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**702.01 Introduction**

(Eff. 04/01/23)

The Family First Coronavirus Response Act, enacted on March 18, 2020, provides health provisions in response to the COVID-19 national public health emergency. This legislation provides provisions for coverage of testing for COVID-19 for uninsured individuals, as well as eligibility protections for the duration of the emergency. These provisions are in effect from the enactment date of the law and end on the last day of the month in which the emergency period ends.

**702.02 Review Guidelines during PHE Unwinding**

(Rev. 01/01/24)

During the unwinding period, starting April 1, 2023, Annual Case Review forms will be mailed to all current beneficiaries that are in review status. Review forms received will be processed using the guidelines provided below for all MAGI, Non-MAGI and LTC cases. Cases selected for review in which a review form is NOT returned will be subject to a Desk Review. Refer to the Desk Review Process for specific instructions.

When a case is in review status, any signed review or application form returned by the member can be used to redetermine eligibility. If the form does not have all the information needed to complete the review, the eligibility specialist must follow up with the member to request the necessary information but cannot require the member to complete a new review form.

If a case is not in review status, eligibility specialists will treat any review form received as a change of circumstances. When the case goes into review status, the normal review process will occur, and the member may receive a review if eligibility could not be automatically extended through the Cúram ex parte process. Refer to MPPM 101.08.06.

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| NoteIf a MAGI Eligibility Specialist receives an application/review for an active beneficiary outside of their annual review event it will be treated as a Change of Circumstance (CoC). When all information is reverified as part of the CoC redetermination, the Eligibility Specialist should check the “Full Re-Determination” box in the CoC script. After submitting the CoC and applying changes, Cúram will no longer apply the protected period rules for the Public Health Emergency (PHE). Please see the [**Change of Circumstance (CoC) Script**](https://schhs.sharepoint.com/%3Ab%3A/r/sites/EES/Training/Curam/HCR/Job-Aids/Evidence/Change%20of%20Circumstance%20%28CoC%29%20Script%20%28WorkerPortal%29.pdf?csf=1&web=1&e=XyJhUD) job aid for guidance on this procedure. |

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| Desk Review ProcessIf the Annual Case Review Form is not received* Review information in OnBase and other sources
* If sufficient information is found, assess for continued eligibility.
	+ If the beneficiary remains eligible, complete the review,
	+ If the beneficiary is active in MEDS, then convert to Cúram by creating a new application or updating a known household in Cúram.
		- If sufficient information is found and a beneficiary appears to be ineligible, request the missing information.
* If the beneficiary fails to respond, close for failure to return information.
	+ If a response is received, complete the review.
* If determined to continue to be eligible, convert to Cúram if applicable.
* If found ineligible, close.
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702.02.01 Guidelines for Completing MAGI Reviews

(Rev. 10/01/23)

Beneficiaries will receive a review form if an ex parte review cannot be completed. When a signed review form is received, process the review using the information on the Review Form, in the System of Record (SOR), and in OnBase. The eligibility specialist must compare the reported income information to current electronic data sources and/or other verifications on file. Check for discrepancies between what is reported on the Review Form and what is currently in the file to determine what other verifications may be needed (i.e., tax forms, paystubs, etc.). **If the beneficiary remains eligible**, the review is completed using this information in accordance with applicable policies and procedures.

**Remember: If the review process determines a member in MEDS remains eligible for Medicaid, convert the case to HCR. Further guidance will be given to the eligibility specialists assigned to MAGI in MEDS cases.**

MAGI Considerations

* Reviews require a signature to be processed.
* Reviews originating in Cúram should be processed in Cúram**.**
* Check the case file for any reported changes, such as a new address or new Authorized Representative. Make necessary changes in the SOR.
* Send a DHHS Form 1282 if a new AR is reported, but do not hold up the Review decision for its return.
* Complete documentation template
* If MEDS is the current System of Record (SOR)
	+ Complete MAGI Workbook. A MAGI workbook is required for each household being moved from MEDS to HCR. This will ensure if coverage is to be continued that the correct determination is given by the system.
	+ If individual continues to be eligible, convert from MEDS to Cúram (For instructions, refer to the [Post PHE Conversion and ACR Training](https://schhs.sharepoint.com/sites/EES/Training/Forms/AllItems.aspx?id=%2Fsites%2FEES%2FTraining%2FMAGI%2FCourse%20Materials%2FPOST%20PHE%20Reviews%20and%20TMA%2FPOST%20PHE%20Reviews%2FPost%20PHE%20Conversion%20and%20ACR%20Training%20%2D%20Student%20%2D%203%2E30%2E2023%2Epdf&parent=%2Fsites%2FEES%2FTraining%2FMAGI%2FCourse%20Materials%2FPOST%20PHE%20Reviews%20and%20TMA%2FPOST%20PHE%20Reviews) PowerPoint, beginning on Slide 5)
	+ If the individual is not eligible in their current category, follow instructions for the Ex Parte process (MPPM 101.08.06)
	+ If the individual was eligible for PCR, and not eligible for any other full benefit category, they must be assessed for TMA. Refer to TMA instructions below.
	+ If the individual is ineligible for any Medicaid category, close in MEDS. Do not convert ineligible cases to HCR.

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| **TMA Procedures*** During the PHE unwinding period, an eligibility specialist will evaluate the income received by the household in the past 12-months to assess if a beneficiary who is no longer eligible for PCR is eligible for TMA.
* Once the PHE unwinding period is over, an eligibility specialist will evaluate the income received by the household in the past 24-months to assess if a beneficiary who is no longer eligible for PCR is eligible for TMA.
* If the household moves from PCR to TMA, the eligibility specialist will grant manual coverage for an additional 6 months prior to updating the tracking form to TMA. This will allow time for the household to be reviewed further.
* Refer to MPPM 205.09 for detailed instructions
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| Ex Parte from MAGI to non-MAGI or Long-Term CareA MAGI review was returned for a beneficiary that is no longer eligible for coverage in their current MAGI coverage category (e.g., aging out of PHC, no longer categorically eligible for PCR, etc.) and the beneficiary has attested to a Non-MAGI or LTC categorical indicator (e.g., disability, aged, needing LTC services, etc.)* MAGI Processes
	+ A MAGI review is received for processing.
	+ MAGI Eligibility Specialist updates the case using the ACR Script.
	+ MAGI Eligibility Specialist applies ACR changes.
		- If MAGI coverage is ending and disability is alleged, a Non-MAGI task generates when Annual Renewal Changes are applied.
		- Eligibility Specialists should check the review status after applying Annual Renewal Changes. If it updates to Review Received - Additional Information Needed unexpectedly, the Eligibility Specialist should check for Deferred Member evidence. If the Deferred Member evidence is not relevant and there is not an Outstanding Verification (OV) remaining on the case, the evidence should be deleted so that the rules can run for that member.
	+ MAGI Eligibility Specialist adds Manual Eligibility evidence for 12 months, starting the 1st of the following month, to protect the existing MAGI coverage during the ex parte process.
	+ MAGI Eligibility Specialist creates an Application Tracking Form in OnBase to send the review form to a Non-MAGI or LTC Eligibility Specialist.
* Non-MAGI/LTC Processes
	+ A Non-MAGI/LTC Eligibility Specialist receives the task and evaluates the beneficiary for Non-MAGI/LTC coverage.
		- Eligibility Specialist enters the information into CGIS as an Income Support Application using the review form received date as the application date.
	+ Non-MAGI/LTC Eligibility Specialist makes necessary collateral calls.
		- If the collateral calls are successful and the beneficiary can be determined eligible in the new category, enter SC Medicaid Benefit evidence on the MAGI Insurance Affordability Case to end MAGI coverage, and process the review form as an Income Support Application in CGIS.
		- If the collateral calls are successful and the beneficiary attests to not meeting the criteria for continued coverage, send the Tracking Form back to MAGI to have the coverage reduced or end dated following adverse action rules.
	+ If the collateral calls are unsuccessful, send the appropriate packet/addendums with the DHHS Form 1233 and allow 15 days to return the needed information. Send to Follow-Up for 17 days in OnBase.
	+ If the requested information is returned, process the pending application
		- Enter SC Medicaid Benefit evidence on the MAGI Insurance Affordability Case to end MAGI coverage.
		- Suppress any MAGI closure notice, ensure that a CGIS approval notice is generated, and disposition any outstanding Tracking Forms or tasks.
	+ If the requested information is not returned
		- Deny the pending application, suppress the denial notice, and send the Tracking Form back to MAGI to have the coverage reduced or end dated following adverse action rules.
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702.02.02 MAGI Desk Review Process

(Rev. 04/01/24)

The MAGI Desk Review procedures are used as part of the PHE Unwinding to process MAGI in MEDS reviews that have not been returned. When the Annual Review Form has not been returned, signed, and completed by the beneficiary or authorized representative and the due date has completely expired, a desk review will be required. During the desk review, Eligibility Specialists must use the Ex Parte process to make an eligibility determination in the current category or any category for which the beneficiary may be eligible.

1. The Eligibility Specialist pulls and accepts task in Workload Pro (WLP).
2. Locate household in OnBase.
3. Verify system of record for all members via MMIS (MEDS or Cúram (State)).
* Check MEDS and the Next Review Date (NRD) that is listed on the MEDELD01 Screen to confirm the time has expired for the members to return their review form.
	+ Locate the person in MEDS
	+ Select the person and F11 to the Recipient Information Screen
	+ Select F2 to the Household Budget Groups Screen
	+ Select an open BG, and SHIFT F5 (PF17) to the Medicaid Eligibility Decision Screen (MEDELD00)
	+ F3 forward to the MEDELD01 Screen
	+ The Next Review Date will be listed on the right side of the Screen

NOTE

The user must either upload a copy of the MEDELD01 screen or a snippet of the WLP task to OnBase as Member Verification to confirm the NRD has passed, and a Desk Review is being completed.

1. Review any recent documentation templates, documents, and the case record.
* Notate any reported changes, applications, or updates since the last determination. Work any reported changes that have not already been processed as a Change of Circumstance prior to completing the Desk Review process.
* Notate the last known information about applying, family planning, and tax filing status.

NOTE: If a Review is returned after the Desk Review begins, follow the normal Post PHE Conversion and ACR Process.

1. Notate the current coverage for all household members from the Recipient Information Screen (MEDHMS54).
* Complete a Desk Review.

The Eligibility Specialist must use the Ex Parte process from MPPM 101.08.06 to determine eligibility in the current category or any other category for which the beneficiary may qualify.

1. Verify evidence listed for the household using the documents within the case file. End date any existing Documentation Template, and open and save a new Documentation Template for the Review. Use the new Documentation Template to record the information used for the Desk Review.
2. Can the member relationship and tax filing status be determined?
* If there is information on file that lists the member relationships and tax filing status for all members, continue with the desk review.
* If there is missing information related to member relationships and tax filing status for any member, attempt a collateral call to gather the necessary information. If the collateral call is unsuccessful, send a 1233 requesting the missing evidence along with any other needed information.
1. Use current resources and recent documents below to determine income/wages:
* Person Composite (PCS)
* CHIP (if available)
* Any paystubs, tax returns, etc.
1. Based on the information on file, can a workbook be completed for the household?
* Yes- complete a MAGI workbook (most recent version) to determine if eligibility will be continued.
* No- complete collateral calls to client to obtain needed information.
	+ If the collateral calls were unsuccessful, pend and send a 1233.
	+ Other reasons a 1233 may be needed before processing can be completed:
		- Self-Employment
		- SSN for member or infant
		- Change of category
		- No EDS for income (Refer to 702.02.03A for additional guidance for Verifying Income Less than 100% FPL with no Electronic Data Source)
1. If the workbook can be completed, determine if the recipient will continue coverage.
* If current or equal coverage continues, close out the MEDS budget groups using codes 004 and 114, convert the case to Cúram by creating a New MAGI Application using the first of the current month that the desk review is being completed. ([Entering a Paper Application](https://schhs.sharepoint.com/%3Ab%3A/r/sites/EES/Training/Curam/HCR/Job-Aids/Application%20Process/Entering%20a%20Paper%20Application.pdf?csf=1&web=1&e=4DhQ2A))

NOTE

The Eligibility Specialist may receive an error code regarding income or the ex parte indicator when closing a BG. Ensure income is entered or the ex parte indicator is set to “N” on each member’s MEDELD02 screen.

* If the client will move from PW to PCR, TMA to PCR, or into another equal benefit category, the review process should be completed, and the client’s coverage can be updated.

NOTE

If the member’s coverage will move from PCR to FP, complete the TMA to PCR tab of the MAGI workbook. The Eligibility Specialist should complete the process to grant TMA in Cúram based on the workbook results.

* If the recipient is not eligible or eligible for lesser coverage, attempt collateral calls to obtain the information needed to make a full redetermination.
	+ If the collateral calls are unsuccessful and the recipient still meets categorical eligibility, leave the case open in MEDS and send a DHHS Form1233 requesting the needed information to make a full eligibility determination.
	+ If the collateral calls are unsuccessful and the recipient is no longer categorically eligible for any categories, coverage can be ended using the appropriate closure code in MEDS, following adverse action rules.
* If the client reports new information regarding Former Foster Care coverage or Pregnancy during the collateral calls, the client must be closed in MEDS and ex parted to Cúram.
	+ The information should be notated on the new Documentation Template and in MEDS and Curam.
* If the client is no longer eligible for current or equal coverage and reports needing Non-MAGI or LTC coverage during a collateral call or based on information collected during the Desk Review, the MAGI case must be ex parted and converted to Cúram to allow time for Non-MAGI/LTC to review the case.
	+ The case must be closed in MEDS and moved to Cúram using Manual Eligibility for 12 months. The Eligibility Specialist will use codes 004 and 114 to close the case in MEDS and 12 months of Manual Eligibility should be granted starting the 1st of the next month in Cúram.
	+ Create a Tracking Form for the appropriate claim type (Non-MAGI or LTC).
	+ If the Non-MAGI/LTC Eligibility Specialist determines that the client is eligible for coverage, they must enter SC Medicaid Benefit evidence on the MAGI Cúram case to end benefits.
	+ If the Non-MAGI/LTC Eligibility Specialist determines that the client is ineligible for coverage, or the client does not respond to the requested information, the case must be sent back to MAGI to have the coverage reduced or end dated following adverse action rules.
1. Complete notes in both SORs, update the new Documentation Template, notate all documents and information used to complete the desk review, close any tasks, and disposition any tracking forms accordingly (if needed).
2. Disposition in WLP.

702.02.03 Guidelines for Completing Non-MAGI and LTC Reviews

(Rev. 08/01/23)

Beneficiaries whose eligibility cannot be determined by the ex parte process will receive a review form. When a signed review form is received, process the review using the information on the Review Form, in the System of Record (SOR), and in OnBase. The eligibility specialist must compare the reported income to current electronic data sources and/or other verifications on file. Check for discrepancies between what is reported on the Review Form and what is currently in the file to determine what other verifications may be needed. **If the beneficiary remains eligible**, the review is completed using this information in accordance with applicable policies and procedures. For information on Disability Determinations please refer to MPPM 102.06 and Section 1.05 in the CGIS Procedural Manual.

**Reminder**

Individuals who will continue to be eligible will be converted from MEDS to CGIS. Refer to the **Move Active and Pending Budget Groups in MEDS to CGIS** Job Aid for further guidance.

**Review Forms Received Prior to the Review Date Assigned in the System of Record**

When a paper or online Annual Review form is submitted prior to the Annual Case Review Event, Eligibility Specialist must treat the Review form as a change of circumstance (CoC). If the system indicates the review process has begun and a form has been sent to the beneficiary or authorized representative, treat the signed paper or online Review form as the Annual Case Review Event document. Then, if the form sent by the system is returned, treat the system-generated form as a change of circumstance (CoC).

Depending on the SOR, follow the appropriate procedure below.

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| Procedure Box MEDS 1. Receive Review
	1. Check for signature; if unsigned, refer to MPPM 702.02.05.
2. End-date any existing Documentation Templates and start a new Documentation Template.
3. Document non-financial and income information. Refer to MPPM 702.02.03A, Income Verification.
4. Complete the Budget Workbook using the income to determine if they will remain eligible.
	1. If not eligible for any other category, close in MEDS.
	2. If pending for LTC, follow the Deferred Conversion of Cases in MEDS with Pending LTC Application Procedures.
	3. If eligible, continue processing review.
5. Document resources that are currently verified in the record. Refer to MPPM 702.02.03B, Resource Verification.
6. Complete conversion wizard. Refer to Move Active and Pending Budget Groups in MEDS to CGIS Job Aid
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| Deferred Conversion of Cases in MEDS with Pending LTC Application Procedures*\*We will defer the conversion from MEDS to CGIS for all cases with pending LTC budget groups in MEDS until LTC is ready for determination.*Active in MEDS with pending LTC budget group:1. Using manual workbook, review for continued eligibility
	1. If continue to be eligible in ABD/Non-MAGI
		1. Process review in MEDS; leave current eligibility in MEDS until eligibility in pending LTC BG can be determined
	2. If no longer eligible in current category
		1. Determine if eligible in another category using the Ex Parte guidelines
		2. Enter current income information, Mod income information, Make decision, but do NOT Act on Decision; leave in soft closure in MEDS until eligibility in pending LTC BG can be determined
		3. Disposition Review Tracking Form (only)
2. LTC Eligibility Specialist will determine eligibility for LTC
	1. If eligible, the Eligibility Specialist will close the current category in MEDS and approve the LTC in MEDS
		1. If SLMB or QI eligible, the worker will have to backdate the end date to ensure they align with LTC eligibility dates
		2. Put in finish later to convert the following day
3. The following day, the Eligibility Specialist will Close the MEDS LTC case and convert to CGIS using the Conversion Wizard
	1. Authorize all programs; check all dates for eligibility
	2. Disposition Application Tracking Form
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| Procedure Box Cúram1. Receive Review
	1. Check for signature; if unsigned, refer to MPPM 702.02.05.
2. End date any existing Documentation Templates and start a new Documentation Template.
3. Document non-financial, income, and resource information.
	1. Refer to MPPM 702.02.03A, Income Verification.
	2. Refer to MPPM 702.02.03B, Resource Verification.
4. Update evidence in Cúram and complete the review. Refer to Move Active and Pending Budget Groups in MEDS to CGIS Job Aid
5. Use the following process if the member is no longer eligible for coverage in their current Non-MAGI coverage category (e.g., income now exceeds the limit) and the beneficiary is not eligible in another full benefit category but attests to needing LTC services
* Non-MAGI Processes
	+ A Non-MAGI review is received for processing.
	+ Non-MAGI Eligibility Specialist updates the evidence on the Income Support case.
	+ Non-MAGI Eligibility Specialist performs an Eligibility Check.
	+ Non-MAGI Eligibility Specialist applies changes.
	+ Non-MAGI Eligibility Specialist suppresses the Non-MAGI closure notice.
	+ If the need for LTC services is indicated on the review form, indicated in CGIS, or if an unprocessed DHHS Form 3401 or 3400B is on file in OnBase.
		- Non-MAGI Eligibility Specialist adds Manual Eligibility evidence for 12 months, starting the 1st of the following month, to protect the existing Non-MAGI coverage during the ex parte process.
		- Non-MAGI Eligibility Specialist performs an Eligibility Check.
		- Non-MAGI Eligibility Specialist applies changes.
		- Non-MAGI Eligibility Specialist returns to the Eligibility Check to authorize coverage for all eligible members.
		- Non-MAGI Eligibility Specialist adds an LTC/OSS service request evidence to The Dashboard.
		- Non-MAGI Eligibility Specialist completes an external BENDEX request to send the case to an LTC Eligibility Specialist.
* LTC Processes
	+ LTC Eligibility Specialist receives the task and evaluates the beneficiary for LTC coverage.
	+ LTC Eligibility Specialist makes necessary collateral calls.
		- If collateral calls are successful, complete the 3400B and the LTC script.
		- If collateral calls are unsuccessful, send appropriate packet/addendums and Request for Information (RFI) Checklist.
		- LTC Eligibility Specialist sends the Tracking Form to Follow-up.
			* If information is returned, the LTC Eligibility Specialist pulls task, updates the evidence on the Income Support Case.
			* If information is not returned, LTC Eligibility Specialist pulls task, denies LTC/OSS request, and end dates Non-MAGI Manual Eligibility evidence allowing for adverse action rules and ensures that a closure letter is sent to the beneficiary.
	+ LTC Eligibility Specialist processing the LTC coverage will end date Non-MAGI Manual Eligibility when they are able to process the LTC application.

NOTE: Manual Eligibility coverage must be end dated prior to authorizing LTC coverage.1. LTC Eligibility Specialist will suppress the Non-MAGI closure notice, ensure that a CGIS approval notice is generated and disposition any outstanding Tracking Forms or tasks.
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702.02.03A Income Verification

(Rev. 10/01/23)

Electronic Data Sources (EDS) are the primary method to verify income. Use collateral calls and request written verification if the member is not eligible for the current Medicaid category. **The following procedures are authorized for use during this annual review process following the Public Health Emergency Only.**

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| Types of Income: * SSA- Verify current amount using BENDEX - EDS
* SCRS- Verify current amount using SCRS Interface - EDS
* Railroad Retirement- Use the PHE Calculator tab in the Non-MAGI workbook to calculate the current amount if updated verification was not provided
* VA- Use the PHE Calculator tab in the Non-MAGI workbook to calculate the current amount if updated verification was not provided
* Civil Service Pension- Use the PHE Calculator tab in the Non-MAGI workbook to calculate the current amount if updated verification was not provided
* Private Pension- Use the last verified amount to process the review
* Annuity/Promissory Note/IRA- use last verified amount
* Wages/Earned Income- Use ESC/PSC. For DDSN, use the last verified amount - EDS
* Self-Employment- Request or Use the most recently filed tax return
* Alimony/Child Support- Use the most recent verified amount
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| Income Verification Procedures Use the current income to determine eligibility. Use electronic sources to verify current income.* If the review form does not include income that was used in the last budget, use the last verified amount. If budgeting the last verified amount along with all other income makes them ineligible or eligible for a lesser PCAT, the income must be verified using normal procedures.
	+ Look at the beneficiary’s response to the income questions on the review form, the income verified in the record, and the EDS response in PCS and other sources.
		- If the member reports income on the review, determine if that income is above or below the FPL for the Medicaid category.
			* If the reported income is above, attempt to ex parte into another PCAT. Refer to MPPM 101.08.06. If the member is not eligible for any other coverage group, then end the coverage.
			* If the reported income is less than or equal to the FPL, compare it to the EDS.
				+ If the EDS is less than or equal to the income limit for the category, then budget the attested income and complete the review.
				+ If the EDS shows income over the limit, request additional information from the member.

If the member did not report income on the review form, check the case record for previously reported income used in the prior decision and use the same process defined in Verifying Income Less Than 100% FPL with no Electronic Data Source. Verifying Income Less Than 100% FPL with no Electronic Data Source* If EDS does not return a response, the existing income evidence may be used.
	+ If the verified income recorded in the case is less than or equal to 100% FPL (refer to MPPM 103.06) for the household size, including self-employment, and:
		- was verified on or after March 2019 and
		- there is no Electronic Data Source

use the existing income evidence in the SOR to budget the case and complete the review. Do not request additional income verification if continued eligibility is established. * + If the verified income is greater than 100% FPL and there is no EDS, request information from the beneficiary.
	+ If the EDS is over the income limit, request income verification from the beneficiary.

NOTEIf the income was verified before March 2019, request verification from the beneficiary.* + If beneficiary contact is necessary, attempt to contact the beneficiary/AR by phone first. If the phone contact is unsuccessful, send DHHS Form 1233 and allow 15 days to return the needed information. Send to Follow-Up for 17 days in OnBase.

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| BudgetingFor ABD beneficiaries only, if budgeting the current SSA income results in the member being ineligible in the current category or eligible in a lower category, check if the COLA disregard is applied correctly (MPPM 303.06.03A). Review the determination after performing Check Eligibility. If the decision does not appear consistent with the expected result of an applied COLA disregard, the eligibility specialist should check to ensure that all evidence was entered correctly. The eligibility specialist may also complete a manual workbook to verify the determination. |

702.02.03B Resource Verification

(Rev. 08/01/23)

Changes and Increases to resources will not be considered during the PHE Unwinding Review process.

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| Documenting Resources While resource changes and increases will not be considered during the PHE Unwinding Review Process, previously verified resource information will be documented and used for the conversion from MEDS to CGIS.1. Research the record for all verified resources
2. Document the resource details on the Documentation Template, using the last verified amount(s)
3. If the review form does not include resources that were used in the last budget, use the last verified amounts.
4. Create the appropriate pieces of evidence in Cúram
	1. Converting from MEDS to Cúram—use the Conversion Wizard
	2. Cúram—update evidences
5. If upon entering the evidences, it is discovered at Review, that the current eligibility was determined incorrectly, due to improper treatment/consideration of resources:
	1. Manual Eligibility may be required to establish continuing eligibility in CGIS
	2. Reach out to the beneficiary, initially through a collateral call, to see if there have been any changes in the excess resource(s)
		1. Send a DHHS Form 1233, explaining the excess resources issue and options available for reducing those resources (such as spend-down procedures) to comply with policy
		2. Do NOT send to follow-up or create a Tracking Form; resources will be evaluated at next review.
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| Newly Reported Resources* ALL Resource information must be documented on the new Documentation Template
* If the review form attests to resources not previously known
	+ Document the resource information on the Documentation Template
	+ Complete the review process using only the verified resources on file
* All resources, including newly reported resources, will be assessed at next review.
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| Spousal Resource Allocation-CGISDuring the Post PHE Unwinding Review process, the spousal resource allocation will not be reviewed. If the system attempts to close a case due to the spousal resource allocation, manual eligibility must be established. The spousal resource allocation will be reassessed at the next review or change of circumstance (CoC).Spousal Resource Allocation-MEDS to CGISMEDS cases with spousal resource allocations will be converted to CGIS, even if no evidence has been provided that the resources were transferred to the spouse. Allow the system to grant the spousal allocation. A reassessment will be done at the next review or change of circumstance (CoC). If evidence exists in the case record that the resources were transferred to the spouse, enter the ownership as appropriate during the conversion process and make the appropriate eligibility determination.  |

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| LTC Procedures* If there is a reported resource transfer on the review form, evaluate for a penalty.
* See Resource Transfer Procedures for special instruction and examples for applying sanctions during the PHE Unwinding Review period.
* Refer to Resource Transfer Policy MPPM 304.09
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| Resource Transfer Procedures

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| Existing Nursing Home Eligibility* If a penalty period began during the PHE and at review the sanction period has not expired, impose a penalty for the remaining period after providing the appropriate advance notice
* A transfer of resource assessment will NOT be conducted as part of this review process unless a transfer of resources is attested to on the received Review Form
* If a beneficiary attests to a transfer of resources on the review
	+ Verify the details of the transfer (property search, deeds, AVS, etc.)
	+ Determine if any exceptions are met prior to imposing a penalty. For Nursing Home eligibility, if the penalty is imposed, undue hardship can be requested
	+ If the transfer is sanctionable, calculate the Resource Transfer penalty period and determine the start and end dates
		- If the transfer start date occurred during the PHE
			* Start penalty the first day of the month in which the asset was transferred
			* The penalty period occurring PRIOR to April 1, 2023, will not be imposed.
			* Any remaining penalty period, extending from April 1, 2023, will be imposed, following the 15-day adverse action notice to the beneficiary
			* Any transfer of resources occurring on or after April 1, 2023, should be processed per instruction in MPPM 304.09

Example 1 A known transfer sanction is in place, but not imposed due to PHE* The beneficiary had a transfer of Homestead Property, with a FMV of $125,000, for $5.00 Love and Affection
* Review is being processed August 10, 2023
* Transfer was reported and assessed for sanction during the PHE
* Transfer penalty is already in place, but not being imposed due to PHE
* The penalty period was determined to be from 08/01/2022 through 10/06/2023
* Remaining sanction will be imposed
* The vendor payment termination date will be on the 16th day from the current date through 10/06/2023
* No overpayment summary needed

Example 2Transfer occurred during the PHE period/ Penalty period has expired* The beneficiary attests to a transfer of Homestead Property on the review, with a FMV of $125,000, for $5.00 Love and Affection
* Date of transfer was August 3. 2020.
* The effective date of the transfer would be 08/01/2020 for $124,995.00
* The penalty period would be from 08/01/2020 through 10/06/2021
* As the penalty period has expired, we would not impose the penalty and no overpayment summary would be required

 Example 3Transfer occurred during the PHE period/ Penalty period has not yet expired based on the current processing month* The beneficiary attests to a transfer of Homestead Property on the review, with a FMV of $125,000, for $5.00 Love and Affection
* Date of the transfer was November 1. 2022
* The effective date of the transfer would be 11/01/2022 for $124,995.00
* The penalty period would be from 11/01/2022 through 01/06/2024
* The penalty period dates prior to April 1, 2023, will not be imposed
* The remaining penalty period between April 1, 2023, through January 6, 2024, will be imposed
* The start date of the vendor payment termination date will be on the 16th day from the current date. Do not use the 1st of the month
* No overpayment summary will be required for the period prior to April 1,2023
* An overpayment summary should be completed for the period between April 1, 2023, and the first day of the month of the end date for the vendor payment

 Example 4Transfer occurred AFTER April 1, 2023/ Full Penalty period will be imposed* The beneficiary attests to a transfer of Homestead Property on the review, with a FMV of $125,000, for $5.00 Love and Affection
* Review is being processed September 10, 2023
* Date of transfer was July 12, 2023
* The effective date of the transfer would be 07/1/2023 for $124,995.00
* The penalty period would be from 07/01/2023 through 09/04/2024
* The start date of the vendor payment termination date will be on the 16th day from the current date. Do not use the 1st of the month
* The overpayment period would begin effective 07/01/2023 through the first day of the month of the end date for the vendor payment
* The following forms must be completed
	+ DHHS Form 3251 ME Notice of Proposed Action,
	+ DHHS Form 928 Notice of Overpayment and
	+ DHHS Form 3252 Overpayment of Medicaid Benefits
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| Existing Waiver eligibility* Calculate the Resource Transfer penalty period, including the start and end dates
	+ If the transfer start date occurred during the PHE
		- Start penalty the first day of the month in which the asset was transferred
		- The penalty period occurring PRIOR to April 1, 2023, will not be imposed.
		- Any remaining penalty period, extending from April 1, 2023, will be imposed, following the 15-day adverse action notice to the beneficiary
		- End eligibility after adverse action notification. Do not create an overpayment summary.
	+ If the transfer start date occurred on or after April 1, 2023, process the transfer per instruction in MPPM 304.09
* Eligibility specialists should determine if any exceptions are met prior to imposing a penalty.

Example 1Transfer occurred during the PHE period/ Penalty period has expired* Member is actively enrolled in a waiver
* The beneficiary attests to a transfer of Homestead Property, with a FMV of $125,000, for $5.00 Love and Affection
* Date of transfer was August 3. 2020.
* The effective date of the transfer would be 08/01/2020 for $124,995.00.
* The penalty period would be from 08/01/2020 through 10/06/2021.
* As the penalty period has expired, we would not impose the penalty, no overpayment summary would be required and eligibility for waiver services would continue.

 Example 2Transfer occurred during the PHE period/ Penalty period has not yet expired based on the current processing month* Member is actively enrolled in a waiver
* The beneficiary attests to a transfer of Homestead Property, with a FMV of $125,000, for $5.00 Love and Affection
* Date of the transfer was November 1. 2022.
* The effective date of the transfer would be 11/01/2022 for $124,995.00.
* The penalty period would be from 11/01/2022 through 01/06/2024
* The penalty period extends past the PHE uncoupling date of April 1, 2023,
	+ The remaining penalty period between April 1, 2023, through January 6, 2024, will be imposed
	+ Eligibility for waiver services will end the first day of the month following the 15-day adverse action notice to the beneficiary.
	+ Eligibility Specialist will need to notify CLTC to end the waiver services; see MPPM 304.09.02
* No overpayment summary will be required for the period prior to April 1,2023.
* An overpayment summary should be completed for the period between April 1, 2023, and the first day of the month of the end date for the waiver services.

Example 3Transfer occurred AFTER April 1, 2023/ Full Penalty period will be imposed* Member is actively enrolled in a waiver
* Review is being processed September 10, 2023
* The beneficiary attests to a transfer of Homestead Property on the review, with a FMV of $125,000, for $5.00 Love and Affection
* Date of transfer was July 12, 2023.
* The effective date of the transfer would be 07/1/2023 for $124,995.00.
* The penalty period would be from 07/01/2023 through 09/04/2024
* Waiver eligibility should be terminated effective the first day of the month following the 15-day adverse action notice to the beneficiary.
* A DHHS Form 3252, Overpayment of Medicaid Benefits, must be completed for 07/01/2023 through 09/30/2023
* Eligibility would be terminated effective October 1, 2023
* Eligibility Specialist will need to notify CLTC to end waiver services; see MPPM 304.09.02
* Check system to make sure all of the appropriate notices were created
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| CGIS Procedure-MEDS Conversion with Resource Transfer (Newly Reported)For new transfers reported during the review, the start date of the vendor payment termination date will be on the 16th day from the current date. Use the conversion process to move cases from MEDS to CGIS. Enter the Resource Transfer Penalty on the Income Support Application created via the Conversion Wizard. Use the manual workbook to calculate the Ineligibility Period start date and end date based on the actual transfer date. Use the dates from the Manual workbook to edit the system-generated ineligibility period start and end date, save the new Ineligibility Period, and check eligibility.CGIS Procedure-MEDS Conversion with Resource Transfer (Previously Assessed)For transfers that were previously implemented in MEDS, the start date of the sanction will be the current date. Use the conversion process to move cases from MEDS to CGIS. Do not enter the Resource Transfer Penalty on the Income Support Application created via the Conversion Wizard. Authorize the coverage on the Income Support Application. Then navigate to the Income Support Case to add a manual Sanction. Use the dates from the original workbook. (i.e. If the original transfer date is 5/1/2022 to 9/25/2023. The manual sanction start date is 5/1/2022 and the end date is 9/25/2023.)Note: The sanction recommendation is in the Compliance Tab. The Resource Transfer evidence must be entered using the date of the transfer.Note: This must be done on the same day as the coverage authorization in CGIS and closure in MEDS.Note: This procedure only applies to cases that are in Review. New applications must be processed as per instructed in MPPM 304.09CGIS Procedure- Existing CGIS Coverage For cases already in CGIS, the LTC OSS Service Request must be entered for the 1st day of the month that the transfer occurred. Follow current instructions for processing resource transfer penalty from the Income Support Case. From the Sanction Recommendation screen, ensure that the date is correct based on the actual month that the transfer occurred. Save the New Sanction.* For new transfers reported during the review, the start date of the vendor payment termination date will be on the 16th day from the current date. Do not use the 1st of the month.
* For transfers that were previously implemented in CGIS, no additional actions should be needed. Ensure that the transfer penalty is still in effect when the eligibility check is performed.

Note: Waiver cases will lose Medicaid coverage effective on the 16th day following the 15-day Adverse Action Notice.  |

702.02.04 Non-MAGI and Long-Term Care Desk Review Process

(Rev. 12/01/23)

The Non-MAGI and Long-Term Care Desk Review procedures are used as part of the PHE Unwinding to process Non-MAGI and Long-Term Care Reviews that have not been returned. In some instances when the Annual Review Form has not been returned, signed, and completed by the beneficiary or authorized representative and the due date has completely expired, a desk review will be required. The system will determine when a desk review will be required, and a Workload Pro task will be generated. During the desk review, eligibility specialists must use the ex parte process to make an eligibility determination in the current category or any category for which the beneficiary may be eligible.

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NOTE: If the Annual Review Form is returned on time, the Annual Review Form will be scanned into OnBase, and a task will be generated in Workload Pro. The Eligibility Specialists will follow the Policy and procedures for processing an Annual Review Form during the PHE unwinding when the case is retrieved.

A case is served in Workload Pro to place the case in front of an Eligibility Specialist. The Specialist should:

* Pull case and review any tasks in Workload Pro (WLP)
* Locate household in OnBase and SOR
* Verify system of record for the primary via MMIS (MEDS or CGIS (State))
* Review any recent documentation templates, documents, and case record
* Search for the primary individual in SOR. Take note of current coverage under their eligibility screens
* End date any active Documentation Templates and create a new Documentation Template for the Desk Review

The Eligibility Specialist must use the ex parte process from MPPM 101.08.06 to determine eligibility in the current category or any other category for which the beneficiary may qualify.

Desk Review Process

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| MEDS Desk Review Process* Locate the person in MEDS
* Select the person and F11 to the Recipient Information Screen
* Select F2 to the Household Budget Groups Screen
* Select an open BG, and SHIFT F5 (PF17) to the Medicaid Eligibility Decision Screen (MEDELD00)
* F3 forward to the MEDELD01 Screen
* The Next Review Date will be listed on the right side of the Screen
* Check MEDS and the Next Review Date (NRD) that is listed on the MEDELD01 Screen to confirm the time has expired for the clients to return their review form.

Note: The user must either upload a copy of the MEDELD01 screen or a snippet of the WLP task to OnBase as Member Verification to confirm the NRD has passed, and a Desk Review is being completed.* Review the case record
* Do not conduct new searches for resources. Increases in resources will not be assessed in the determination process
* Obtain updated income verifications from the available databases, interfaces, and/or electronic sources and document on the Documentation Template
	+ If the previously verified income is stable, such as annuities and pensions that are not likely to change, use the last verified amount for income. If SCDHHS is aware that income receives a guaranteed annual increase (i.e., Railroad Retirement, SC State Retirement, Civil Service, and VA Benefits), use the PHE Calculator tab in the Non-MAGI workbook to determine the increase in Income.
		- If previous COLA increases need to be considered, use the appropriate COLA workbooks to determine the amount to be entered on the PHE Calculator tab of the current workbook.
* Collect and document on the new Documentation Template the information available in the case history for previous resources
	+ During the conversion process, the resources and their last verified values need to be added into CGIS
	+ New resources will not be added in CGIS. Record on the Documentation template and verify at the next annual review
* Make a collateral call to attempt to obtain any additional missing income information and to clarify any discrepancies
	+ Is additional information still needed?

NO* + - Complete a Non-MAGI workbook (most recent version) to determine continued eligibility.
		- If they will continue to be eligible in the current category, use the Move Active and Pending Budget Groups in MEDS to CGIS Job Aid to convert the case to CGIS
		- If they are NOT eligible in the original category, use the ex parte process from MPPM 101.08.06 to determine eligibility for any other category for which the beneficiary may qualify. If potentially eligible in another category, use the Move Active and Pending Budget Groups in MEDS to CGIS Job Aid to convert the case to CGIS
		- If they are NOT eligible in any category, see MEDS Closure Process for instruction

YES* + - Send DHHS Form 1233 requesting the additional information allowing 15 days for a response. Send the case to Follow-Up for 17 days in OnBase.
		- If additional information is not returned for a case active in MEDS, close the case in MEDS using Reason Code 014; see MEDS Closure Process for instructions.

NOTE: For ABD beneficiaries only, if budgeting the current SSA income results in the member being ineligible in the current category or eligible in a lower category, check if the COLA disregard is applied correctly (MPPM 303.06.03A). |

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| MEDS Closure ProcessIf they continue to be eligible in another category:* Use the Move Active and Pending Budget Groups in MEDS to CGIS Job Aid to convert the case to CGIS

If NOT eligible in any other category:* Locate the person in MEDS
* Select the person and F11 to the Recipient Information Screen
* Select F2 to the Household Budget Groups Screen
* Select an open BG, and SHIFT F5 (PF17) to the Medicaid Eligibility Decision Screen (MEDELD00)
* F3 to the MEDELD01 screen and update the screen with the current income. Set the Next Review Date to one year from the current date and MOD the screen, then shift + F3 to Make Decision
* If the income is over the limit, the system should display reason 051- Your income is more than policy allows.
* If this reason code does not generate, enter 051 under REASON(S) FOR DENIAL/CLOSURE/CHANGE:
	+ Enter MOD in the ACTION: field and hit Enter
	+ Select F3 to MEDELD02 screen
	+ Review the dates and make any corrections, if necessary
	+ Set the Ex Parte indicator to “N” on each Member’s MEDELD02 Screen
	+ Select Shift + F12 to Act on Decision
* If closure is due to Failure to Return Information, close the case in MEDS using Reason Code 014
	+ Enter MOD in the ACTION: field and hit Enter
	+ Select F3 to MEDELD02 screen
	+ Review the dates and make any corrections, if necessary
	+ Set the Ex Parte indicator to “N” on each Member’s MEDELD02 Screen
	+ Select Shift + F12 to Act on Decision
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| CGIS Desk Review Process* Review the case record
* Do not conduct new searches for resources. Increases in resources will not be assessed in the determination process
* Obtain updated income verifications from the available databases, interfaces, and/or electronic sources and document on the Documentation Template
	+ If the previously verified income is stable, use the last verified amount for income such as annuities and pensions that are not likely to change. If SCDHHS is aware that income receives a guaranteed annual increase (i.e., Railroad Retirement, SC State Retirement, Civil Service, and VA Benefits), use the PHE Calculator tab in the Non-MAGI workbook to calculate determine the increase in Income.
* Collect and document on the new Documentation Template the information available in the case history for previous resources
	+ During the conversion process, the resources and their last verified values need to be added into CGIS
	+ New resources will not be added in CGIS. Record on the Documentation template and verify at the next annual review
* Make a collateral call to attempt to obtain any additional information and to clarify any discrepancies
	+ Is additional information still needed?

NO* + - Complete an Eligibility Check
		- Use the [Annual\_Case\_Review\_ACR\_JA.pdf](https://schhs.sharepoint.com/%3Ab%3A/r/sites/EES/Training/Curam/CGIS/Job%20Aids/Annual_Case_Review_ACR_JA.pdf?csf=1&web=1&e=vqbYPQ)

YES* + - Send DHHS Form 1233 or RFI requesting the additional information, allowing 15 days for a response. A system generated RFI will send the case to Follow-Up for 21 days. A DHHS Form 1233 sent manually by an eligibility specialist will require a Manual Tracking Form. Set the follow-up date for 17 days in OnBase.
			* If additional information is not returned for a case active in CGIS, use the Product Delivery Case (PDC) Programs, Decisions, and PDC Actions Job Aid
			* CLOSE A PDC
				+ Navigate to the Income Support Case
				+ Click the Home tab
				+ Click the PDC Reference hyperlink
				+ Click the Page Actions button and select the Close Case option
				+ Edit the following information in the Close Case pop-up, if applicable:
				+ Closure Date: Enter the last date of the month the case is closing
				+ Actual Outcome: Leave the default
				+ Reason: Select Reason: Certification Grace Period Exceeded
				+ Comments: Enter a comment: Checklist items not returned
				+ Click the Save button
* Complete notes in both SORs, update the new Documentation Template, ensure notation of all documents and information used to complete the desk review, close any tasks, and Tracking Forms accordingly (if needed). Disposition in WLP.

NOTE: If a system-generated notice is created, suppress the notice and create an ELD085. The notice must contain the reason for closure referencing Manual Section 702.02 |

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| Continuing Disability Review Process For cases active in MEDS, if the beneficiary is financially eligible and a Continuing Disability Review is needed, the Eligibility Specialist must convert and authorize the case in CGIS using the most recent MAO99, including the diary date. Even if the diary date is in the past, the system will allow the case to be approved.* After the review is completed, a DHHS Form 1233 must be sent to the beneficiary with the Continuing Disability Review packet following the steps in MPPM 102.06.02F
* Create a Tracking Form and send the case to Follow-up.
	+ If the Continuing Disability Review packet is returned, continue the process in MPPM 102.06.02F.
	+ If they fail to return the CDR, close the case for Failure to Return
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Non-MAGI Considerations

* Only the information available in the case history in OnBase, CGIS, and Phoenix will be used to process the case
* Determine if the beneficiary is requesting additional coverage (i.e., unprocessed DHHS Form 3400-A, DHHS Form 3400-B, or DHHS Form 3401 on file)
	+ If the beneficiary is requesting additional coverage, and will continue to be eligible for ABD coverage, complete the ABD Review in the current SOR. The LTC Eligibility Specialists will move any MEDS coverage to CGIS once the LTC determination is made.
	+ If the beneficiary is requesting additional coverage, do not terminate the coverage if they no longer qualify until a decision is determined for the new requested coverage.

MEDS

* The LTC Eligibility Specialist will complete the Manual Conversion, Authorize the ABD coverage and dispose of the Application
* Add the LTC OSS Service Request to the Income Support Case
	+ Refer to the [Move Active and(or) Pending Budget Groups in MEDS to CGIS Past PHE Job Aid](https://schhs.sharepoint.com/sites/EES/Training/Forms/AllItems.aspx?OR=Teams%2DHL&CT=1689017251553&clickparams=eyJBcHBOYW1lIjoiVGVhbXMtRGVza3RvcCIsIkFwcFZlcnNpb24iOiIyNy8yMzA2MDQwMTEzOCIsIkhhc0ZlZGVyYXRlZFVzZXIiOmZhbHNlfQ%3D%3D&id=%2Fsites%2FEES%2FTraining%2FCuram%2FCGIS%2FJob%20Aids%2FMove%5FActive%20and%5For%5FPending%5FBudget%5FGroups%5Fin%5FMEDS%5Fto%20CGIS%2Epdf&viewid=011298ae%2Dbf47%2D449d%2Dbd39%2Dd6017101a69c&parent=%2Fsites%2FEES%2FTraining%2FCuram%2FCGIS%2FJob%20Aids)

CGIS

* Follow the Annual Review Job Aid to complete the Review in the CGIS
* Add the LTC OSS Service Request to the Income Support
* If the beneficiary is requesting additional coverage (i.e., unprocessed DHHS Form 3400-A, DHHS Form 3400-B, or DHHS Form 3401 on file), do not terminate the coverage if they no longer qualify until a decision is determined for the new requested coverage.
	+ If the beneficiary is in CGIS and Non-MAGI coverage is expected to end at review, use Manual Eligibility to authorize the Non-MAGI coverage
	+ Add the LTC OSS Service Request to the Income Support Case.
		- If a Tracking Form exists for the LTC Request, no further action is required.
		- If there is no active Tracking Form for the LTC request, create an LTC Tracking Form and place the case in Follow-up for two days.
* If the beneficiary is in CGIS, maintain eligibility in their current category and do not close the PDC. If the system will not allow the beneficiary to remain eligible in the current category, use Manual Eligibility to continue coverage. Add the LTC OSS Service Request evidence in CGIS if it does not already exist.
* No new property and resources searches will be conducted unless additional/higher coverage is requested.

Example 1

The applicant is ABD active and no longer meets the financial requirements. There is a DHHS Form 3400-A on file, and the beneficiary does qualify for SLMB coverage. Terminate the ABD coverage and authorize the SLMB coverage. No new resources are required.

Example 2

The applicant is currently SLMB active and based on the Electronic Data Sources (EDS), is no longer financially eligible. An unprocessed DHHS Form 3400-B is on file requesting LTC. Updated income and resources are required before coverage in the new category can be authorized. Do not terminate the SLMB coverage until the LTC coverage can be accurately processed.

Example 3

The applicant is ABD active and no longer meets the financial requirements. There is a DHHS Form 3400-A on file requesting OSS, and the beneficiary does not qualify for SLMB coverage using standard practices. The case needs to be processed by the Specialty Unit for OSS coverage. Leave the ABD active until an OSS determination can be made. The specialty unit will terminate the ABD coverage once a decision is made on the OSS coverage.

LTC Considerations

* Only the information available in the case history in OnBase, CGIS, and Phoenix will be used to process the case.
* No new property and resource searches will be conducted. However, a look-back must be conducted in the case record
* Transfers will only be assessed if reported by the beneficiary or previously discovered/reported during the PHE.
	+ Refer to MPPM 702.02.03B for instructions.
* Process any outstanding DHHS Form 181s located in OnBase. The DHHS Form 181 must be completed for authorizations and denials.
* If the applicant’s income exceeds the Income cap and an Income Trust is needed, a DHHS Form 1233 along with the Income Trust packet must be sent to the beneficiary and any Authorized Representative for completion.
* If the Income Trust packet is not returned, the case must be closed for not returning the requested information.

MEDS

* Complete the Manual Conversion, Authorize the ABD coverage and dispose the Application
* Add the LTC OSS Service Request to the Income Support Case and complete an External BENDEX Request

CGIS

* Follow the Annual Review Job Aid to complete the Review in the CGIS
* Add the LTC OSS Service Request to the Income Support
* If the beneficiary is requesting additional coverage (i.e., unprocessed DHHS Form 3400-A, DHHS Form 3400-B, or DHHS Form 3401 on file), do not terminate the coverage if they no longer qualify until a decision is determined for the new requested coverage.

MEDS

* + Refer to the [Move Active and(or) Pending Budget Groups in MEDS to CGIS Past PHE Job Aid](https://schhs.sharepoint.com/sites/EES/Training/Forms/AllItems.aspx?OR=Teams%2DHL&CT=1689017251553&clickparams=eyJBcHBOYW1lIjoiVGVhbXMtRGVza3RvcCIsIkFwcFZlcnNpb24iOiIyNy8yMzA2MDQwMTEzOCIsIkhhc0ZlZGVyYXRlZFVzZXIiOmZhbHNlfQ%3D%3D&id=%2Fsites%2FEES%2FTraining%2FCuram%2FCGIS%2FJob%20Aids%2FMove%5FActive%20and%5For%5FPending%5FBudget%5FGroups%5Fin%5FMEDS%5Fto%20CGIS%2Epdf&viewid=011298ae%2Dbf47%2D449d%2Dbd39%2Dd6017101a69c&parent=%2Fsites%2FEES%2FTraining%2FCuram%2FCGIS%2FJob%20Aids)

CGIS

* + If the beneficiary is in CGIS, use Manual eligibility to authorize the Non-MAGI coverage
	+ Add the LTC OSS Service Request to the Income Support Case and complete an External BENDEX Request
		- If a tracking form exists for the LTC Request no further action is required.
		- If there is no active tracking Form for the LTC request, create a LTC Tracking Form and place the case in Follow-up for two days.
* If the beneficiary is in CGIS, maintain eligibility in their current category and do not close the PDC. If the system will not allow the beneficiary to remain eligible in the current category, use Manual Eligibility to continue coverage. Add the LTC OSS Service Request evidence in CGIS if it does not already exist.
* No new property and resources searches will be conducted unless additional/higher coverage is requested.

Example 1

The applicant is ABD active and no longer meets the financial requirements. There is a DHHS Form 3400-A on file, and the beneficiary does qualify for SLMB coverage. Terminate the ABD coverage and authorize the SLMB coverage. No new resources are required.

Example 2

The applicant is currently SLMB active and based on the Electronic Data Sources (EDS), is no longer finically eligible. An unprocessed DHHS Form 3400-B is on file requesting LTC. Updated income and resources are required before coverage in the new category can be authorized. Do not terminate the SLMB coverage until the LTC coverage can be accurately processed.

Example 3

The applicant is ABD active and no longer meets the financial requirements. There is a DHHS Form 3400-A on file requesting OSS, and the beneficiary does not qualify for SLMB coverage using standard practices. The case needs to be processed by the Specialty Unit for OSS coverage. Leave the ABD active until an OSS determination can be made. The specialty unit will terminate the ABD coverage once a decision is made on the OSS coverage.

LTC Considerations

* Only the information available in the case history in OnBase, CGIS, and Phoenix will be used to process the case.
* No new property and resource searches will be conducted unless the applicant has a DHHS Form 3400-B requesting additional coverage. (For example: General Hospital to NH or Waiver or OSS to NH or Waiver)
* Transfers will only be assessed if reported by the beneficiary or previously discovered/reported during the PHE
	+ Refer to MPPM 702.02.03B for instructions
* Process any outstanding DHHS Form 181s located in OnBase. The DHHS Form 181 must be completed for authorizations and denials.
* If the applicant’s income exceeds the Income cap and an Income Trust is needed, a DHHS Form 1233 along with the Income Trust packet must be sent to the beneficiary and any Authorized Representative for completion.
* If the Income Trust packet is not returned, the case must be closed for not returning the requested information.

702.02.05 Unsigned Review Form

(Rev. 08/01/23)

All Annual Review forms require a signature. For specific instructions regarding acceptable signatures, see MPPM 101.03.04 Signature Requirements. If a review form is returned unsigned, we will treat it similarly to how we treat an unsigned application (MPPM 101.03.04C).

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| Procedures1. Check the Annual Review Form for a signature.
2. If the Review Form is unsigned, attempt a collateral call to obtain a verbal signature.
	1. If the primary person is reached, use the Unsigned Review script located in MPPM 702.02.06
		1. Explain that the Review was not signed, and it is necessary to get a signature. We can get a verbal signature to satisfy the requirement.
		2. Using the [DHHS Form 3403](http://medsweb.scdhhs.gov/EligibilityForms/Form3403_IntakeInterview_RightsAndResponsibilities.pdf), Your Rights and Responsibilities, read the penalty of perjury statement to the individual. It is not necessary to read the rights and responsibilities to the individual unless requested.
		3. On the DHHS Form 3403, document the following:
			1. The name of the person who agrees to the R&R
			2. The date and time
			3. The staff member completed the call
		4. Document the verbal signature on the documentation template and in the System of Record (SOR). Use the following format:

Verbal Signature of <<Beneficiary/Authorized Representative>> obtained by <<User ID>> on <<Date>> at <<Time>>* + 1. Mark the review as received in the SOR.
		2. Mail a copy of the DHHS Form 3403 to the beneficiary.
		3. Upload the completed DHHS Form 3403 into OnBase
	1. If the Beneficiary or Authorized Representative is not reached
		1. Return the Review Form to the beneficiary. Include a copy of the [Unsigned Review Form](http://medsweb.scdhhs.gov/EligibilityForms/Unsigned_Review_Cover_Letter.pdf) letter. DO NOT include a DHHS Form 3403
		2. DO NOT mark the review as received in the SOR
			1. If the review status has been updated Review Received, change the status back to Review Sent
		3. Record on the Documentation Template that the review was received unsigned and that the review was returned to the beneficiary.
 |

702.02.06 Unsigned Review Form Script

(Rev. 06/01/23)

During the collateral call with the beneficiary or authorized representative to obtain the electronic signature, use the following script:

| Step | Script | Action |
| --- | --- | --- |
| Review Received |  | Check the last page of the Review to determine if the review has been signed. |
| Call |  | Make a call using the contact information on the review or in the case file. If a person answers the call, go to [Introduction](#Intro).If you get voice mail, go to [Call Back Message](#Call_Back_Message).If there is no answer, make a call to the authorized representative if there is one. If not able to contact anyone, return the review with the cover letter.  |
| Call Back Message | *→* Hi, this is Name with the South Carolina Department of Health and Human Services, Healthy Connections. I am calling today because someone recently contacted our agency. Since I am unable to reach anyone at this time, I will follow up with you through the mail. If you have any questions about this call, you may contact the Healthy Connections Member Services Call Center at 1-888-549-0820 and someone will be able to help you. Once again, that number is 1-888-549-0820. Thank you. | After 3-5 minutes, attempt a second call to the beneficiary. If a person answers the call, go to [Introduction](#Intro). If you reach voice mail on your second attempt, go to [Failed Contact](#Failed_Contact). |
| Failed Contact | *→* Hi, this is Name with the South Carolina Department of Health and Human Services, Healthy Connections. I am calling today because someone recently contacted our agency. Since I am unable to reach anyone at this time, I will follow up with you through the mail. If you have any questions about this call, you may contact the Healthy Connections Member Services Call Center at 1-888-549-0820 and someone will be able to help you. Once again, that number is 1-888-549-0820. Thank you. | If person on the phone says the beneficiary/authorized representative is not available, go to [Not Available](#Not_Avail). If able to speak with the beneficiary/authorized representative, go to [Available](#Avail).If the beneficiary/authorized representative is the person on the phone, go to [Available](#Avail).  |
| Introduction  | *→* Hi, this is Name with the South Carolina Department of Health and Human Services, Healthy Connections. May I speak with Mr./Ms. Beneficiary (or Authorized Representative)? | If the person on the phone says the beneficiary/ authorized representative is not available, go to [Not Available](#Not_Avail). If able to speak with the beneficiary/authorized representative, go to [Available](#Avail).If the beneficiary/authorized representative is the person on the phone, go to [Available](#Avail).  |
| Not Available  | *→* Mr./Ms. Last Name recently contacted our agency and we need to speak with him/her to get some more information. Is there another number we can use to speak with him/her or is there another time we can call back? | Obtain the alternate contact number and/or call back time.END CALL  |
| Available  | *→* Mr./Ms. Last Name, you recently returned your review form and we need to follow up to get some additional information. I just need to first confirm that I am speaking with the correct person. | If someone other than the beneficiary answered the call, reintroduce yourself before continuing with the script.Ask for name and date of birth of the individual and match and confirm with the information on the review. Ask for additional elements such as address and the last four digits of the SSN. If confirmed, go to [Signature Script](#Interview_Script).  |
| Signature Script  | *→* We received your annual review form. However, all Annual Review Forms require a signature from the beneficiary or authorized representative. The South Carolina Department of Health and Human Services will accept a verbal signature during this phone call if the participant agrees to the terms and conditions provided in the Rights and Responsibilities. *Are you willing to complete the verbal signature process during this call?*[ ]  Yes, proceed to Rights and Responsibilities[ ]  No, proceed to End Call | Signature Script If yes, proceed to Rights and Responsibilities.If no, send the Review Form along with an Unsigned Review Letter to the Beneficiary/Authorized Representative. |
| Rights and Responsibilities | Since you have returned an Annual Review Form which listed your Rights and Responsibilities, we will not read the entire Rights and Responsibilities document in this call. SCDHHS will mail a copy of the form used to get your verbal signature. Please refer to your copy of the Rights and Responsibilities if you have any questions after this call.In the next step, I will read penalty of perjury.*By signing, I state that I have read and agree to the rights and responsibilities stated on this review. I am signing this review under penalty of perjury. This means I have provided true answers to all the* *questions on this form to the best of my knowledge. I know that if I am not truthful, there may be a penalty under federal law.*Do you agree with the statement that have been read to you in this call?☐ Yes ☐ No | If answered yes, complete DHHS Form 3403, Rights and Responsibilities, signature section as instructed in MPPM Chapter 702.02.03.If answered no or if the Beneficiary or Authorized Representative refuses to complete the process via the collateral call, send the Review Form along with an Unsigned Review Letter to the Beneficiary/Authorized Representative. |
| End Call | *Did the beneficiary or authorized Representative agree to the penalty of perjury statement?**If yes, say:* *“Thank you for providing a verbal signature for your Annual Review form. SCDHHS will continue with the annual review process. We will send you a copy of the Rights and Responsibilities showing that the agency received your verbal signature by phone. We may contact you if we need additional information.**You will receive notice once a decision is made about your eligibility.”**If no, say:**We are sorry that we were unable to obtain a verbal signature today. SCDHHS will mail the Annual Review form back to Mr./Ms. Last Name. If you wish to continue receiving services, please return the signed form back to The South Carolina Department of Health and Human Services using one of the following ways:*Apply.SCDHHS.gov Submit OnlineSelect Submit Annual Review and complete the review online.Document Upload ToolSelect the Document Upload tool under Healthy Connection Quick Tools.SCDHHS Central MailPost Office Box 100101Columbia, South Carolina 29201Fax or email the review:Fax number—888-820-1204Email address—8888201204@fax.scdhhs.gov |  |

**702.03 SSI Beneficiaries Losing Coverage after the PHE**

(Eff. 04/01/23)

SSI beneficiaries who became ineligible for SSI benefits during the Public Health Emergency (PHE) will receive an application. Eligibility specialists will receive additional instructions prior to the forms being mailed.

**702.04 Economic Impact Payments (EIPs)**

(Eff. 4/01/23)

[POMS SI 00830.620](http://policy.ssa.gov/poms.nsf/lnx/0500830620%21opendocument)

[POMS SI 01130.620](http://policy.ssa.gov/poms.nsf/lnx/0501130620%21opendocument)

The Internal Revenue Service issued first, second and third rounds of Economic Impact Payments (EIPs), also known as Recovery Rebates, authorized by Congress in the CARES Act beginning in March 2020, CAA beginning in December 2020 and ARPA beginning in March 2021.

First Round: Payment levels were up to:

* $1,200 for individuals,
* $2,400 for couples filing jointly, and an additional $500 per qualifying child.

Second Round: Payment levels were up to:

* $600 for individuals,
* $1,200 for couples filing jointly, and an additional $600 per qualifying child.

Third Round: Payment levels were up to:

* $1,400 for individuals,
* $2,800 for couples filing jointly, and an additional $1,400 per qualifying child.

MAGI Determinations

The payments are not taxable income and are therefore not countable in MAGI-based eligibility determinations.

Non-MAGI Determinations

EIPs are considered disaster assistance. Therefore, they are excluded as income in the month received and any retained funds are excluded as a resource. If excluded amounts are commingled with countable funds in an account, assume countable funds are spent first. MPPM 302.23.04

**702.05 Electronic Document Submission and Signature Requirements**

(Eff. 05/01/23)

The following policies and procedures in this section remain in effect after the end of the PHE.

702.05.01 Electronic Document Submission

(Eff. 05/11/23)

Applicants, beneficiaries, authorized representatives, and third parties providing application assistance are now encouraged to submit documents electronically to SCDHHS using the email address 8888201204@fax.scdhhs.gov.

For third parties assisting multiple individuals, a separate secure email is required for each applicant or beneficiary. The secure email must include the applicant or beneficiary’s name, phone number, date of birth, Medicaid number (if applicable), and Social Security number.

702.05.02 Electronic Signatures

(Eff. 05/11/23)

The South Carolina Department of Health and Human Services (SCDHHS) has modified the eligibility signature policy in recognition of the current challenges in obtaining physical signatures from individuals during the COVID-19 emergency response period. An applicant, or a person authorized by SCDHHS policy to apply on behalf of an individual, may “sign” an application by typing the name on the signature line and completing the “Is someone helping you fill out this application?” section of the form. This signature is valid and commits the person completing the document to the penalty of perjury if signing under false pretenses or if false or inaccurate information is provided. All current policies regarding applicant rights and responsibilities are still applicable.

702.05.03 Authorized Representatives

(Eff. 05/11/23)

If the applicant wishes to designate an Authorized Representative but is unable to sign the appropriate form (DHHS FM 1282), the form allows for an individual to sign on someone’s behalf. The reason the applicant cannot sign the form must also be entered as instructed on the form.

702.05.04 Admission and Billing Documents for Long Term Care

(Eff. 05/11/23)

The following forms are modified to allow the Eligibility Specialist to enter an electronic signature for documents sent to a provider or the OSS Program Area.

* DHHS Form 181, Notice of Admission, Authorization & Change of Status for Long Term Care, and
* DHHS Form CRCF-01, Optional State Supplementation (OSS) Slot Reservation Request & Notice of Admission, Authorization & Change of Status for Community Residential Care Facility

Use this feature when printing is not available so that documents can be sent in a timely manner. If emailing documents to a facility, be sure the documents are sent via secure email by entering “[secure]” in the subject line of your email.

**702.06 Admission and Billing Documents for Medicare Skilled Nursing Home**

(Eff. 05/11/23)

During the COVID-19 period, CMS waived Medicare requirements that skilled nursing facility (SNF) care can only be reimbursed when a beneficiary has met at least three consecutive inpatient hospital stay dates. Effective May 11, 2023, the waiver of the three-day requirement ended.

DHHS Form 181s with a SNF admission received from a NH facility during the duration of the Public Health Emergency period will not contain hospital stay dates. Facilities may/may not indicate in the comments “no hospital stay dates” on such 181s.

* For Active PCAT 10 or 33 recipients, workers should process the SNF 181 without further verification of hospital stay dates from the facilities during the emergency period.
* For Approvals of PCAT 10/33 cases, worker must reach out to the facility and/or AR to determine if the individual was in a community setting at any time during the month of admission to a nursing facility as per MPPM 304.18.02.
* For ALL Skilled Nursing Facility (SNF) 181s, with processing dates on or after May 11, 2023, hospital stay dates will be required. Refer to MPPM 304.22

702.06.01 Level of Care for Initial COVID-19 Admission

(Eff. 05/11/23)

This policy is only effective for dates of service from March 18, 2020, to May 11, 2023.

In response to a CMS waiver, SCDHHS has amended the current Level of Care (LOC) and Notice of Admission, Authorization, and Change of Status for Long Term Care, DHHS Form 181, policies as followed:

The initial Level of Care, DHHS Form 185, is completed by CLTC upon admission to the nursing facility during the COVID-19 emergency period. However, the facility will change the LOC to Medicare (Medicare Spell of Illness) for individuals who will remain in the facility under observation or quarantine due to COVID-19. When the individual needs to convert back to Medicaid, the facility must reassess if the individual meets Intermediate or Skilled LOC. The new LOC will be completed and documented by the facility on the DHHS Form 210, Resident Case Mix Classification Change. The facility will complete a Medicaid Conversion Form 181 with “COVID” or “CVD” written in the top right-hand corner or Section II under comments, indicating it to be a COVID-19 related case. An LTC eligibility specialist will process these.

**702.07 Protected Eligibility**

(Rev. 10/01/23)

Per Section 6008 (b)(3) of the Act, the State must provide that “an individual who is enrolled in benefits under such plan (or waiver) as of the date of enactment of this section or enrolls for benefits under such plan (or waiver) during the period beginning on such date of enactment and ending the last day of the month in which the emergency period described in subsection (a) ends shall be treated as eligible for such benefits through the end of the month in which such emergency period ends unless the individual requests a voluntary termination of eligibility or the individual ceases to be a resident of the State.”

Eligibility is protected for any beneficiary who is eligible for SC Medicaid in any payment category on March 18, 2020, or who became eligible on or after this date. Effective March 31, 2023, the end of the continuous enrollment condition was separated from the end of the Public Health Emergency (PHE) by the Consolidated Appropriations Act of 2023. This act allows the state to terminate the coverage of those individuals who remained Medicaid eligible due to the Public Health Emergency (PHE) effective April 1, 2023. The emergency period expired on May 11, 2023. Given this date, systematic closure mitigations and manual eligibility are to be updated to extend eligibility to 5/31/23. The beneficiary's protected period will last until there is a full case review, regardless of changes in family income or other circumstances.

This includes individuals at risk of losing eligibility due to a change in categorical eligibility (such as a child aging out or a pregnant woman at the end of her post-partum period). The beneficiary approved prior to April 1, 2023, must remain in their current payment category until there is a full case review, following the end-date (May 11, 2023) of the emergency period.

The following exceptions apply:

* The individual dies,
* The individual requests a voluntary termination of eligibility, or
* The individual is no longer a resident of the state,
* Do not close based on PARIS report during this emergency period. Only close if requested by beneficiary/AR.
* Vendor Payments can be terminated effective April 1, 2023

**702.08 Assumptive Pregnant Woman Eligibility and Deeming Infants**

(Eff. 04/01/23)

Assumptive Eligibility decision made before April 1, 2023

A woman approved assumptively for Pregnant Women coverage during the PHE period will remain eligible until her case is reviewed. A child born while the mother is assumptively approved for Pregnant Women must be deemed.

Assumptive Eligibility decision made on or after April 1, 2023

Refer to MPPM 204.02.01B.

**702.09 Manual Request for Information**

(Eff. 10/01/23)

When generating a Manual Request for Information DHHS Form 1233, the Eligibility Specialist should set the Application or Review Manual Tracking Form follow-up date for 17 days in OnBase. This policy applies for all applications and reviews processed on or after October 1, 2023. The Eligibility Specialist that generates the DHHS Form 1233 will enter 15 days for the due date and will add an additional two (2) days to the active Manual Tracking Form to allow for mailing, scanning, and task creation in Workload Pro.

**702.10 Property and Probate Search Procedures After the COVID-19 Emergency Period**

(Eff. 10/01/23)

Use the following procedures for Property and Probate searches for pending institutional application that require a 5-year look-back following the end of the COVID-19 Public Health Emergency.

|  |
| --- |
| ProcedureResearch the following* Review the application to verify where the applicant/spouse has lived in the last 5 years and if any property ownership has been alleged.
* Review the case history for any previous applications, information, and documentation to determine if property ownership was alleged and/or verified in the past.
* Research the county/counties where the applicant/spouse has lived in the last 5 years to determine if a deed search is accessible online. If so, follow the normal procedures for uploading and documenting the verification(s).
* Determine if current property and deed searches are accessible online for current county of residence and any counties where the applicant alleges property or lived for long periods of time.
	+ South Carolina: refer to the [Property Search Contact Information](https://schhs.sharepoint.com/%3Ax%3A/r/sites/EES/Shared%20Documents/Property%20Search%20Contact%20Information%20September%2015%202020.xlsx?d=w33fca4913c6f47fa81627ec6c0334500&csf=1&web=1&e=0IixaV) spreadsheet in SharePoint.
	+ All other states: follow the normal procedures of searching online via Netronline (<https://publicrecords.netronline.com>) Refer to MPPM Chapter 104, Appendix H.
 |
| Register of Deeds – Clerk of CourtFollowing the end of the Public Health Emergency, SCDHHS will revert to standard processing procedures for Property Searches. If a deed search is not available online, refer to the [Property Search Contact Information](https://schhs.sharepoint.com/%3Ax%3A/r/sites/EES/Shared%20Documents/Property%20Search%20Contact%20Information%20September%2015%202020.xlsx?d=w33fca4913c6f47fa81627ec6c0334500&csf=1&web=1&e=0IixaV) spreadsheet in SharePoint to determine where to send the send DHHS Form 1255. Eligibility Specialists must wait for the DHHS Form 1255 to return. If the form has not returned within 21 days (15+6), follow-up via collateral call to the County Office or Register of Deeds (or Clerk of Court).  |
| County Treasurer’s OfficeResearch the county treasurer’s office website using the information that is available in the file (current and history) to determine if the applicant/spouse paid taxes on any property in the last 5 years.* Verify each tax year of the 5-year look back (if the site allows the search by year option).
* Document in the “Look-Back” section of the template of each county searched and the search result(s):
	+ If no property is found, document the tax year(s) and include, “No property found”.
	+ If property is found:
		- Document the tax year(s) and the tax information (TMS, address, type of property, etc.)
		- If the applicant/spouse is no longer paying taxes, document the tax year the applicant/spouse no longer paid taxes on the property and/or property was no longer in the applicant/spouse’s name.
 |
| County Assessor’s OfficeResearch the county assessor’s office website to determine if ownership changed from the applicant/spouse during the 5-year look back:* Search by applicant/spouse’s name and search the last known address
* Document in the ‘Look-Back’ section of the template of each county searched and the search result(s):
	+ If no property found, document the tax year(s) and “No property found”.
	+ If property is found:
		- Document the date the ownership was deeded to another person if it occurred during the 5-year look back and include the property details (TMS, address, type of property, etc.)

For discrepancies in online search results* + Conduct a collateral call to the county Register of Deeds office to verify if there are/were any deeds for the applicant/spouse in the last 5 years.
	+ If Register of Deeds indicates a deed of transfer took place during the 5-year look back period, document on the template the details (TMS#, date of transfer, Grantor/Grantee, amount received, etc.) and verify the tax value at the time of the transfer.
	+ Conduct a collateral call to the applicant/AR to discuss findings and obtain clarification as to the circumstances surrounding the transfer and explain the potential transfer penalty and possible exceptions. (see MPPM 304.09.03).
	+ Send a DHHS Form 1233 to the applicant to obtain any necessary documentation concerning the transfer as discussed during the collateral call.
	+ Seek supervisor’s assistance:
		- The supervisor will determine if the agency should wait to see if Form 1255 is returned (allowing 20 days from the date it was mailed).
		- If additional assistance is needed, the supervisor will submit a Service Manager ticket to Policy and Process Management.
 |
| Probate Court SearchInheritances* If an inheritance is not alleged on the application, do not complete a probate search.
* If an inheritance is alleged on the application and the probate office is available online, conduct a search at [South Carolina Probate Search](https://www.southcarolinaprobate.net/search/).
* If an inheritance is alleged on the application, but the probate office is not available online and the [Property Search Contact Information](https://schhs.sharepoint.com/%3Ax%3A/r/sites/EES/Shared%20Documents/Property%20Search%20Contact%20Information%20September%2015%202020.xlsx?d=w33fca4913c6f47fa81627ec6c0334500&csf=1&web=1&e=0IixaV) spreadsheet provides a SCDHHS staff member, email the DHHS Form 1255 to the assigned SCDHHS staff member.
* If an inheritance is alleged on the application, but the probate office is not available online and the [Property Search Contact Information](https://schhs.sharepoint.com/%3Ax%3A/r/sites/EES/Shared%20Documents/Property%20Search%20Contact%20Information%20September%2015%202020.xlsx?d=w33fca4913c6f47fa81627ec6c0334500&csf=1&web=1&e=0IixaV) spreadsheet indicates contacting the county office directly, conduct a collateral call to the county probate office where the estate was probated.
	+ Have ready the name of the deceased and the date of death.
	+ Verify if the probate was completed and the value of any asset(s) the applicant received from the probate of the estate.
* If unable to contact the county probate office by phone:
	+ Send a DHHS Form 1255 to the county probate office where the estate was probated and allow the 15 days for return of information plus 5 days for scanning. On the DHHS Form 1255 include the name of the deceased and date of death.
	+ Conduct a collateral call to the applicant/AR to explain the need to provide verification of the inheritance and to discuss what type of documentation could be used
	+ Send DHHS Form 1233 to the applicant/AR requesting verification of the inheritance received. Allow 15 days for return of information plus 5 days for scanning.

Deceased Spouse* If the applicant’s spouse passed away within the 5-year look back period and the application notes probate has been completed:
	+ Check online for probate records at [South Carolina Probate Search](https://www.southcarolinaprobate.net/search/).
	+ Check the [Property Search Contact Information](https://schhs.sharepoint.com/%3Ax%3A/r/sites/EES/Shared%20Documents/Property%20Search%20Contact%20Information%20September%2015%202020.xlsx?d=w33fca4913c6f47fa81627ec6c0334500&csf=1&web=1&e=0IixaV) spreadsheet to see if any SCDHHS staff member is provided, and email the DHHS Form 1255 to the assigned SCDHHS staff member.
	+ If probate records are not available online and there is no SCDHHS staff member assigned from the county LEP Office:
		- Conduct a collateral call to the county probate office where the spouse passed away.
			* Have ready the name of the deceased and the date of death.
			* Verify if probate was completed and the value of any asset(s) the applicant received from the probate of the estate.
			* Determine if the applicant received the at least the elective share of 1/3 of the estate. (MPPM 304.10)
				+ If there is no will for the estate (intestate), assume the applicant received the elective share of 1/3 of the estate unless the probate court indicates otherwise.
				+ If there is a will for the estate (testate), ask if the applicant received the elective share of 1/3 of the estate or filed a petition to claim the elective share.
			* If the probate court is unable to provide confirmation of any details of the estate, including the receipt of the elective share, conduct a collateral call to the applicant/AR to explain what information is required. Send a DHHS Form 1233 to request the necessary information.
		- If unable to contact the county probate office by phone:
			* Send a DHHS Form 1255 to the county probate office where the estate was probated and wait 20 days for the probate information to be returned and scanned in. On the DHHS Form 1255, include the name of the deceased and the date of death.
			* Conduct a collateral call to the applicant/AR to explain the requirement to obtain the elective share of the estate.
			* Send the DHHS Form 1233 and request verification that the applicant received or petitioned the court for the spouse’s required elective share of the estate.
* If the applicant’s spouse passed away within the 5-year look-back period and the application does NOT indicate that probate has been completed:
	+ Check online for probate records at [South Carolina Probate Search](https://www.southcarolinaprobate.net/search/).
	+ Check the [Property Search Contact Information](https://schhs.sharepoint.com/%3Ax%3A/r/sites/EES/Shared%20Documents/Property%20Search%20Contact%20Information%20September%2015%202020.xlsx?d=w33fca4913c6f47fa81627ec6c0334500&csf=1&web=1&e=0IixaV) spreadsheet to see if any SCDHHS staff member is provided and email the DHHS Form 1255 to the assigned SCDHHS staff member.
	+ If there are no probate records found on the probate court website, or if the county does not have probate online, and the [Property Search Contact Information](https://schhs.sharepoint.com/%3Ax%3A/r/sites/EES/Shared%20Documents/Property%20Search%20Contact%20Information%20September%2015%202020.xlsx?d=w33fca4913c6f47fa81627ec6c0334500&csf=1&web=1&e=0IixaV) spreadsheet indicates contacting the county directly. Then attempt a collateral call to the probate court to collect the information.
		- If you are unable to contact the probate court by phone, send a DHHS Form 1255 to the county probate office where the spouse passed away and wait for the probate information to be returned. On the DHHS Form 1255, include the name of the deceased and the date of death.
	+ If the DHHS Form 1255 is returned and no probate has been completed:
		- Complete a collateral call with the applicant/AR notifying them of the requirement for the applicant to claim the elective share within 8 months of the decedent’s death or within 6 months from the date the estate is probated.
		- Send a DHHS Form 1233 to the applicant/AR notifying them of the requirement for the applicant to claim the elective share within 8 months of the decedent’s death or within 6 months from the date the estate is probated and to request documentation.
	+ If the DHHS Form 1255 is not returned, make a collateral call to the applicant/AR to explain the requirement to obtain the elective share of the estate.
		- Send the DHHS Form 1233 and request verification that the applicant received or petitioned the court for the spouse’s required elective share of the estate.
		- If the estate has not been probated, follow up at the next annual review.
		- At the next annual review, if probate has been completed and the elective share is not obtained, a transfer penalty may be incurred.
* Document search efforts, findings, and actions taken on the template.
 |