eyeglasses not otherwise covered by the Medicaid program, not to exceed a total of $108.00 per occurrence for lenses, frames and dispensing fee. A licensed optometrist or ophthalmologist must certify the necessity for eyeglasses.
2. Dentures
   * A one-time expense
   * Not to exceed $651.00 per plate or $1320.00 for one full pair of dentures
   * A licensed dental practitioner must certify necessity.
   * An expense for more than one pair of dentures must be prior approved by State DHHS.
3. Denture Repair
   * Justified as necessary by a licensed dental practitioner
   * Not to exceed $77.00 per occurrence.
4. Physician and other medical practitioner visits that exceed the yearly limit, not to exceed $69.00 per visit
5. Hearing Aids
   * A one-time expense
   * Not to exceed $1000.00 for one or $2000.00 for both
   * Necessity must be certified by a licensed practitioner
   * An expense for more than one hearing aid must be prior approved by State DHHS.
6. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty is limited to zero.
7. The deduction for pre-eligibility medical expenses is limited to three months prior to the application date.

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APPENDIX C DHHS Form 181

(Eff. 10/01/05)

The following are instructions for completing the [DHHS Form 181](http://medsweb.scdhhs.gov/EligibilityForms/FM%20181.pdf), Notice of Admission, Authorization, and Change of Status for Long Term Care.

**Section I** **Identification of Provider and Patient** – To be completed by the nursing facility or the DHHS Medicaid eligibility worker.

Item 1 Enter the individual’s first name, middle initial and last name.

Item 2 Enter the individual’s date of birth (two digits each for day, month, year).

Item 3 Enter the individual’s 10-digit Medicaid ID number.

Item 4 Enter the street number and name, the city, and the state in which the individual resides.

Item 5 Enter the name of the county in which the individual resides.

Item 6 Enter the individual’s Social Security claim number, including the suffix.

Item 7 Enter the name and address of the nursing facility.

Item 8 Enter the provider's 6-digit Medicaid ID number.

Item 9 Enter the termination date of Medicare benefits reimbursed to the provider. If no Medicare benefits were involved, leave this item blank. (This is a through date.)

Item 10 Enter the date the form was prepared.

**Section II Type of Coverage and Statistical Data** – To be completed by the nursing facility or the DHHS Medicaid eligibility worker.

Item 11 (A) Check the box that indicates the Level of Care: Skilled, Intermediate, SNF Co-insurance or Psychiatric.

Item 11 (B) Enter the appropriate change in type of care and the effective date.

Item 11 (C) Enter the date the individual was admitted as a Medicaid patient.

Item 11 (D) Enter the date the individual was transferred **to** another facility and the name of the facility to which he/she was transferred.

Item 11 (E) Enter the date the patient transferred **from** another facility and the name of the **transferring** facility.

Item 11 (F) Enter the date the individual transferred and the name of the hospital.

Item 11 (G) Enter the date the individual was re-admitted to the hospital.

Item 11 (H) Enter the number of days the individual was absent from the facility.

Item 11 (I) Enter the effective date of termination. If the patient died, enter the date of death. Specify the reason for termination or other change of status, if not covered by the above. Enter any changes not listed above. If the termination is for a reason other than death, write the reason for termination in the Remarks section on the DHHS Form 181, (such as the 80 days were exhausted, the individual was discharged to the home, the individual no longer meets level of care.)

Item 11 (J) Enter the date the individual was admitted under Medicare for the current spell of illness.

Item 11 (K) Enter the co-insurance dates for the current spell of illness.

**Section III Authorization and Change of Status** – To be completed by the DHHS Medicaid eligibility worker.

Item 12 (A) Enter the date Medicaid sponsorship of stay is authorized to begin.

Item 12 (B) Enter the reason that the individual was not qualified for long-term care.

Item 12 (C) Enter the individual’s recurring income, which is the total monthly income less the personal needs allowance.

Item 12 (D) Enter any change in the individual’s monthly recurring income and the effective date of the change.

Item 12 (E) Enter the current name and any correction necessary.

Item 12 (F) Enter other changes or information.

**Note:** The DHHS Medicaid supervisor or lead eligibility worker must sign and date the DHHS Form 181 when Section III is used.

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APPENDIX D Current Average Monthly Nursing Facility and Medicaid Payment Rates

(Eff. 01/01/23)

**Note:** The current average private pay nursing home rate in South Carolina is $8,797.11 per month ($289.22 per day).

| **AVERAGE MONTHLY NURSING FACILITY AND MEDICAID PAYMENT RATES**  **Payment Rates Effective January 1, 2023** | | |
| --- | --- | --- |
| **MMIS Provider #** | **MMIS Facility Name** | **Average Monthly**  **Medicaid Cost** |
| 0098SB | ABBEVILLE COUNTY MEMORIAL | 6,139.91 |
| 330090 | ABBEVILLE NURSING HOME INC | 6,400.88 |
| 0041SB | ALLENDALE COUNTY HOSPITAL | 6,139.91 |
| NF1094 | ANCHOR REHABILITATION AND | 7,701.80 |
| NF1112 | ANGEL OAK NURSING AND REHA | 7,717.32 |
| 401621 | BATESBURG GROUP HOME | 10,598.69 |
| 0898NF | BAYVIEW MANOR LLC | 5,877.11 |
| 0189NF | BETHEA HEALTH CARE CENTER | 7,000.09 |
| NF1097 | BLACKVILLE HEALTHCARE AND | 5,106.05 |
| NF1067 | BLUE RIDGE IN BROOKVIEW HO | 5,738.71 |
| NF1064 | BLUE RIDGE IN GEORGETOWN L | 5,618.87 |
| NF1063 | BLUE RIDGE OF SUMTER LLC | 6,157.55 |
| 173286 | BRIAN CTR ST ANDREWS | 6,583.38 |
| NF1070 | BRUSHY CREEK POST ACUTE | 7,418.02 |
| NF1075 | CARLYLE SENIOR CARE OF AIK | 5,647.16 |
| NF1073 | CARLYLE SENIOR CARE OF FLO | 6,019.76 |
| NF1072 | CARLYLE SENIOR CARE OF FOR | 5,526.40 |
| NF1074 | CARLYLE SENIOR CARE OF FOU | 7,266.24 |
| NF1076 | CARLYLE SENIOR CARE OF KIN | 5,711.03 |
| NF1079 | CAROLINA HEALTHCARE INC | 6,776.83 |
| 0878NF | CHARLESTON MEDICAL INVESTO | 6,792.95 |
| 0602NH | CHERAW HEALTHCARE INC | 5,371.28 |
| 0738NF | CLARENDON MEMORIAL HOPSITA | 6,541.41 |
| 0736NF | CLARENDON MEMORIAL HOSPITA | 6,889.38 |
| 291168 | COMMUNITY SERVICES FOR THE | 7,278.71 |
| NF1108 | CONDOR HEALTH ANDERSON | 5,818.10 |
| 0899NF | CONWAY MANOR LLC | 6,216.86 |
| 0897NF | DUNDEE MANOR LLC | 5,269.38 |
| NF1055 | EDISTO POST ACUTE | 6,565.13 |
| NF1065 | ELLEN SAGAR | 6,669.16 |
| 0927NF | FAITH HEALTHCARE CENTER | 5,786.77 |
| NF1113 | FLEETWOOD POST ACUTE | 6,643.00 |
| 419022 | FLORENCE COMMUNITY RESIDEN | 10,598.69 |
| NF1056 | GREENVILLE POST ACUTE | 6,656.99 |
| NF1114 | GREER POST ACUTE | 6,830.67 |
| NF1105 | HALLMARK HEALTHCARE CENTER | 6,471.75 |
| 0918NF | HEALTHCARE PANASCOPE | 5,541.31 |
| 0952NF | HEARTLAND HEALTH CARE CENT | 6,890.29 |
| 0953NF | HEARTLAND HEALTH CARE CENT | 6,203.48 |
| NF1000 | HEARTLAND HEALTH CARE CENT | 6,610.76 |
| NF1002 | HEARTLAND OF COLUMBIA REHA | 6,488.79 |
| 0450NH | HERITAGE HOME OF FLORENCE | 7,005.57 |
| 117042 | HONORAGE NURSING CENTER | 7,101.38 |
| NF1045 | INMAN GOLDEN AGE OPERATING | 6,321.80 |
| NF1044 | INMAN HEALTH OPERATING COM | 6,433.43 |
| NF1120 | IVA POST ACUTE | 6,890.59 |
| NF1032 | JF HAWKINS NURSING HOME | 6,172.15 |
| 118285 | JOHN EDWARD HARTER NURSING | 6,286.82 |
| NF1052 | JOHNS ISLAND POST ACUTE | 6,423.09 |
| 0929NF | JOLLEY ACRES HEALTHCARE CT | 6,205.61 |
| 332258 | KERSHAWHEALTH KARESH LONG | 7,583.79 |
| 0928NF | LAKE CITY SCRANTON HEALTHC | 5,727.76 |
| NF1061 | LANCASTER HEALTH CARE LLC | 5,780.38 |
| 0730NF | LEXMED INC | 7,929.63 |
| 0725NF | LIFE CARE CENTERS OF AMERI | 5,472.57 |
| NF1117 | LINLEY PARK POST ACUTE | 7,508.05 |
| NF1057 | LORIS REHAB AND NURSING CE | 8,051.90 |
| 332134 | LUTHERAN HOMES OF SC INC | 7,170.73 |
| NF1102 | MANNA REHABILITATION AND H | 7,371.48 |
| NF1104 | MCCORMICK REHABILITATION A | 6,145.38 |
| NF1077 | MCCOY MEMORIAL NURSING CEN | 5,702.52 |
| 0681SB | MCLEOD HEALTH CHERAW | 6,139.91 |
| 0930SB | MCLEOD HEALTH CLARENDON | 6,139.91 |
| 0384SB | MCLEOD MEDICAL CENTER DARL | 6,139.91 |
| 0854SB | MCLEOD MEDICAL CENTER DILL | 6,139.91 |
| 0891NF | MEDFORD NURSING CENTER | 7,084.04 |
| 0881NF | MORRELL NURSING CENTER LLC | 6,853.79 |
| 0896NF | MOUNT PLEASANT MANOR LLC | 5,801.07 |
| 0895NF | MUSC HEALTH CHESTER NURSIN | 7,291.79 |
| NF1010 | MUSC HEALTH MULLINS NURSIN | 7,504.70 |
| 0028SB | MUSC MARION MEDICAL CENTER | 6,139.91 |
| 262441 | NHC HEALTHCARE ANDERSON LL | 6,981.23 |
| NF1008 | NHC HEALTHCARE BLUFFTON | 7,870.01 |
| NF1110 | NHC HEALTHCARE CHARLESTON | 6,598.59 |
| 0601NH | NHC HEALTHCARE CLINTON LLC | 6,673.72 |
| 0574NH | NHC HEALTHCARE GARDEN CITY | 6,768.01 |
| 0570NH | NHC HEALTHCARE GREENVILLE | 7,441.13 |
| 400227 | NHC HEALTHCARE GREENWOOD | 5,973.83 |
| 155210 | NHC HEALTHCARE LAURENS LLC | 5,877.72 |
| 0629NH | NHC HEALTHCARE LEXINGTON L | 6,896.68 |
| 0732NF | NHC HEALTHCARE MAULDIN LLC | 7,308.82 |
| 0569NH | NHC HEALTHCARE NORTH AUGUS | 6,693.49 |
| 0722NF | NHC HEALTHCARE PARKLANE LL | 7,362.05 |
| 0471NH | NHC HEALTHCARE SUMTER | 5,510.89 |
| NF1086 | OAKBROOK HEALTH AND REHABI | 6,434.34 |
| 0890NF | OAKHAVEN NURSING CENTER LL | 7,473.68 |
| NF1093 | PATEWOOD REHABILITATION AN | 7,905.29 |
| NF1068 | PEACHTREE CENTRE | 6,311.46 |
| NF1126 | PEPPER HILL CENTER FOR REH | 5,525.80 |
| 0861NF | PHYSICAL REHABILTATION AN | 6,367.12 |
| NF1115 | PIEDMONT POST ACUTE | 6,776.53 |
| NF1106 | POINSETT REHABILITATION AN | 6,331.53 |
| NF1122 | POWDERSVILLE POST ACUTE | 6,808.77 |
| NF1034 | PRESBYTERIAN HOME OF SC CO | 6,598.59 |
| 0930NF | PRINCE GEORGE HEALTHCARE C | 5,831.79 |
| NF1062 | PRISMA HEALTH LILA DOYLE | 6,611.37 |
| NF1096 | PRUITTHEALTH - CONWAY | 7,573.14 |
| 0942NF | PRUITTHEALTH AIKEN LLC | 6,901.85 |
| NF1007 | PRUITTHEALTH BAMBERG | 8,230.75 |
| NF1011 | PRUITTHEALTH BARNWELL LLC | 8,259.65 |
| 0880NF | PRUITTHEALTH COLUMBIA LLC | 6,878.12 |
| 0835NF | PRUITTHEALTH DILLON LLC | 6,362.86 |
| 0922NF | PRUITTHEALTH ESTILL LLC | 5,542.53 |
| 0943NF | PRUITTHEALTH MONCKS CORNER | 6,902.76 |
| NF1004 | PRUITTHEALTH NORTH AUGUSTA | 7,350.49 |
| NF1006 | PRUITTHEALTH ORANGEBURG | 6,885.12 |
| NF1005 | PRUITTHEALTH PICKENS | 7,349.58 |
| 0710NF | PRUITTHEALTH RIDGEWAY LLC | 6,635.09 |
| 0836NF | PRUITTHEALTH ROCK HILL LLC | 7,257.42 |
| 0711NF | PRUITTHEALTH WALTERBORO | 6,326.06 |
| 0634NF | RCM COLUMBIA | 5,411.73 |
| NF1058 | REHAB CENTER OF CHERAW LLC | 5,273.64 |
| NF1123 | RIDGELAND NURSING AND REHA | 5,803.20 |
| NF1087 | RIDGEWAY MANOR HEALTHCARE | 6,027.06 |
| NF1091 | RIVER FALLS REHABILITATION | 7,662.57 |
| NF1071 | ROCK HILL HEALTHCARE INC | 6,413.05 |
| NF1059 | SAINT MATTHEWS HEALTH CARE | 5,357.90 |
| 421834 | SALUDA NURSING CENTER | 7,269.28 |
| NF1009 | SANDPIPER REHAB AND NURSIN | 7,633.06 |
| NF1109 | SEDGEWOOD MANOR HEALTHCARE | 6,047.44 |
| 0917NF | SENECA HEALTH AND REHABILI | 6,392.06 |
| NF1111 | SENIOR CARE OF MARION LLC | 6,598.59 |
| NF1099 | SIMPSONVILLE REHABILITATIO | 6,676.76 |
| 0435NF | SOUTH CAROLINA BAPTIST MIN | 6,986.40 |
| 136078 | SOUTH CAROLINA DEPT OF MEN | 11,973.52 |
| 0549NH | SOUTH CAROLINA DEPT OF MEN | 8,135.55 |
| NF1078 | SOUTHERN CHARM HEALTHCARE | 7,002.53 |
| NF1128 | SOUTHLAND HEALTH CARE CENT | 7,317.03 |
| NF1060 | SPARTANBURG HEALTH CARE LL | 5,817.19 |
| 0925NF | SPRINGDALE HEALTHCARE CTR | 5,732.33 |
| 0919NF | SSC SUMTER EAST OPERATING | 5,907.22 |
| NF1082 | ST GEORGE HEALTH CARE LLC | 5,993.60 |
| NF1066 | STONEY HILL HEALTHCARE INC | 6,100.06 |
| 323391 | THE METHODIST OAKS | 7,183.50 |
| NF1012 | THE OAKS OF BLYTHEWOOD INC | 8,526.40 |
| NF1127 | THE PALMS AT FLORENCE | 6,787.18 |
| NF1092 | THE RIDGE REHABILITATION A | 6,348.87 |
| 0859NF | THI OF SOUTH CAROLINA AT | 7,067.92 |
| 0862NF | THI OF SOUTH CAROLINA AT C | 5,771.26 |
| 0868NF | THI OF SOUTH CAROLINA AT C | 7,317.34 |
| 0870NF | THI OF SOUTH CAROLINA AT C | 6,319.67 |
| 0860NF | THI OF SOUTH CAROLINA AT G | 6,152.68 |
| 0866NF | THI OF SOUTH CAROLINA AT G | 6,759.50 |
| 0863NF | THI OF SOUTH CAROLINA AT M | 5,732.93 |
| 0869NF | THI OF SOUTH CAROLINA AT M | 6,010.03 |
| 0867NF | THI OF SOUTH CAROLINA AT S | 5,670.58 |
| 131054 | THIRD MIDLANDS IMR | 15,524.67 |
| NF1125 | VIVIANT HEALTHCARE OF CHAR | 5,773.08 |
| NF1124 | VIVIANT HEALTHCARE OF HANA | 5,476.52 |
| 271877 | WESLEY COMMONS | 7,958.83 |
| 0466NH | WHITE OAK ESTATES | 7,680.82 |
| 0458NH | WHITE OAK MANOR CHARLESTON | 7,515.05 |
| 0461NH | WHITE OAK MANOR COLUMBIA | 6,745.50 |
| NF1081 | WHITE OAK MANOR INC | 8,644.11 |
| 0508NH | WHITE OAK MANOR LANCASTER | 7,244.64 |
| 0462NH | WHITE OAK MANOR NEWBERRY | 6,773.18 |
| 0460NH | WHITE OAK MANOR SPARTANBUR | 8,175.39 |
| 0565NH | WHITE OAK MANOR YORK | 7,574.36 |
| 0459NH | WHITE OAK MANOR-ROCK HILL | 7,703.63 |
| NF1098 | WILLISTON HEALTHCARE AND R | 5,397.74 |
| 0737NF | WINDSOR MANOR | 5,760.00 |
| NF1085 | WOODRUFF MANOR | 6,272.22 |

APPENDIX E Comparison of Applicable Required Elements for Institutional Programs (NH-HCBS-GH)

(Eff. 01/01/21)

|  |  |  |  |
| --- | --- | --- | --- |
| Comparison of Applicable Required Elements for Institutional Programs | | | |
| Element | **Nursing Home** | **HCBS** | **General Hospital** |
| 30 Consecutive Day Criteria | Required, UNLESS Medicaid-eligible in another category | Required, UNLESS Medicaid-eligible in another category | Required |
| Look-back; Transfer of Assets Penalty | Applicable | Applicable | Not Applicable |
| Categorical Eligibility | Aged, Blind or Disabled | Aged, Blind or Disabled | Aged, Blind or Disabled |
| Estate Recovery | Applicable | Applicable | Not Applicable |
| Income Limit | Medicaid Cap  IF income exceeds the Medicaid Cap, an Income Trust must be established. | Medicaid Cap  IF income exceeds the Medicaid Cap, an Income Trust must be established. | Medicaid Cap  An Income Trust is not an option. |
| Level of Care | Certification required, UNLESS entering  facility under  Medicare Sponsorship | Certification required | Level of Care  is presumed. |
| Obtaining  Other Assets/  Elective Share | Applicable | Applicable | Not Applicable |
| Recurring Income (Cost of Care) | Applicable | Not applicable, UNLESS an Income Trust  must be established | Not Applicable |
| Resource Limit | $2,000  $7,970 - IF eligibility can be established under the ABD program. | $2,000  $7,970 - IF eligibility can be established under the ABD program. | $2,000 |
| Spousal Resource Provisions | Applicable | Applicable | Applicable |
| Standard of Promptness | 45 days  May be extended to  90 days, IF eligible but  a bed is not available. | 45 days  May be extended to  90 days, IF eligible but  a slot is not available. | 45 days |
| Vendor Payment | Applicable | Not Applicable | Not Applicable |

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APPENDIX F Recurring Income (Cost of Care) Allowable Deductions – NH/HCBS Cases

(Eff. 01/01/21)

| Allowable Deductions When Calculating Recurring Income | | | | |
| --- | --- | --- | --- | --- |
|  | Nursing Home Case | | HCBS Case | |
| **Deduction** | Standard | **Income Trust** | **Standard** | **Income Trust** |
| Bank  Service Charge | Not Applicable | Actual amount –  up to $20/mo. | Not Applicable | Actual amount –  up to $20/mo. |
| Family Income Allocation | Allowed – (Refer to [304.15.02](#MPPM_304_15_02).) | Allowed – (Refer to [304.15.02](#MPPM_304_15_02).) | Not Applicable | Allowed – (Refer to [304.15.02](#MPPM_304_15_02).) |
| Health Insurance Premiums | Actual amount –  IF paid for, and by the beneficiary | Actual amount –  IF paid for, and by the beneficiary | Actual amount –  IF paid for, and by the beneficiary | Actual amount –  IF paid for, and by the beneficiary |
| Home Maintenance Allowance | Actual amount –  up to SSI FBR  Allowed up to 6 months, IF a physician certifies beneficiary is expected to return home within  6 months | Actual amount –  up to SSI FBR  Allowed up to 6 months, IF a physician certifies beneficiary is expected to return home within  6 months | Not Applicable | Not Applicable |
| Income Tax Payments | Not Applicable | Allowed once per year, IF owed by the trust, not the beneficiary | Not Applicable | Allowed once per year, IF owed by the trust, not the beneficiary |
| Non-Covered Medical Expenses | Limited amount - deducted by  the facility | Limited amount - deducted by  the facility | Not Applicable | Limited amount deducted by the eligibility worker |
| Personal Needs Allowance | $30/mo.  or  $100/mo.- IF has earnings from Work Therapy | $30/mo.  or  $100/mo. - IF has earnings from Work Therapy | Equal to the Medicaid Cap | Equal to the Medicaid Cap |
| Protected Income | Allowed month of entry and/or discharge from a community setting | Not Allowed | Not Applicable | Not Applicable |
| Spousal Income Allocation | Up to a max. of $3,259.50/mo. | Up to a max. of $3,259.50/mo. | Not Applicable | Up to a max. of $3,259.50/mo. |
| Trustee Fee | Not Applicable | $10/mo. | Not Applicable | $10/mo. |

**Note: Recurring Income is not applicable for General Hospital.**

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APPENDIX G Home Equity Procedures Flowchart

(Eff. 01/01/21)

$688,000

$688,000?

APPENDIX H Waiver Programs Comparison Chart

(Rev. 01/01/20)

| **Program** | **Community Choices Waiver** | **HIV/AIDS Waiver** |
| --- | --- | --- |
| **Group Served** | Medicaid eligible, age 18 or older,  & meets Nursing Facility level of care | Medicaid eligible, any age,  diagnosed with HIV/AIDS, & meets  At-Risk of Hospitalization level of care |
| **Contact Agency** | DHHS/CLTC Centralized Intake: **888-971-1637**  For electronic referrals: <https://phoenix.scdhhs.gov/cltc_referrals/new> | |
| **Level of Care** | Nursing Facility | At-Risk of Hospitalization |
| **Available Services** | * Case Management * Personal Care I/II * Attendant Care * Companion Care * Home Delivered Meals * Nutritional Supplements * Adult Day Health Care * Adult Day Health Care Transportation * Adult Day Health Care Nursing * Respite Care * Personal Emergency Response System * Tele-monitoring * Pest Control * Home Accessibility Adaptations * Residential Personal Care II * Specialized medical Equipment & Supplies * Enhanced Pest Control | * Case Management * Personal Care I/II * Attendant Care * Companion * Home Delivered Meals * Nutritional Supplements * Pest Control * Private Duty Nursing * Home Accessibility Adaptations * Specialized medical Equipment & Supplies * Enhanced Pest Control |

| **Program** | **Mechanical Ventilator Waiver** | **Medically Complex Children’s**  **(MCC) Waiver** |
| --- | --- | --- |
| **Group Served** | Medicaid eligible, age 21 or older,  requires mechanical ventilation, &  meets Nursing Facility level of care | Medicaid eligible, under age 18,  meets medical criteria &  At-Risk of Hospitalization level of care |
| **Contact Agency** | DHHS/CLTC Centralized Intake: **888-971-1637**  For electronic referrals: [https://phoenix.scdhhs.gov/cltc\_referrals/new](https://phoenix.cltc.state.sc/cltc_referral/new) | |
| **Level of Care** | Nursing Facility & dependent on Mechanical Ventilation | At-Risk of Hospitalization &  Medical Criteria |
| **Available Services** | * Case Management * Personal Care I/II * Attendant Care * Private Duty Nursing * Specialized Medical Equipment & Supplies * Respite Care * Personal Emergency Response System * Home Accessibility Adaptations * Pest Control * Home Delivered Meals * Nutritional Supplements * Enhanced Pest Control | * Care Coordination * Pediatric Medical Day Care |

| **Program** | **Intellectual Disabilities & Related Disabilities (ID/RD) Waiver** | **Head & Spinal Cord Injuries**  **(HASCI) Waiver** |
| --- | --- | --- |
| **Group Served** | Medicaid eligible, all ages, with  intellectual or related disability, & meets  ICF/IID level of care | Medicaid eligible, age 0-65, with head or spinal cord injury, or similar disability,& meets Nursing Facility or ICF/IID level of care |
| **Contact Agency** | DDSN Single Point of Entry  **1-800-289-7012** (toll-free) | |
| **Level of Care** | ICF/IID | Nursing Facility or ICF/IID |
| **Available Services** | * Personal Care I/II * Residential Habilitation * Environmental Modifications * Private Vehicle Modifications * Private Vehicle Assessment/Consultation * Specialized Medical Equipment, & Assistive Technology * Specialized Medical Equipment, & Assistive Technology Assessment/ Consultation * Incontinence Supplies * Respite Care * Audiology Services * Adult Companion Services * Nursing Services * Adult Dental * Adult Vision * Adult Day Health Care * Adult Day Health Care Nursing * Adult Day Health Care Transportation * Adult Attendant Care * Behavior Support Services * Career Preparation * Employment Services * Day Activity * Community Services * Support Center Services * Personal Emergency Response System * Pest Control * Waiver Case Management | * Career Preparation * Day Activity * Employment Services * Attendant Care/Personal Assistance * Health Education for Consumer Directed Care * Peer Guidance for Consumer Directed Care * Residential Habilitation * Supplies, Equipment & Assistive Technology * Incontinence Supplies * Respite Care * Personal Emergency Response System * Physical Therapy * Occupational Therapy * Psychological Services * Behavior Support Services * Nursing Services * Speech and Hearing * Private Vehicle Modifications * Environmental Modifications * Assistive Technology Consultation * Vehicle Modification Consultation * Pest Control * Waiver Case Management |

| **Program** | **Community Supports (CS) Waiver** |
| --- | --- |
| **Group Served** | Medicaid eligible, all ages, with intellectual or related disability, & meets ICF/IID level of care |
| **Contact Agency** | DDSN Single Point of Entry  **1-800-289-7012** (toll-free) |
| **Level of Care** | ICF/IID |
| **Available Services** | * Personal Care I/II * Adult Day Health Care * Adult Day Health Care Nursing * Adult Day Health Care Transportation * Respite Care * Environmental Modifications * Assistive Technology and Appliances * Assistive Technology and Appliances Assessment/Consultation * Incontinence Supplies * Private Vehicle Modifications * Private Vehicle Assessment/Consultation * Behavior Support Services * Day Activity Services * Career Preparation Services * Community Services * Employment Services * Support Center Services * In-Home Support * Personal Emergency Response System * Waiver Case Management |

APPENDIX I Look-back Procedures for ABD Applicants

(Rev. 09/01/22)

For Nursing Home or Home and Community Based Services (HCBS) applicants who are current Medicaid beneficiaries in the Aged, Blind and Disabled Category (ABD), the DHHS Form 3400-B may be used to expedite the look-back process. The completed form must be submitted by the applicant before an eligibility determination can be made.

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| **Procedure**  ABD Eligible NH and HCBS Applicants:   1. If the individual is receiving Medicaid benefits as an ABD beneficiary, the individual should complete the [DHHS Form 3400-B](http://medsweb.scdhhs.gov/EligibilityForms/FM%203400-B.pdf), Additional Information for Nursing Home and In-Home Care 2. A look-back is required to determine if the beneficiary’s self-reported information indicates a sanctionable transfer occurred during the 60 months preceding the date of application. (For more information about look-backs refer to MPPM 304.09.02C.)    1. Review the DHHS Form 3400-B for any transfers    2. If no transfers are alleged,       1. Create an AVS request for the current month and for the three months prior to the request.       2. Complete a property check. Include a check in Probate court if an inheritance is indicated in the past five years. Refer to **Procedure – Conducting a Look-back** in MPPM 304.09.02C.    3. If a potential transfer is indicated, create an AVS request for the period when the transfer may have occurred and a property check. Request any additional information needed to evaluate the alleged transfer 3. If the beneficiary is eligible, with no sanctionable transfers, approve the application. 4. If the beneficiary is eligible, but has any transfers that do not meet exclusion criteria, follow MPPM policies and procedures to impose penalty 5. If the beneficiary is not eligible, deny the application 6. Following the notification of NH or HCBS approval, SC DHHS will send the applicant a [DHHS Form 3229](http://medsweb.scdhhs.gov/EligibilityForms/FM%203229%20ME.pdf), Notice of Cost of Care, which lists the amount of the applicant’s cost of care and any payments due |

APPENDIX J Phoenix Procedures

(Eff. 03/01/17)

| Nursing Home New Applicant Phoenix Procedure (Pilot Sites ONLY) | | |
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| WORKER | TASK | PROCEDURE |
| APPLICANT, PROVIDER, OR ELIGIBILITY WORKER | **REFERRAL** | 1. A referral for Nursing Home (NH) Level of Care (LOC) is submitted by an applicant, provider, or eligibility worker to CLTC. The referral is submitted through the Phoenix system at the following website: <https://phoenix.scdhhs.gov/cltc_referrals/new> 2. After submitting a Phoenix referral, the applicant is assigned a reference number. The reference number is a unique CLTC client identifier. The reference number should be recorded on the Tracking Form for future use but is only needed to check a referral’s status that does not appear in Eligibility Workflow. 3. If a referral is made by an eligibility worker, the eligibility worker will send the appropriate forms to the applicant and document the referral in MEDS and OnBase. 4. If a referral is not made by an eligibility worker, the worker may locate the referral in the Phoenix dashboard daily check. The eligibility worker will send the appropriate forms to the applicant and document the referral in MEDS and OnBase.   **NOTE:** The Request for Assessment of Level of Care, FM 1231, is obsolete and must not be used.  **REMEMBER:** Phoenix must be used in the Google Chrome web browser. |
| CLTC NURSE | **FORMS AND INTAKE** | 1. CLTC receives the referral through centralized intake, and the referral is assigned to a nurse consultant. The nurse contacts the client to complete the appropriate forms. The CLTC worker inserts information in Phoenix’s NF Active Workflow. The eligibility worker sends the applicant the appropriate forms if the applicant is awaiting an application. |
| CLTC NURSE | **LOC DECISION** | 1. The CLTC worker determines the LOC. |
| ELIGIBILITY WORKER | **ELIGIBILITY DECISION** | 1. The eligibility worker conducts a look-back to determine if the applicant is financially eligible. 2. The eligibility worker will check the Phoenix’s Active NF Workflow for updates to active and pending cases on a daily basis. The following events would trigger a necessary update by the eligibility worker: LOC submission, NF admittance, NF discharge, Medicare co-insurance, Medicaid conversion, Medicaid bed hold, and recurring income changes. 3. In the comments section, the worker must update when the following actions occur: when an application is received, when an application is not received, and when financial eligibility is determined in Phoenix, MEDS, and OnBase. 4. If an application is not received within 45 days, the worker should enter a comment to deny the application in Phoenix. |
| PROVIDER | **UPDATE** | 1. The Provider will post in Phoenix when an event triggers a necessary update. |

| Nursing Home (NH) Phoenix Procedure for Aged, Blind, Disabled (ABD) Recipients | | |
| --- | --- | --- |
| WORKER | TASK | PROCEDURE |
| APPLICANT, PROVIDER, OR ELIGIBILITY WORKER | **REFERRAL** | 1. A referral for Nursing Home (NH) Level of Care (LOC) is submitted by an applicant, provider, or eligibility worker to CLTC. The referral is submitted through the Phoenix system at the following website: <https://phoenix.scdhhs.gov/cltc_referrals/new> 2. After submitting a Phoenix referral, the applicant is assigned a reference number. The reference number is a unique CLTC client identifier. The reference number should be recorded on the Tracking Form for future use, but is only needed to check a referral’s status that does not appear in Eligibility Workflow. 3. If a referral is made by an eligibility worker, the eligibility worker will send the appropriate forms to the applicant, and document the referral in OnBase and MEDS. 4. If a referral is not made by an eligibility worker, the worker will receive notification that a referral has been created. The worker should conduct a name search and document information in OnBase and MEDS.   **NOTE:** The Request for Assessment of Level of Care, FM 1231, is obsolete and must not be used.  **REMEMBER:** Phoenix must be used in the Google Chrome web browser. |
| CLTC NURSE | **FORMS AND INTAKE** | 1. CLTC receives the referral through centralized intake, and the referral is assigned to a nurse. The nurse contacts the client to complete the appropriate forms. The CLTC worker inserts information in Phoenix’s Active Workflow. The eligibility worker sends the applicant the appropriate forms if the applicant is awaiting an application. 2. FM 3400-D, Statement of Transfer of Assets, is used for ABD beneficiaries only. FM 3400-D may be distributed by the eligibility worker when a request for LTC services is received or by CLTC’s initial assessment by phone or home visit. |
| CLTC SCANNER | **SCAN**  **FM 3400-D** | 1. The scanner scans FM 3400-D into Phoenix. The form must be signed by the applicant or the Authorized Representative. |
| CLTC NURSE | **LOC DECISION** | 1. The CLTC worker determines the LOC. |
| ELIGIBILITY WORKER | **ELIGIBILITY DECISION** | 1. The eligibility worker conducts an expedited look-back as described in MPPM 304, Appendix I. 2. The eligibility worker will check the Dashboard’s Active NF Workflow tab for updates to active and pending cases on a daily basis. The following events would trigger a necessary update by the eligibility worker: LOC submission, NF admittance, NF discharge, Medicare co-insurance, Medicaid conversion, Medicaid bed hold, and recurring income changes. 3. In the comments section, the worker must update when an application is received, an application is not received, and financial eligibility is determined. 4. If an application is not received within 45 days, the worker should enter a comment to deny the application in Phoenix. |
| PROVIDER | **UPDATES** | 1. The Provider will post in Phoenix when an event triggers a necessary update. |

| **Community Long Term Care (CLTC) Phoenix Procedure for New Medicaid Applicants** | | |
| --- | --- | --- |
| **WORKER** | **TASK** | **PROCEDURE** |
| **APPLICANT, PROVIDER, OR ELIGIBILITY WORKER** | **REFERRAL** | 1. A referral for Community Long Term Care (CLTC) services is entered into the Phoenix by an applicant, provider, or eligibility worker on behalf of an applicant who wishes to apply for CLTC services. The referral is submitted through the Phoenix system at the following website: <https://phoenix.scdhhs.gov/cltc_referrals/new>   **NOTE:** FM 1231, Request for Assessment of Level of Care, is obsolete and must not be used.  **REMEMBER:** Phoenix must be used in the Google Chrome web browser. |
| **CLTC INTAKE WORKER** | **PHONE ASSESSMENT** | 1. A phone assessment is conducted between the applicant and the CLTC Intake Worker.  * If the applicant is not receiving Medicaid services and appears to meet the LOC requirements, the CLTC worker sends FM 3401, Application for Nursing Home, Residential, or In-Home Care, to the applicant, and documents that they provided the necessary forms in the Phoenix Dashboard. * If the applicant does not appear to meet the LOC requirements, the CLTC worker documents that the applicant does not meet the LOC criteria in the Phoenix Dashboard. The case should not be added to the Eligibility Workflow. |
| **CLTC NURSE** | **HOME ASSESSMENT** | 1. For applicants who appear to be medically eligible, the CLTC Nurse conducts a home assessment to determine if the applicant meets the LOC. 2. If the applicant is not receiving Medicaid services and meets the LOC, the nurse asks the applicant if FM 3401 was submitted to SCDHHS. If the applicant has not submitted FM 3401, the nurse will issue a new FM 3401 and/or assist the applicant with completion of the form if needed. The nurse should document that she provided and/or assisted with completion of FM 3401 in the Phoenix Dashboard. |
| **ELIGIBILITY WORKER** | **ELIGIBILITY DECISION** | 1. After retrieving a case from the Phoenix Dashboard, the eligibility worker reviews the case, and determines the applicant’s eligibility. 2. If the applicant meets the LOC, the eligibility worker:  * Reviews the documents in OnBase; * Conducts a look-back to determine if the applicant is financially eligible; * Assesses whether the applicant meets all other LTC eligibility criteria; * Completes the eligibility determination in Phoenix, MEDS, and OnBase; * Notifies CLTC of the applicant’s status by documenting the eligibility status in Phoenix.  1. If the applicant does not meet the LOC and the eligibility worker created the referral, the worker must document that the applicant does not meet the LOC criteria in Phoenix, MEDS, and OnBase, and deny the case.   **NOTE:** DHHS FM 118, Client Status Document (CSD), is no longer valid as of 1/1/2014. |
| **CLTC WORKER** | **SERVICES BEGIN** | 1. Once the eligibility worker notifies CLTC of the applicant’s tentative approval in Phoenix, CLTC services begin. A final approval determination will not occur until 30 days after services begin. 2. The CLTC worker should document the start date as a Phoenix Comment. The start date for services occurs when the applicant enters the HCBS waiver. This action is completed after the LOC is determined and the financial eligibility status is approved. |
| **ELIGIBILITY WORKER** | **UPDATES** | 1. The eligibility worker checks the Phoenix Enrollment Tab to confirm the applicant has met the 30-day requirement for CLTC services. Once confirmed, the eligibility worker approves the case in OnBase and MEDS. |

| Community Long Term Care (CLTC) Phoenix Procedure for Aged, Blind, Disabled (ABD) Recipients | | |
| --- | --- | --- |
| WORKER | TASK | PROCEDURE |
| APPLICANT, PROVIDER, OR ELIGIBILITY WORKER | **REFERRAL** | 1. A referral for Community Long Term Care (CLTC) services is entered into the Phoenix by an applicant, provider, or eligibility worker on behalf of an applicant, who wishes to apply for CLTC services. The referral is submitted through the Phoenix system at the following website: <https://phoenix.scdhhs.gov/cltc_referrals/new>   **NOTE:** The Request for Assessment of Level of Care, FM 1231, is obsolete and must not be used.  **REMEMBER:** Phoenix must be used in the Google Chrome web browser. |
| CLTC INTAKE WORKER | **PHONE ASSESSMENT** | 1. A phone assessment is conducted between the applicant and the CLTC Intake Worker. If the ABD beneficiary is likely to meet the Level of Care (LOC), the worker will add the case to Phoenix, add the case to the Eligibility workflow, and send the appropriate application and addendum. An ABD beneficiary should complete FM 3400-B, Additional Information for Nursing Home and In-Home Care. 2. Once the phone assessment is complete, CLTC services for the ABD beneficiary begin. |
| CLTC NURSE | **HOME ASSESSMENT** | 1. For applicants who appear to be medically eligible, the CLTC nurse conducts a home assessment to determine if the applicant meets the LOC. 2. If the applicant is an ABD beneficiary and meets the LOC, the nurse conducts the following actions:  * Asks the applicant if FM 3400-B was submitted to SCDHHS. If the applicant has not submitted FM 3400-B, the nurse will issue a new FM 3400-B and/or assist the applicant with completion of the form if needed, * Assists in completing and signing FM 3400-D, and * Documents that she provided assistance with the completion of FM 3400-B in the Phoenix Dashboard. |
| CLTC SCANNER | **SCAN** | 1. The CLTC scanner scans FM 3400-D into Phoenix. |
| ELIGIBILITY WORKER | **ELIGIBILITY DECISION** | 1. After retrieving a case from the Phoenix Dashboard, the eligibility worker reviews the case, and determines the applicant’s eligibility. 2. If the applicant meets the LOC, the eligibility worker:  * Reviews the documents in OnBase; * Conducts an expedited look-back as described in MPPM 304, Appendix I.   **NOTE:** For beneficiaries evaluated by CLTC on or after March 13, 2017, the expedited process cannot be used for the Look-Back.   * Assesses whether the applicant meets all other LTC eligibility criteria; * Completes the eligibility determination in Phoenix, MEDS, and OnBase; * Notifies CLTC of the applicant’s status by documenting the eligibility status in Phoenix.  1. If the applicant does not meet the LOC and the eligibility worker created the referral, the worker must document that the applicant does not meet the LOC criteria in Phoenix, MEDS, and OnBase, and deny the case. 2. If the applicant is already receiving Medicaid benefits, the applicant is given 30 days to return FM 3400-B/3401.  * If the applicant returns FM 3400-B/3401 within 30 days, the eligibility worker should click the “Receive Application” button on the Phoenix Dashboard. * If the applicant does not return FM 3400-B/3401 within 30 days, the eligibility worker should click the “Close Workflow” button on the Phoenix Dashboard.   **NOTE:** DHHS FM 118, Client Status Document (CSD), is no longer valid as of 1/1/2014. |
| CLTC WORKER | **SERVICES BEGIN** | 1. Once the eligibility worker notifies CLTC of the applicant’s tentative approval in Phoenix, CLTC services begin. A final approval determination will not occur until 30 days after services begin. 2. The CLTC worker should document the start date as a Phoenix Comment. The start date for services occurs when the applicant enters the HCBS waiver. This action is completed after the LOC is determined and the financial eligibility status is approved. |
| ELIGIBILITY WORKER | **UPDATE** | 1. The eligibility worker checks the Phoenix Enrollment Tab to confirm the applicant has been enrolled in CLTC services. Once confirmed, the eligibility worker approves the case in MEDS and OnBase. The 30-day requirement does not apply to ABD beneficiaries. |