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101.01 Introduction

(Eff. 01/01/14)

This chapter provides guidelines for processing eligibility determinations for all Medicaid coverage groups.

**101.02 Definitions**

(Eff. 01/01/14)

**101.02.01 Applicant**

(Eff. 01/01/14)

An individual whose signed application for Medicaid has been received by the South Carolina Department of Health and Human Services (SC DHHS).

**101.02.02 Authorized Representative**

(Rev. 09/01/17)

An Authorized Representative is an individual granted authority to act via [SC DHHS Form 1282](http://medsweb.scdhhs.gov/EligibilityForms/FM%201282%20ME.pdf), Authorization for Release of Information and Appointment of Authorized Representative for Medicaid Applications Reviews and Appeals, who is acting for the Applicant/Beneficiary with the Applicant/Beneficiaries’ knowledge and consent and who has knowledge of his circumstances. The DHHS Form 1282 must be signed by the applicant/beneficiary or a legal representative of the applicant/beneficiary to be valid.

The **Authorized Representative** should be informed of his responsibilities for the Medicaid determination and appeals process. The DHHS Form 1282 ME must be given to the Authorized Representative. A copy of all agency communications sent to an applicant/beneficiary, including notices and requests for information, must be sent to the Authorized Representative.

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| **Examples of an Authorized Representative:**   * Relative * Friend * Attorney * Employee of an agency or facility which holds custody (ex. Medical Facility) * Third Party Medical Service Organization * Third Party Private Eligibility Service Organization |

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| **Procedure for Recognizing an Authorized Representative** |
| **MEDS Procedure**  Scan any documents related to Authorized Representatives into OnBase as part of the electronic case record.  If the Form 1282 is submitted at the time of application, then the Form 1282 should be processed with the Application.  If the Form 1282 is submitted after the application is submitted, then scan the Form 1282 into OnBase as a MEDS-Member Verification trailing document. The specialist should then enter the Authorized Representative information into MEDS and note on the Documentation Template.  **NOTE:** If the SC DHHS Form 1282 is submitted after the application, it should be mailed to:  SC DHHS – Central Mail  P O Box 100101  Columbia, SC 29202-3101  **NOTE:** When an application is submitted online, if an Authorized Representative is indicated on the application, the specialist must send a DHHS Form 1233 to the applicant to request a signed DHHS Form 1282. Until the signed DHHS Form 1282 or other legal authorization (such as a Power of Attorney) is received, application information cannot be shared with anyone except the applicant, a current spouse, or the parent of a minor child who is shown on the application.   * An Applicant/Beneficiary should only have one Authorized Representative designated at a time. * An Authorized Representative remains valid until the Applicant/Beneficiary or legal representative submits a DHHS Form 1282 which either:   + Names a new Authorized Representative; or   + Requests removing an AR.   If an Applicant/Beneficiary has two or more Authorized Representatives, enter a note in MEDS and OnBase on the Documentation Template with the additional authorized representative’s information.  **Cúram Procedure**  The appropriate procedure may be found in the [Authorized Representative Process](https://schhs.sharepoint.com/:b:/r/sites/EES/Training/Curam/HCR/Job-Aids/Case%20Management/Authorized%20Representative%20Process.pdf?csf=1&web=1&e=zC9wxg) job aid at [Training Materials Portal-MAGI](https://www1.scdhhs.gov/ees/trainingportal/). |

**101.02.03 Beneficiary**

(Eff. 01/01/14)

An applicant approved for and receiving Medicaid benefits.

**101.02.04 Incapacitated Individual**

(Eff. 01/01/14)

An individual unable to act on his own behalf due to a physical or mental condition.

**101.02.05 Incompetent Individual**

(Eff. 01/01/14)

An individual adjudged to be mentally incompetent by a probate court.

**101.02.06 Individual with Limited English Proficiency (LEP)**

(Eff. 01/01/14)

An individual whose primary language is not English and who is not competent enough to communicate in any language other than his native language.

**101.02.07 Sensory Impaired Individual**

(Eff. 01/01/14)

An individual who has a partial, profound, or complete loss of hearing or sight.

**101.02.08 Legal Representative**

(Eff. 06/01/14)

A Legal Representative is a person who has been granted legal authority to look after another’s affairs, such as an attorney, executor, administrator, holder of power of attorney, etc.

A Legal Representative acting on the Applicant/Beneficiary’s behalf through the application and appeals process must:

* Be appointed via the [SC DHHS Form 934-A](http://medsweb.scdhhs.gov/EligibilityForms/FM%20934-A.pdf), Appointment of Applicant’s Legal Representative for Medicaid application and appeals process. (A [DHHS Form 1282](http://medsweb.scdhhs.gov/EligibilityForms/FM%201282%20ME.pdf) or SCDHHS HIP-02 will not be necessary.) However, the [SC DHHS Form 934-A](http://medsweb.scdhhs.gov/EligibilityForms/FM%20934-A.pdf) **is not required** if an attorney is providing legal representation for an applicant in a legal proceeding.
* If an organization, designate an individual appointee to sign the form and communicate with the agency. (**Note:** The Company’s name does not qualify as the signature.)

Obtain the signature of the applicant to allow for the release of protected health information under HIPAA regulations.

**101.02.09 Primary Individual**

(Eff. 06/01/14)

A person who is the primary contact person regarding his and his household’s application. This person may submit an application on behalf of himself; a spouse, who may or may not live in his household; and/or a family member(s) who lives in his household.

**101.02.10 Third Party Applicant**

(Eff. 11/01/15)

A person/entity who submits an application on behalf of another person. The Applicant must be both aware that the Third Party Applicant is submitting an application on his behalf and he must consent to it. (The Eligibility Specialist does NOT have to view written consent or contact the Applicant to confirm consent. By signing the application the Third Party Applicant represents that these requirements have been met.) The designation by an applicant or beneficiary is valid until (1) he or she revokes the designation, (2) the designated individual decides to no longer accept the role, or (3) when an application is denied or an ongoing case is terminated, including any appeals or hearings.

**Appointing an Authorized Representative:** Unless (1) the Applicant has completed a SC DHHS Form 1282 naming the Third Party Applicant as an Authorized Representative, or (2) the court has appointed/approved the Third Party Applicant as a legal representative (ex. Power of Attorney), a Third Party Applicant’s authority is limited to submitting an application. Without the aforementioned authorizations, the Third Party Applicant cannot act beyond the application’s submission or receive information about the application/case; i.e., he cannot request information on the status of the application, manage the Applicant’s case, or access his personal information. The Authorized Representative must be entered in MEDS or Cúram and on the Documentation Template in OnBase. An applicant/beneficiary can name more than one person or organization as an Authorized Representative. These must be documented in notes in MEDS or Cúram and in OnBase. A designated Authorized Representative cannot sign a DHHS Form 1282 to appoint someone else to act as an Authorized Representative or to receive information about an application of case.

**Permission to Release Information:** The Applicant may also complete the “Permission to Release Information” section on SC DHHS Form 1282, granting the Third Party Applicant permission to receive information about the application/case without the Third Party being in the position to act on the applicant’s behalf as an Authorized Representative. SC DHHS may release information on the application/case to the Third Party Applicant for the purposes of informing the Third Party of the status of a Medicaid eligibility determination. Document any persons or organizations that an applicant/beneficiary has given permission to receive information in the notes sections of MEDS or Cúram and in OnBase.

**101.03 Application Process**

(Eff. 06/01/14)

Applications may be submitted online, in person, by mail, and by telephone. Locations for local eligibility offices may be found at [County Offices Contact Info](https://www.scdhhs.gov/historic/popupoffices.html). The Healthy Connections Member Service Center will receive calls from citizens who may be seeking assistance to complete the [SCDHHS Form 3400](http://medsweb.scdhhs.gov/EligibilityForms/FM3400.pdf), Healthy Connections Application for Medicaid and/or Affordable Health Coverage.

All applications for Medicaid should be (i) filed on a SC DHHS approved application form, (ii) be legible, and (iii) should be completed online, in ink, or by typing when possible. A signed and dated application provides a legal document that:

* Clearly signifies intent to apply;
* Puts the Applicant on notice that he/she is liable for the truthfulness of the information on the application;
* May be introduced as evidence in court;
* Provides sufficient information to begin an accurate determination of eligibility; and
* Provides notice to the Applicant of his rights and responsibilities.

Eligibility Staff must accept any valid Medicaid application that is submitted. If additional information is required to process the application for a particular category, it must be requested from the applicant, but the applicant cannot be required to complete an additional application.

**A completed application form must be on file for every Applicant/Beneficiary.** Once a properly signed and dated application has been submitted, the Medicaid Eligibility Specialist must not alter the application by adding, changing, or deleting any information. During an interview, an applicant can make changes to the information on an application. The change must be initialed by the Applicant on any submitted paper application. Changes reported to the Eligibility Specialist by any other means must be documented in the appropriate MEDS or Cúram Notes screen.

Supplemental Security Income Recipients

* SSI recipients who enter a facility and have their SSI benefits terminated will be required to file a Medicaid application.
* Dual eligibles (recipients of both Retirement, Survivors, and Disability Insurance (RSDI) and SSI benefits) who enter a facility permanently (more than 90 calendar days) and whose RSDI benefit is greater than $50 will usually have their SSI benefits terminated. Therefore, a Medicaid application will be required.

Dual eligibles entering a facility temporarily (less than 90 calendar days) usually continue to qualify for SSI. Therefore, they will not be required to complete a Medicaid application.

**101.03.01 Application Form**

(Rev. 12/01/22)

Applicants may apply for Medicaid using the [DHHS Form 3400](http://medsweb.scdhhs.gov/EligibilityForms/FM3400.pdf), Healthy Connections Application for Medicaid and/or Affordable Health Coverage. Some specialty programs may require an addendum to collect additional information. An addendum is a supplement to the application and is not a valid application by itself.

* If an application is denied for a reason other than failure to return information, a new application and addendum is required if the applicant wants to apply for Medicaid coverage.
* If an application is denied for failure to return information,
  + If the applicant provides all the requested information within 30 days from the date on the denial notice, the existing application and addendum is still valid.
  + If the applicant does not provide all of the requested information within 30 days from the date on the denial notice, a new application and addendum is required.

Applicants applying for a non-MAGI category, Optional State Supplementation (OSS), or General Hospital may apply using the DHHS Form 3400 with the DHHS Form 3400-A, Additional Information for Select Medicaid Programs.

A person applying only for Nursing Home (Institutional), Waiver Services (Waiver), or Optional State Supplementation (OSS) may apply using:

* the [DHHS Form 3400](http://medsweb.scdhhs.gov/EligibilityForms/FM3400.pdf) with the [DHHS Form 3400-B](http://medsweb.scdhhs.gov/EligibilityForms/FM3400-B.pdf), Additional Information for Nursing Home and In-Home Care, or
* the [DHHS Form 3401](http://medsweb.scdhhs.gov/EligibilityForms/FM%203401.pdf), Healthy Connections Application for Nursing Home, Residential or In-Home Care**.**

Applicants who only want Family Planning and no other coverage may apply using the DHHS Form 400, Family Planning Only Application.

Applicants who only want to be considered for TEFRA may apply using the DHHS Form 3290, TEFRA Application.

Applicants referred by Continuum of Care to apply for the Palmetto Coordinated System of Care (PCSC) waiver can use either the:

* DHHS Form 3400 if applying as part of the family, or
* [DHHS Form 3405](http://medsweb.scdhhs.gov/EligibilityForms/Form3405_Single%20Person_HH.pdf), Healthy Connections Medicaid Application - Single Person Household, if only the child who needs PCSC waiver services is applying.

**101.03.02 Choice of Category**

(Rev. 12/01/19)

CFR [§435.907](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-J/subject-group-ECFR9b4bff9082050a1/section-435.907)

The Eligibility Specialist should advise the Applicant which category of assistance may be the best choice based on a review of the family's circumstances. If the Applicant would likely be eligible under numerous coverage groups, the Medicaid Eligibility Specialist should explain which coverage group is more appropriate and the associated advantages of that group. If an Applicant meets the eligibility criteria of more than one coverage group, he/she generally has the option to choose the group under which eligibility is established.

Applicants are allowed to apply for streamlined Medicaid (MAGI) and/or the Non-MAGI Medicaid program of their choice. If an applicant insists on applying for Medicaid under a specific category of assistance, he/she must be given the opportunity to have eligibility determined using the criteria for that category. The individual will be approved only for one payment category.

If a current Medicaid Beneficiary seeks assistance under another category, a new application is not required. The Eligibility Specialist must evaluate the application on file, and request any additional information needed to determine if the beneficiary meets the eligibility criteria for the new category.

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| **Exceptions:**   * Supplemental Security Income (SSI) recipients - Applications maintained by the Social Security Administration * SSI recipients entering a nursing facility or the Home and Community-Based Services waiver program who will continue to qualify for SSI * Title IV-E Foster Care beneficiaries * Title IV-E Adoption Assistance beneficiaries |

| **an application**  **OR REQUEST**  **for . . .** | **payment category** | **should be**  **received and**  **processed**  **by . . .** | **recommended**  **application**  **form** |
| --- | --- | --- | --- |
| Adoption Assistance (Title IV-E) | 51 | Local eligibility specialist | No application form necessary |
| Adoption Assistance (Special Needs/-Subsidized) | 13 | Local eligibility specialist | [DHHS Form 3400](http://medsweb.scdhhs.gov/EligibilityForms/FM3400.pdf), Healthy Connections Application |
| Aged, Blind, and Disabled (ABD) | 32 | Local eligibility specialist | DHHS Form 3400 and [DHHS Form 3400-A](http://medsweb.scdhhs.gov/EligibilityForms/FM3400-A.pdf), Healthy Connections Additional Information for Select Medicaid Programs |
| ABD-Nursing Home (ABD-NH) | 33 | Local eligibility specialist | [DHHS Form 3401](http://medsweb.scdhhs.gov/EligibilityForms/FM%203401.pdf), Healthy Connections Application for Nursing Home, Residential or In-Home Care  OR  DHHS Form 3400 AND  [DHHS Form 3400-B](http://medsweb.scdhhs.gov/EligibilityForms/FM3400-B.pdf), Additional Information for Nursing Home and In-Home Care |
| Breast and Cervical Cancer Program (BCCP) | 71 | Received by: BestChance Network (BCN), Local Eligibility Specialist or Division of Central Eligibility Processing (DCEP)  Processed by: DCEP | DHHS Form 3400 and DHHS Form 3400-A |
| Disabled Adult Children (DAC) | 19 | Local eligibility specialist | DHHS Form 3400 and DHHS Form 3400-A |
| Disabled Widows/-Widowers (DWW) | 18 | Local eligibility specialist | DHHS Form 3400 and DHHS Form 3400-A |
| Elderly Widows/-Widowers (EWW) | 17 | Local eligibility specialist | DHHS Form 3400 and DHHS Form 3400-A |
| Essential Spouse (ES) | 81 | Local eligibility specialist | DHHS Form 3400 and DHHS Form 3400-A |
| Family Planning (FP) | 55 | Local eligibility specialist | DHHS Form 3400 |
| Foster Care (Title IV-E) | 31 | Local eligibility specialist | No application form necessary |
| Foster Care - Regular (RFC) | 60 | Local eligibility specialist | DHHS Form 3400 |
| General Hospital (GH) | 14 | Local eligibility specialist | DHHS Form 3400 AND DHHS Form 3400-A |
| Partners for Healthy Children (PHC) or  In Cúram - Child | 88 | Local eligibility specialist | DHHS Form 3400 |
| Parent/Caretaker Relative (PCR) or  Low Income Families (LIF) | 59 | Local eligibility specialist | DHHS Form 3400 |
| Nursing Home – No SSI | 10 | Local eligibility specialist | DHHS Form 3401  OR  DHHS Form 3400 AND DHHS Form 3400-B |
| Nursing Home for SSI Recipient (SSI-NH) | 54 | Local eligibility specialist | No application form necessary |
| Income Trust –  Nursing Home & HCBS | 10, 15 | Local eligibility specialist | DHHS Form 3401  OR  DHHS Form 3400 AND DHHS Form 3400-B |
| Pass-Along (Pickle) | 16 | Local eligibility specialist | DHHS Form 3400 and DHHS Form 3400-A |
| Pass-Along Children (PAC) | 20 | State Office completes ex parte determination when child reaches age 18. | (Refer to category to which child is being “ex parted.”) |
| Pregnant Women and Infants (PW) or  Optional Coverage for Women and Infants (OCWI) | 12, 87 | Local eligibility specialist | DHHS Form 3400 |
| Optional State Supplementation (OSS) - No SSI | 85 | Local eligibility specialist | DHHS Form 3401  OR  DHHS Form 3400 AND DHHS Form 3400-B |
| Optional State Supplementation (OSS) for SSI recipient | 86 | Local eligibility specialist | [DHHS Form 1728 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201728%20ME.pdf)  SSI Recipient Request for OSS |
| Qualified Disabled Working Individuals (QDWI) | 50 | Local eligibility specialist | DHHS Form 3400 and DHHS Form 3400-A |
| Qualified Medicare Beneficiaries (QMB) | 90  Not a current PCAT | Local eligibility specialist | DHHS Form 3400 and DHHS Form 3400-A |
| Qualifying Individuals (QI) | 48 | DCEP  (Eligibility is determined during the limited enrollment period) | DHHS Form 3400 and DHHS Form 3400-A |
| Refugee Assistance | 70 | Local eligibility specialist | DHHS Form 3400 |
| Ribicoff | 91  Not a current PCAT | Local eligibility specialist | DHHS Form 3400 |
| Specified Low Income Medicare Beneficiaries (SLMB) | 52 | Local eligibility specialist | DHHS Form 3400 and DHHS Form 3400-A |
| Supplemental Security Income (SSI) | 80 | N/A | N/A |
| TEFRA/Katie Beckett | 57 | DCEP | DHHS Form 3290, TEFRA Application  OR  DHHS Form 3400 and DHHS Form 3400-A |
| Waiver Services (WS) -No SSI | 15 | Local eligibility specialist | DHHS Form 3401  OR  DHHS Form 3400 AND DHHS Form 3400-B |
| Home and Community Based Services for SSI recipient (SSI-WS) | 80 | N/A | N/A |
| Working Disabled (WD) | 40 | Local eligibility specialist | DHHS Form 3400 and DHHS Form 3400-A |
| Former Foster Care (FFC) | 61 | Local eligibility specialist | DHHS Form 3400 |

**Qualifying Categories for Medicaid**

Qualifying Category (QCAT) is the categorical eligibility criteria under which the Applicant/Beneficiary is applying for or receiving assistance. This field is completed on ELD00 in MEDS.

| **Q-CAT** | **Allowable Payment Category** | **Beneficiaries** |
| --- | --- | --- |
| 10 | 10, 14, 15, 16, 32, 33, 54, 80, 85, 86, 90 | Aged (Over age 65) |
| 20 | 10, 14, 15, 16, 19, 32, 33, 40, 54, 57, 80, 81, 85, 86, 90 | Blind |
| 30 | 11, 12, 30, 55, 59, 87, 88, 91 | FI-Related Groups |
| 31 | 31, 51 | IV-E Foster Care |
| 50 | 10, 14, 15, 16, 17, 18, 19, 20, 32, 33, 40, 50, 54, 56, 57, 71, 80, 81, 85, 86, 90 | Disabled (Under age 65) |
| 60 | 13, 60 | Regular Foster Care |
| 70 | 70 | Refugee/Entrant |

Applicants assessed for Medicaid eligibility are assessed utilizing either MAGI or Non-MAGI methodology, depending on the Payment Category for which they are applying.

| **Medicaid Categories** | |
| --- | --- |
| **MAGI** | |
| **PCAT** | **Category** |
| 11 | Transitional Medicaid |
| 12 | Deemed Infants (Infants up to Age 1) |
| 13 | Special Needs/Subsidized Adoption |
| 31 | Title IV-E Foster Care |
| 51 | Title IV-E Adoption |
| 55 | Family Planning |
| 59 | Parent/Caretaker Relative |
| 60 | Regular Foster Care |
| 61 | Former Foster Care |
| 87 | Pregnant Women |
| 88 | Partners for Healthy Children |

| **Non-MAGI** | |
| --- | --- |
| **PCAT** | **Category** |
| 16 | 1977 Pass Along |
| 17 | Early Widows/Widowers |
| 18 | Disabled Widows/Widowers |
| 19 | Disabled Adult Children |
| 20 | Pass Along Children |
| 32 | ABD |
| 40 | Working Disabled |
| 48 | Qualifying Individual |
| 50 | Qualified Disabled and Working Individual |
| 52 | SLMB |
| 80 | SSI |
| 81 | SSI with Essential Spouse |
| 90 | Qualified Medicare Beneficiaries |

|  |  |
| --- | --- |
| **INSTITUTIONAL** | |
| **PCAT** | **Category** |
| 10 | MAO – Nursing Home |
| 14 | MAO – General Hospital |
| 15 | MAO – Other |
| 33 | ABD - Nursing Home |
| 54 | SSI Nursing Home Beneficiaries |
| 85 | OSS Only |
| 86 | OSS with SSI |

|  |  |
| --- | --- |
| **SPECIALTY** | |
| **PCAT** | **Category** |
| 57 | TEFRA |
| 70 | Refugee Assistance |
| 71 | Breast and Cervical Cancer |

**101.03.03 Applying Without Delay**

(Rev. 09/01/14)

CFR [§435.907](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-J/subject-group-ECFR9b4bff9082050a1/section-435.907); [CFR §435.912](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-J/subject-group-ECFR2b847721e0bfa03/section-435.912)

An application must be taken immediately for any person expressing a desire to apply. A clearly ineligible person may file an application that must be accepted and then denied.

The person must be allowed to complete the application while in the office. An application is considered complete when it has enough information to determine eligibility.

* The date the signed application is received must be documented.
* For paper applications, the Application Date is the date the application is received and must be documented on the first page of the application.
* All paper applications must be scanned into OnBase within three (3) business days of its receipt.
* All applications must be entered into Cúram or MEDS as appropriate within five (5) days of receipt.
* A face-to-face interview is not required; however, if an application filed online, in person, or by mail is not complete, the Eligibility Specialist must contact the applicant within five (5) business days from the date of the request to obtain the required information. The Eligibility Specialist can require a telephone or personal interview in order to obtain the information necessary to complete the eligibility determination. However, if the contact is by mail, the Eligibility Specialist must retain the original application and mail a copy to the applicant requesting the missing information. The applicant cannot be required to complete another application form.
* If an applicant calls SC DHHS to request an application, the effective date of the application is the date on which the signed and dated application is received, NOT the date of the phone call.
* For applications completed by telephone, the date of application is the date the telephonic signature is captured.
* An unsigned application should never be discarded. If an unsigned application is received, it should be returned to the Applicant with an explanation that it must be signed. No further action is required since an application is not valid until signed.
* The date a faxed application is received by the agency is considered the date of application.
* The date an online application is electronically signed and submitted to the agency is considered the date of application.
* Regardless of when the application is entered into the MEDS/Cúram computer system, the date of application is the date the signed application was received, whether complete or incomplete.
* If an applicant needs to return any other information needed to make a decision, a written list must be sent to the applicant.
  + The written list must give the Applicant a deadline to return the information.
  + For applications submitted through the Healthy Connections Citizen Portal or the Health Information Marketplace, the Applicant may receive a list of unverified information, such as identity or income. This is provided on a PDF copy of the application generated by Cúram. The Eligibility Specialist will utilize current verification policies to verify this and any other financial and non-financial information needed to determine eligibility.
  + The [SC DHHS Form 1233 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201233%20ME.pdf), Medicaid Eligibility Checklist, should be used to request additional information for an application to be completed.
  + The request must be mailed or given to the Applicant by the end of the business day following the day the completed application is received.

**101.03.04 Signature Requirements**

(Eff. 06/01/14)

A Medicaid application must contain a valid signature to be processed. Signature requirements vary based on whether the individual seeking services is an adult or a minor.

**101.03.04A Applicants Age 18 or Older**

(Rev. 09/01/23)

**Who May Sign the Application**

The following persons may sign the application provided the relevant criteria are met.

The Applicant

An adult Applicant who has the mental capacity to legally conduct his own affairs may sign and submit his own application for Medicaid coverage.

A Household Member

A household member may sign and submit an application on behalf of himself, his spouse, and any family members living in his household. The person completing the application will be considered the Primary Individual (See SC MPPM [101.02.09](#MPPM_101_02_09)).

**Example**

An individual may submit an application on behalf of himself and his sibling who lives with him.

A Third Person

Someone other than the Applicant may submit an application on the Applicant’s behalf if he acts with the Applicant’s knowledge and consent (See SC MPPM [101.02.10](#MPPM_101_02_10)).

**NOTE**

If a Legal Representative has been appointed to act on the Applicant’s behalf that Legal Representative stands in the shoes of the Applicant. To submit an application, a Third-Party Applicant must act with the Legal Representative’s knowledge and consent.

If an application is submitted without the Applicant’s knowledge and consent, the Medicaid office must advise the Third-Party Applicant that the agency cannot take action until such knowledge and consent is obtained.

**Example**

An adult daughter may submit an application on behalf of her elderly mother, who lives in a separate household, if her mother knows about and consents to the daughter applying for her.

**NOTE:**

A Form 1282 is NOT required for a Third-Party Applicant to submit an application on an adult Applicant’s behalf. However, that Third Party Applicant will have NO right to manage the Applicant’s case unless he is (i) the Applicant’s spouse, (ii) appointed Authorized Representative by the Applicant via the Form 1282, or (iii) the court grants/approves legal authority.

**Methods of Signing**

Paper Application

If the Applicant is submitting a paper application, the application is considered complete when the Applicant or his authorized party signs it.

If the Applicant is physically unable to write his or her name (i.e., he does not know how to read or write), he may sign with an “X”. Two witnesses must also sign the application verifying the mark is intended to serve as the Applicant’s signature.

**NOTE**

An applicant who does not know how to write is treated differently than an applicant who is legally declared mentally incapacitated or incompetent.

Telephonic Application

A telephonic signature is valid if submitted through an approved source. As part of the telephone application process the person assisting the Applicant must read him the Rights and Responsibilities associated with the application, and the Applicant must acknowledge his understanding. A recording will capture the Applicant’s permission to submit the application and his acceptance of the Rights and Responsibilities.

Effective April 1, 2018, telephone applications will be primarily received by the Member Services Contact Center. The applicant’s signature will be documented on the application by the Contact Center Agent as demonstrated below. The audio file will not be uploaded into OnBase but will be archived by the Contact Center.

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|  |

A telephone application may also be conducted through contact with SCThrive. The PDF and a copy of the audio file will be loaded into OnBase.

Electronic Application

An electronic signature is valid for applications submitted through an approved online source, such as the Healthy Connections Citizen Portal, the Federally Facilitated Marketplace (FFM), or SCThrive. If an applicant applies online, he will be asked to type his name into the application field. This act will serve as his electronic signature.

|  |
| --- |
| **Cúram Procedure for Verifying a Signature on Electronically Submitted Applications** |
| When processing an electronic application, the Eligibility Specialist should ensure that a proper electronic signature is included on the pending application case. Applications ingested into Cúram that do not have an OnBase pdf generated at the time of processing can be processed if an electronic signature is verified.  If submitted via an electronic means:   1. The Eligibility Specialist should navigate to the evidence dashboard of the pending application case 2. Select *Application Filer* evidence 3. Toggle twice to view the case participant listed within the application filer details evidence 4. Notate the case participant name   Return to the evidence dashboard   1. Select *Application Filer Consent* evidence 2. Toggle twice to open and view the consent details 3. Confirm the case participant listed in the application filer details is the same as the client listed on the ESignature lines |

The Specialist Portal

The Specialist Portal is used in the following instances:

* When an applicant submits an application in a walk-in interview,
* When a paper application is entered by a specialist,
* When a telephone application is received by the Member Services Contact Center, and
* When SCThrive sends a PDF application and audio file to Central Mail.

After an applicant completes an application during an interview in a county office, the specialist will give the applicant a printed copy of the DHHS Form 3403, Rights and Responsibilities, to sign. A Medicaid application must contain a valid signature to be processed. The specialist will scan the form into OnBase with the rest of the application. The applicant’s signature on the Rights and Responsibilities Form is not needed if the applicant’s signature is already on file.

**Authorized Representative**

An Authorized Representative (see MPPM [101.02.02](#MPPM_101_02_02)) designated in a written statement may sign the application on the Applicant’s behalf.

**No Individual Authorized to Sign**

If the applicant lacks legal capacity such that he cannot sign the application himself (i.e. the applicant is legally incompetent or incapacitated) and does not have an Authorized Representative or Legal Representative the application may not proceed until such a responsible party is obtained.

When the Applicant is a long term care resident, Eligibility Specialist should coordinate with the facility and/or the Ombudsman’s office to identify and secure a legal representative.

The State Long Term Care Ombudsman’s Office may be reached by calling 1-800-868-9095.

**Pending Individual Authorized to Sign**

If the applicant lacks legal capacity such that he cannot sign the application himself (i.e. the applicant is legally incompetent or incapacitated) and does not have an Authorized Representative or Legal Representative, the application may proceed IF the procedures have been initiated to legally appoint a Legal Representative. Eligibility Specialist should complete as much of the application process as possible based on the information available then pend the case in MEDS/Cúram until the court appoints a representative.

**Procedure for Determining Who Can Sign the Application**

|  |
| --- |
| **Procedure for Determining Who Can Sign the Application** |
| Before processing an application for Medicaid, the Eligibility Specialist should determine if a proper signature is included.  If the application is signed by someone other than the Applicant or if one application is submitted on behalf of numerous individuals, determine the following:  If submitted by a person:   1. Are any adults included in the application other than the Primary Individual’s spouse?    * If yes, continue to question 2.    * If no, the signature is proper. 2. Does the adult Applicant have a court appointed Legal Representative, such as a Guardian or holder of Power of Attorney, who is required to sign this application on that Applicant’s behalf?    * If yes, continue to question 3.    * If no, continue to question 4. 3. Is the Primary Individual the legally appointed representative acting on the Applicant’s behalf?    * If yes, accept signature as proper.    * If no, there is no proper signature. The application cannot be processed until a valid representative signs it. 4. Does the Applicant know that you are submitting this application and does he consent to it?    * If yes, the signature is proper.    * If no, there is no proper signature. The application cannot be processed until consent is obtained.   If submitted by an institution, entity, or organization (Ex. A nursing home)   1. Does the Applicant have the legal capacity to submit his own application?    * If yes, continue to question 4.    * If no, continue to question 2. 2. Does the Applicant have a court appointed Legal Representative, such as a Guardian or holder of Power of Attorney, who is required to sign this application on that Applicant’s behalf?    * If yes, continue to question 3.    * If no, see SC MPPM [101.03.04A](#MPPM_101_03_04A) sections “No Individual Authorized to Sign” and “Pending Individual Authorized to Sign”. 3. Is the organization submitting the application the legally appointed representative acting on the Applicant’s behalf?    * If yes, accept signature as proper.    * If no, there is no proper signature. The application cannot be processed until a valid representative signs it. 4. Does the Applicant know that the organization is submitting this application and does he consent to it?    * If yes, the signature is proper.    * If no, there is no proper signature. The application cannot be processed until consent is obtained. |

**101.03.04B Applicants Under Age 18**

(Eff. 06/01/14)

When an applicant is under age 18, a parent, legal guardian, or, if the child is in DSS’ custody, a DSS worker may submit an application on the child’s behalf. Alternatively, a minor is legally able to sign his own Medicaid application if he is (1) legally emancipated from his parents; (2) no longer under the care and control of his parents, legal guardian, or caretaker relative who would normally file for benefits on his behalf; or (3) applying for Family Planning or Pregnant Woman coverage.

NOTE: A minor whose parents’ claim her as a tax-dependent may only apply for Pregnant Woman coverage independently of her family **IF she is able to provide her complete household income information**. MAGI requires the income of every household member to be counted, and selective income disregards can no longer be applied to Pregnant Woman eligibility. Any reported income that is not reasonably compatible with electronic sources will need to be verified with additional sources.

**Minor Parent Applying for His Child**

A parent under age 18 may apply for Medicaid for his own child because he is the parent of the child.

**Enrollee Turns 18**

When a child who is enrolled in Medicaid turns 18, it is not necessary to obtain a new application signed by the enrollee.

When a child who is enrolled in Medicaid turns 19, the child must apply as an adult.

**101.03.04C Unsigned Applications**

(Eff. 06/01/14)

An unsigned application should never be discarded. If an unsigned application is received, it should be returned to the applicant with an explanation that it must be signed. No further action is required since an application is not valid until signed.

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**101.03.05 Processing Applications**

(Rev. 12/01/21)

[CFR §435.912](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-J/subject-group-ECFR2b847721e0bfa03/section-435.912)

Applications are accepted and processed by the South Carolina Department of Health and Human Services (DHHS).

* The Specialty Unit in Richland County processes applications for the TEFRA and Breast and Cervical Cancer (BCCP) programs. Applications received by LEP staff should be scanned into OnBase. Scan applications to be processed in MEDS using Document Type “MEDS Application” and Claim Type “BCCP/TEFRA”. Scan applications to be processed in Cúram using Document Type “MEDS-Cúram Application” and Claim Type “CGIS BCCP/TEFRA”.
* The Local Eligibility Processing (LEP) and the Processing Centers processes all other FI (MAGI) and SSI (Non-MAGI) related programs. Refer to [MPPM 101.03.06](#MPPM_101_03_06) for instructions concerning applications of SC DHHS employees and immediate family members.

Note: An initial budget based on the applicant's self-reported income, pregnancy, citizenship, and family circumstances must be completed on the day an application is received to determine eligibility for Pregnant Women. If the Eligibility Specialist cannot process the application the date it is received, (i) a decision must be made by the end of the next business day and (ii) the reason the application could not be processed must be documented in the case record. It is important that the pregnant woman has coverage to access prenatal care as quickly as possible. Refer to SC MPPM 204.02 for specific instructions on processing Pregnant Women applications.

* Department of Disabilities and Special Needs (DDSN) sponsored eligibility specialists are located in the DDSN regional offices. These eligibility specialists are responsible for processing Medicaid applications for the following groups:
  + Institutionalized individuals who must meet the Intermediate Care Facility/Intellectual Disabilities (ICF/ID) level of care to qualify for Medicaid coverage of the cost of care in the facility;
  + Individuals applying for waivered services under the Intellectual Disabilities and Related Disabilities (ID/RD) Waiver; and
  + Persons applying for waivered services under the Head and Spinal Cord Injury (HASCI) Waiver.
  + An application taken by the county or Local Eligibility Processing office for services through the ID/RD waiver should be forwarded with available verifications to the DDSN sponsored eligibility specialist for processing. The application must not be held for the return of additional information.
  + An application taken by the county or Local Eligibility Processing office for services through the HASCI waiver should be forwarded with available verifications to the DDSN sponsored eligibility specialist for processing. The application must not be held for the return of additional information.

**101.03.05A Procedure for MAGI, Non-MAGI, and Blended Household Cases – Online Applications**

(Rev. 04/01/24)

When applications have been submitted to the agency through the FFM’s Citizen Portal, the eligibility specialist must take the following steps to determine eligibility.

| **Procedure for MAGI, Non-MAGI, and Blended Household Cases** | |
| --- | --- |
| **MAGI Household** | MAGI households are those that include the PHC, PCR, PW, Deemed Baby, and FP categories. When an applicant applies online:   1. The MAGI Eligibility Specialists will retrieve the application from Workload Pro. 2. If all members are not categorically eligible for MAGI and there is an indication of disability, need for long term care, or anyone over age 65, the specialist determines if the application is a non-MAGI household or a blended household. Refer to [Eligibility - OnBase Indexing Tool.pdf - All Documents (sharepoint.com)](https://schhs.sharepoint.com/sites/EES/Training/Forms/AllItems.aspx?id=%2Fsites%2FEES%2FTraining%2FOnBase%2FOnBase%20Indexing%20Tool%2Epdf&viewid=011298ae%2Dbf47%2D449d%2Dbd39%2Dd6017101a69c&parent=%2Fsites%2FEES%2FTraining%2FOnBase) for any additional indexing instructions.   **Note**  If a beneficiary qualifies for full coverage in a MAGI payment category, is not expected to terminate from the MAGI payment category before the next review date and has indicated disability on a new application or review, it is not necessary to assess the beneficiary for disability, unless Nursing Home (NH) coverage or Optional State Supplemental (OSS) coverage is requested. |
| **Non-MAGI Household** | For an application with all Non-MAGI applicants:   1. The Non-MAGI Eligibility Specialist will retrieve the application from Workload Pro. The online application may already be keyed into CGIS. If so, use the existing household. **Do not** create another. If there is not an existing household in CGIS a new household will need to be created. Refer to [Processing a Non-MAGI Application](https://schhs.sharepoint.com/sites/EES/Training/Forms/AllItems.aspx?id=%2Fsites%2FEES%2FTraining%2FCuram%2FCGIS%2FPPTs%2FEnter%5Fa%5FNon%2DMAGI%5FApplication%5FPPT%2Epdf&parent=%2Fsites%2FEES%2FTraining%2FCuram%2FCGIS%2FPPTs). Refer to [Eligibility - OnBase Indexing Tool.pdf - All Documents (sharepoint.com)](https://schhs.sharepoint.com/sites/EES/Training/Forms/AllItems.aspx?id=%2Fsites%2FEES%2FTraining%2FOnBase%2FOnBase%20Indexing%20Tool%2Epdf&viewid=011298ae%2Dbf47%2D449d%2Dbd39%2Dd6017101a69c&parent=%2Fsites%2FEES%2FTraining%2FOnBase) for any additional indexing instructions. 2. The Non-MAGI Eligibility Specialist sends the appropriate addendum and the Healthy Connections Checklist, DHHS FM 1233, for the non-MAGI determination. 3. The Non-MAGI Eligibility Specialist selects the Follow-up workflow ad hoc task to add a follow-up date to the document. |
| **Blended Household** | A blended household includes members of the household that are MAGI and non-MAGI eligible.  For an application with a blended household:   1. A MAGI Eligibility Specialist will review the case to see if the MAGI determination has been completed. If it has not been completed, the specialist will send FM 1233 with the necessary information required to complete a determination.   \*See job aid for [MAGI Workflow](https://schhs.sharepoint.com/sites/EES/Training/Forms/AllItems.aspx?id=%2Fsites%2FEES%2FTraining%2FCuram%2FHCR%2FJob%2DAids%2FCase%20Management%2FC%C3%BAram%20Workflow%20and%20Tasks%2Epdf&parent=%2Fsites%2FEES%2FTraining%2FCuram%2FHCR%2FJob%2DAids%2FCase%20Management)  **Note:** All MAGI and Non-MAGI members must be included in the application case, and the MAGI specialist must make sure that the MAGI members' applicant boxes are correctly marked to indicate that they are applying, while the Non-MAGI members' boxes should remain unmarked unless they have indicated Family Planning on their application.   1. The MAGI Eligibility Specialist will create a duplicate Tracking Form to send to the correct work team and send the original Tracking Form to the correct Follow-up queue. 2. The duplicate Tracking Form will enter the CGIS Intake queue where a Non-MAGI Eligibility Specialist will process it. 3. The Non-MAGI Eligibility Specialist will enter the application data into Cúram (CGIS). This includes entering the MAGI eligible members as non-applying members in the *Non-MAGI* *household*. 4. The Non-MAGI Eligibility Specialist sends an addendum and FM 1233 for the non-MAGI determination. 5. The Non-MAGI Eligibility Specialist selects the Follow-up date workflow ad hoc task to add a follow-up date to the document. 6. When verifications are returned, the specialist must take the following steps:    * 1. Complete the determination in Cúram (CGIS).      2. If the applicant is eligible for full coverage in CGIS, the specialist closes the limited coverage case in Cúram. The Eligibility Specialist must ascertain which coverage the applicant/beneficiary chooses if they are qualified for either of the two Non-MAGI limited benefits, SLMB (PCAT 52) or QI (PCAT 48).      3. The Non-MAGI Eligibility Specialist enters SC Medicaid Evidence on the Cúram (HCR) limited coverage case to block the coverage effective the month the Cúram (CGIS) coverage starts.      4. Check for open Cúram tasks and OnBase ACTIVE Tracking forms.      5. The Eligibility Specialist must add a case note to the Insurance Affordability Case in Cúram as well as the OnBase Documentation Template. |

**101.03.05B Procedure for MAGI, Non-MAGI, and Blended Household Cases – Paper Applications**

(Rev. 04/01/24)

When applications have been submitted via paper application, the following steps must be taken to determine eligibility.

| **Procedure for Blended Household Cases** | |
| --- | --- |
| **MAGI Household** | 1. The applicant applies with a paper application. 2. The application is scanned in OnBase. Once the application is received by the MAGI Eligibility Specialist, the specialist reviews the application to determine if it requires a MAGI, Non-MAGI, or blended household analysis. 3. The application will be processed in Cúram (HCR) unless the application is FM 3401. The MAGI Eligibility Specialist must follow the standard process to register the primary applicant, enter the application into Cúram, and submit the application. 4. If the MAGI Eligibility Specialist is able to complete a MAGI determination (there are no outstanding verifications), the MAGI Eligibility Specialist authorizes the application case in Cúram (HCR). 5. If the MAGI Eligibility Specialist is not able to complete the MAGI determination, the specialist must send FM 1233 to the applicant. 6. The MAGI Eligibility Specialist creates a MEDS-Application Tracking Form with the appropriate claim type should be created, with no follow-up date. The Tracking Form will enter workflow and be directed to the appropriate work team. 7. The original Tracking Form will enter the correct follow up queue. 8. The duplicate Tracking Form will enter the CGIS Intake queue where it will be processed by a Non-MAGI Eligibility Specialist. 9. The Non-MAGI Eligibility Specialist will enter the application data into Cúram (CGIS). This includes entering the MAGI eligible, and potentially MAGI eligible members, as non-applying members in the *Non-MAGI household.* |
| **Non-MAGI Household** | 1. The Non-MAGI Eligibility Specialist sends the appropriate addendums and FM 1233 for the non-MAGI determination to the applicant. 2. The Non-MAGI Eligibility Specialist selects the Follow-up date workflow as hoc task to add a follow-up date to the document 3. When verifications are returned, the specialist must take the following steps:    1. Complete the determination in Cúram (CGIS).    2. If the applicant is eligible for full coverage in CGIS, the Eligibility Specialist closes the case in Cúram. The Non-MAGI eligibility specialist enters SC Medicaid Evidence on the Cúram (HCR) limited coverage case to block the coverage effective the month the Cúram (CGIS) coverage starts.    3. The Eligibility Specialist will need to disposition any open Cúram tasks or open OnBase Active Tracking Forms that are related to the Non-MAGI case.    4. The Eligibility Specialist must add a case note to the Insurance Affordability Case in Cúram as well as the OnBase Document Template. |

**101.03.06 Processing Applications of DHHS Employees and Family Members**

(Rev. 12/01/19)

Regarding his own application for Medicaid benefits, a SC DHHS employee must not:

* Process, re-determine, re-budget, or make changes to his application;
* Edit his case information in OnBase, MEDS, or Cúram;
* Directly add, remove, replace, or edit documents or verification in the case record; OR
* Scan any additional information into OnBase.

Regarding the application of an immediate family member or household member, a SC DHHS employee must not:

* Process or maintain the case;
* Edit information in OnBase, MEDS, or Cúram;
* Directly add, remove, replace, or edit documents or verification in the case record; OR
* Scan any additional information into OnBase.

An “immediate family member” includes the employee’s spouse, children, parents, siblings, grandparents, grandchildren, in-laws, and legal guardians.

If an employee is aware that any other family member will apply to receive Medicaid benefits, he/she must discuss the situation with the immediate supervisor. The supervisor will determine the proper course of action for handling the case.

Depending on the circumstances of the application, the supervisor may determine one of the following:

* No special treatment of the case is required, and another Eligibility Specialist may pick up the case in normal workflow;
* The case must be processed and maintained by another employee outside of the county office;
* The case must be processed by the supervisor or their designee; or
* Another course of action is necessary.

The supervisor must document in the case record the decision and the reasoning for the specific course of action recommended.

| **Procedure for Processing Applications of SC DHHS Employees, Members of their Household or Immediate Family Members:** |
| --- |
| Any application or active case in any local eligibility office must be processed using the following procedures.   * When the application is made in person, a supervisor or the Eligibility Specialist appointed by the supervisor must provide intake. The supervisor, or his designee, is responsible for generation a [SC DHHS Form 1233 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201233%20ME.pdf) to request any additional information needed to determine eligibility.   **MEDS Procedure**  Non-MAGI and MAGI applications must be pended in Cúram by the supervisor or appointed Eligibility Specialist  **Cúram Procedure**  MAGI applications should be entered into Cúram by the supervisor or appointed eligibility specialist.  **OnBase Procedure**  When an Eligibility Specialist is assigned his own or a family member’s application, he should document the Tracking Form and send it to the Supervisor Queue.  Once the application has been sent to the Supervisor Queue, the Supervisor will review the case and make a determination on how it should be processed. If the Supervisor determines that the case should be assigned to another Eligibility Specialist (rather than the Supervisor processing it himself), the Supervisor will specifically assign an Eligibility Specialist to process the application, document the Tracking Form, and send the application back to the Assessment/Processing Queue for that specialist to retrieve and process. |

**101.03.07 SC DHHS Employees Conflict of Interest**

(Rev. 01/01/14)

SC DHHS employees must never directly or indirectly request that another SC DHHS employee process an application for themselves, family members, or friends. An application for a SC DHHS employee, family members, or friends must be discussed with his or her immediate supervisor and/or Regional Administrator to avoid a conflict of interest. Applications for an employee or immediate family members must be handled according to the policy in MPPM [101.03.06](#MPPM_101_03_06). An application for the friend of an agency employee must be assigned by the supervisor or Regional Administrator. SC DHHS employees must not review, research, or change information in MEDS, Cúram, or OnBase related to a member of their household or immediate family. SC DHHS employees must not review, research, or change information in MEDS, Cúram, or OnBase related to friends of an employee unless the case has been assigned to the employee by the supervisor or Regional Administrator.

**101.03.08 Informing the Applicant**

(Eff. 11/01/14)

Should an application interview be needed, the interview (which may be conducted by telephone or in person) must include at a minimum the following explanations:

* The eligibility requirements, the agency's standard of promptness, the right to a fair hearing, the procedure for requesting a hearing, rights under Title VI of the Civil Rights Act of 1964, and rights under Title V and Section 504 of the Rehabilitation Act of 1973;

Note:The Rights and Responsibilities of SC Healthy Connections Medicaid Applicants and Beneficiaries brochure must be given to the applicant/authorized representative. This brochure replaces the individual Civil Rights Pamphlet and Fair Hearing and Appeals Brochure. MEDS/Cúram can be updated to document that the brochures have been given to the applicant/authorized representative;

* The responsibility of the applicant to give complete and accurate information, to report any changes in circumstances and penalties for providing false information (Refer to MPPM [101.12](#MPPM_101_12) for a complete discussion of these Rights and Responsibilities.);
* An explanation of the methods of establishing eligibility, including the need for making collateral contacts and the use of documentary and other records for verifying pertinent information, including the use of computer matches (such as BENDEX, IEVS) to verify the presence of income of family members;
* The services covered by Medicaid, including instructions on the appropriate use of the Medicaid insurance card;
* The third-party liability process, including the responsibility to cooperate in obtaining medical support;
* The services available through the Women, Infants, and Children (WIC) program at the county health department. Where appropriate, the applicant must be referred to the WIC program;
* The estate recovery program, when appropriate. (Refer to MPPM 304.27, Nursing Home, Waiver Services, General Hospital.);
* The services available to children under age 21 through the Early, Periodic Screening, Diagnosis and Treatment program (EPSDT).

**101.03.09 Request for Informal Medicaid Eligibility Opinion**

(Renum. 01/01/09; Eff. 01/01/07)

Individuals seeking assistance from other social service agencies may be required to obtain a statement from SC DHHS indicating he/she is not eligible for Medicaid. If the individual indicates through questioning that none of the categorical eligibility requirements would be met, the Eligibility Specialist may complete a [DHHS Form 3300](http://medsweb.scdhhs.gov/EligibilityForms/FM%203300.pdf), Informal Medicaid Eligibility Opinion, to give to the individual. It must be explained that the decision is not an official denial, and it cannot be appealed. If a proper denial letter is required, an application must be filed, and a decision rendered after all eligibility factors have been examined according to Medicaid policy. The DHHS Form 3300 cannot be used to indicate a person’s ineligibility due to financial or other non-categorical eligibility criteria.

**101.03.10 Account Transfer Applications**

(Eff. 06/01/14)

Individuals may apply for state Medicaid coverage through the Federal Facilitated Marketplace (FFM). An Application received from the FFM is referred to as an Account Transfer Application (ATA). ATAs are delivered from the FFM to the state in which the applicant resides as a PDF.

**101.03.10A Effective Date**

(Eff. 06/01/14)

ATAs submitted prior to January 1, 2014, will have an Application Effective Date (AED) of January 1, 2014. ATAs submitted on or after January 1, 2014, will have an AED of the date of the application. Refer to the chart below for the correct AED based on date of application.

|  |  |
| --- | --- |
| If the Applicant applied… | Then the Application Effective Date will be… |
| Between October 1 – December 31, 2013 | January 1, 2014 |
| On or After January 1, 2014 | the Date of Application |

*Example 1*: Charles submitted an application for his family on October 13, 2013. The AED on his application will be January 1, 2014, and coverage will begin January 1, 2014.

*Example 2*: A pregnant woman applied to the FFM on January 3, 2014. Before she receives an eligibility determination, she submits an additional application for Medicaid on February 10, 2014. Based on the February application, she was determined eligible in MEDS for Medicaid benefits beginning February 1, 2014. Later the PDF of her January ATA is received. Based on a review of the January ATA, it is determined that she is reasonably compatible for Pregnant Woman (PW). SCDHHS should change the AED to January 3, 2014.

**NOTE**: A Help Desk ticket is required to insert the eligibility dates in Example 2.

**101.03.10B Identifying ATA Household Member’s Current Eligibility or Application Status**

(Eff. 06/01/14)

The ATA is color-coded to assist the Eligibility Specialist with quickly identifying each household member’s current eligibility or application status. Each household member’s “About Applicant” section is shaded one of the following colors:

* **Green** indicates the applicant is applying for coverage and not currently eligible for benefits in MEDS.
* **Blue** indicates the applicant is currently eligible for benefits in MEDS; however, the Eligibility Specialist needs to determine if the individual was eligible for Medicaid in the month that he/she submitted the application to the FFM.
* **Pink** indicates the individual is a member of the household but is not seeking Medicaid benefits.

**101.03.10C Processing Account Transfer Applications**

(Rev. 11/01/18)

ATAs received from the FFM must be evaluated for both MAGI and Non-MAGI eligibility.

**A. Evaluate for MAGI Eligibility**

Specialists should first determine if the individuals listed on an ATA are eligible under MAGI methodology.

* Income:

The application’s reasonable compatibility section determines if a named applicant is income eligible for Medicaid under a MAGI category. The result is based on whether the applicant’s self-attested income is reasonably compatible (RC) with the electronic data source’s reported income.

If only hourly income is provided on the application, in order to determine income, first attempt to contact the applicant by phone to determine the expected number of hours per week the applicant works, and how frequently the applicant is paid. If the applicant’s hours vary then ask for annual income and divide by 12. If the information cannot be obtained by phone contact, send the applicant a FM 1233 to obtain this information. Calculate income following procedures outlined in MPPM 203.04.01.

Note: The RC section does NOT take into account categorical eligibility. (i.e. an adult with no minor children in the home will be listed as income eligible for PCR even if they are not a parent or caretaker relative.)

* Pregnancy:

If a member of the household reports she is pregnant, assume that number of expected children is 1. However, if an additional expected-child will impact eligibility, contact the applicant to confirm the number of expected children.

| **Procedure for Determining whether a Workbook is necessary.** |
| --- |
| A Workbook **MAY NOT** be necessary to determine MAGI eligibility.  The workbook is required if:   * No reasonable compatible section is shown nor are results available. * The household has a child who receives an earned income higher than the tax-filing threshold.   Note: If the child’s earned income exceeds the tax-filing threshold, his earned income and any Social Security income he receives are counted in the household income.  The workbook is **NOT** required if:   * Reasonable compatible and countable income is given. * All applicants are over-income (in this case you are required to deny the case). |

**B. Evaluate for Non-MAGI Eligibility**

Next, review the application to determine if:

* + - Any applicant is over 65 years old, or indicates that he/she is blind and/or disabled.

If so, the Eligibility Specialist should: complete a FM 1233; create a second tracking form in OnBase; and send the appropriate Non-MAGI addendum(s) and needed verifications to collect the necessary information to make a SSI-related determination.

* + - Any applicant indicates he may be eligible for long-term care services by stating he is living in a medical facility or institution or indicates that he has limited activities of daily living (ADL).

If so, apply the same steps as above.

**C. When do I need to send a 1233?**

The following table details when a Form 1233 should be sent.

| **Factor** | **Send 1233?** | **Instead:** |
| --- | --- | --- |
| Household composition is self-reported | NO | Accept the self-attestation |
| Income is verified on PDF with WAGE Match | NO | Accept DS reported on PDF. Person Composite Service (PCS) Wage Verification does not need to be used. |
| Income data source not in PDF | NO | Check PCS Wage Verification |
| Income data source not in PDF OR available in Person Composite Service (PCS) Wage Verification | YES |  |
| Attested income over $300 and no data match. | YES |  |
| Attested income under $300, including zero income, and no data match | NO | Accept self-attestation |
| Income is only provided in hourly format | YES, if unable to contact the Applicant and determine the number of hours worked per week. |  |
| Citizenship is not verified | YES |  |
| SSN is not verified | YES |  |
| Quarters are not verified | YES, only if a required condition of eligibility |  |
| The applicant is over 65 | YES, Send 3400A or 3400B, whichever is most applicable |  |
| The applicant indicates disability | YES, Send 3400A |  |

**Note:** If no income is recorded, complete the unemployment workbook to identify if the individual needs to be referred to SCDEW for Unemployment Benefits. If referral is needed, complete the checklist and send to client. Regardless, complete the determination.

**D. Retroactive Coverage**

Retroactive coverage must be requested by the applicant. If an applicant indicated on the application that he has medical bills in any of the three months prior to the Application Effective Date (AED), the Eligibility Specialist should first process current eligibility based on the AED. If retroactive coverage is requested outside of the ATA, follow the policy and procedures below.

|  |
| --- |
| **Procedure for Processing Retroactive Coverage** |
| If an applicant is eligible for retroactive benefits, the Eligibility Specialist should mail FM 3400-C, Request for Retroactive Coverage, to the applicant.  An applicant may also request Retroactive Coverage by phone or in person. For requests by phone or in person, the Eligibility Specialist is to ask the applicant for their monthly income and verify electronically while the person is present or on the phone if possible. Request documentation only if electronic verifications are not available. Follow current income verification policies and procedures (MPPM Section 203).  For Retroactive Coverage requests received by mail, attempt to verify income electronically. Request documentation only if necessary.  If MEDS will not allow the Eligibility Specialist to approve the month(s) requested, then a Help Desk ticket is required to insert the eligibility dates. |

The Eligibility Specialist should not hold up the eligibility determination of benefits from the application date. If able to approve or deny the application, the eligibility specialist should take that action, and then process eligibility for the retroactive months.

**101.04 Retroactive Applications**

(Rev. 09/01/17)

The agency may authorize Medicaid for any or all of the three (3) calendar months preceding the month of application for medical assistance. An applicant may be eligible for retroactive coverage even though the application for current or continuing medical benefits is denied. A separate application is not required for retroactive benefits unless the application is made posthumously. Retroactive eligibility will only be considered after a full application has been submitted. A request for a retroactive decision can be made at any time by the following means:

1. An indication on the application
2. Filing a DHHS Form 3400-C, Request for Retroactive Medicaid Coverage
   1. A DHHS Form 3400-C can be submitted if the individual did not indicate on the application that retroactive coverage is requested and now wants a retroactive determination
   2. A DHHS Form 3400-C can be submitted if an individual requested retroactive coverage on an application, but a decision was not made by the agency at the time of approval or denial
   3. The DHHS Form 3400-C can be completed by agency or call center staff when a retroactive request is made by phone OR by the applicant/ beneficiary

**Note:** A DHHS Form 3400-C should be scanned into OnBase as MEDS-Retro Request. The request will either be added to an Active Tracking Form or a Tracking Form will be created and go into the Change Queue

The following requirements must be met after retroactive Medicaid is explained to the applicant:

* Retroactive coverage must be explored if the individual self-reports that he/she has outstanding medical expenses and requests that eligibility be determined for Medicaid benefits.
* It must be established that the individual met all financial and categorical criteria in each of the retroactive month(s) for which Medicaid eligibility is requested. Eligibility is also determined based on the individual’s actual financial circumstances for each of the retroactive months in question.
* When the individual’s categorical eligibility is based on the factors of blindness or disability, blindness or disability must be established and/or verified for the retroactive period.

If the above requirements are met, the individual may be found eligible for Medicaid for any or all of the retroactive months. The eligibility decision must be made independently for each of the three (3) months and documented in the case file.

Use the following table for MAGI retroactive determinations.

| **Income** | **Household**  **Composition** | **Action** |
| --- | --- | --- |
| Same | Same | Budget application month income for each Retroactive month |
| Same | Different | Contact applicant for details |
| Same | Not shown | Budget application month income for each Retroactive month  Assume same Household Composition |
| Different | Same | Budget the reported income for each retroactive month  Check electronic data sources if available |
| Different | Different | Contact applicant for details  Check electronic data sources if available for income |
| Different | Not shown | Budget reported income for each Retroactive month  Check electronic data sources if available  Assume same Household Composition |
| Not shown | Not shown | Contact applicant for details |

Income and Resources must be verified for each retroactive month for non-MAGI/SSI-Related categories

**Reminder:** If eligibility can be established for application month but the necessary information to make a retroactive decision is missing, complete the eligibility decision and request the missing information. If unable to obtain through a phone call, send a DHHS Form 1233 and place the case in follow-up.

|  |
| --- |
| **Procedure For Retroactive Decisions Made After The Initial Medicaid Determination** |
| **MEDS Procedure**   1. MEDS does not generate a notice for a retroactive determination made after the initial Medicaid eligibility decision.The Eligibility Specialist must notify the applicant/beneficiary using the [DHHS Form 3229-D](http://medsweb.scdhhs.gov/EligibilityForms/FM%203229-D.pdf), Notice of Approval/Denial for Retroactive Medicaid Benefits. 2. The eligibility specialist must also provide [DHHS Form 945](http://medsweb.scdhhs.gov/EligibilityForms/FM%20945.pdf), Verification of Medicaid, for retroactive decisions made after the initial Medicaid determination for dates of service outside of the one year timely filing period. The User ID identifying the specialist completing the form must be included on the DHHS Form 945.   **Note the Following**   1. Medicaid policy requires that only “clean” claims received and entered into the claims processing system within one year from the date of service be considered for payment. A “clean” claim is free of errors and can be processed without obtaining additional information from the provider or another third party. 2. [DHHS Form 945](http://medsweb.scdhhs.gov/EligibilityForms/FM%20945.pdf) is also used for other requests to verify Medicaid eligibility. 3. Specific instructions regarding retroactive coverage for OCWI-Pregnant Woman cases are found in MPPM 204.02.01D. 4. In some situations, the individual may be found eligible for Medicaid benefits, but not for a vendor payment because certain Medicaid requirements specific to long-term care were not met. 5. If the individual was a resident in another state throughout one of the months in the retroactive period, he/she must apply for benefits in that state. (Refer to MPPM 102.03.09) |
| **Procedure For Updating Retroactive Coverage** |
| **MEDS Procedure**  (Do not change the Begin Date set by the system after performing *Make Decision* in MEDS)  **MEDELDOO**  Go to the top of the screen to change the date to the retroactive coverage month needed.  DATES-FROM: MM / YYYY THRU: 00 / 0000  **MEDELDO1**  Complete the screen by entering the countable Budget Group members, countable income and other information pertinent to the payment category. Do not update the “Next Review Date”.  **MEDELD02**  MEDS will display an ELD02 screen for each member included in the Budget Group. The eligibility *Begin* and *End* dates for that retroactive month will display.  **Note:** If the *Medical Services in the Last 3 Months* indicator on the HMS06, Household Member Detail screen in MEDS was set to N when the application was locked, the retroactive budget months will not be found. A Service Manager ticket must be submitted. |
| **Cúram Procedure**  The appropriate procedure may be found in the [Processing Retroactive Medicaid](https://schhs.sharepoint.com/:b:/r/sites/EES/Training/Curam/HCR/Job-Aids/Case%20Management/Processing%20Retroactive%20Medicaid.pdf?csf=1&web=1&e=g4J9gB) job aid at the [Training Materials Portal-MAGI](https://www1.scdhhs.gov/ees/trainingportal/). |

**101.04.01 Appeal Rights**

(Rev. 10/01/23)

An applicant/ beneficiary or his authorized representative may request an appeal within thirty (30) calendar days from the date on a Notice of Adverse Action. Authorized representatives assigned by the applicant/beneficiary prior to the death of the applicant/beneficiary are still valid. The Eligibility Specialist must follow the policy and procedures listed in [MPPM 101.12.11](#MPPM_101_12_10), Right to Appeal and Fair Hearing when a request to appeal a retroactive determination is received.

**101.04.02 Claims for Retroactive Eligibility**

(Rev. 12/01/15)

Medicaid policy requires that only “clean” claims received and entered into the claims processing system within one year from the date of service be considered for payment. A “clean” claim is free of errors and can be processed without obtaining additional information from the provider or another third party. Claims involving retroactive eligibility for dates of service that are outside of the one-year timely filing period must meet both of the following criteria to be considered for payment:

1. Be received and entered into the claims processing system within six (6) months of the beneficiary’s eligibility being added to the Medicaid eligibility system; **AND**
2. Be received within three (3) years from the date of service or date of discharge. Claims for dates of service that are more than three (3) years old will not be considered for payment.

When the individual’s eligibility is to be established based on the factors of blindness or disability, the individual’s blindness or disability must be established for the retroactive period, if not already established.

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**101.05 Posthumous Applications**

(Rev. 10/01/23)

An application for Medicaid may be made on behalf of a deceased person. An application for retroactive coverage can also be filed on behalf of a deceased person and must be filed before the end of the third month following the date of death.

Death is not an appropriate reason to deny an application for Medicaid benefits **unless** the applicant has no outstanding medical expenses subject to payment by Medicaid in the eligibility period surrounding his application.

When the applicant has incurred medical expenses before death, a full eligibility determination must be made.

**NOTE**

If the applicant/beneficiary is deceased and the DHHS Form 1282 and application were signed by the applicant/beneficiary prior to the applicant/beneficiary’s death, the DHHS Form 1282 is still valid. If the DHHS Form 1282 is submitted after the applicant is already deceased, the document would not be valid.

If there is any uncertainty about the validity of the signed DHHS Form 1282, submit a service Manager Ticket as a document review.

**101.06 Access to the Application Process**

(Eff. 01/01/14)

Each application intake site is required to provide services to the limited English proficient, deaf, blind, or disabled applicant to comply with non-discrimination mandates under the Civil Rights Act and the Americans with Disabilities Act.

**101.06.01 Interpreters**

(Rev. 03/01/19)

Applicants/beneficiaries who are limited English proficient, deaf, or blind must be provided with an interpreter to eliminate barriers to applying for services offered under the Medicaid program.

The Eligibility Specialist must arrange for auxiliary services such as an interpreter of a person’s native language, sign language, teletypewriter, telecommunication device for the deaf, telebrailles, visual or tactile signaling devices and assisted listening devices for the blind.

If the Eligibility Specialist determines that a language interpreter is needed, he/she must access Telelanguage, Inc. (Refer to MPPM Chapter 802, Appendix B.) With supervisory approval, the Eligibility Specialist should contact an interpreter and arrange for the service.

For applicants/beneficiaries requiring hearing or vision interpretive services, submit a ticket through Service Manager to make a request for assistance.

The agency has the Healthy Connections application and various other forms available in Braille. If an applicant makes a request for a Braille application, they can contact the Healthy Connections Member Services Center at 1-888-549-0820. This request will be forwarded to the appropriate local eligibility office to send what the requested form(s). The date of application will be the date the individual makes the request for the application from the Member Services Center.

Many application forms and addendums, as well as other supplementary forms, such as DHHS Form 1233, are available in Spanish. To view or print a Spanish language form, visit the [Medicaid Eligibility Forms](http://medsweb.scdhhs.gov/formslisting.htm) page.

**101.06.02 Request for Document Translation Services**

(Rev. 12/01/23)

Spanish version applications may not require translation services if a specialist is able to clearly determine the answer to the question by comparing the English version of the application with the Spanish version. There is no difference in the meanings of the questions on the two applications. When Spanish is selected as the Primary Contact or Primary Applicant’s preferred language, then the Spanish language version of the Annual Review Form will be sent to the household. Both the Spanish and English language Annual Review Forms will be stored in OnBase. If the answer to a question cannot be clearly determined, translation services must be requested.

|  |  |
| --- | --- |
| Graphical user interface, application, email  Description automatically generated | Graphical user interface, application, Word  Description automatically generated |

When an application or other document requires translation, a request must be made through Service Manager as illustrated below:

|  |  |
| --- | --- |
| Graphical user interface, text, application, email  Description automatically generated | Graphical user interface, text, application  Description automatically generated |

**101.06.03 Barriers**

(Eff. 01/01/14)

Access to the facility should not be a barrier. Each facility where Medicaid eligibility specialists are located should have access for handicapped persons. Elimination of barriers may be accomplished by sending eligibility specialists to interview the person in his home or at a barrier-free alternative site.

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**101.06.04 Electronic Application for Medicare Savings Programs (MSP) from the Social Security Administration**

(Rev. 10/01/21)

For individuals who apply for the Low-Income Subsidy (LIS) with the Social Security Administration (SSA), the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requires SSA to forward an electronic application to the state Medicaid agency to determine if the individual may be eligible for a Medicare Savings Program (MSP). Medicare Savings Programs are ABD/QMB, SLMB, and QI.

**101.07 Standard of Promptness**

(Eff. 01/01/14)

[CFR §435.912](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-J/subject-group-ECFR2b847721e0bfa03/section-435.912)

Eligibility must be determined within the following timeframes.

**101.07.01 FI-Related Applications (MAGI Eligibility Groups)**

(Rev. 08/01/23)

Federal rules require that applications be approved or denied, and the applicant notified of the decision within 45 calendar days from the effective date of the application. The date the application is received is counted as the first day of the 45-day count. For more information see [MPPM 101.03.03](#MPPM_101_03_03).

* For all applications, if verification is needed from the applicant for information not reported on the application/addendum or for additional information regarding reported information, the eligibility specialist must follow the collateral call process defined in MPPM 101.07.04 before sending a [DHHS Form 1233](http://medsweb.scdhhs.gov/EligibilityForms/FM%201233%20ME.pdf), Medicaid Eligibility Checklist, requesting the needed information. Allow at least fifteen (15) calendar days for the applicant to submit the information to allow the application to be processed within 45 calendar days. For example, if the DHHS Form 1233 is created on January 1, the due date will be January 16.
  + If there is outstanding verification in the SOR and the SOR sends a request for information to the applicant, the system will generate the necessary timers and tasks. When Workload Pro serves the task into workflow, the eligibility specialist should respond and process the task. The eligibility specialist should not put the task into follow-up if the timer has expired.
  + If generating a Manual Tracking Form and setting the follow-up date in OnBase, add an additional six (6) days to allow for mailing, scanning, and task creation in Workload Pro. This provides a total of 21 days from the date the DHHS Form 1233 is created and allow for the form to be mailed.

Example: For a manually generated DHHS Form 1233 created on January 1 and is due on January 16, set the follow-up date in OnBase as January 22.

* + When information is scanned into OnBase, a Workload Pro task will be generated for an eligibility specialist to evaluate.
    - If an applicant/beneficiary returns partial or incomplete information, refer to MPPM 101.07.05.
  + If the task was generated due to other information being scanned into the OnBase, respond to the scanned information, and put the case back into follow-up for any remaining time.
  + If an applicant/beneficiary returns partial or incomplete information before the follow-up date, process the returned information, and complete a collateral call to the applicant/beneficiary to identify the missing requested information and remind them the information needs to be returned by the original due date. Put the case back into follow-up.

Example: A DHHS Form 1233 is sent on January 1 with a follow-up date of January 22 in OnBase. On January 10, the applicant returns half of the requested information. The eligibility specialist will:

* + - Complete a collateral call to the applicant/beneficiary
    - List the missing information
    - Remind the applicant/beneficiary about the original due date
    - Update the Documentation Template;
    - Update any systems as appropriate; and
    - Put the case back into follow-up with the original January 22 follow-up date.
  + If any applicant/beneficiary returns partial or incomplete information and the follow-up date has passed, deny based on failure to return requested information.
  + A task is created in Workload Pro if the information is not returned by the follow-up date in OnBase. The Eligibility Specialist can process the task when it is claimed if the OnBase follow-up date was set properly.

**Note:**If the original follow-up date for a manually created tracking from does not include the additional six (6) days to allow for scanning and task creation in Workload Pro, put the case back into follow-up with the correct date if the date has not already passed.

**Date Examples**

|  |  |  |  |
| --- | --- | --- | --- |
| DHHS Form 1233  Creation Date | Due Date | OnBase  Follow-up  Date | Workload Pro  Task Date |
| January 1 | January 16 | January 22 | January 22 |
| February 15 | March 2 | March 8 | March 8 |
| March 26 | April 10 | April 16 | April 16 |

* The applicant has the primary responsibility for providing documentary evidence to support statements made on the application or to resolve any questionable information.
* The eligibility specialist will accept any reasonable documentary evidence provided by the applicant and will be primarily concerned with how adequately the verification proves the statements on the application or review form.
* If the applicant is unable to obtain information necessary to establish eligibility in a timely manner, the eligibility specialist must make a reasonable effort to assist the applicant.
* Refer to SC MPPM [101.07.03](#MPPM_101_07_03) for MEDS Extension of Promptness procedures.

**South Carolina specific standards** impose the following additional requirements:

* For all FI-related applications, **except Pregnant Women and Family Planning,** income must be verified before approval.
* If an application is denied solely for failure to provide information, and the applicant provides all needed verifications within 30 calendar days from the date on the denial notice, the date of the previous original application must be used to determine the effective date.
* If a case is closed solely for failure to return a Review and a completed review form is received within 90 calendar days from the date of the closure notice, the case should be treated as a review and continued eligibility for the beneficiary should be determined using the information provided and/or requesting additional information.
* If a case is closed solely for failure to return information and the applicant provides all needed verifications within 30 calendar days from the date on the denial notice, the date of the original application must be used to determine the effective date.

**Exception:** The Transitional Medicaid Quarterly Report cannot be treated as a “Review” if they are not returned by the 21st day of the month following the month in which the quarterly report was received. The beneficiary must re-apply for Medicaid.

* If a case is closed for failure to return and a review form is received more than 90 days after closure,
  + If the review is signed, treat it as an application.
  + If the review form is unsigned, treat it as an unsigned application (See MPPM 101.03.04C).
    - the review should be treated as an application once the individual has signed a [DHHS Form 3403](http://medsweb.scdhhs.gov/EligibilityForms/FM%203295.pdf), Your Rights and Responsibilities or the Review form.
    - Send the DHHS Form 3403 to the individual.
      * If the DHHS Form 3403 is returned within 15 days, use the date the review was received as the application date.
      * If the DHHS Form 3403 is returned after 15 days, use the date the form is received as the application date.
      * If the DHHS Form 3403 is not returned, no additional action is needed.
* Eligibility should be determined as if the verification was received with the first request. The case record should be documented with the date the information was received. If retroactive eligibility is requested, it should be based on the date of the previous application.
* An initial budget based on the applicant's self-reported income, pregnancy, citizenship, and family circumstances must be completed on the day an application is received to determine eligibility for Pregnant Women. If the eligibility specialist cannot process the application the date received, a decision must be made by the end of the next business day, and the reason the application could not be processed must be documented in the case record. It is important that the pregnant woman has coverage to access prenatal care as quickly as possible. Refer to MPPM 204.02 for specific instructions on processing OCWI (Pregnant Women) applications.

**101.07.02 SSI-Related Applications (Non-MAGI Eligibility Groups)**

(Rev. .04/01/24)

Federal rules require that applications be approved or denied, and the applicant notified within 45 calendar days from the date the application was filed. The date of application is counted as the first day of the 45-day count. The timeframe is 90 calendar days where disability must be determined before the eligibility determination can be completed.

* For all applications and addendums, if verification is needed from the applicant for information not reported on the application/addendum or for additional information regarding reported information, the eligibility specialist must follow the collateral call process defined in MPPM 101.07.04 before sending a [DHHS Form 1233](http://medsweb.scdhhs.gov/EligibilityForms/FM%201233%20ME.pdf), Medicaid Eligibility Checklist, requesting the needed information. Allow at least fifteen (15) calendar days for the applicant to submit the information to allow the application to be processed within 45 calendar days. For example, if the DHHS Form 1233 is created on January 1, the due date will be January 16.
  + If there is outstanding verification in the SOR and the SOR sends a request for information to the applicant, the system will generate the necessary timers and tasks. When Workload Pro serves the task into workflow, the eligibility specialist should respond and process the task. The eligibility specialist should not put the task into follow-up if the timer has expired.
  + If generating a Manual Tracking Form and setting the follow-up date in OnBase, add an additional six (6) days to allow for mailing, scanning, and task creation in Workload Pro. This provides a total of 21 days from the date the DHHS Form 1233 is created and allow for the form to be mailed.

Example: For a manually generated DHHS Form 1233 created on January 1 and is due on January 16, set the follow-up date in OnBase as January 22.

* + When information is scanned into OnBase, a Workload Pro task will be generated for an eligibility specialist to evaluate.
    - If an applicant/beneficiary returns partial or incomplete information, refer to MPPM 101.07.05.
  + If the task was generated due to other information being scanned into the OnBase, respond to the scanned information, and put the case back into follow-up for any remaining time.
  + If an applicant/beneficiary returns partial or incomplete information before the follow-up date, process the returned information, and complete a collateral call to the applicant/beneficiary to identify the missing requested information and remind them the information needs to be returned by the original due date. Put the case back into follow-up.

Example: A DHHS Form 1233 is sent on January 1 with a follow-up date of January 22 in OnBase. On January 10, the applicant returns half of the requested information. The eligibility specialist will:

* + - Complete a collateral call to the applicant/beneficiary
    - List the missing information
    - Remind the applicant/beneficiary about the original due date
    - Update the Documentation Template;
    - Update any systems as appropriate; and
    - Put the case back into follow-up with the original January 22 follow-up date.
  + If any applicant/beneficiary returns partial or incomplete information and the follow-up date has passed, deny based on failure to return requested information.
  + A task is created in Workload Pro if the information is not returned by the follow-up date in OnBase. The eligibility specialist can process the task when it is claimed if the OnBase follow-up date was set properly.

**Note:** If the original follow-up date for a manually created tracking from does not include the additional six (6) days to allow for scanning and task creation in Workload Pro, put the case back into follow-up with the correct date if the date has not already passed.

**Date Examples**

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| **DHHS Form 1233**  **Creation Date** | **Due Date** | **OnBase**  **Follow-up**  **Date** | **Workload Pro**  **Task Date** |
| January 1 | January 16 | January 22 | January 22 |
| February 15 | March 2 | March 8 | March 8 |
| March 26 | April 10 | April 16 | April 16 |

* For disability cases, the blindness/disability determination process outlined in SC MPPM 102.06.02A must be initiated within five (5) business days from the date of application.
* For SSI-related applications, income and resources must be verified using SSI verification standards.
* For persons residing in an institution or receiving home and community-based services, additional verifications must be obtained. For example, the Medicaid Eligibility Specialist must verify:

1. that a sanctionable transfer did not occur,
2. the level of care determination, and
3. that all trusts were evaluated by the Eligibility, Enrollment and Member Services at the Department of Health and Human Services.

* If an application needs to be processed for both Non-MAGI and LTC services by an eligibility specialist, the LTC specialist must confirm that the information request was sent to the correct location (i.e., the information request was sent to the applicant at a facility and to the applicant’s authorized representative’s mailing address listed on the application or DHHS form 1282).
* If a separate determination was needed for both Non-MAGI and LTC and the application was found to be closed after 30 days and is unable to be re-opened, but both determinations were not completed, a new application case must be opened and pended with the original application date. (Refer to CGIS Manual 2.02 enter/Submit Application in Cúram)
* If an **application** is denied solely for failure to provide information, and the applicant provides all needed verifications within 30 calendar days from the date on the denial notice, the date of the original application must be used to determine the effective date.
* If a case is closed solely for failure to return a Review and a completed review form is received within 90 calendar days from the date of the closure notice, the case should be treated as a review and continued eligibility for the beneficiary should be determined using the information provided and/or requesting additional information.
* If a case is closed solely for failure to return information and the applicant provides all needed verifications within 30 calendar days from the date on the denial notice, the date of the original application must be used to determine the effective date.
* If a case is closed for failure to return and a review form is received more than 90 days after closure,
  + If the review is signed, treat it as an application
  + If the review form is unsigned, treat it as an unsigned application (See MPPM 101.03.04C).
    - the review should be treated as an application once the individual has signed a [DHHS Form 3403](http://medsweb.scdhhs.gov/EligibilityForms/FM%203295.pdf), Your Rights and Responsibilities or the Review form.
    - Send the DHHS Form 3403 to the individual.
      * If the DHHS Form 3403 is returned within 15 days, use the date the review was received as the application date.
      * If the DHHS Form 3403 is not returned, no additional action is needed.
* Eligibility should be determined as if the verification was received with the first request. The case record should be documented with the date the information was received. If retroactive eligibility is requested, it should be based on the date of the previous application.
* Refer to MPPM Chapter 304, Nursing Home – Home and Community-Based Services - General Hospital, for additional policy regarding persons residing in institutions or receiving home and community-based services.
  + For individuals who have been determined to meet all eligibility requirements except the requirement to be in a nursing home for 30 consecutive days, the standard of promptness may be extended. On the 45th day following the application date, the Eligibility Specialist should request an Extension of Promptness. (Refer to [MPPM 101.07.03](#MPPM_101_07_03)). The application should remain in pending status while the applicant is waiting to enter a facility after the applicant/beneficiary has been financially cleared (Refer to MPPM 304.07).
    - When an applicant has not yet entered a nursing facility, but has been financially approved
      * The Eligibility Specialist will send out a CGIS717—Cover Letter-NH-Notification to Enter Nursing Facility, which allows the applicant an Extension of Promptness for 90 days after being financially cleared.
      * The applicant/authorized representative must be contacted to obtain the applicant’s current income if unable to verify for the month of entry.
      * The case record must be updated with any information that has changed.
    - If the applicant/beneficiary enters a nursing facility after 90 days of being financially cleared (income and resources) and the application has not been denied in the SOR
      * The Eligibility Specialist must obtain current income and resources for the month of entry (Refer to MPPM 304.07).
    - If the application has already been denied in the SOR due to not entering a facility, then the applicant/beneficiary will have to reapply, as the CGIS717—Cover Letter-NH-Notification to Enter Nursing Facility only allows the applicant an Extension of Promptness for 90 days after being financially cleared and is no longer valid once the application is denied.
  + For individuals who have been determined to meet all eligibility requirements except the requirement for a Level of Care to receive Home and Community-Based Services (HCBS) for 30 consecutive days (if not already in a full Medicaid Payment Category), the standard of promptness may be extended. On the 45th day following the application date, the Eligibility Specialist should request an Extension of Promptness (Refer to [MPPM 101.07.03](#MPPM_101_07_03)). The application should remain in pending status while the applicant is waiting to enter waiver/HCBS program with Community Long-Term Care after the applicant/beneficiary has been financially cleared (Refer to MPPM 304.07).
    - The applicant/authorized representative must be contacted using [DHHS Form 3229-A](https://medsweb.scdhhs.gov/formslisting.htm) Notice of Approval/Denial for Medical Assistance/Optional Supplementation
      * The Eligibility Specialist will complete the required fields:
        + From, To, Date,
        + Applicant Name, and
        + You have been approved for:

Financially approved, pending:

Level of Care

Enrollment in waiver/PACE services

30 consecutive days of service (Required if not already in a full Medicaid Payment Category).

* + - If the applicant/beneficiary enters waiver/HCBS after 90 days of being financially cleared (income and resources) and the application has not been denied in the SOR
      * The Eligibility Specialist must obtain current income and resources for the month of entry (Refer to MPPM 304.07).

**101.07.03 Extension of Promptness**

(Rev. 12/01/22)

If an application has not been approved within the 45 or 90-calendar day standard of promptness and there is a valid reason, the corresponding Extension of Promptness code must be entered into MEDS/ Cúram. A code should only be entered into MEDS/ Cúram once the application is over the standard of promptness. The only exception is for an applicant who is awaiting the 30 consecutive day requirement for institutional care. The valid reason code may be entered into MEDS/Cúram once the applicant starts the 30-calendar day wait if approval would take place after the standard of promptness.

| **Procedure to Request an Extension of Promptness** |
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| **MEDS Procedures:**   * Go to the Specialist Alert Screen. * Select alert number 572 for that budget group (BG). * Press <PF12> to access the Extension of Promptness Screen. * The Extension of Promptness Screen will display for the BG. The BG start date will display at the top of the screen. The period shown is the one for which you are requesting an extension. * Select the appropriate reason for the extension.   + AD = Administrative or other delay that cannot be prevented (Note**:** To be used for situations such as awaiting clarification from State DHHS, the office is closed due to weather, MEDS was not available, or if an eligibility determination cannot be made on a non-citizen pregnant woman case within the 45 day standard of promptness).   + AR = Applicant requests delay until necessary information can be obtained   + CC = Awaiting proof of Citizenship information   + DD = Disability determination pending   + EF = Awaiting enrollment of the facility in the Medicaid program   + CI = Awaiting proof of Citizenship and Identity   + ID = Awaiting proof of Identity Information   + IT = Income Trust being established   + LC = CLTC level of care pending   + NB = Waiting placement on a Nursing Facility   + NT = Following up on verification requests   + RD = Reason to doubt allegations   + TD = Awaiting 30 consecutive days   + TP = Failure/delay in receiving third party source verification * Type <MOD> in the Action field and press <Enter>.   The Eligibility Specialist has the option of selecting the “Extension of Promptness” menu item from the Household Maintenance Menu. Eligibility Specialists should use the budget group number to access the BG for which they are requesting the extension. On the screen, select the appropriate reason for the delay and type <MOD> in the Action field. |
| **Cúram Procedure**   * Go to Application Case by clicking the Reference number found on the home dashboard under Pending Application cases * From Application Case, click the Timers tab. * Click the Action button on the far right of the banner. * Select Extend. An Extend Timer pop up appears. * Choose an Extension Reason from the dropdown. * Click Save * The Expiry Date will reflect the extension.   The appropriate procedure may be found at [Training Materials Portal-MAGI](https://www1.scdhhs.gov/ees/trainingportal/) or [Training Materials Portal-Non-MAGI](https://www1.scdhhs.gov/ees/TrainingPortal_NonMAGI/).  Note: Extension of promptness can only be done at the application case level. It can’t be done once an application has been authorized in Cúram. |
| **Procedure to Open the Denied Budget Group** |
| **MEDS Procedure:**  Eligibility specialists should update RSN CD1 on ELD01 screen in MEDS with code 104 and the <MOD> to reopen the denied nursing home or the home and community based services budget group. MEDS screens ELD00 and ELD01 will have to be updated and <MOD>. Make Decision and Act on Decision to put the BG in Active status. |

101.07.04 Collateral Calls

(Rev. 04/01/23)

Prior to sending a DHHS Form 1233, Medicaid Eligibility Checklist, an Eligibility Specialist must attempt to call the applicant/beneficiary/AR to:

* obtain missing information,
* clarify what is still needed,
* attempt three-ways calls with 3rd parties, and
* answer questions.

Central eligibility is not required to complete a collateral call attempt pending and mailing out the DHHS Form 3400-A Addendum for MSP/QI electronic applications received from the Social Security Administration.

**If a checklist has been sent before and new information is needed, any calls made for the first checklist do not count towards the call attempts for the new request.**

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| Prior to attempting to call the Applicant/Beneficiary/AR, review System of Record and Documentation Template for documentation that may help with the determination as well as documentation of previous call attempts.   * Determine whether the applicant/beneficiary has called the Member Services Contact Center (Conduent) and what resulted. * Review the casefile to make sure required documentation has not already been received. |

| **Call Procedures** |
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| 1. Attempt to call the applicant/beneficiary/AR.   **Note:** If you do not reach the person on the initial call, follow current procedures, and leave a message that you will follow up with another call in 5 minutes. Do not put the case in "finish later" while waiting the 5 minutes. The initial and follow-up calls are part of the same attempt.   1. Exhaust all options for obtaining needed information if you cannot reach the applicant. Attempt to call any legal representatives (such as a POA) or Authorized Representative(s) with proper documentation in the record. (Note: This is part of the same attempt, not a separate attempt.) If the applicant has multiple authorized representatives listed, call each one until you have spoken to someone or cannot reach anyone. 2. If the applicant/beneficiary and any legal representatives or Authorized Representatives cannot be reached, **send the checklist(s) at this time**. 3. Document each attempted call in the SOR and in the General Comments section on the Documentation Template. Record all calls on the same day as part of one entry.  * Attempted to call applicant/beneficiary/AR. Provide details of the person(s) called, why, and result. The attempt may include phone calls to several individuals if the applicant/beneficiary has more than one Authorized Representative. Document each contact as appropriate.   + If the call is successful and needed information could not be obtained during the collateral call, then:   + Send DHHS Form 1233 checklist to the applicant, beneficiary, and each of the authorized representatives.   + Send case to follow up in OnBase for a total of 21 days (15 days + 6 days to allow for scanning).   + If the call is NOT successful, then   + Leave a voice message according to current process.   + Send DHHS Form 1233 checklist to the applicant, beneficiary, and each of the authorized representatives.   + Send case to follow up in OnBase for a total of 21 days (15 days + 6 days to allow for scanning). |

**101.07.05 Partial Information**

(Eff. 08/01/23)

* If an applicant/beneficiary returns partial or incomplete information before the follow-up date, process the returned information, and complete a collateral call to the applicant/beneficiary to identify the missing requested information and remind them the information needs to be returned by the original due date. Put the case back into follow-up.
* If any applicant/beneficiary returns partial or incomplete information and the follow-up date has passed, deny based on failure to return requested information.

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| Diagram  Description automatically generated |

**Example 1**

A DHHS Form 1233 is sent on January 1 with a follow-up date of January 22 in OnBase. On January 10, the applicant returns half of the requested information. The eligibility specialist gets the task on January 12 and:

* Completes a collateral call to the applicant
* Lists the missing information
* Reminds the applicant/beneficiary about the original due date
* Updates the Documentation Template
* Updates any systems as appropriate; and
* Puts the case back into follow-up with the original January 22 follow-up date.

**Example 2**

A DHHS Form 1233 is sent on January 1 with a follow-up date of January 22 in OnBase. On January 10, the applicant returns half of the requested information. The eligibility specialist gets the task on January 12 and:

* Attempts a collateral call to the applicant but is unsuccessful
* Updates the Documentation Template
* Updates any systems as appropriate; and
* Puts the case back into follow-up with the original January 22 follow-up date.

**Example 3**

A DHHS Form 1233 is sent on January 1 with a follow-up date of January 22 in OnBase. On January 10, the applicant returns half of the requested information. The eligibility specialist gets the task on January 25 and:

* Checks OnBase to make sure the information is not in the record
* Updates the Documentation Template; and

Denies the application for Failure to Return Information.

**101.08 Disposition of Applications/Active Cases**

(Rev. 02/10/21)

As part of the initial and continuing eligibility process, the information provided by the applicant/beneficiary and/or obtained from other sources must be verified, documented in the case record, and evaluated in accordance with the program requirements. Components of this process are explained below.

An application or review must be evaluated based on the date order received. Treat the form with the later date as a reported change. The applicant or beneficiary must be contacted to clarify any conflicting information which results in a change in benefit level.

The Documentation Template in OnBase must be completed for all case decisions in MEDS or Cúram with the exception of cases that are processed straight through without specialist intervention. The template should be started by the eligibility specialist who first begins processing an application or review and updated by each subsequent eligibility specialist throughout the process until a decision is completed.

**101.08.01 Verification**

(Rev. 10/01/13)

[CFR §435.945](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-J/subject-group-ECFRc649656b2ed45a8/section-435.948) - [CFR §435.956](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-J/subject-group-ECFRc649656b2ed45a8/section-435.965)

Verification is the substantiation, confirmation, authentication, or validation of an assertion, a claim, or previously submitted information. Refer to SC MPPM Chapter 102 and program specific instructions for verification procedures.

* The applicant/beneficiary has the primary responsibility for providing documentary evidence to support statements made on the application or, if necessary, to resolve any questionable information.
* The Eligibility Specialist will accept any reasonable documentary evidence provided by the applicant/beneficiary and will be primarily concerned with how adequately the verification proves the statements on the application or review form.
* Documentary evidence provided by the applicant/beneficiary must never be discarded, destroyed, ignored, or altered by the Eligibility Specialist.
* If the applicant/beneficiary is unable (physically, emotionally, mentally, or due to circumstances beyond his control) to obtain information necessary to establish eligibility in a timely manner, the Eligibility Specialist must offer assistance.
* When the applicant/beneficiary claims no income or resources, the Eligibility Specialist must fully document the facts provided to substantiate these claims in the MEDS/Cúram notes screen.

**Collateral Contacts**

If it is necessary to request information from banks, insurance companies, or other sources that do not disclose information without authorization, such authorization must be obtained in writing from the applicant/beneficiary using [SC DHHS Form 943](http://medsweb.scdhhs.gov/EligibilityForms/FM%20943.pdf), Information Release Form.

* However, permission from the applicant/beneficiary for needed verifications other than those specified above is not necessary if the applicant/beneficiary (or a responsible person acting on his behalf if he/she is incapacitated or incompetent) signs a dated application form.
* Public records or records available from other agencies may be consulted without the consent of the applicant/beneficiary.
* When information is sought from a collateral source, the applicant/beneficiary must be given a clear explanation of the information needed, what the information is needed for, and how it will be used.
* When the applicant/beneficiary has a valid objection to the use of a particular source, his reasons for objecting should be considered and another source selected, if reasonable.
* However, certain sources, such as the employer of the applicant/beneficiary, can be contacted over his objection.
* If someone has definite facts relating to certain eligibility criteria, he/she may be used as a collateral source of information. He must be advised of the necessity to reveal his identity to the applicant upon request, if the information provided results in an adverse action.
* If the collateral source does not agree to have his identity revealed, the information obtained from him/her may not be used to take action. This information may only be used as a lead toward securing other evidence.
* Documentary evidence provided by a collateral source must never be discarded, destroyed, ignored, or altered by the Eligibility Specialist.

**101.08.02 Documentation**

(Rev.07/01/15)

[CFR §435.945](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-J/subject-group-ECFRc649656b2ed45a8/section-435.948) - [CFR §435.956](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-J/subject-group-ECFRc649656b2ed45a8/section-435.965)

Documentation is the written record of verified information methods used. All information pertaining to the eligibility of the applicant/beneficiary must be recorded in the case record. Documentation provided by an applicant/beneficiary must never be discarded, destroyed, ignored, or altered by the Eligibility Specialist.

* The information is evaluated, taking into consideration legal requirements and program limitations, to determine if all eligibility criteria are met.
* If several source’s give conflicting information, the reliability of each source must be evaluated, and the case record should specify which source was accepted and why. The final determination of eligibility is made based on the most reliable source available.
* The applicant must be informed of his responsibility to cooperate in supplying the information and documentation necessary to complete the eligibility process.
* The Eligibility Specialist will provide to the applicant, in writing, an outline of the information that the applicant is responsible for obtaining. [DHHS Form 1233](http://medsweb.scdhhs.gov/EligibilityForms/FM%201233%20ME.pdf), Medicaid Eligibility Checklist, may be used for this purpose. A copy of the request for information should be placed in the case file.
* If an applicant does not provide the information necessary to determine eligibility or continued eligibility within the specified timeframe, the Eligibility Specialist should take action to deny/close. MEDS/Cúram will then send an appropriate notice to the applicant/beneficiary.
* The notice will inform the applicant/beneficiary that assistance is being denied or discontinued because of failure to provide information necessary to determine or re-determine eligibility.
* Current documentation is required to make an eligibility determination. Unless otherwise specified, documentation is considered current if it is dated within 35 calendar days prior to and including the:
  + Application signature date;
  + Date the application/review is received/stamped in a SC DHHS office; or
  + Date an eligibility decision is completed in MEDS/Cúram on a review.

**101.08.03 Application Actions**

(Rev. 03/01/24)

All applications will be subject to one of the following actions:

* **Approval** – When all of the eligibility criteria are met, the application is approved.
* **Denial** – When one or more eligibility criteria are NOT met, the application is denied. Death is not an appropriate reason to deny an application. If the applicant dies before a final eligibility determination is made, the application process must be continued to completion. An application for TEFRA, Nursing Home, or HCBS that requires both a level of care and disability determination cannot be denied by the Eligibility Specialist until both decisions have been received.
* **Withdrawal** – An application is considered withdrawn when the applicant indicates verbally or in writing his intent not to continue with the eligibility process.

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| **Procedure for Verbal Request for Application Withdrawal** |
| 1. On the Documentation Template, the Eligibility Specialist will document the following:    * The name of the person who is requesting the application withdrawal.    * The date and time of the request.    * The name of the Eligibility Specialist who completed the call and received the verbal request. 2. Document the verbal request on the documentation template and in the System of Record (SOR). Use the following format:    * Verbal Request for Application withdrawal received from <<Beneficiary/Authorized Representative>> obtained by <<User ID>> on <<Date>> at <<Time>> 3. Withdraw/Deny the application in the SOR, ensuring the form DHHS 3229-A is sent to the Beneficiary/Authorized Representative, and including the following explanation within the Reason for Denial:   “A Verbal Request for Application withdrawal was received from [Name of Beneficiary/Authorized Representative] by SCDHHS on [Date]. If for some reason, this request was made in error or you have reconsidered your request, you will need to contact the agency within 15 days of this notice for the application to be processed. After 15 days, you will need to re-apply.”   1. If a request for reconsideration of the application is received within 15 days of the denial notice, the application case can be reopened and processed.    * If the case is ready for approval on the same day that the case is re-opened, the Eligibility Specialist will place the case in not finished as a two-day process. Cúram will not allow the approval on the same day as the reopen.      1. On day one of the two-day process, the Eligibility Specialist will place the case in “Not Finished” in WLP.      2. On day two of the two-day process, the Eligibility Specialist will complete the approval and disposition the case in WLP.   A new application would be required effective the 16th day after the withdrawal. |

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| **Case Review Prior to Making a Determination**  Prior to making an eligibility determination, the specialist must ensure the case file is complete for all eligibility criteria based on policy. This includes reviewing the case file for the following:   * Required documents are in the case file (e.g. signed application, review form, Adoption decrees) * Information from the application and other documents is correctly entered into the System of Record * Required verification documents for financial, non-financial and categorical eligibility criteria are in OnBase and recorded on the Documentation Template and/or System of Record where appropriate (such as SSN if not system verified, MAO99, Level of Care) * Documentation Template has been completed, including details of verified information such as for income or resources * The determination reflects reported changes found on application, review forms or other reported changes received in person, by mail, fax or phone * Information requested via DHHS Form 1233: Was requested information needed to make a determination? The specialist should not deny/close a case for failure to return information if the requested information is not needed. (For instance, information is already in the case file) * Completed budget workbook where appropriate |

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| **Cúram Certification Periods for Non-MAGI**  A PDC (Product Delivery Case) is created by Cúram when an Income Support Case is assessed (or reassessed) and at least one case member qualifies for at least one month of coverage.   * The Certification Period is generated along with the PDC. * It represents a date range in Cúram within which eligibility determinations are made. Cúram makes determinations for each case member within the appropriate timeframe. This includes retroactive coverage and ongoing coverage. The combined Coverage Periods usually equal the total length of the Certification Period. * Cúram then determines eligibility for each case member for each month within the Certification Period. * The end date of the Certification Period is 12 months from the decision date.   **Editing the Certification Period**  Sometimes a Certification Period in Cúram needs to be extended. The Certification Period should be one year from the last day of the month prior to the month the case is authorized. This Policy applies to both applications, reviews, and some changes.  **EXAMPLE**  Application received 1.10.2021 and processed on 3.10.2021. The Certification Period should be extended to 2.28.2022.  When editing the Certification Period in Cúram, the **From Date** and **Date Received** fields must **not** be modified. The eligibility specialist must edit the **To Date** field only. |

**101.08.04 Effective Date of Eligibility/Accrual Rights**

(Rev. 11/01/23)

In most cases, eligibility begins with the month of application. (Refer to individual program chapters for rules applicable to specific categories.)

When an applicant is awaiting a disability determination, there are multiple outcomes that could happen.

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| **Procedures - When a Disability Determination is Required**   1. Individual becomes **aged while awaiting the disability determination,** a task is received, and all other eligibility criteria are met    1. Authorize the coverage to begin the month the individual turned 65 and place the case back in Follow Up for the disability determination.    2. If the MAO99 returns as approved, authorize any additional coverage as necessary.    3. If the MAO99 returns denied, send a manual notice to the applicant and authorized representative indicating the months denied and the reason. 2. Individual’s **MAO99 returned as denied** and all other eligibility criteria are met    1. Check to see if the individual has turned 65       1. If yes, authorize the coverage beginning the month the individual turned 65.       2. If no, deny the coverage. 3. Individual’s **MAO99 returned as approved** and all other eligibility criteria are met    1. Check to determine the disability onset date.    2. Authorize the coverage based on application date and the Disability Onset Date regardless of age. |

101.08.05 Case Actions

(Rev. 03/01/20)

All active cases will be subject to one of the following actions:

* **Review** – (Refer to SC MPPM [101.10](#MPPM_101_10).)
* **Closure/Termination** - When the beneficiary no longer meets the eligibility criteria, the beneficiary’s eligibility is terminated and/or the case is closed, if appropriate. This action may also be taken if the beneficiary requests to have the case closed.

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| **Case Review Prior to Making a Determination**  Prior to making an eligibility determination, the specialist must ensure the case file is complete for all eligibility criteria based on policy. This includes reviewing the case file for the following:   * Required documents are in the case file (e.g. signed application, review form, Adoption decrees) * Information from the application and other documents is correctly entered into the System of Record * Required verification documents for financial, non-financial and categorical eligibility criteria are in OnBase and recorded on the Documentation Template and/or System of Record where appropriate (such as SSN if not system verified, MAO99, Level of Care) * Documentation Template has been completed, including details of verified information such as for income or resources * The determination reflects reported changes found on application, review forms or other reported changes received in person, by mail, fax or phone * Information requested via DHHS Form 1233: Was requested information needed to make a determination? The specialist should not deny/close a case for failure to return information if the requested information is not needed. (for instance, information is already in the case file) * Completed budget workbook where appropriate |

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101.08.05A Continuation of Coverage when Eligibility Correction is Required

(Eff. 11/01/23)

When a beneficiary is authorized in error, the eligibility specialist must allow the beneficiary an opportunity to provide any missing verifications or documents required to make a corrected eligibility determination prior to closing the case.

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| **Procedure**   * The eligibility specialist must conduct a collateral call to explain   + Why the case was approved incorrectly and   + What needs to be done to rectify the incorrect eligibility determination * Once the beneficiary or authorized representative has been reached, mail the DHHS Form 1233 with the details explained during the collateral call   + Give 15 days to return the information   + Place the case in Follow Up in OnBase for 21 days * If the beneficiary or authorized representative cannot be reached, mail the DHHS Form 1233 with the details explaining   + Why the case was approved incorrectly and   + What needs to be done to rectify the incorrect eligibility determination   + Give 15 days to return the information   + Place the case in Follow Up in OnBase for 21 days |

When an applicant/beneficiary is denied in error, the eligibility specialist must re-open the case and correct the error (See CGIS Manual Re-open an ISA). When an applicant/beneficiary’s PDC was closed in error, the eligibility specialist must re-activate the case and correct the error (see CGIS Manual Reactivate a PDC).

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| **Procedure**   * The eligibility specialist must conduct a collateral call to explain   + Why the case was denied in error and   + What needs to be done to rectify the incorrect eligibility determination     - Explain additional information that is required, if necessary * Following the collateral contact with the applicant or authorized representative, mail the DHHS Form 1233 to request any additional information needed and include the details explained during the call.   + Give 15 days to return the information   + Place the case in Follow Up in OnBase for 21 days * If the beneficiary or authorized representative cannot be reached, mail the DHHS Form 1233 with the details explaining   + Why the case was denied in error and   + What needs to be done to rectify the incorrect eligibility determination   + Give 15 days to return the information   + Place the case in Follow Up in OnBase for 21 days * If no additional information is required and the beneficiary or authorized representative cannot be reached, proceed to correct the eligibility decision and ensure that the correct notice is mailed to the beneficiary and authorized representative. |

**101.08.06 Ex parte Determinations**

(Rev. 10/01/23)

When Medicaid eligibility for an applicant/beneficiary is denied or terminated under one coverage group, the Eligibility Specialist must determine whether each applicant/ beneficiary applying for or receiving coverage is eligible under any other coverage group. This determination is called an ex parte determination. An ex parte determination is a Medicaid eligibility decision using information that is readily available to the Eligibility Specialist with minimal contact with the applicant/beneficiary. If during the process it is determined a beneficiary may be eligible for Medicaid, but additional information is required to make a final determination, the beneficiary will remain eligible in the original category while the Eligibility Specialist secures the documentation needed to make the determination for the new category. If it is decided that the beneficiary is not eligible for the new category, the beneficiary does not have to repay benefits received during this period.

For an ex parte determination to be made, the Eligibility Specialist must be in the process of making a decision on a current application, review, or reported change. If the Eligibility Specialist is denying or closing the applicant/beneficiary for failure to return information or a review (an administrative denial or termination), the Eligibility Specialist is not required to complete an ex parte determination.

All applicants/beneficiaries who are no longer eligible for Medicaid will be assessed for eligibility of other affordable insurance programs. If the individual is assessed as potentially eligible their application data will be sent to the Federal Marketplace (FFM) for determination of eligibility for these programs. Do not refer administrative denials and terminations to the FFM.

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| **Example 1**  Jack Spratt, who is receiving PCR, reports a change in income. The amount he now receives is over the income limit. The eligibility specialist must review the record and complete an ex parte determination.  **Example 2**  Rip Van Winkle failed to return his annual review. The eligibility specialist does not complete an ex parte determination. |

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| **Procedure**  Applications processed in MEDS for individuals who do not have Medicare and who are either denied for full benefits or approved for Family Planning (PCAT 55) must be referred to the FFM. An email must be sent to [SP\_FFMTransfer@scdhhs.gov](mailto:SP_FFMTransfer@scdhhs.gov).   1. Subject Line of the email: Household Number 2. Body of the email: First and Last Name   Note: Applications processed in Cúram (HCR) will be referred automatically to the FFM.  Applications processed in Cúram (CGIS) for individuals who do not have Medicare and who are either denied for full benefits or approved for Family Planning (PCAT 55) must be referred to the Federally Facilitated Marketplace (FFM). An email must be sent to [SP\_FFMTransfer@scdhhs.gov](mailto:SP_FFMTransfer@scdhhs.gov).   1. Subject Line of the email: Household Number/Income Support Case Number 2. Body of the email: First and Last Name of the applicant   **Note:** Medicare recipients must not be referred to the FFM because they already have health insurance coverage.  **Do not** refer administrative denials (i.e., failure to return information) to the FFM. |

Examples of readily available information used to complete an ex parte determination include case record documentation and system interface information. Information in an ACTIVE case is considered accurate if the specialist has no reason to believe otherwise. Information in an INACTIVE case can be relied upon if the information was obtained within one year and the specialist has no reason to doubt its accuracy.

**Ex parte Guidelines**

1. Readily available information must be reviewed to find out if each beneficiary receiving or applying for Medicaid is potentially eligible under any other program. The last application must be reviewed to see if the applicant/beneficiary may be eligible in another category. Check SDX, BENDEX, and the latest application or review to find out if any beneficiary is receiving or has received disability or claims to be disabled. For specific procedures for Deemed Babies, refer to SC MPPM 204.02.02A.

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| **Example 3**  A mother and child are receiving PCR. Later, when the child turns age 19, the case is to be closed. On the last review, the mother indicated she was disabled. She must be given the opportunity to be evaluated for ABD before terminating her PCR coverage. |

1. After reviewing the available information:

| **Procedure for an Ex Parte Determination** |
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| **Cúram Procedure**  In CGIS, ensure that the job aids have been followed to update the appropriate evidence. Refer to the [Non-MAGI Training Portal](https://www1.scdhhs.gov/ees/TrainingPortal_NonMAGI/) and the [MAGI Training Portal](https://schhs.sharepoint.com/sites/ET/data/SitePages/training-1.aspx) for job aids. The system will determine if the applicant qualifies in another payment category.  **Special Note**  When the applicant/beneficiary is pending for Long-Term Care (LTC) coverage, the system will not test for the Qualified Individual (QI) payment category. Eligibility Specialist must be mindful of the QI eligibility criteria if there is an active (unauthorized) LTC OSS Service Request in CGIS. |
| **MEDS Procedure**   * If the applicant/beneficiary is eligible in a different payment category, approve the case in the new category. * If the applicant/beneficiary is not eligible in any other payment category, deny/ terminate the original payment category using the original denial/termination reason. * If the applicant/beneficiary appears potentially eligible based on the case record, but all information is not available to make the decision, contact the applicant/ beneficiary for the required information. The [SC DHHS Form 1233-E](http://medsweb.scdhhs.gov/EligibilityForms/FM%201233-E.pdf), Medicaid Eligibility Ex Parte Checklist, must be sent to the beneficiary requesting the information necessary to make a final determination on the case. The beneficiary will be given 10 calendar days to provide this information. The 10 days begin on the date the SC DHHS Form 1233-E is sent.   + When setting the follow-up date in OnBase, add an additional six (6) days to allow for scanning and task creation in Workload Pro (WLP). For example, if a DHHS Form 1233-E is due on January 16, set the follow-up date in OnBase as January 22.   + A task will be created in WLP either when information is returned by the individual or when the follow-up date is reached. Once a task is claimed, a specialist can take the appropriate action.   + For current beneficiaries, continue the eligibility in the existing category. If the case is currently due for review, the Eligibility Specialist must enter the Form Received Date in MEDS on the WKR008 (Regular Review) screen to avoid a system closure. Make Decision can be made at this time, but the Eligibility Specialist must not call Act on Decision. The Anticipated Closure Date (ACD) must be set to 90 calendar days in the future and the Next Review Date (NRD) must be set for 12 months. Do not create a new budget group for the alleged payment category. If the beneficiary returns all required information within 10 calendar days, the Eligibility Specialist will proceed with making the eligibility determination. If the beneficiary is eligible under the alleged payment category, ex parte to the new payment category and set NRD to one year. If the beneficiary is determined ineligible for the alleged payment category, the specialist must close out the existing budget group using the original denial/termination reason code. The ACD must be removed and the system may prompt you to Make Decision (to update the eligibility end date) before continuing with Act on Decision.   + If the requested information is not returned within 10 calendar days, the Eligibility Specialist must proceed with closing the case. If at any point ineligibility is determined, coverage can be denied or terminated. It is not necessary that all eligibility criteria be verified before denial or closure can take place.   **Exception:** If the potential category is TEFRA, Nursing Home, or HCBS, both a level of care and disability determination decision must be made before the application is denied.  **Special Note**  Optional State Supplemental Program (OSS) payments can only be made for any month a client is showing eligibility under categories 85 or 86. Therefore, if the new payment category will be OSS, the dates of coverage may have to be adjusted in the System of Record to reflect the correct OSS payment category effective date. |

1. If a disability decision is required in the potential category, refer to SC MPPM 102.06.02A for the blindness/disability determination process.

* If an applicant/beneficiary indicates disability but describes a condition that would realistically not be considered disabling, such as admitting to having high blood pressure that is under control with medication but no other problems, then this individual would not be considered disabled. Also, if there is a recent Social Security denial for disability and there is no allegation of a change in condition, an independent determination is not necessary. If there is any reasonable doubt, the Eligibility Specialist should complete a disability determination. Regardless of the applicant/beneficiary’s medical condition, if he insists on a disability determination, one must be completed.

1. If a beneficiary receives a closure notice (that is, was Medicaid eligible and the case is going to close or has been closed) and requests a continuation of coverage within 30 calendar days from the date on the closure notice and appears potentially eligible based on the alleged categorical requirements, coverage must be re-instated in the original category. The DHHS Form 1233-E must be sent to the beneficiary requesting the information necessary to make a final determination on the case. The beneficiary will be given 10 calendar days to provide this information. The 10 days begin on the date the DHHS Form 1233-E is sent.

**Reminder:** Add six (6) additional days when setting the follow-up date in OnBase.

* If a disability decision is required in the potential category, refer to MPPM 102.06.02A for the disability/blindness process. When the information is received, the Eligibility Specialist will proceed with making a final determination on the case.
* If the beneficiary requests coverage to continue but does not indicate any reason that falls under a potential category, this must be documented in the record, and the process for termination continues.

1. If an applicant receives a denial notice (that is, has not been approved for Medicaid and the application has been denied in MEDS) and requests reconsideration for another category within 30 calendar days from the date on the notice and appears potentially eligible based on the alleged categorical requirements, the original application date can be used. Pend the application in MEDS using the potential category. The DHHS Form 1233-E must be sent to the applicant requesting the information necessary to make a final determination on the case. The applicant will be given 10 calendar days to provide this information. The 10 days begin on the date the DHHS Form 1233-E is sent.

**Reminder:** Add six (6) additional days when setting the follow-up date in OnBase.

* If a disability decision is required in the potential category, refer to MPPM 102.06.02A for the disability/blindness process. When the information is received, the Eligibility Specialist will proceed with making a final determination on the case.
* After making the final determination for the potential category, approve or deny the application in MEDS using the appropriate reason.
* The case cannot be ex parted if the request is received after 30 calendar days. If the request is made after 30 calendar days, a new application is required.

1. For Pregnant Women cases, once the 12-month post-partum period ends, the Eligibility Specialist must determine if the beneficiary is eligible for Medicaid under any other coverage group with full benefits (ex. PCR, PHC). If the beneficiary is not eligible for a full benefit category, then the Eligibility Specialist must consider eligibility for Family Planning. If the applicant/beneficiary is not eligible under any other coverage group, she will be assessed for eligibility of other affordable insurance programs. If she is assessed as potentially eligible, her application data will be sent to the Federal Marketplace (FFM) for determination of eligibility for these programs.
2. Minor applicants/beneficiaries cannot be ex parted from any Medicaid category to Family Planning unless requested by a parent or legal guardian or by the minor. An adult of childbearing age who applies for or receives Medicaid benefits can be considered for all Medicaid categories for which eligibility can be established, including Family Planning and for eligibility for other affordability insurance programs through the Federally Facilitated Marketplace.

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**101.08.07 Continuous Eligibility for Children Under Age 19**

(Rev. 04/22/14)

If a child under age 19 is approved for full range of Medicaid benefits, eligibility continues for 12 months regardless of changes in family income or other circumstances. This policy should be applied when determining or re-determining eligibility for a child under age 19, regardless of the category. This continuous coverage may also be referred to as a protected period. When approving a Budget Group (BG) with a child under 19, enter the Next Review Date (NRD) on ELD01 as one year from the current date. The Protected Period End Date (PPED) will be set to one year from the decision date.

The following exceptions apply:

* If a child dies, his eligibility should be terminated.
* If a child moves out of state, his eligibility should be terminated.
* If a child attains the maximum age for the category, an ex parte determination must be completed.
* If a child becomes an inmate of a public institution, the Eligibility Specialist must indicate an “I” on the ELD02 screen in MEDS. (Refer to SC MPPM 102.09.01)
* If a child under age 19 is eligible for Pregnant Woman at the end of her postpartum period, determine if she is eligible for PHC for the remainder of her protected period.
  + If eligible for PHC, move her to the new category. Do not change PPED.
  + If she is not eligible for PHC, leave her in PW until her protected period ends.
* If the beneficiary is approved for retroactive coverage but not approved for the application month.
* If a child is approved for coverage and has been given up to 90 calendar days as a reasonable opportunity to supply verification of Citizenship and/or Identity and verification is not returned, his eligibility can be terminated.

**101.08.08 SSI Recipients in E01 Payment Status**

(Eff. 01/01/14)

Some SSI recipients are eligible for SSI, but do not receive a payment. These recipients are identified on SDX with payment status code E01: Eligible for Federal and/or State benefits based on eligibility computation, but no payment is due based on the payment computation. The SDX subsystem establishes Medicaid as payment category 32 (ABD) with a review date six months from the date the payment status code was received and processed. The case is automatically assigned to the default Eligibility Specialist for the county. The Eligibility Specialist receives alert 350: BUDGET GROUP HAS BEEN ASSIGNED TO YOU. These cases must not be transferred to the Division of Central Eligibility Processing.

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| **Procedure for Processing E01 Payment Status Review:** |
| **MEDS Procedure:**   * Sixty days before the date the review is due, a review form is automatically sent to the beneficiary. * When the review form is received in the county:   + Check MEDS screens ELD00, ELD01, or ELD02 using the assigned BG number on the review. The system ID on the screen will show SDX1000.   + SDX information screen may also be checked. SDX01 or SDX03 will show an E01 payment status code. * Establish a case record using the review form as the application and complete the review obtaining appropriate verification. * Enter any missing information needed to complete the review into MEDS. * If a review form is not returned, the case will close automatically. |

**101.08.09 Case Record Retention Schedule**

(Eff. 01/01/14)

Case Records are to be retained in the active file until denial of the request for, or termination of participation in the Medicaid Program. Once assistance is denied or terminated, transfer the case record to the inactive file. The record is retained in the inactive file within the agency for a minimum of four years. After this period, the case record can be destroyed.

If an audit by or on behalf of the state or federal government has begun but is not completed at the end of the retention period, the records will be retained until the resolution of the audit findings, then destroyed.

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**101.09 Written Notification**

(Eff. 09/01/17)

An applicant/beneficiary must be given written notification of any positive or negative action taken on his case. This requirement applies to applications and active cases. If a notice is not automatically sent by MEDS or Cúram, the Eligibility Specialist must send a manually generated notice. To send a notice manually, navigate to the [Medicaid Eligibility Forms](http://medsweb.scdhhs.gov/noticelisting.htm) library of manual notices, choose the appropriate notice and fill out the relevant information in the fields provided. Scan the completed notice into OnBase and mail a paper copy to the primary address listed on the case.

**101.09.01 Applications**

(Eff. 01/01/14)

The agency must send each applicant a written notice of the decision on his application. If eligibility is denied, the notice must include the reason for the action, the specific regulation supporting the action, and an explanation of the right to request a hearing. Applicants requesting retroactive coverage must receive a written notice of eligibility in the retroactive period. The [SC DHHS Form 3229-A](http://medsweb.scdhhs.gov/EligibilityForms/FM%203229-A.pdf), Notice of Approval\Denial for Medical Assistance/Optional Supplementation, is used to notify applicants when retroactive coverage is added to MEDS or Cúram. The appropriate procedure for adding retroactive eligibility in Cúram may be found in the [Processing Retroactive Medicaid](https://schhs.sharepoint.com/:b:/r/sites/EES/Training/Curam/HCR/Job-Aids/Case%20Management/Processing%20Retroactive%20Medicaid.pdf?csf=1&web=1&e=1crXe8) job aid at the [Training Materials Portal-MAGI](https://www1.scdhhs.gov/ees/trainingportal/).

**101.09.02 Active Cases**

(Rev. 01/01/14)

When an action is taken on an active case due to a change in circumstances, the beneficiary must be notified in writing. The agency will send an appropriate notice to the beneficiary. A beneficiary must be given advance notice about any adverse action, for example termination or reduction of benefits. The notice must include the reason for the action, the specific regulation supporting the action, and an explanation of the right to request a hearing.

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| **Procedure for Re-Opening a Budget Group** |
| **MEDS Procedure**  A MEDS notice is generated anytime an individual in a budget group closes. Should the individual need to be re-opened, the eligibility specialist can enter Reason Code 110 on ELD02 in MEDS to re-open the closed budget group member. The Budget Group Status (active, closed or pending) and Action Type (review or maintenance), will remain the same as before the re-open.  **Cúram Procedure:**  The appropriate procedure may be found in one of the following job aids at [Training Materials Portal-MAGI](https://www1.scdhhs.gov/ees/trainingportal/).   * [Resume Benefits Closed Less Than 30 Days](https://schhs.sharepoint.com/:b:/r/sites/EES/Training/Curam/HCR/Job-Aids/Case%20Management/Resuming%20Benefits%20Closed%20Less%20Than%2030%20Days.pdf?csf=1&web=1&e=vScfuf) or * [Resume Benefits Closed Over 30 Days](https://schhs.sharepoint.com/:b:/r/sites/EES/Training/Curam/HCR/Job-Aids/Case%20Management/Resuming%20Benefits%20Closed%20Over%2030%20Days.pdf?csf=1&web=1&e=7wDlVb) |

**101.09.03 Advance Notice**

(Rev. 09/01/17)

To meet the advance notice requirement, the agency must generate the Notice of Adverse Action to be mailed at least fifteen (15) calendar days before the date of action. The advance notice period may be shortened to five (5) calendar days before the date of action if the agency has facts that indicate probable fraud, and the facts have been verified by secondary sources.

A Notice of Adverse Action may be mailed on the date of the action, if:

* The beneficiary died.
* The beneficiary provides a signed statement that he/she no longer wishes services or that he/she waives his right to a fifteen (15) calendar day notice.
* The beneficiary has been admitted to an institution where he/she is ineligible for further services (such as an inmate of a public institution).
* The beneficiary's whereabouts are unknown and mail addressed to him/her is returned indicating no forwarding address.
* The agency verifies that the beneficiary has been approved for Medicaid services in another State.
* The beneficiary no longer meets level of care.

Notices meeting these timeframes are considered adequate. In some instances, applicants/beneficiaries are notified of case actions by automated letter that meet the timeframes discussed above.

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| **Procedure for Sending a Manual Notice** |
| **Procedure**:  In some scenarios, MEDS and Cúram are not triggered to send an auto-generated notice. In those cases, the Eligibility Specialist must send a manually generated notice. To send a notice manually, navigate to the [Medicaid Eligibility Forms](http://medsweb.scdhhs.gov/noticelisting.htm) library of manual notices, choose the appropriate notice and fill out the relevant information in the fields provided. Scan the completed notice into OnBase and mail a paper copy to the primary address listed on the case.  If eligibility was terminated and MEDS or Cúram did not automatically create and send a closure notice, the eligibility specialist must:   * Re-establish eligibility for the impacted members, * Create a manual closure notice with the appropriate closure reason and manual citation, * Scan the completed notice into OnBase, * Add a case note in MEDS or Cúram AND on the Documentation Template * Mail a paper copy to the primary address listed on the case, and * Close the case allowing for the correct 15-day advance notice. |

101.09.04 General Delivery Addresses

(Eff. 11/01/23)

General Delivery is a mail service for those without a permanent address, often used as a temporary mailing address. General Delivery is intended to be used for a participating Post Office location to serve transients (people who travel extensively) and those without a permanent address. The agency must have basic contact information to be able to communicate and provide notice to individuals.

* If the application lacks an address, the Eligibility Specialist should attempt a collateral call to try to obtain the missing address information.
  + If the applicant does not have a residence or cannot provide a trusted place for mail to be received, then the Eligibility Specialist should encourage the use of General Delivery at a local post office.
  + If the applicant is in a location that will not allow transient or homeless individuals to use General Delivery, the application will be considered incomplete until an address can be provided.

Notices sent as General Delivery should be addressed with the following using the city/post office location the applicant has provided:

(Name of Applicant)

General Delivery

City, State, Zip-9999

The addition of “-9999” indicates General delivery.

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**101.10 Review**

(Rev. 02/01/23)

A redetermination of eligibility must be completed when a change in circumstances is reported or identified. The redetermination must be completed within 10 calendar days from the date that notification of the change is received in the eligibility office. It must be documented in OnBase and on the appropriate notes screen in MEDS/Cúram how the change was evaluated by the Eligibility Specialist and what impact the change may have had on eligibility. If required, the Eligibility Specialist must take all actions in MEDS/Cúram and send the appropriate notices to the beneficiary. If a beneficiary with active Medicaid benefits submits an application, treat the application as a change of circumstances.

Eligibility must be reviewed annually or according to the Medicaid Review Schedule that follows. A review is considered timely if it is received prior to the Next Review Date (NRD) in MEDS **AND** the review is completed by the NRD or within ten (10) calendar days of receipt, whichever is later.

If an applicant or beneficiary with active Medicaid benefits submits an application or review form and answers the question: “Do you want health coverage?”, with ***No***, attempt a collateral call to address the discrepancy. If a collateral call is unsuccessful, process the application or review as if the person answered ***Yes***.

If an applicant or beneficiary with active Family Planning coverage submits an application or review form and answers the question: Do you want to apply for Family Planning benefits?, with ***No***, attempt a collateral call to address the discrepancy. If a collateral call is unsuccessful, process the application or review as if the person answered Yes.

The details of the collateral call must be documented on the Documentation Template. This includes the date and time of the call, if the Eligibility Specialist spoke to the beneficiary, the beneficiary’s answer, and the case action taken by the Eligibility Specialist.

Listed below are examples of when conflicting information needs to be clarified with the beneficiary.

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| **Example 1**  Jack Terrier, who is receiving Family Planning, submits an application and indicates he is applying for coverage. Jack answered ***No*** to the Family Planning question on the application. A collateral call is made but was not successful. Family Planning coverage will continue unless the person becomes eligible for a full coverage category.  **Example 2**  Jack Terrier, who is receiving Family Planning, submits a MAGI annual review form and indicates he is applying for coverage. Jack answered ***No*** to the Family Planning question on the review form. A collateral call is made, and Jack indicates he wants to continue current coverage if not eligible for full coverage. Family Planning coverage will remain active.  **Example 3**  Jack Terrier submits an application applying for coverage for himself. He indicates he is not applying for coverage for his children, but they are already covered by Children’s (PHC/CHIP) Medicaid. A collateral call is made but was not successful. Children’s (PHC/CHIP) Medicaid will remain in effect.  **Example 4**  Jack Terrier submits a MAGI annual review form and indicates no one in the household is applying for coverage, but everyone in the household has active Medicaid coverage. A collateral call is made, and the beneficiary states the household no longer wants coverage. Coverage can be closed for all members. |

**Note**

When completing reviews in MEDS, all screens must be updated, beginning with Create Household (HMS03.) If there are children under age 19, enter the NRD on ELD01 as one year from the current date. The Protected Period End Date (PPED) will be set to one year from the decision date.

| **Medicaid Review Schedule** | | |
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| **Eligibility Category** | **Frequency** | **Review Requirement** |
| 10 MAO – Nursing Home | Annually |  |
| 11 Transitional Medicaid (TM) | Once | If requirements for Transitional Medicaid were met, action required in 18th month.  A computer-generated notice (WKR004) will be sent to the beneficiary.  If requirements for Transitional Medicaid were not met, action required in 6th month of Transitional Medicaid.  In either situation, ex parte determination required in last month. |
| 12 PW – Deemed Infants  (reason code “CB” or “DB”)  PW – Infants up to age 1  (reason code “PB”) | At Age One  One Year |  |
| 1. Special Needs/Subsidized Adoption | No Review |  |
| 14 MAO - General Hospital | Annually | An alert will be generated quarterly to verify continued hospitalization. |
| 15 MAO - Other (definition dependent upon reason code) | Annually |  |
| 16 1977 Pass-Along (Pickle) | Annually |  |
| 17 Early Widows/Widowers | Annually |  |
| 18 Disabled Widows/Widowers | Annually |  |
| 19 Disabled Adult Children | Annually |  |
| 20 Pass-Along Children | Once | When child reaches age 18, complete ex parte determination. |
| 31 Title IV-E Foster Care | No Review | Eligibility maintained as long as Title IV-E eligible. |
| 32 Aged, Blind and Disabled (ABD) | Annually |  |
| 33 ABD – Nursing Home | Annually |  |
| 40 Working Disabled (WD) | Annually |  |
| 48 Qualifying Individuals (QI) | Annually |  |
| 50 Qualified Disabled and Working Individuals (QDWI) | Annually |  |
| 51 Title IV-E Adoption Assistance | No Review |  |
| 52 SLMB1 | Annually |  |
| 54 SSI Nursing Home Beneficiary | No Review |  |
| 55 Family Planning (FAMILY PLANNING) | Annually |  |
| 56 Proviso Children (not Medicaid) | No Review | (Left for historical purposes) |
| 57 Katie Beckett (TEFRA) Children | Annually |  |
| 59 Low Income Families (LIF)/ Parent Caretaker Relative (PCR) | Annually |  |
| 60 Regular Foster Care (RFC) | Annually - for children under age 18.  No review for children ages 18 through 20.  Ex parte determination required at age 21. |  |
| 61 Former Foster Care (FFC) | No Review | Eligibility maintained until age 26 |
| 70 Refugee Assistance Program (RAP) | No Review -  Entitled to 12 months of Refugee Assistance benefits. |  |
| 71 Breast and Cervical Cancer Program (BCCP) | Annually or Semi-Annually | Every six months for pre-cancerous lesion cases (CIN 2/3 or atypical hyperplasia |
| 80 Supplemental Security Income (SSI) | No Review |  |
| 81 SSI with an Essential Spouse | No Review |  |
| 85 Optional State Supplemental (OSS) Only | Annually |  |
| 86 OSS with SSI | No Review |  |
| 87 Optional Coverage for Women and Infants (OCWI) - Pregnant Women | No Review |  |
| 88 Optional Coverage for Women and Infants (OCWI) - Infants  Partners for Healthy Children (PHC) - up to age 19 | Annually |  |
| 90 Qualified Medicare Beneficiaries (QMB) | Annually |  |
| 91 Ribicoff Children | Annually | (Left for historical purposes) |

**101.10.01 MAGI Renewals**

(Rev. 04/01/22)

The eligibility of Medicaid beneficiaries enrolled in a MAGI eligibility group must be renewed once, and only once, every 12 months. The agency must make the redetermination without requiring additional information from the individual if able to do so based on the individual’s case or current information available. If the agency is able to make the redetermination without requiring additional information from the individual, the agency must notify the individual of the eligibility determination, the basis for the determination, and have the individual indicate if any information in the case is inaccurate.

If the agency is unable to make the redetermination without requiring additional information from the individual, the agency must provide the individual with the following:

* A pre-populated renewal form,
* A response time of thirty (30) days from the date of the renewal form to answer and provide necessary information; and
* Notice of the agency’s eligibility decision once the review is complete.

The agency must also:

* Verify any information provided by the beneficiary;
* Reconsider the eligibility of an individual who was terminated for failure to submit a renewal form or necessary information. If an individual submits a renewal form or necessary information within ninety (90) days following the termination date, his eligibility should be considered without requiring a new application; and
* Not require an individual to complete an in-person interview as part of the renewal process.

**Extending the Certification Period when there is a Change of Circumstance**

Medicaid beneficiaries are required to report changes in their circumstances to SCDHHS within ten (10) days. Eligibility specialists must act on those changes as they are reported. Some changes may require a case review, and some changes may not. When completing a case review, extend the Certification Period to one year from the last day of the month before the month the case is authorized.

**When to extend the Certification Period**

If a change of circumstance is reported within 90 days of the Certification Period end date:

* A full case review must be completed
* The Certification Period must be extended

If a change of circumstance is reported within 90 days of the last case review or case approval:

* Update the evidence only on the Evidence Dashboard
  + Add required verifications
  + Apply Changes
  + Check Eligibility
* Do not complete a full case review
* Do not extend the Certification Period

If a change of circumstance is reported that does not impact eligibility:

* Update the evidence only on the Evidence Dashboard
  + Add required verifications
  + Apply Changes
  + Check Eligibility
* Do not complete a full case review
* Do not extend the Certification Period

If the change of circumstance will have an impact on eligibility such as a loss in coverage, moving from full to limited coverage, or limited to full coverage (Exception: PCR to FP due to change in income, send to TMA for review):

* A full case review is required
* Certification Period must be extended

**Note**

If the change of circumstance results in a change in payment category but not a change in coverage level (Ex: PCR to PW) a full case review **is** required.

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| **Change of Circumstance and when to complete a case review for MAGI cases** | |
| The following changes may require a full case review:   * Income (addition or loss) * Additional person added per Application page * Marital Status (includes marriage or divorce) * Living Arrangement (non-institutional to institutional) * Death of a spouse | The following changes may **not** require a full case review:   * Address * Household Composition except for marriage or divorce * Citizenship Status * Disability Status (send to Non-MAGI) * Authorized Representative * Name |

**101.10.02 Non-MAGI Renewals**

(Rev. 12/01/21)

The eligibility of Medicaid beneficiaries enrolled in a non-MAGI eligibility group must be redetermined at least every 12 months. The agency must make the redetermination without requiring additional information from the individual if able to do so based on the individual’s case or current information available. If the agency is able to make the redetermination without requiring additional information from the individual, the agency must notify the individual of (i) the eligibility determination, (ii) the basis for the determination, and (iii) have the individual indicate if any information in the case is inaccurate.

If the agency is unable to make the redetermination without requiring additional information from the individual, the agency must provide the individual with the following:

* A pre-populated renewal form,
* A response time of thirty (30) days from the date of the renewal form to answer and provide necessary information; and
* Notice of the agency’s eligibility decision once the review is complete.

The agency must also:

* Verify any information provided by the beneficiary;
* Reconsider the eligibility of an individual who was terminated for failure to submit a renewal form or necessary information. If an individual submits a renewal form or necessary information within ninety (90) days following the termination date, his eligibility should be considered without requiring a new application; and
* Not require an individual to complete an in-person interview as part of the renewal process.

The agency must promptly redetermine eligibility between regular renewals of eligibility whenever it receives information about a change in a beneficiary’s circumstances that may affect eligibility. The agency may consider blindness and disability as continuing until the reviewing physician/team determines that the beneficiary’s condition no longer meets the definition of blindness or disability.

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| **Extending the Certification Period when there is a Change of Circumstance**  Medicaid beneficiaries are required to report changes in their circumstances to SCDHHS within 10 days. Eligibility specialists must act on those changes as they are reported. Some changes may require a case review and some changes may not. When a case review is completed, the Certification Period must be extended to one year from the last day of the month prior to the month the case is authorized.  **When to extend the Certification Period**  If a change of circumstance is reported within 90 days of the Certification Period end date:   * A full case review must be completed * The Certification Period must be extended   If a change of circumstance is reported within 90 days of the last case review or case approval:   * Update the evidences only on the Evidence Dashboard   + Add required verifications   + Apply Changes   + Check Eligibility * Do not complete a full case review * Do not extend the Certification Period   If a change of circumstance is reported that does not impact eligibility:   * Update the evidences only on the Evidence Dashboard   + Add required verifications   + Apply Changes   + Check Eligibility * Do not complete a full case review * Do not extend the Certification Period   If the change of circumstance will have an impact on eligibility such as a loss in coverage, moving from full to limited coverage, limited to full coverage or Non-MAGI to LTC (Exception: Nursing Home to HCBWS and vice versa):   * A full case review is required * Certification Period must be extended   **Note:** If the change of circumstance results in a change in payment category but not a change in coverage level (Ex: SLMB to QI) a full case review **is** required.   |  |  | | --- | --- | | **Change of Circumstance and when to complete a case review for Non-MAGI cases** | | | The following changes may require a full case review:   * Income (includes Cost of Living Adjustments) * Resources * Receipt of Medicare * Marital Status (includes marriage or divorce) * Living Arrangement (non-institutional to institutional) * Death of a spouse | The following changes may **not** require a full case review:   * Address * Household Composition except for marriage or divorce * Citizenship Status * Disability Status * Authorized Representative * Name |  |  |  | | --- | --- | | **Change of Circumstance and when to complete a case review for Long Term Care cases** | | | The following changes may require a case review for Long Term Care cases:   * Income (includes Cost of Living Adjustment and Income Trust) * Resources * Receipt of Medicare * Marital Status (includes marriage or divorce) * Death of spouse * Living Arrangement (institutional to non-institutional) | The following changes **do** **not** require a case review for Long Term Care cases:   * Deductions (includes HMA, Health Insurance Premiums and Allocations) * Household Composition except for marriage or divorce * Citizenship Status * Disability * Authorized Representative * Name * Living Arrangement (Institutional to Institutional) | | **Note:** Nursing Home or HCBWS to OSS and vice versa, a full case review **is** required. | | |

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**101.10.03 Processing Review Forms**

(Rev. 12/01/21)

[CFR §435.916](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-J/subject-group-ECFR0717d3fdf4a090c/section-435.918); [CFR §435.908](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-J/subject-group-ECFR9b4bff9082050a1/section-435.908)

When a beneficiary’s eligibility is up for redetermination, the state must make that determination based on reliable information currently available to the agency. The state may not request any additional information from the beneficiary if that additional information is not necessary to make a determination.

If continuing eligibility can be approved based on available information, the agency must send a (i) notice to the beneficiary indicating the pending re-approval and (ii) form stating what information was used to approve the case. The beneficiary must review the information on the form and, if there are any inaccuracies, return a corrected version within 30 days. If form is received outside of 30-day period, it will be treated as a reported change.

If additional information is necessary, the agency must send a form pre-populated with information available to the agency to the beneficiary indicating what information is missing. The beneficiary will have 30 calendar days to provide missing information.

If necessary, an Eligibility Specialist must make a reasonable effort to assist the beneficiary. Once all information is received, an Eligibility Specialist must complete the review process.

Prior to making a determination of ineligibility, the agency must consider other eligibility programs for an ex parte decision. Following a determination of ineligibility, the agency must determine potential eligibility for other insurance affordability programs at the FFM. Any renewal form or notice must be accessible to persons who have limited English skills and to persons with disabilities.

Note: For PHC cases that go into review status on or after April 1, 2011, a data match will be completed with the DSS CHIP system. If the beneficiary is currently receiving SNAP (food stamps) or TANF (FI), continuing Medicaid eligibility will be determined by MEDS/ Cúram. If the beneficiary is not receiving SNAP or FI, the Eligibility Specialist must complete a regular eligibility determination as stated below.

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| **Procedure for Processing Review Form**  **MEDS Procedure**:  When a beneficiary submits a review form, the review form and any other information/ verifications received **must** be scanned into OnBase and the **“Form Received Date”** must be updated in MEDS.  If additional verifications are required, the beneficiary must be given fifteen (15) days to provide any needed information. The [DHHS Form 1233](http://medsweb.scdhhs.gov/EligibilityForms/FM%201233%20ME.pdf), Medicaid Eligibility Checklist, must be sent to the beneficiary requesting any additional information. If necessary, the Eligibility Specialist must make a reasonable effort to assist the beneficiary. Once all information is received, an Eligibility Specialist must complete the review process.   * When setting the follow-up date in OnBase, add an additional six (6) days to allow for scanning and task creation in WLP. This provides a total of 21 days from the date of the DHHS Form 1233 is created.   For example, if a DHHS Form 1233 created on January 1 and is due on January 16, set the follow-up date in OnBase as January 22.   * A task will be created in WLP either when information is returned by the individual or when the follow-up date is reached. Once a task is claimed, a specialist can take the appropriate action. * If the task was generated due to other information being scanned into the OnBase, respond to the scanned information, and put the case back into follow-up for any remaining time. * If an applicant/beneficiary returns partial or incomplete information before the follow-up date, process the returned information, and if there is any remaining time, put the case back into follow-up.   For example, a DHHS Form 1233 is sent on January 1 with a follow-up date of January 22 in OnBase. On January 10, the applicant returns half of the requested information. The eligibility specialist will:   * + Update the Documentation Template;   + Update any systems as appropriate; and   + Put the case back into follow-up with the original January 22 follow-up date. * If the information is not returned by the follow-up date in OnBase, a task will be created in WLP so a specialist can deny the application when the task is claimed.   + If the original follow-up date does not include the additional six (6) days to allow for scanning and task creation in WLP, put the case back into follow-up with the correct date if the date has not already passed. * If the individual is not eligible, no additional action needs to be completed in MEDS. * If the individual is eligible and the specialist is taking action within 90 days of the closure, the existing Budget Group can be reopened using code 100. There should be no gap in eligibility * If the individual submits the renewal form or necessary information after 90 days, then the renewal form should be used as a new application. |
| **Cúram Procedure**:  Refer to the [MAGI Annual Review Process](https://schhs.sharepoint.com/:b:/r/sites/EES/Training/Curam/HCR/Job-Aids/Reviews/MAGI%20Annual%20Review%20Process.pdf?csf=1&web=1&e=QQjw4V) job aid at [Training Materials Portal-MAGI](https://www1.scdhhs.gov/ees/trainingportal/) for the appropriate instructions. |

If the beneficiary fails to return the review form and/or any requested information within the 30-calendar day period and the case closes, the case can be re-opened if the beneficiary returns the review within 90 calendar days from the date of closure. If the information is received later than 90 calendar days, the review form must be treated as a re-application.

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| **Processing a Review Flow Chart** |
| Diagram  Description automatically generated |

**Exception:** Nursing Home, Waivered Services, and OSS budget groups (Payment Categories 10, 15, 33, and 85) do not close automatically. If a review is not received, MEDS will put the case in Maintenance Status. If the review is received after the case has been placed in Maintenance Status, the Eligibility Specialist must treat this as a reported change and complete a redetermination.

**TMA Quarterly Reports**

* 1. For signed or unsigned reports, determine if any wages are included.

1. If any wages are included, register the report receipt date in MEDS.
2. If no wages are included, do not register the report receipt date in MEDS unless Good Cause is alleged.
   1. All TMA Quarterly Reports must be scanned into OnBase.

**101.11 Reserved for Future Use**

**101.12 Rights of Applicants/Beneficiaries**

(Eff. 01/01/14)

Any individual applying for and/or receiving assistance has certain rights and responsibilities relating to receipt of Medicaid benefits. This section describes the rights and responsibilities of applicants/beneficiaries.

**101.12.01 Opportunity to Apply**

(Eff. 01/01/14)

Any individual who requests Medicaid assistance, including those who are clearly ineligible, must be allowed to apply immediately. Eligibility Specialists must make a reasonable effort to assist the applicant in establishing eligibility.

**101.12.02 Civil Rights and Non-Discrimination**

(Eff. 01/01/14)

Persons applying for, or receiving benefits or services under, any program administered by or through the SC DHHS, shall not be discriminated against in any manner. The following non-discrimination laws apply to Medicaid:

* Title VI of the Civil Rights Act of 1964 prohibits discrimination based on race, color, or national origin.
* Title V, Section 504 of the Rehabilitation Act of 1973, as amended, prohibits discrimination based on handicap.
* Title II, Section 202 of the Americans with Disabilities Act of 1990, guarantees equal opportunity for qualified individuals with disabilities in employment, public accommodations, transportation, public service, state and local government services and communications. This Act requires that interpreters be available for applicants/beneficiaries, if needed.
* The Age Discrimination Act of 1975 prohibits discrimination based on age.

Any individual who feels that he/she has been subjected to such discrimination may file a signed, written complaint within 180 calendar days of the alleged discriminatory act, by mailing the complaint to:

South Carolina Department of Health and Human Services

Attn: Civil Rights Division

Post Office Box 8206

Columbia, South Carolina 29202-8206

All complaints will be investigated in accordance with state and federal laws and regulations.

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**101.12.03 Confidentiality of Information**

(Rev. 10/01/13)

[CFR §431.305](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-431/subpart-F/section-431.305)

The South Carolina Medicaid program will adhere to state laws and federal regulations regarding the protection of applicant’s and beneficiaries’ confidential information. Federal Regulations include Title 42, Code of Federal Regulations at Part 431 and state law includes the applicable provisions of State Regulations at SC Code Ann. R. 126-170 et seq. Information (i) obtained during the application process or (ii) contained in records of beneficiaries or former beneficiaries is confidential and must be safeguarded. Medicaid will also adhere to the Health Insurance Portability and Accountability Act (HIPAA) regulations regarding applicant/beneficiaries’ confidential information. There are two types of protected information: (i) financial and (ii) medical. Both types may be disclosed without beneficiary authorization only for purposes directly connected with the administration of the program, including:

* + - * Establishing eligibility;
      * Determining the amount of medical assistance;
      * Providing or arranging for services for a given beneficiary; and,
      * Prosecution of civil or criminal proceeding related to the administration of the State Plan.

**Protected/Safeguarded Information**

Eligibility and medical information which must be safeguarded includes, but is not limited to, the following:

**1. Eligibility information**

* Name and address of applicants/beneficiaries
* Social Security Number
* Date of Birth
* Social and economic conditions or circumstances
* Evaluation of personal information such as financial status, citizenship, residence, age and other demographic characteristics
* Information received for verifying income eligibility and amount of benefits. (Refer to Chapter 104, Appendix P)
* Information received in connection with the identification of a liable third-party resource

**2.** **Medical information**

* Medical data, including diagnosis and history of diseases or disabilities
* Medical services provided
* Medical status, psycho behavioral status, and functional ability
* Results of laboratory tests
* Medication records

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| **Note**  Medical information/evaluation provided by the Department of Mental Health (DMH) and/or the Veterans Administration (VA) is not to be released to anyone without the approval of DMH and/or VA. In addition, alcohol and drug abuse information is subject to special confidentiality standards. |

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**101.12.04 Release of Eligibility Information**

(Eff. 10/01/13)

Disclosure of eligibility/financial information without the permission of the applicant/ beneficiary should only occur for purposes directly connected with the administration of the program and then only to persons, agencies, and entities with comparable confidentiality standards. Listings of Medicaid applicants/beneficiaries may not be released to anyone without the consent of SC DHHS.

As required by federal law, all application data will be automatically sent to the Federally Facilitated Marketplace (FFM) for those applications who contain an individual who is not eligible for Medicaid but is assessed to be potentially eligible for other affordable insurance programs.

Application data will also be automatically received from the FFM for any individual or their family who is assessed potentially Medicaid eligible by the FFM.

Eligibility information may be automatically sent to the FFM for any applicant who requests eligibility assessment or determination by either the FFM or SC DHHS.

Medical providers who are enrolled in the South Carolina Medicaid program may verify a beneficiary’s eligibility for Medicaid benefits for the previous 12 months by utilizing the Medicaid Interactive Voice Response System (IVRS) or a Point of Sale (POS) device. SC DHHS has contracted with GovConnect to maintain the IVRS.

To access IVRS, medical providers must use a touch-tone phone to call the toll-free telephone number: 1-888-809-3040, and enter their six (6)-character Medicaid Provider Identification. Medical providers will be prompted to enter the related Dates of Service and one of the following beneficiary identifiers:

* Medicaid Health Insurance Number,
* Social Security Number, or
* Full name and date of birth.

The system then submits the data provided and plays the beneficiary eligibility information back to the medical provider over the phone to include beneficiary special program status; Medicare coverage, third-party insurance coverage, and service limitations/visit count information. This service is provided 24 hours per day, seven (7) days per week in a real time environment, and there is no charge to the medical provider for this service.

In addition, on the back of the Healthy Connections (Medicaid) Insurance Card is a magnetic strip that may be utilized in POS devices to access information regarding Medicaid eligibility, third-party insurance coverage, beneficiary special programs, and service limitations 24 hours per day, seven (7) days per week in a real time environment. There is a fee to the medical provider for this service.

Medical providers that have contracted with the SC DHHS to provide a Sponsored Medicaid Specialist must have a [SC DHHS Form 934 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%20934.pdf), Appointment of Agent for Medicaid Determination and Appeal Process, signed by the applicant/beneficiary to receive information concerning an application/review or appeal being processed by a specialist for individuals in the facility.

Organizations who have signed a Memorandum of Agreement with SC DHHS to act as an intake site, must also use the SC DHHS Form 934 in order to receive information from the Eligibility Specialist regarding the applicant/ beneficiary during the Medicaid application/review and/or appeal process.

**101.12.05 Release of Medical Information**

(Eff. 01/01/14)

Generally, release of medical information must be authorized by the patient/beneficiary.

Beneficiary consent should be obtained before responding to a request for information from an outside source. Consent should include a description of the information to be released and identification of the receiving entity. The consent should be signed by the beneficiary or responsible party and witnessed. Only the information described may be released and only to the entity described.

Emergency requests for medical information should be forwarded to Eligibility, Enrollment and Member Services at SC DHHS. If the Eligibility Specialist is instructed that, due to an emergency, prior consent is not possible, the beneficiary or responsible party must be notified as soon as possible after the information is released.

**101.12.06 Release of Application/Case Information**

(Eff. 11/01/15)

The applicant may authorize SC DHHS to release information about his or her application/case to an individual or an organization by completing the appropriate section on the SC DHHS Form 1282. Unlike the Authorized Representative, this section only grants the individual or organization permission to receive information on the applicant’s application/case and not permission to act on behalf of the applicant.

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| **Procedure for Recognizing an Individual or Organization with Permission to Receive Application/Case Information** |
| If the DHHS Form 1282 ME is submitted at the time of application, then the Form 1282 should be processed with the Application.  If the Form 1282 ME is submitted after the application is submitted, then scan the Form 1282 into OnBase as a MEDS-Member Verification trailing document. The specialist should then enter the individual or organization’s information into notes in MEDS and on the Application Tracking Form in OnBase.  **NOTE:** If the SC DHHS Form 1282 is submitted after the application, it should be mailed to:  SC DHHS – Central Mail  P O Box 100101  Columbia, SC 29202-3101  **NOTE:** Until the signed DHHS Form 1282 ME or other legal authorization (such as a Power of Attorney) is received, application information cannot be shared with anyone except the applicant, a current spouse, or the parent of a minor child who is shown on the application.  If an Applicant/Beneficiary has two or more individuals or organizations with permission to receive application/case information, staff should enter a note in MEDS and OnBase on the Application Tracking Form with the additional individual or organization’s information.  **Cúram Procedure**  The appropriate procedure may be found in the [Authorized Representative Process](https://schhs.sharepoint.com/:b:/r/sites/EES/Training/Curam/HCR/Job-Aids/Case%20Management/Authorized%20Representative%20Process.pdf?csf=1&web=1&e=TfM4zP) job aid at [Training Materials Portal-MAGI](https://www1.scdhhs.gov/ees/trainingportal/). |

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| Nature of Provider Request | Valid Form 1282 Needed? |
| Application status | Yes |
| Information needed to process an application/Copy of Form 1233 Checklist | Yes |
| Verification that application has been submitted | Yes |
| Retroactive coverage status | Yes |
| Requests for retroactive coverage | Yes |
| Appeal status | Yes |
| Information regarding an individual’s appeal | Yes |
| Review status | Yes |
| Information regarding an individual’s annual review | Yes |
| Check eligibility for specific date of service  (Provider must have either a Medicaid ID# OR a date of birth and either the individual’s name or Social Security Number) | No |
| Form 945 needed | No |
| Provider wants to provide information to deem an infant (complete Form 1716 by phone) | No |
| Completed Form 1716 with infant Medicaid ID# | No |
| Questions about the application process or forms (not for a specific individual) | No |

**101.12.07 South Carolina Health Information Exchange (SCHIEx)**

(Eff. 01/01/14)

SCHIEx (SKY-eks), the South Carolina Health Information Exchange, gives healthcare providers, such as doctors and hospitals, the ability to view medical information on Medicaid beneficiaries. The information available includes medications, diagnosis, procedures, and common problems. Having this information will help the healthcare provider coordinate care for better continuity and quality, as well as assist with controlling cost. This clinical data is collected from 10-years of paid SC Medicaid claims, as well as information shared from participating providers' electronic medical record (EMR) systems.

Medical Information for Medicaid beneficiaries will be included in SCHIEx, but participation is not mandatory. A beneficiary can opt-out, or choose not be included, by contacting the Resource Center at 1-888-549-0820. If a beneficiary decides not to participate, a healthcare provider will not be able to see any of that person’s medical information. Individuals who have opted-out can later opt-in by contacting the Resource Center.

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**101.12.08 Request for Information on Medicaid Beneficiaries from External Parties**

(Rev. 01/01/14)

The Attorney General’s Medicaid Fraud Control Units (provider and beneficiary) are directly involved in the administration of the Medicaid program and handle cases under agreements with the Division of Program Integrity. Therefore, SC DHHS is committed to cooperating with these units of the Attorney General’s office in providing information on beneficiaries who receive Medicaid.

SC DHHS is not authorized to disseminate information directly to external parties other than those units of the Attorney General’s office. Any requests coming from other entities such as: The State Law Enforcement Division (SLED), The Federal Bureau of Investigations (FBI), Drug Enforcement Administration (DEA), The U.S. Attorney’s office, other units of the Attorney General’s Office or the U.S. Marshal’s office, must be referred by the local eligibility office to the Office of General Counsel (OGC) within SC DHHS.

Upon receipt of the request, the Office of General Counsel will review the request and advise the local office. For any requests that are deemed questionable, local offices may contact the Office of General Counsel.

**101.12.09 Receipt of Subpoena to Request Release of Information to Courts**

(Eff. 01/01/14)

If confidential information is requested through a subpoena, the Eligibility Specialist should immediately contact the Office of General Counsel at SC DHHS. A copy of the subpoena must be faxed to the Office of General Counsel, which will instruct the Eligibility Specialist regarding the action to be taken.

**101.12.10 Confidentiality Release of Aggregate Data and Information for Audits**

(Rev. 01/01/14)

General or statistical information such as total expenditures, the number of beneficiaries served and other information that cannot be identified with a specific person may be released. Protected information may be released to state and federal auditors performing bona fide audits.

**101.12.11 Right to Appeal and Fair Hearing**

(Rev. 07/01/22)

At the time of any action affecting an Applicant or Beneficiary’s Medicaid application or benefits, the agency must inform the individual of:

* The right to request a fair hearing;
* The ways to request a fair hearing;
* The right to be represented by the person of their choice at the hearing. They may represent themselves or designate someone as a representative, such as a lawyer, relative, friend, or another spokesman.

**NOTE:**

During a hearing, an applicant/beneficiary can designate anyone attending to represent them. A written statement is unnecessary as long as the applicant/beneficiary is present and can give permission.

If the applicant/beneficiary is not present, a designated individual must be authorized either with a valid DHHS Form 1282 or other legal documentation, such as a Power of Attorney or Certificate of Appointment for a Guardianship or Conservatorship. Authorized Representatives assigned by the applicant/beneficiary prior to the death of the applicant/beneficiary are still valid. Power of Attorney or Certificate of Appointment for a Guardianship or Conservatorship is no longer valid once the beneficiary is deceased.

The agency must grant the opportunity for a fair hearing to any Applicant/Beneficiary who requests it because:

* His/her claim for medical assistance is denied or is not acted upon with reasonable promptness;
* He/she believes that the agency has taken an action erroneously; and/or
* He/she believes a nursing facility has erroneously determined that he/she needed to be transferred or discharged.

The agency will not grant a hearing when the sole issue is a federal or state law requiring an automatic change which adversely affects some or all beneficiaries.

The applicant or beneficiary must submit the appeals request to the South Carolina Department of Health and Human Services (SCDHHS) Division of Appeals and Hearings within thirty (30) calendar days of the date on the Notice of Action to be a valid appeal. The applicant or beneficiary can provide a good cause for an untimely filing for the Hearing Officer to consider continuing with the appeal request. The following methods are available to submit a request:

* Appeals Website [msp.scdhhs.gov/appeals/](https://msp.scdhhs.gov/appeals/),
* Email [appeals@scdhhs.gov](file://dhhs-fsredir/users/jul13114/Documents/MPPM%20Current%20Files/SCMPPM/appeals@scdhhs.gov),
* Fax (803)-225-8251
* Phone (888) 549-0820
* Mail SCDHHS Division of Appeals and Hearings

PO Box 8206

Columbia, SC 29202

The faxed or mailed appeal request should take the form of either a letter or a signed DHHS Form 3260, Request for Fair Hearing for Medicaid Applicant or Beneficiary.

Information about the appeal process and what should be included in a request for appeal can be found at the following link: [msp.scdhhs.gov/appeals/](https://msp.scdhhs.gov/appeals/).

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| **Procedure to Request a Fair Hearing** |
| 1. The request for a fair hearing can be made in writing (online, email, fax, or mail) 2. Intake for a telephonic appeal request is accepted through the Member Contact Center at (888)-549-0820. 3. The request can also be made in-person by coming into a county SCDHHS location. If the Applicant/Beneficiary or their authorized representative comes to a county SCDHHS location to ask for an appeal, the Eligibility Specialist should complete Part I of [DHHS Form 3260](https://medsweb.scdhhs.gov/EligibilityForms/FM%203260%20ME.pdf), Request for Fair Hearing for Medicaid Applicant/Beneficiary and provide the form to the Applicant/Beneficiary to complete and return, or instruct the individual to submit his own written appeal request or refer him to the Appeals website ([msp.scdhhs.gov/appeals/](https://msp.scdhhs.gov/appeals/)) and note the telephonic appeal option. 4. The request must be made within 30 calendar days from the date on the Notice of Action. If the request is received after 30 days, the Hearing Officer will decide if the appeal should continue or be dismissed. A request for a fair hearing by mail is timely if postmarked by the thirtieth (30th) calendar day following receipt of the notice. 5. Beneficiaries who submit their own written appeal request must be informed of the option to continue Medicaid benefits during the appeal process. 6. Appeal requests are sent directly to the Division of Appeals and Hearings. The Division of Appeals and Hearings will notify the Eligibility Determination Respondent Team of the appeal filed and documents needed. 7. If the Applicant/Beneficiary requests an appeal by email or letter, DHHS Form 3260 does not need to be completed. |

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| **Procedure for online request** |
| **Appeals Request**   1. The applicant/beneficiary or authorized representative submits a request through the website: [msp.scdhhs.gov/appeals/](https://msp.scdhhs.gov/appeals/). 2. The appeals request is automatically sent to the Division of Appeals and Hearings   **Appeals Withdrawal Request**   1. The applicant/beneficiary or authorized representative submits a request through the website: [msp.scdhhs.gov/appeals/](https://msp.scdhhs.gov/appeals/). 2. The appeals request is automatically sent to the Division of Appeals and Hearings. |
| **Procedure for Telephonic Appeal Request and Appeal Withdrawal** |
| **Appeals Request**   1. The Member Contact Center will receive the call from the applicant/beneficiary or authorized representative requesting to appeal the case. 2. The Member Contact Center will complete the online Appeals Request Form with the applicant/beneficiary and submit the form to the Division of Appeals and Hearings. 3. Member Contact Center obtains a verbal signature for the appeal. 4. Member Contact Center checks the indicator when the signature file is obtained for the verbal signature and stores the signature file. The file will be available upon request.   **Exception:** When an appeals request is received via a telephonic request in to a local LEP Office the eligibility specialist will:   * Provide the number to the Member Contact Center if the applicant/beneficiary or authorized representative wants to complete a telephonic request; or * If the applicant beneficiary declines to complete the telephonic request, the eligibility specialist will complete Part I of DHHS Form 3260, Request for Fair Hearing for Medicaid Applicant/Beneficiary and send the form to the Applicant/Beneficiary to complete and return, or instruct the individual to submit his own written appeal request or refer him to the Appeals website ([msp.scdhhs.gov/appeals/](https://msp.scdhhs.gov/appeals/)).   **Appeals Withdrawal Request**   1. The member services representative will complete the assigned form with the applicant/beneficiary. A verbal signature recording is obtained. 2. The Member Contact Center will submit the form to the Division of Appeals and Hearings. |
| **Procedures for In-person Appeal Request** |
| **Appeals Request**   1. The eligibility specialist will complete Part I of DHHS Form 3260, Request for Fair Hearing for Medicaid Applicant/Beneficiary and give the form to the applicant/beneficiary or the authorized representative. 2. The applicant/beneficiary or the authorized representative will complete the form and return the form to the eligibility specialist. 3. The eligibility specialist must reopen the eligibility if continued benefits were requested by the beneficiary. (See MPPM 101.12.10A, Continuation of Benefits during Appeals Process.) 4. The eligibility specialist will date stamp and email the DHHS Form 3260 to the Division of Appeals and Hearings ([appeals@scdhhs.gov](file://dhhs-fsredir/users/jul13114/Documents/MPPM%20Current%20Files/SCMPPM/appeals@scdhhs.gov)).   **NOTE:** If the applicant/beneficiary or the authorized representative decides to complete the DHHS Form 3260 at home, the eligibility specialist will provide the options for returning the form to the Division of Appeals and Hearings (mail or fax).  **NOTE:** If the applicant/beneficiary does not want to complete the written version of the DHHS Form 3260, the eligibility specialist will provide the applicant/beneficiary or authorized representative with the website and the telephone number to make a verbal request.  **Appeals Withdrawal Request**   1. The applicant/beneficiary or authorized representative will complete a DHHS Form 1766, Declaration Statement, or a written letter requesting to withdraw the appeal case. The applicant/beneficiary must sign the request. 2. The eligibility specialist will date stamp the withdrawal request then email the withdraw request to the Division of Appeals and Hearings. |
| **Procedure for written request via letter or DHHS Form 3260 (fax, email, or mail)** |
| **Appeals Request**  The applicant/beneficiary or authorized representative will send a written letter or DHHS Form 3260 via fax, email or mail to the Division of Appeals and Hearings.  NOTE: If CDM receives the request, do not scan the documents into OnBase. Stamp the documents with the date received by CDM and mail the documents to the Division of Appeals and Hearings at SCDHHS Division of Appeals and Hearings, PO Box 8206, Columbia, SC 29202.  **Appeals Withdrawal Request**  The applicant/beneficiary or authorized representative will mail or fax a written letter or send an email requesting to withdraw the appeal case directly to the Division of Appeals and Hearings. The applicant/beneficiary must sign the written request. |
| **Eligibility Procedure to Process an Appeal** |
| 1. The Division of Appeals and Hearings sends a copy of the appeal request via email to the Eligibility Respondent Coordinator Manager or Supervisor 2. The Eligibility Respondent Coordinator Manager/Supervisor places the information in OnBase and assigns the case to an Eligibility Respondent Coordinator (ERC) in the ERC Database. A response timeframe is entered in the database as indicated in correspondences from the Division of Appeals and Hearings. The email from the Division of Appeals and Hearings is forwarded to the assigned ERC to review the appeals case. 3. The assigned ERC must reopen the eligibility if continued benefits were requested by the beneficiary. (Refer to MPPM 101.12.10A, Continuation of Benefits during Appeals Process.) 4. If an eligibility error is suspected, the ERC notifies his/her manager/supervisor that an Eligibility Quality Assurance (EQA) case review is needed. The manager/supervisor notifies EQA of the needed review. EQA reviews the case then notifies the EDR manager/supervisor of the review outcome. The manager/supervisor communicates EQA review outcome with the assigned ERC.   If an eligibility error is confirmed, the case is sent to the Escalations Team for processing. A DHHS Form 1233 will be sent to the applicant/beneficiary if additional information is needed. The applicant/beneficiary has 15 days to return the requested information.   1. If no additional information is needed, the ERC will complete the appeals summary packet and send it to the Division of Appeals and Hearings by secure email for standard documents or by SCDHHS drop (https://drop.scdhhs.gov) for large documents. A hard copy must be mailed to the applicant/beneficiary or authorized representative. The packet must include at minimum the following information:  * DHHS Form 3317, Appeal Summary,   Note: An Appeals Summary is a brief explanation of the reason for the appeal, the relevant facts, and the policy/law that served as the basis for the determination   * DHHS Form 3260, Request for Fair Hearing for Medicaid Applicant or Beneficiary, or a written appeal request, * Application/Review form, * All Notices of Action, manual notices, and/or the Letter of Correction, * DHHS Form 1282, Authorization for Release of Information and Appointment of Authorized Representative for Medicaid Applications/Reviews and Appeals—if the appeal was request by a person other than the Applicant/Beneficiary.   + If the applicant/beneficiary is deceased and the DHHS Form 1282 was signed by the applicant/beneficiary prior to the death, the DHHS Form 1282 is still valid. * Verifications used in the decision   + For example, when an application is denied due to excess income, include income verification. If the case is closed due to excess resources, include verification of the countable resources. * Applicable sections of the MPPM in effect at the time of the decision (if the appeal is not withdrawn) * If the applicant/beneficiary requests to withdraw an appeal, the ERC will only send the appeal request and withdrawal request to the Division of Appeals and Hearings. * The ECR will upload the appropriate documents to OnBase as an “MEDS-Appeal Documents”. Select “No” to trailing.   **IMPORTANT:** If an Appeal Summary packet cannot be produced by the indicated time, a request for an extension must be made to the hearing officer and petitioner/ applicant/AR.  **NOTE:** Eligibility specialists should continue to process cases based on current policy and procedures even when the case is in the appeal process. |
| **OnBase Procedure** |
| All documents associated with the appeal, including new verifications, workbooks, emails and documents, such as Orders to Produce, Interlocutory Orders, and decisions, must be scanned into OnBase. For Orders to Produce, Interlocutory Orders, and decisions, select “MEDS-Appeal Documents” as the document type. Select “no” in the trailing documents field.  **NOTE**  Be sure to scan the documents into OnBase using the Case Number, Social Security Number, and Person ID Number. |
| **MEDS/Cúram Procedure** |
| A note must be created in MEDS or Cúram documenting actions taken during the appeal process, such as an appeal was requested, an appeal packet was sent to the Petitioner and the Division of Appeals and Hearings, and a new decision was made.  A note must be created in MEDS or Cúram about any emails and documents, such as Orders to Produce, Interlocutory Orders, and decisions, scanned into OnBase.  The Documentation form in OnBase must also be updated with any actions made to the case and emails or documents received. |

**101.12.11A Continuation of Benefits during the Appeal Process**

(Rev. 12/01/23)

If SCDHHS has met the advance notice requirements of MPPM [101.09.03](#MPPM_101_09_03), the agency may not terminate or reduce Medicaid benefits for a Beneficiary who submits a written request for a fair hearing before the date of adverse action until a decision is rendered after the hearing unless:

* It is determined by the Hearing Officer that the sole issue is one of Federal or State law requiring an automatic change which adversely affects some or all beneficiaries; **and**
* The agency promptly informs the Beneficiary in writing that benefits are to be terminated or reduced until the hearing decision is issued.

SCDHHS must reinstate and continue benefits for 90 days or until a decision is made by the Hearing Officer if the following three conditions are met:

* The adverse action is taken without the advance notice required under MPPM [101.09.03](#MPPM_101_09_03);
* The beneficiary requests a hearing within 10 calendar days from the date that the individual receives the notice of action. The date on which the notice is received is considered to be 5 calendar days after the date on the notice unless the beneficiary shows that he or she did not receive the notice within the 5-day period; **and**
* SCDHHS determines that the action resulted from other than the application of Federal or State law requiring an automatic change which adversely affects some or all beneficiaries.

If an appeals case decision has not been rendered, the case should be extended another 90 days or until a decision has been made.

If the request for a fair hearing is received within 10 calendar days after the date of the adverse action, SCDHHS may reinstate benefits. The decision to reinstate benefits in this instance is based on the specifics of the case and at the discretion of the Deputy Director of Eligibility, Enrollment, and Member Services or his/her designee. If reinstated, the benefits must continue until the decision is made by the Hearing Officer, unless the Hearing Officer determines that the sole issue is one of Federal or State law requiring an automatic change that adversely affects some or all beneficiaries.

If a Beneficiary’s whereabouts are unknown, or if the Notice of Adverse Action is returned by U.S. Postal Mail and cannot be forwarded, any discontinued services must be reinstated if his or her whereabouts become known during the time he or she is eligible for services.

Only closed cases may receive continued or reinstated benefits. The assigned Eligibility Specialist must take the appropriate steps in MEDS or Cúram to reopen the benefits.

The Beneficiary can decline the continuation of benefits on the DHHS Form 3260, Request for Fair Hearing for Medicaid Applicant or Beneficiary, or by other written request, such as a letter, fax, or email. If the Beneficiary declines continued benefits in writing, the Eligibility Specialist should not reopen the benefits. If the beneficiary declines continued benefits in writing after the case has been reopened, the Eligibility Respondent Coordinator must immediately close the case using the appropriate Reason Code. Either a system generated, or manual closure notice must be sent.

The assigned Eligibility Specialist must explain to the Beneficiary that if the Hearing Officer rules in support of the decision made by SCDHHS, any payments made to providers, including Managed Care Organizations, for services received by the Beneficiary during this period are subject to repayment from the Beneficiary. If the Hearing Officer rules in support of the agency’s decision, the assigned Eligibility Respondent Coordinator must prepare an overpayment summary in accordance with policy as outlined in MPPM [101.16.01](#MPPM_101_16_01).

Regardless of whether the request for an appeal is submitted timely, Medicaid benefits cannot be approved for an Applicant unless the decision is reversed by the Hearing Officer.

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| **Appeal Examples** |
| * Ringo Starr receives a closure notice dated January 15 indicating his Medicaid eligibility will end effective February 1. His request for a fair hearing is received on January 31. Unless he declines, Ringo will receive a continuation of Medicaid benefits because his request is received before the date of the adverse action. * Kendrick Lamar receives a closure notice dated January 15 indicating his Medicaid eligibility will end effective February 1. His request for a fair hearing is received on February 9. Because his request was made within ten days of the date of the adverse action, Kendrick may receive a reinstatement of Medicaid benefits based on the specifics of the case and at the discretion of the Eligibility Respondent Coordinator assigned to the appeal. * Miles Davis received a notice on January 20 dated January 15 indicating his Medicaid eligibility will end effective January 16. His request for a fair hearing is received on January 29. If the adverse action did not result from the application of Federal or State law requiring an automatic change which adversely affects some or all beneficiaries, Miles will receive a reinstatement of Medicaid benefits because SCDHHS did not provide enough advance notice (which is at least 10 days before the action) and his request was received within 10 days from when Miles received the action. |

**101.12.11B Interlocutory Order, Order to Produce, Pre-Hearing Conference Order**

(Rev. 04/01/21)

The Hearing Officer in the Division of Appeals and Hearings may issue an Interlocutory Order, an Order to Produce, or a Pre-Hearing Conference Order. These orders request that either additional actions be taken, or additional information be provided. The orders may be addressed to any or all of parties involved, including the applicant/beneficiary, their representative, and/or the assigned Eligibility Respondent Coordinator.

The order will have specific instructions about what actions each party must take. The Hearing Officer will require a response to the Order by a specified date. If a response is not provided, the appeal may be dismissed, or the decision reversed. If a response is received, the Hearing Officer will determine the next appropriate action.

**101.12.11C Pre-Hearing Conference**

(Rev. 04/01/21)

A Pre-Hearing Conference may be initiated by the assigned Eligibility Respondent Coordinator, a Pre-Hearing Conference Order, issued by the Hearing Officer, or by request of the Applicant/Beneficiary or his/her representative. The Pre-Hearing Conference does not nullify the Applicant/ Beneficiary’s right to a hearing.

A Pre-Hearing Conference may be used to discuss:

* + - Continued benefits,
    - How the decision was made,
    - If the decision has been modified,
    - If the Applicant/Beneficiary’s circumstances have changed,
    - The issues being appealed,
    - Additional information needed to change or continue with the eligibility determination process,
    - The appeal process, and
    - Whether the appellant wishes to continue with the appeal process.

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| **Prehearing Conferences** |
| 1. Prehearing Conferences are ordered by the Hearing Officer. (Refer to MPPM 101.12.11 C) Adhere to the timeframes indicated in the order. The order will outline which party is to initiate contact. If the Respondent is to initiate contact, follow the actions below: 2. The assigned Eligibility Respondent Coordinator must contact the applicant/ beneficiary or their representative as outlined in the order via phone, email, or mail to schedule a pre-hearing conference. 3. Hold the prehearing conference as scheduled. During this conference, the assigned Eligibility Respondent Coordinator should discuss:    * + Continued benefits,      + How the decision was made,      + If the decision has been modified,      + If the Applicant/Beneficiary’s circumstances have changed,      + The issues to be appealed,      + Additional information needed to change or continue with the eligibility determination process,      + The appeal process, and      + Whether the Applicant/Beneficiary wishes to continue with the appeal process.        - The assigned Eligibility Respondent Coordinator should ask for a written withdrawal if the Applicant/Beneficiary does not wish to continue with the appeal process. This can be sent via online, email, fax, mail or verbally requested through member services. 4. If the order is for the Petitioner to contact the Respondent (ERC), the ERC should wait until the deadline for the conference. If contact is not received from the Petitioner by the deadline, the ERC should submit a Prehearing Conference Summary/Motion to Dismiss. This must be submitted to the Hearing Officer and the Petitioner. |

If the decision appears to be incorrect following the Pre-Hearing Conference, the assigned Eligibility Respondent Coordinator will correct the case and notify the Applicant/Beneficiary or their representative via a new Notice of Action a corrected appeal packet must be sent to the Division of Appeals and Hearings and the Applicant/ Beneficiary or their representative.

**101.12.11D Notification of Hearing**

(Rev. 04/01/21)

Staff in the Division of Appeals and Hearings will notify the Applicant/Beneficiary at least 30 calendar days before the scheduled hearing date unless an expedited hearing is requested. The Notice of Hearing will include the following information:

* The time and place of the hearing,
* The subject of the hearing,
* The hearing procedures,
* The Applicant/Beneficiary’s right to present written evidence, testimony, and to call witnesses,
* The Applicant/Beneficiary’s right to review the case file in advance of the hearing,
* The name of the appropriate person to notify in the event the Applicant/Beneficiary or designated representative cannot keep the scheduled appointment, and
* A statement indicating that the appeal summary will be forwarded to the individual by the assigned Eligibility Respondent Coordinator, who should be contacted if the appeal summary is not received.

A copy of the notice is also sent to the assigned Eligibility Respondent Coordinator.

**101.12.11E Hearing Participants and Hearing Format**

(Rev. 04/01/21)

A Hearing Officer from the Division of Appeals and Hearings conducts the hearing. Individuals who have taken part in the decision may not conduct the hearing or take part in the final decision-making process. The following persons will be present at the hearing:

* Petitioner – The Applicant/Beneficiary making the request for a hearing and/or his representative.
* Respondent – SCDHHS, as the State Medicaid Agency, is the Respondent. The assigned Eligibility Respondent Coordinator will appear for the Respondent.
* Respondent’s Agent – The Respondent’s Agent may include, but is not limited to, the Department of Vocational Rehabilitation, the Department of Disabilities and Special Needs, etc.

In general, the hearing’s format begins with a statement of issue, followed by a period of testimony, summation, and the conclusion of the hearing.

**101.12.11F Group Hearings**

(Rev. 08/01/14)

A group hearing on two or more appeals may be held under the following circumstances:

* + - * The issue is confined solely to state policy or a change in state policy, and
      * Each Applicant/Beneficiary is permitted to present his own case or have his case presented by a representative.

All policies and procedures governing hearings apply to group hearings. Once a decision is rendered, each Applicant/Beneficiary will receive an individually written decision concerning his appeal.

**101.12.11G Decision**

(Rev. 04/01/21)

The Division of Appeals and Hearings will make the final decision on the appeal within 90 calendar days of the date the initial request was received, if possible. The Hearing Officer will review the record in its entirety and make a decision. The decision will be issued in writing and will set forth the issues, relevant facts presented, pertinent provisions in law, regulations, agency policy, and reasoning that led to the decision.

Once the decision is mailed by the Division of Appeals and Hearings to all responsible parties, the assigned Eligibility Respondent Coordinator shall implement the directives of the decision.

**101.12.11H Order of Remand**

(Rev. 05/01/22)

The Hearing Officer in the Division of Appeals and Hearings may issue an Order of Remand. The Order of Remand is a final decision that directs the agency to perform certain actions. If an Order of Remand is received from the Hearing Officer, the assigned Eligibility Respondent Coordinator should follow the directives found under the "ORDER" section of the Order of Remand.

The Hearing Officer may direct the agency to make a new eligibility determination. A new Notice of Action must be issued by an Eligibility Specialist. The Applicant/Beneficiary has the right to appeal the new decision.

**101.12.11I Order of Dismissal**

(Rev. 02/01/16)

The Hearing Officer in the Division of Appeals and Hearings may issue an Order of Dismissal, if the Applicant/Beneficiary:

* Submits a written withdrawal request,
* Fails to appear at the scheduled hearing without good cause,
* Fails to provide the Hearing Officer with an error of fact or law that could possibly reverse the agency’s decision, or
* Fails to provide the Hearing Officer with good cause for failing to provide a timely appeal.

The Order of Dismissal is a final decision.

**101.12.11J Appellate Review**

(Rev. 02/01/16)

Any party has the right to petition for further review of a final decision, pursuant to the Administrative Procedures Act, SC Code Ann. Section 1-23-310, et seq. (1976, as amended). In accordance with the Rules of Procedure for the SC Administrative Law Judge Division, the request from the petitioner must be made within 30 calendar days of receipt of the final decision and should be directed to:

Administrative Law Court

1205 Pendleton Street

Edgar Brown Building – 2nd Floor

Columbia, South Carolina 29201

If an appeal to the Administrative Law Court is filed, the Applicant/Beneficiary or their representative should send a copy of the petition to Office of General Counsel at the same time of the appeal.

**101.13 Responsibilities of Applicants/Beneficiaries/Agency**

(Eff. 01/01/14)

**101.13.01 Applicants/Beneficiaries**

(Eff. 01/01/14)

Medicaid applicants/beneficiaries have the following responsibilities:

* **Provide Complete and Accurate Information**

Any person applying for and/or receiving assistance is required, by law, to provide complete and accurate information about his circumstances and others in whose behalf he/she has applied. Penalties are imposed for making false statements and misrepresentation of material facts, concealing or failing to disclose information with fraudulent intent, and converting benefits intended for use of one person to another.

* **Cooperation**

The applicant/beneficiary is expected to assist in the eligibility determination process by obtaining information (verifications or documentation) necessary to determine eligibility.

* **Report Changes**

The applicant/beneficiary is required to report any changes in circumstances that may affect eligibility. Such changes must be reported within ten (10) calendar days of the change. Failure to do so may constitute willful withholding of information.

* **Repayment**

A beneficiary must repay the amount paid by Medicaid for services rendered during a period of ineligibility due to failure to report changes or to provide accurate information.

**101.13.02 Agency**

(Eff. 01/01/14)

As employees of SC DHHS, eligibility staff will be committed to the following agency goals:

* To provide a benefit plan that improves member health, is evidence-based and market-driven;
* To provide a credible and continually improving eligibility process that is accurate and efficient; and
* To provide administrative support at the best possible value to ensure programs operate effectively.

To achieve this goal, staff will adhere to certain standards that will reflect positively on the agency as a whole, as well as, promote its mission to use the available resources to ensure the health and well-being of every South Carolinian.

With this in mind, employees will commit to:

* Respectful, patient, responsible customer service;
* Effective, cooperative teamwork;
* The highest standards of ethical and professional conduct;
* Competency in the function to which staff have been assigned; and
* A willingness to respond positively to the inevitable changes that occur in Medicaid policy.

**101.14 Beneficiary Lock-In Program**

(Rev. 04/01/15)

One intervention used by the Department of Health and Human Services to help identify and prevent prescription drug abuse and its harmful effects is the Beneficiary Lock-In Program. This is a statewide program that reviews pharmacy utilization data with a screening tool that helps identify beneficiaries at risk of inappropriate or unsafe prescription drug use, especially narcotics and other controlled substances. When beneficiaries meet the lock-in criteria established by SCDHHS, they will be placed in the Medicaid Pharmacy Lock-In Program to monitor their drug utilization and to require them to utilize one designated pharmacy. This program encompasses beneficiaries receiving services directly from SCDHHS under its fee-for-service program as well as those enrolled with a Managed Care Organization.

**101.14.01 Beneficiary Lock-In Program Selection Criteria**

(Rev. 04/01/15)

The Division of Program Integrity manages a Beneficiary Lock-In Program that screens all Medicaid members against clinically-vetted criteria designed to identify drug seeking behavior and inappropriate use of prescription drugs. The Beneficiary Lock-In Program addresses issues such as coordination of care, patient safety, quality of care, improper or excessive utilization of benefits, and potential fraud and abuse associated with the use of multiple pharmacies and prescribers. The policy implements SC Code of Regulations R 126-425. The Division of Program Integrity reviews beneficiary claims data in order to identify patterns of inappropriate, excessive, or duplicative use of pharmacy services. If beneficiaries meet the lock-in criteria established by SCDHHS, they will be placed in the Medicaid Lock-In Program to monitor their drug utilization and to require them to utilize one designated pharmacy.

Beneficiaries who are enrolled in the Lock-In Program with an effective date of October 1, 2014, and forward will remain in the program for two years. The beneficiary has the opportunity to select a pharmacy and has the right to appeal. The program also has provisions that allow the beneficiary to obtain emergency medication and/or go to another pharmacy should the first pharmacy provider be unable to provide the needed services.

**101.14.02 Beneficiary Lock-In Program Procedures**

(Rev. 04/01/15)

On a quarterly basis, the Division of Program Integrity screens all Medicaid-enrolled beneficiaries (with some exceptions) against multiple criteria. These criteria are primarily based on claims data and show the number of pharmacies and physicians used by the beneficiaries over the past 6 – 12 months, the number and type of drugs prescribed for them, the beneficiaries’ diagnoses, and other potential risk factors. These criteria are clinically vetted by SCDHHS and managed care pharmacy and medical directors. All beneficiaries are screened, including those enrolled with a Medicaid MCO, with the following exceptions:

* Hospice patients
* Nursing home patients
* Children under age 16 and who are medically fragile, severely disabled, or are in a Medicaid waiver program.

SCDHHS can revise these criteria as needed. Lock-In candidates can also be identified from other sources, such as complaints received on the Fraud Hotline, Managed Care Organizations, physicians, and other sources.

Once a beneficiary has been identified for Lock-In, the Department of Recipient Utilization will:

* Send via Certified Mail a notification letter informing the beneficiary that they will be placed in the Medicaid Lock-In Program and providing them the opportunity to choose a pharmacy from which they will receive all their Medicaid prescriptions while in the program. The letter will specify the pharmacy that the beneficiary has been assigned to, but also give the beneficiary the option of choosing a different pharmacy and will describe the beneficiary’s appeal rights. The beneficiary has twenty (20) calendar days to request a change from the pre-selected pharmacy.
* After the twenty (20) day period SCDHHS will send a letter to the pharmacy selected to inform them of the beneficiary lock-in.
* If the beneficiary does not select a pharmacy within twenty (20) calendar days of the date of the letter, the lock in pharmacy will default to the one pre-selected.
* Division of Hearings and Appeals will be contacted before the beneficiary is locked in to ensure they have not filed an appeal.
* SCDHHS will concurrently inform Magellan of the beneficiaries locked-in and the selected pharmacies via MMIS data input.

If the beneficiary requests a copy of their Detailed Claims Report (DCR) in order to respond to the lock-in notification, this will be promptly provided by SCDHHS. The pharmacy provider selected will be notified of the lock-in and has ten (10) days to respond to allow adequate time for selection of another provider should the first provider determine they cannot provide the needed services.

The Division of Program Integrity, Department of Recipient Utilization, will monitor the beneficiary’s pharmacy use while in lock-in. Information regarding any beneficiaries identified for lock-in may also be provided to the SCDHHS medical director and/or pharmacy director for clinical review.

Pharmacy providers will be notified of the beneficiary pharmacy restriction via the Magellan point-of-sale (POS) system. The Magellan POS system will cause the denial of any claims for pharmacy services submitted by any provider other than the provider selected by the beneficiary.

A similar process will be followed by the Managed Care Organizations for their members who are identified for the Pharmacy Lock-in Program. SCDHHS will manage the process for fee-for-service beneficiaries; the respective MCOs will manage the process for members enrolled in their plans. The Department will refer the members selected as eligible lock-in candidates to their respective MCOs for pharmacy lock-in. Once the SCDHHS identifies members eligible for the Pharmacy Lock-in Program to the MCO, the MCO shall conduct a second review to identify any members that should not be in the program due to complex drug therapy or other case management needs.

The MCO shall have a process at the point-of-sale to “lock-in” the member to the chosen pharmacy, therefore denying claims from pharmacy providers other than the designated pharmacy.

Application of this rule will not result in the denial, suspension, termination, reduction, or delay of medical assistance to any beneficiary. As required by 42 CFR431 Subpart E, any Medicaid beneficiary who has been notified in writing by SC DHHS of a pending restriction due to misutilization of Medicaid services may exercise his/her right to a fair hearing, conducted pursuant to R126-150 et. Seq. (Refer to MPPM [101.12.10](#MPPM_101_12_10))

If a beneficiary moves, he/she can request to change the Lock-In pharmacy to one more conveniently located. Other reasons for a change of pharmacy may be considered. However, if a beneficiary changes from one managed care plan to another during the course of the two-year lock-in period, they remain in the Lock-in program regardless of which MCO is paying for the beneficiary’s medical care.

**101.15 Fraud**

(Eff. 10/01/05)

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/her or some other person. It includes any act that constitutes fraud under applicable federal or state law.

South Carolina state law at Section 43-7-70 defines beneficiary fraud and the penalties as they relate to the South Carolina Medicaid program. It is unlawful for:

* A person to knowingly and willfully make, or cause to be made, a false statement or representation of material fact on an application for assistance, goods or services under the state's Medicaid program when the false statement or representation is made for the purpose of determining the person's eligibility for Medicaid.
* Any applicant, beneficiary or other person acting on his behalf to knowingly and willfully conceal or fail to disclose any material fact affecting the initial or continued eligibility of the applicant/beneficiary for Medicaid.
* A person eligible to receive benefits, services or goods under the state's Medicaid program to sell, lease, lend or otherwise exchange rights, privileges or benefits to another person.

**101.15.013 Fraud Penalties**

(Rev. 11/01/08)

A person who violates the provisions of Section 43-7-70 of the S.C. Code of Laws is guilty of medical assistance fraud which is a Class A misdemeanor. Upon conviction, the person must be imprisoned not more than three (3) years or fined not more than $1,000 or both. Section 43-7-70 does not prohibit the prosecution of a person for conduct that constitutes a crime under another statute or at common law.

**101.15.02 Referral of Suspected Fraud Cases**

(Rev. 10/01/10)

Cases of suspected fraud will be investigated by SC DHHS in coordination with the Attorney General's Office. An Eligibility Specialist who suspects that fraud has been committed must discuss the case with his/her supervisor and refer the case for investigation by forwarding a fraud summary to:

South Carolina Department of Health and Human Services

Division of Program Integrity

Post Office Box 8206

1801 Main Street

Columbia, South Carolina 29202-8206

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**101.15.03 Fraud Summary**

(Rev. 10/01/10)

The fraud summary must include the following information:

* Identifying Information
  + Name and address of beneficiary;
  + Type of benefits received or requested;
  + County, case number and Medicaid number; and
  + Name of specialist making the report.
* Summary of the Situation
  + Date of certification;
  + Date of review prior to date that alleged fraud was discovered;
  + A brief statement concerning the beneficiary's circumstances as reported at the last review;
  + The date alleged fraud was discovered and a statement of the facts supporting the fraud allegation; and
  + The period of ineligibility.
* Verification

Give the facts that verify the correct information concerning the eligibility factor involved. Such facts include:

* + Names and location of records used;
  + Names and addresses of persons providing information;
  + Names of other sources used to substantiate the information; and
  + A copy of the application form and last review form, when applicable.

The fraud summary must be signed by the Eligibility Specialist’s supervisor, indicating that the supervisor has reviewed the case record and fraud summary and have determined that, to the best of his/her knowledge, it contains all of the relevant information. SC DHHS Division of Program Integrity will contact the Eligibility Specialist should additional information about the facts of the case be required.

**101.16 Overpayments/Underpayments**

(Eff. 10/01/05)

An overpayment may occur because:

* The beneficiary was ineligible for a period during which he/she received Medicaid benefits; or
* Medicaid paid more for the cost of medical services than it should have.

The overpayment could have resulted from agency or beneficiary error. If the overpayment resulted from agency error, the beneficiary is not required to repay the funds. Therefore, no overpayment summary is required. The Eligibility Specialist documents the case record with the fact of the agency error and the period of time covered by the overpayment. Examples of agency error are:

* Failure to take action on reported information
* Failure to follow up on an anticipated change in circumstances
* Failure to re-determine eligibility in a timely manner
* Failure to apply policy or procedures correctly

If the overpayment resulted from beneficiary error, an overpayment summary is required. Examples of beneficiary error are:

* Withholding information
* Providing incorrect information
* Unreported changes

The beneficiary may willfully withhold information that he/she knows will affect his eligibility. In this case, refer to MPPM [101.15](#MPPM_101_15) in this chapter regarding beneficiary fraud. On questionable cases, the SC DHHS Division of Program Integrity will determine if information was willfully withheld.

An underpayment may occur when a beneficiary's income was overstated, and Medicaid failed to pay its full share of medical expenses. All underpayments are to be corrected upon discovery. If the underpayment resulted from agency error, the error may be corrected retroactively. Underpayments that resulted from beneficiary error are corrected, but they are not corrected retroactively. Necessary adjustments are made effective with the next month a change can be made. Underpayments must be corrected within 12 months from the month of discovery.

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**101.16.01 Completing an Overpayment Summary**

(Rev. 07/01/16)

Once it has been determined that a beneficiary error has occurred resulting in a potential overpayment, the Eligibility Specialist must take the following actions:

1. Verify an error occurred.

2. Complete the [DHHS Form 928](http://medsweb.scdhhs.gov/EligibilityForms/FM%20928.pdf), Notice of Overpayment, and obtain supervisor’s signature and forward to the beneficiary informing him/her an overpayment referral has been made. The beneficiary will have 10 calendar days from the date on the SC DHHS Form 928, Notice of Overpayment, to contact the supervisor if he/she has questions or would like to discuss the referral.

3. Complete the [DHHS Form 3252](http://medsweb.scdhhs.gov/EligibilityForms/FM%203252%20ME.pdf), Overpayment of Medicaid Benefits, which must include the following:

* Beneficiary’s name, address and telephone number
* Medicaid ID Number and Social Security Number
* Period covered by the overpayment
* Summary of the facts pertaining to the overpayment including any background information on how the overpayment came to our attention (e.g., the client did not report the overpayment, SC DHHS discovered the overpayment later, etc.)

4. After 10 calendar days, submit the completed DHHS Form 3252 and DHHS Form 928 to the Division of Policy and Planning via a Service Manager ticket. In Service Manager, enter the following information:

**Group:** Medicaid Eligibility

**Category:** Medicaid Policy

**Category Option:** Overpayment Summary

**Subject line:** Overpayment of Medicaid Benefits.

Attach the completed DHHS Form 3252 and DHHS Form 928 to your ticket and submit. After reviewing the overpayment, the Division of Policy and Planning will forward the ticket to Program Integrity.

**101.16.02 Repayment of Medicaid Benefits Resulting from an Overpayment**

(Eff. 10/01/05)

The Division of Program Integrity will determine if the beneficiary owes a refund resulting from an overpayment. The amount owed depends upon whether the beneficiary used his Medicaid card. If it is determined that the beneficiary owes a refund for the error, the beneficiary will receive a letter from the Division of Program Integrity which will include his rights to file an appeal.

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**101.16.03 Repayment of Medicaid Benefits Resulting from Continued Benefits During an Appeal**

(Eff. 10/01/05)

If a beneficiary files an appeal and requests continued benefits pending the outcome of an appeal hearing, the [DHHS Form 3260](http://medsweb.scdhhs.gov/EligibilityForms/FM%203260%20ME.pdf), Request for a Fair Hearing, or written notice to receive continued benefits must be in the case record. If the decision upholds the action taken on the case, any Medicaid payments received during this period are subject to repayment. (Refer to MPPM [101.12.10A](#MPPM_101_12_10A).)

The Medicaid supervisor must complete the [DHHS Form 3252](http://medsweb.scdhhs.gov/EligibilityForms/FM%203252%20ME.pdf), Overpayment of Medicaid Benefits - Notice to Department of Receivables, to notify the Division of Program Integrity.

The Division of Program Integrity will determine the amount owed and bill the beneficiary. The amount owed depends upon whether the beneficiary used his Medicaid card during the continued benefits period. If it is determined that the beneficiary owes a refund, the beneficiary will receive a letter from the Division of Program Integrity, which will include his rights to file an appeal.

**101.17 Healthy Connections (Medicaid) Insurance Card**

(Eff. 03/01/08)

Medicaid eligible beneficiaries receive a plastic South Carolina Healthy Connections (Medicaid) Insurance Card. The front of the card includes the member’s name, date of birth, and Medicaid health insurance number. The back of the card includes:

* A number that providers may call for prior authorization of services outside the normal practice pattern or outside a 25-mile radius of South Carolina
* A toll-free number that may be utilized by providers to access the Medicaid IVRS. (Refer to MPPM [101.12.04](#MPPM_101_12_04) for information on IVRS.)
* A magnetic strip that may be utilized by providers in POS devices. (Refer to MPPM [101.12.04](#MPPM_101_12_04) for information on POS services.)

Refer to MPPM Chapter 104, Appendix X, for a copy of the Healthy Connections (Medicaid) Insurance Card.

**101.17.01 Instructions on the Use of the Medicaid Insurance Card**

(Eff. 03/01/08)

Beneficiaries must be informed of the proper use of the Healthy Connections (Medicaid) Insurance Card. This is accomplished via the card carrier. The explanation must ensure that the beneficiary understands the following:

* Possession of the card does not guarantee Medicaid coverage.
* The card is permanent and will not be replaced monthly.
* Only one person’s name appears on each card. If more than one family member is eligible for Medicaid, the family will receive a card for each eligible member.
* The card should be in the beneficiary’s possession at all times.
* The card should be shown to the provider of service(s) at the time of treatment.
* The card is not transferable. Only the person whose name is listed on the card is eligible. Use by other persons is illegal.
* The card may be used to obtain only those services/supplies/equipment covered by Medicaid.
* Inappropriate use of the card may result in the beneficiary being restricted to specified providers.
* The card may be used for emergency services out-of-state (outside a 25-mile radius of South Carolina). Emergency services must be reported to and authorized by the State Department of Health and Human Services program representatives. The out-of-state provider must call or write its program representative within 30 calendar days from the date of service/discharge for approval. Physicians must call (803) 898-2660. Hospitals must call (803) 898-2665.

**101.17.02 Procedures for Handling Returned Medicaid Insurance Card and Returned Mail**

(Rev. 11/01/23)

**Procedure for Handling Returned Medicaid Cards:**

Healthy Connections (Medicaid) Insurance Cards that are undeliverable by the United States Post Office are returned to the Eligibility Specialist for disposition. To ensure the safety and security of the returned Medicaid cards, the following controls should be implemented:

* Returned cards are stored in a secure location.
* Proper disposition is made for each card within 30 calendar days.

Cases must be researched for a correct address. Those cards for which no address can be located or are a general delivery address must be kept in the secure location, and notification of case closure must be made. If a correct address is obtained, the card may be released to the beneficiary.

**Procedure for Handling Returned Mail:**

If mail is returned to the Local, Central Eligibility or Central Institutional unit processing office with a forwarding address, the Eligibility Specialist must update HMS04 (Primary Individual Screen) in MEDS with the correct mailing address. The Eligibility Specialist will use the new mailing address to forward the letter to the applicant/beneficiary.

If mail is returned because of an insufficient address, the Eligibility Specialist must research MEDS for a correct address.

Those letters, for which a correct address cannot be located, must be kept in the case record. The Eligibility Specialist must document in the case record that mail was returned and a forwarding address could not be located.

**101.17.03 Requesting a Replacement Medicaid Insurance Card**

(Eff. 03/01/08)

When a beneficiary requests a replacement Healthy Connections (Medicaid) Insurance Card, the Eligibility Specialist must take the following steps:

1. Ensure that the beneficiary’s mailing address in the Medicaid computer system is correct.
2. If the beneficiary is an SSI recipient, instruct him/her to notify the county Social Security Administration office of the correct mailing address. (Note:This is very important because the mailing address cannot be corrected permanently until the Social Security Administration corrects the State Data Exchange file.)

If the beneficiary has called 1-800-772-1213 to report the address change, it will not correctly change the address to affect the Medicaid card. The beneficiary should be instructed to contact the area SSA office.

3. Check the secure location where returned cards are kept to see if the card is there. If so, give or mail the card to the beneficiary. If the card is not found, key the necessary information into the computer system to request a replacement card.

For Cúram, refer to the [Request a Medicaid Replacement Card](https://schhs.sharepoint.com/:b:/r/sites/EES/Training/Curam/HCR/Job-Aids/Case%20Management/Request%20a%20Medicaid%20Replacement%20Card.pdf?csf=1&web=1&e=ZPnRKu) job aid at [Training Materials Portal-MAGI](https://www1.scdhhs.gov/ees/trainingportal/).

**101.18 Voter Registration**

(Eff. 03/01/14)

Congress enacted the National Voter Registration Act of 1993 (NVRA), requiring states to establish procedures to assist public assistance applicants and beneficiaries with registering to vote. Pursuant to the NVRA, all SC DHHS staff – including third party’s employees providing contract services to SC DHHS – must offer the following Voter Registration Services (VRS) to all applicants and beneficiaries:

* Distribution of Voter Registration Cover Letter;
* Distribution of Voter Registration Application (VRA);
* Distribution of Voter Registration Declination (VRD);
* Assistance selecting the appropriate form to complete, if requested;
* Assistance completing the appropriate form, if requested; and
* Acceptance and transmittal of completed VRAs to the appropriate County Board of Voter Registration, if returned to SC DHHS.

NOTE: The Voter Registration Cover Letter, VRA, and VRD collectively comprise the Voter Registration Packet. Each SC DHHS site shall keep an adequate supply of Voter Registration Packets available. Individual forms may be downloaded from [SC DHHS Medicaid Eligibility Forms](http://medsweb.scdhhs.gov/formslisting.htm).

SC DHHS will provide local eligibility offices with signs alerting visitors of the voter registration services. Local eligibility offices will be responsible for maintaining these signs.

**101.18.01 Voter Registration Services**

(Rev. 01/01/24)

VRS shall be offered (i) in person, (ii) electronically, and (iii) via telephone, fax, or mail, whenever an applicant/ beneficiary:

1. Applies for services;
2. Renews a service (i.e. at annual review); or
3. Submits a change of address.

|  |
| --- |
| **Procedures for Providing Voter Registration Packets** |
| **Face-to-Face:**  When an applicant/ beneficiary visits a local eligibility office, the person designated by that office will offer the individual a copy of the Voter Registration Packet. The Eligibility Specialist should document in Cúram/OnBase that the form was offered.  **NOTE**  This service may be provided by a receptionist or an Eligibility Specialist. At least one person must be present during all business hours to provide assistance.  **By Telephone, Mail, Fax, or E-mail:**  **At Time of Application Request**  The Eligibility Specialist must inquire if the applicant would like to receive a voter registration packet when they request a Healthy Connections Medicaid Application. If the Eligibility Specialist receives a “Yes” answer, they will send the Voter registration packet and record in the documentation template that the form was sent. If the applicant/beneficiary answers “No”, the Eligibility Specialist must record in the documentation template that the form was declined.  image  If the applicant/beneficiary opts not to receive the Voter Registration Application (VRA), the Eligibility Specialist will:   * Mark the Voter Registration Declination (VRD) checkbox * Enter the Date Received as the date the collateral call is made * Note the date and time of the collateral call and the individual to whom the call was made   **NOTE**  The General - Voter Registration section allows for additional comments if more space is needed.  **After an Application or Completed Review Form is Received by an Eligibility Specialist for Processing**  When additional information is needed to make an eligibility determination, the Eligibility Specialist will attempt to ask if they would like a Voters Registration packet during the collateral call process before sending the DHHS Form 1233. If the applicant/beneficiary can be contacted and they respond with “Yes”, the Eligibility Specialist will also include the Voter Registration Packet. “Voter Registration Form” is to be checked on the DHHS Form 1233. If the applicant/beneficiary is not able to be contacted, we are to assume the answer is “No” and the Voter Registration packet will not be sent out. |

When VRS are offered, the Eligibility Specialist should proceed as follows:

**Step 1**

**Inform the applicant/beneficiary of Voter Registration Services.**

This may be completed by offering a verbal explanation and/or providing a Voter Registration Packet.

**Step 2**

**Determine if the applicant/beneficiary would like to receive Voter Registration Services**.

The applicant/beneficiary will be given the option whether or not to participate in VRS. If the applicant/beneficiary accepts services, continue to Step 3. If the applicant/beneficiary declines services, request the applicant/beneficiary complete a VRD to verify he was offered the service.

**Step 3**

**Determine if the applicant/beneficiary is registered to vote at his current address**.

If the applicant/beneficiary is registered at his current address, VRS are not needed; request that the applicant/beneficiary complete a VRD to verify he was offered the services. If the applicant/beneficiary has (i) never registered to vote in SC or (ii) changed his legal address since he registered to vote, provide a Voter Registration Packet and continue to Step 4.

**Step 4**

**Determine if the applicant/beneficiary needs assistance completing the Voter Registration Packet**.

Eligibility Specialists may explain forms contained in the Voter Registration Packet, answer questions related to voter registration, and offer assistance reading and filling out the form. If the Eligibility Specialist assists the applicant/beneficiary, he must copy and attach any documents offered by the applicant/beneficiary to his VRA (such as a current photo ID or copy of a current utility bill, bank statement, paycheck or other government document showing name and address).

**Step 5**

**Submitting and processing forms.**

Different procedures will be followed depending on whether the applicant/beneficiary elects to complete the VRA or VRD.

The applicant/beneficiary may return a completed VRA to either (i) their County Election Commission office or (ii) the Department of Motor Vehicles (DMV).

If the applicant/beneficiary returns a completed VRD to SC DHHS, the VRD shall be stored separately from the applicant/beneficiary’s case file for at least twelve (12) months. VRDs will be entered into OnBase strictly to allow SC DHHS to track how many forms have been received. VRDs are to be scanned into OnBase as document type VRD, Keyword “Current Year”; e.g., “2023”. VRDs will not be associated with a Medicaid ID #.

| **Procedure for Entering Voter Registration** |
| --- |
| Scanners and Eligibility Specialist should follow the below procedures if any voter registration documents are submitted with an application.  **Scanners**  If a voter registration is submitted with a paper application, add an electronic sticky note to the Cúram application in OnBase. For example, “VRD received with application” or “VRA received with application.” There is no need to complete the form on the OnBase Tracking Form.  **Eligibility Specialists**  When working new applications, Eligibility Specialist should complete the following tasks:   1. Look for any sticky notes and/or indicator on the application in OnBase to see if there is documentation of Voter Registrations materials. 2. If there is nothing indicating Voter Registration forms have been sent or received, and unless the applicant has specifically indicated on the application that they would like the Voter registration Packet sent to them, the Eligibility Specialist will assume the answer is “No”. If there is information needed to complete the processing of the case and a collateral call is made to the applicant/beneficiary, the Eligibility Specialist will need to ask if they would like the Voter Registration Packet sent to them. If that answer is “Yes”, the Eligibility Specialist would then send the Voter Registration packet with DHHS Form 1233 as part of the request for additional information. If that answer is “No”, the Eligibility Specialist will record the No response in the documentation template.   *Note: It is recognized that an applicant might receive/send more than one copy of the VR packet. However, to be compliant with federal regulations, we must have assurance that the person is given every opportunity to receive assistance to register to vote.*   1. Update the OnBase Tracking Form with the appropriate response. If the Eligibility Specialist is providing the whole packet and has not had direct contact with the applicant, the appropriate response is: “C = Services Offered –Registration by Mail Form Given.”   Regardless of an applicant or beneficiary’s previous responses to this service, Voter Registration services must be offered at the time of application, at the time of review, and when the applicant notifies the agency of a change of address. If the Voter Registration form status changes from an initial entry, it does not need to be updated on the OnBase Tracking Form or in MEDS. The original entry is sufficient.  Document action using both the MEDS and OnBase procedures below to allow for transition from MEDS to Cúram.  **Cúram Procedure (all actions):**  The Eligibility Specialist will be prompted during the application script to record a response to the question: “If you are not registered to vote where you live now, would you like to apply to register to vote here today?”  If the applicant/beneficiary responds with “Yes”, the system will send a Voter Registration packet to the applicant. If the applicant/beneficiary responds with “No” or “Response not included with the paper application”, the system will not send a Voter Registration packet to the applicant.  **MEDS Procedure (all actions):**  The valid values for “Voter Registration” can be accessed on HMS06 (Household Member Detail Screen) by pressing shift F1 on the <REASON> field.  When the applicant/beneficiary accepts the application to register to vote or when the voter registration packet is mailed out, enter code “Y” under reason code F13.  When the applicant/beneficiary rejects the application to register to vote, enter code “N”.  Enter a reason code regardless of whether initial answer is “Y” or “N”. Valid reason codes are as follows:  A = APPLICANT/RECIPIENT REGISTERED BY SPECIALIST.  B = APPLICANT/RECIPIENT ALREADY REGISTERED.  C = SERVICES OFFERED - REGISTRATION BY MAIL FORM GIVEN.  D = APPLICANT/RECIPIENT DECLINED OFFER TO REGISTER.  E = APPLICANT/RECIPIENT NOT ELIGIBLE TO REGISTER TO VOTE.  F = APPLICANT/RECIPIENT REFUSED TO SIGN DECLINATION FORM.  NOTE: Code “G”, “No face-to-face contact with applicant/recipient,” previously entered for any applications received by mail, will no longer be used in any scenarios.  **OnBase Procedure (all actions):**  For All Voter Registration Services:  Document action using the OnBase Tracking Form, MEDS-VRD, located under the SCDHHS-Misc document group.   * + Select the SCDHHS-Misc group to retrieve only VRD documents.   + Select the SCDHHS-Medicaid group to retrieve all other MEDS documents.   On Tracking Form, select “Voter Registration” from the drop-down menu and indicate one of the following:  A = APPLICANT/RECIPIENT REGISTERED BY SPECIALIST.  B = APPLICANT/RECIPIENT ALREADY REGISTERED.  C = SERVICES OFFERED - REGISTRATION BY MAIL FORM GIVEN.  D = APPLICANT/RECIPIENT DECLINED OFFER TO REGISTER.  E = APPLICANT/RECIPIENT NOT ELIGIBLE TO REGISTER TO VOTE.  F = APPLICANT/RECIPIENT REFUSED TO SIGN DECLINATION FORM.  **For Voter Registration Declination Forms Only**   * Only VRDs will be scanned into OnBase. * VRDs are to be scanned into OnBase as document type “VRD”, Keyword “Current Year”; e.g. “2023”. * VRDs will not be associated with a Medicaid ID #. |

**101.18.02 Political Neutrality and Confidentiality**

(Eff. 03/01/14)

In providing these services, SC DHHS will adhere to standards of political-neutrality and strict confidentiality.

To maintain a standard of political neutrality, SC DHHS employees shall not:

* Display any personal political preference or party allegiance;
* Seek to influence an applicant/beneficiary’s political preference or party registration through any statement or action;
* Seek to discourage an applicant/beneficiary from registering to vote through any statement or action;
* Intentionally convey to an applicant/ beneficiary, through words or actions, that a decision to use or not use VRS will have any bearing on the availability of Medicaid services or benefits;
* Intentionally convey to an applicant/ beneficiary, through words or actions, that a decision to register or to not register to vote will have any bearing on the availability of Medicaid services or benefits;
* Hold completed VRA forms for more than two business days from the date received.

To maintain a standard of strict confidentiality, SC DHHS employees are reminded that the following is considered confidential:

* Information contained in the completed VRA or VRD, including social security number, date of birth, etc.;
* Information regarding the physical location where an applicant applies to register to vote; and
* Driver’s License or State ID Number.

NOTE: This list is not comprehensive. If a SC DHHS employee at any time has questions regarding what constitutes confidential information, he should contact his supervisor for guidance.

For questions regarding SC DHHS NVRA policy contact:

SC DHHS NVRA Compliance

P.O. Box 8206

Columbia, SC 29202

Email: nvra-compliance@scdhhs.gov

**101.19 Medicaid Eligibility Quality Assurance (MEQA)**

(Rev. 03/01/13)

SC DHHS has contracted with the Center for Health Services & Policy Research (CHSPR) at the University of South Carolina (USC) to conduct eligibility monitoring reviews that will identify and/or develop:

1. Error trends
2. The need for policy clarifications
3. The need for additional training
4. Employee performance standards

USC submits written requests for files to be reviewed. SC DHHS must take the following steps within 15 calendar days of receiving the request:

1. Locate the requested file
2. Complete [DHHS Form 1259](http://medsweb.scdhhs.gov/EligibilityForms/FM%201259.pdf), Quality Assurance Case Review Checklist, and attach it to the front of the file
3. Ensure that the most current action and the action for the date to be reviewed are included in the file
4. Attach a copy of the email if the file is sent in response to a specific request from a reviewer
5. Attach a copy of the original request if file was not located and sent timely
6. Indicate if the file is sent to MEQA, PERM, or EQUIP

**101.19.01 Quality Measurements**

(Eff. 03/01/13)

The quality measurements used by USC to conduct SC DHHS eligibility reviews are:

1. Eligibility Quality Improvement Process (EQUIP)
2. Medicaid Eligibility Quality Assurance (MEQA)
3. Payment Error Rate Measurement (PERM)
4. Medicaid and Children’s Health Insurance Program Review Pilots
5. Special Project Reviews

**101.19.01A Eligibility Quality Improvement Process (EQUIP)**

(Eff. 03/01/13)

EQUIP is an internal eligibility review process that is used by the agency without contact with the beneficiary. EQUIP is limited to errors that were identified in PERM/MEQA reviews, and includes Alerts that report eligibility issues not included in the scope of the review. The primary objectives of EQUIP are:

1. Identify and address error trends
2. Develop employee performance standards

**101.19.01B Medicaid Eligibility Quality Assurance (MEQA)**

(Eff.01/01/13)

Medicaid Eligibility Quality Assurance (MEQA) is a federally mandated study. The primary objectives of MEQA are:

1. To measure, identify, and eliminate or reduce dollar losses as a result of erroneous eligibility determinations
2. To ensure that clients receive all of the benefits to which they are entitled

Note: Medicaid and Children’s Health Insurance Program Eligibility Review Pilots (MPPM 101.19.01D) will be substituted for MEQA Reviews until June 30, 2016.

**101.19.01C Payment Error Rate Measurement (PERM)**

(Eff. 01/01/14)

Payment Error Rate Measurement (PERM) is a federally mandated study. The primary objectives of PERM are:

1. To review fee for service, managed care, and Medicaid and SCHIP eligibility
2. To provide results of the reviews to be used to produce a national error rate

Note: Medicaid and Children’s Health Insurance Program Eligibility ReviewPilots (MPPM 101.19.01D will be substituted for MEQA Reviews until June 30, 2016.

**101.19.01D Medicaid and Children’s Health Insurance Program Eligibility Review Pilots**

(Eff. 01/01/14)

The Medicaid and Children’s Health Insurance Program Eligibility Review Pilots are federally mandated studies. The goal is to evaluate the transition to policy mandated by the implementation of the Affordable Care Act (ACA). Four streamlined review pilots will be conducted in lieu of Medicaid Eligibility Quality Assurance (MEQA) and Payment Error Rate Measurement (PERM) reviews. The primary objectives are:

1. To evaluate automated processes.

2. To evaluate casespecialist actions.

**101.19.01E Special Project Reviews**

(Eff. 03/01/13)

The Center for Health Services & Policy Research (CHSPR) at the University of South Carolina (USC) also periodically conducts special project reviews as requested by the SC DHHS Management Team. Eligibility staff must cooperate with these reviews to the same degree as federally mandated quality reviews.

**101.19.02 Report of Eligibility Findings for EQUIP**

(Eff. 03/01/13)

EQUIP findings include any procedural and/or eligibility errors, and Alerts that identify eligibility information that falls outside of the scope of the review. Alerts provide changes and/or information that were discovered during the review but not considered by the Eligibility Specialist who completed the determination. Alerts may or may not be the result of specialist error.

Upon the completion of each case review, the USC reviewer will publish the EQUIP review findings in the Eligibility Quality Management Site in SharePoint.

**101.19.02A USC will report EQUIP findings in the following ways**

(Eff. 03/01/13)

1. Correct
2. Incorrect
   1. Eligibility Errors – Medicaid eligibility was incorrectly determined for a single member, or all members of a budget group
   2. Procedural Errors – Medicaid eligibility was correctly determined but policy and/or procedures have been overlooked or misinterpreted. A procedural error may or may not result in an eligibility error.
3. Unable to locate
4. Dropped

**101.19.02B SC DHHS Response to EQUIP Findings**

(Eff. 03/01/13)

The Quality Manager will retrieve EQUIP findings from SharePoint, and submit a report of error and Alert findings for each supervisory unit to the following:

1. The Eligibility supervisor
2. The appropriate Regional Administrator
3. The appropriate Division Director
4. The appropriate Regional Trainer
5. The Director of Eligibility Training
6. The Director of Eligibility Policy
7. The Performance Manager

Within five (5) business days of receiving the EQUIP findings, the supervisor must schedule a conference with the appropriate specialist to review all error findings. The specialist must complete the following action(s) within ten (10) calendar days of receiving the EQUIP error and/or Alert findings:

1. Correct all eligibility errors
   1. The supervisor and Eligibility Specialist must schedule a conference with the Quality Manager to discuss the finding and corrective action(s)
2. Correct all procedural errors
   1. If necessary, the supervisor and/or eligibility specialist may contact the Quality Manager to ask questions or obtain clarifications regarding the findings
3. Initiate or complete required actions needed to address any reported finding that was not considered in the eligibility determination.

Within fifteen (15) calendar days of receiving an error finding, the supervisor must:

1. Review the case to ensure the required corrective action(s) are completed, and verification regarding any new findings is requested and/or acted upon, if required. Following the review, submit DHHS Form 947, Response to Preliminary QA Findings via Service Manager ticket to the Eligibility, Enrollment and Member Services designee. The response must explain:
   1. The corrective action(s) initiated or completed, and/ or
   2. A rebuttal of the Preliminary Findings, including a detailed rationale and documentary evidence to support the disagreement
2. The Eligibility, Enrollment and Member Services designee will distribute the DHHS Form 947, Response to Preliminary QA Findings to:
3. The eligibility supervisor
4. The appropriate Regional Administrator
5. The appropriate Division Director
6. The appropriate Regional Trainer
7. The Director of Eligibility Training
8. The Director of Eligibility Policy
9. The Performance Manager
10. The Quality Manager
11. The Quality Manager must take the following action when the DHHS Form 947, Response to Preliminary QA Findings reports a disagreement with the review:
    1. Submit any supported disagreement to the USC MEQA Staff Manager for reconsideration
    2. Respond to any unsupported disagreement
12. Alert disputes are sent to the Quality Manager, who must take one of the following actions:
    1. Inform USC and the eligibility staff of supported findings, or
    2. Inform the eligibility staff of unsupported findings

**101.19.03 Report of Eligibility Findings for MEQA, PERM, and Medicaid and Children’s Health Insurance Program Review Pilots**

(Eff.01/01/14)

At the completion of each case review, the USC reviewer will submit DHHS Form 946, Preliminary QA Findings, including any procedural errors and eligibility errors.

The USC reviewer will submit a report of the MEQA or PERM findings to:

* 1. The Eligibility Specialist who completed the action
  2. The supervisor of the eligibility specialist who completed the action
  3. The supervisor of the current eligibility specialist\*
  4. The Director of Eligibility Training
  5. The Director of Eligibility Policy
  6. The appropriate Regional Administrator
  7. The appropriate Division Director
  8. The appropriate Regional Trainer
  9. The Performance Manager
  10. The Quality Manager

\*The current Eligibility Specialist is responsible for the completion of any corrective action(s).

**101.19.03A USC will report MEQA and PERM findings in the following ways**

(Eff. 03/01/13)

1. Eligible – Medicaid eligibility was correctly determined. Policy and/or procedures may have been overlooked or misinterpreted but did not result in an eligibility error.
2. Ineligible – Medicaid eligibility was incorrectly determined for all members of a budget group
3. Ineligible budget group member(s) – Medicaid eligibility was incorrectly determined for one or more members of a budget group.
4. Eligible – Liability overstated (when an institutionalized individual’s recurring liability is determined to be more than it should be)
5. Eligible – Liability understated (when an institutionalized individual’s recurring liability is determined to be less than it should be)

**101.19.03B SC DHHS Response to MEQA and PERM Error Findings**

(Eff. 03/01/13)

Within five (5) business days of receipt, the supervisor must schedule a conference with the Eligibility Specialist to review the case findings. The following issues must be discussed and documented:

1. Policy relative to the eligibility finding
2. Actions that must be taken to correct any procedural and/or eligibility error(s) identified, or
3. The decision to rebut the findings, if applicable, including policy and supporting documentation that supports the disagreement

Upon completion of this discussion, a response to the findings is provided on the [DHHS Form 947](http://medsweb.scdhhs.gov/EligibilityForms/FM%20947.pdf), Response to Preliminary QA Findings, which supports:

1. Agreement With the Review Findings
2. Within ten (10) calendar days of the conference, the Eligibility Specialist must take the required actions to correct the case.
3. Within fifteen (15) calendar days of receiving the error finding, the supervisor must:
   1. Review the case to ensure the required corrective action(s) are completed and/or initiated, and verification regarding any new findings is requested and/or acted upon.
   2. Submit DHHS Form 947 via Service Manager ticket that explains the corrective action(s) discussed in the conference and completed by the Eligibility Specialist.
4. Rebuttal of the Review Findings
5. Within ten (10) calendar days of the conference, the supervisor must report the decision to rebut the error finding via Service Manager ticket.
6. The rebuttal must include policy and supporting documentation that supports the disagreement.
7. If the rebuttal is not supported following review, the Quality Manger will schedule a conference within ten (10) calendar days with:
   1. The eligibility specialist;
   2. The eligibility supervisor; and
   3. The Regional Trainer.
8. If the rebuttal is supported following review, the Quality Manager will submit the rebuttal to USC MEQA/PERM and schedule a conference within ten (10) calendar days with:
   1. The eligibility supervisor;
   2. The Regional Trainer; and
   3. A representative from USC MEQA/PERM.
9. If an agreement is reached between all parties during the conference that supports the review findings, the Eligibility Specialist must follow the procedures for Agreement with the Review Findings to complete the corrective action(s).
10. If an agreement is not reached between all parties during the conference, the Quality Manager will schedule a conference with the following:
    1. The eligibility supervisor
    2. A representative from USC MEQA/PERM
    3. The Director of Eligibility Training, or designee
    4. The Director of Eligibility Policy, or designee

When an agreement is reached between all parties during this conference that supports the review finding, the Eligibility Specialist must follow the procedures for Agreement With the Review Findings to complete the corrective action(s).

When an agreement is reached between all parties during this conference that overturns the review finding, USC must issue a revised finding within ten (10) calendar days.

**101.19.03C Corrective Action Plan for MEQA and PERM Quality Management**

(Eff. 08/01/19)

The Eligibility, Enrollment and Member Services will maintain a log to track activities related to the Quality Assurance Findings. At the conclusion of the review process, the following actions are required:

1. The Eligibility, Enrollment and Member Services will provide the completed tracking document within sixty (60) calendar days to:
   1. The Director of Eligibility Policy;
   2. The Director of Eligibility Training;
   3. The Regional Administrators;
   4. The Division Directors;
   5. The Performance Manager; and
   6. The Quality Manager.
2. USC will provide a final report within sixty (60) calendar days to:
   1. The Director of Eligibility Policy;
   2. The Director of Eligibility Training;
   3. The Regional Administrators;
   4. The Division Directors;
   5. The Performance Manager;
   6. The Quality Manager; and
   7. The Program Director.
3. Within thirty (30) calendar days of receiving the USC Final Report, a Corrective Action Plan (CAP) must be developed to address the trends that were identified from the tracking document and the USC Final Report. The CAP must address, but is not limited to the following:
4. Additional training (should contain specific information regarding who will conduct the training, length of the training, who will attend, and the topic of the training);
5. Special monitoring efforts by the supervisor (should contain specific information regarding the length of the monitoring effort, the method used to conduct the effort, and issue(s) being monitored); and
6. Staff meetings to go over policy clarifications that were provided in the form of manual clarifications or Medical Support Mailbox answers.
7. The Corrective Action Plan will be sent to:
   1. The Eligibility, Enrollment and Member Services Director;
   2. The Division of Eligibility Training Director;
   3. The Division Directors;
   4. The appropriate Regional Administrator;
   5. The Performance Manager; and
   6. The Quality Manager.

**101.19.04 Beneficiary Error**

(Eff. 03/01/13)

If an eligibility error is the result of an action by the beneficiary and results in an overpayment of benefits, within five (5) business days of discovery of the error, [SC DHHS Form 928](http://medsweb.scdhhs.gov/EligibilityForms/FM%20928.pdf), Notice of Overpayment Referral, must be sent to the beneficiary. At the end of ten (10) calendar days, a copy of SC DHHS Form 928, [SC DHHS Form 3252](http://medsweb.scdhhs.gov/EligibilityForms/FM%203252%20ME.pdf), Overpayment of Medicaid Benefits, and [SC DHHS Form 947](http://medsweb.scdhhs.gov/EligibilityForms/FM%20947.pdf), Response to Preliminary QA Findings, must be submitted to the Eligibility, Enrollment and Member Services. Upon review, the Eligibility, Enrollment and Member Services will take one of the following actions:

1. Determine that the overpayment is supported
   1. Forward the overpayment summary to the Division of Program Integrity
   2. Inform the supervisor
   3. Inform the Quality Manager
2. Determine that the overpayment is unsupported and inform the following of the reason
   1. The supervisor
   2. The eligibility specialist
   3. The Quality Manager

**101.19.05 Beneficiary Cooperation**

(Eff. 03/01/13)

All Medicaid beneficiaries are required to cooperate with USC/MEQA/PERM during their review process. When a beneficiary fails to cooperate, USC/MEQA/PERM will notify the supervisor and Eligibility Specialist.

Upon receipt of [SC DHHS Form 946](http://medsweb.scdhhs.gov/EligibilityForms/FM%20946.pdf), USC Preliminary Error Findings, indicating beneficiary non-cooperation, the eligibility specialist must send [SC DHHS Form 1234](http://medsweb.scdhhs.gov/EligibilityForms/FM%201234.pdf), Medicaid Quality Assurance Review Checklist, to request contact and/or information from the beneficiary.

1. For SSI-related categories
   1. Initiate a full review of the beneficiary’s eligibility, requesting the information that was not provided within ten (10) calendar days
   2. If the beneficiary provides all of the requested information, it must be forwarded to USC/MEQA/PERM within five (5) business days.
   3. If the requested information is not provided to complete the review, close the case for failure to provide requested information.
      1. For beneficiaries residing in a nursing home, work closely with the facility to avoid closure, if possible.
2. For FI-related categories
   1. If the beneficiary is an eligible adult in Low Income Families, initiate an annual review, requesting the information that was not provided within ten (10) calendar days
   2. If the requested information is not provided to complete the review, the Eligibility Specialist must initiate closure for the adult members of the budget group for failure to provide requested information.
      1. The eligibility of children is protected and must not be terminated for one year from the date of the decision unless it is determined that eligibility was approved inaccurately.
      2. The children remain eligible in the LIF/PCR budget group until the next review date.
   3. If information is returned that would affect the child’s current eligibility, but there is no evidence that eligibility was approved inaccurately, file the information in the case record. Act on the information at the next annual review to determine if it is still valid.
   4. The eligibility of a pregnant woman is protected until the end of the post-partum period and cannot be terminated unless it is determined that eligibility was approved inaccurately. File the information in the case record.

**101.20 Telecommuter Supplemental Policy – Eligibility Application Processing at Home**

(Eff. 08/01/14)

The South Carolina Department of Health and Human Services (SCDHHS) eligibility specialists and supervisors may submit a request to work from home in order to process eligibility applications outside normal working hours (8:30 a.m. – 5:00 p.m.) including evenings and weekends. Any specialist or supervisor interested in participating must submit a written request to his/her supervisor for consideration. This is a time limited opportunity to address the high number of pending applications. This option can be used by staff eligible to work overtime, as well as staff who is participating in dual employment with SCDHHS for the purpose of assisting with eligibility determinations.

A Telecommuter Agreement must be signed by the employee, the supervisor and the Program Director for Eligibility, Enrollment and Member Services.

All existing SCDHHS Telecommuter, HIPAA, IT and overall agency policies are to be followed by eligibility employees wishing to process eligibility applications outside of their normal scheduled working hours. In addition, the following supplemental policies must be followed:

**Orientation and Terms**

All employees requesting approval to telecommute, as well as their supervisors must participate in an orientation session regarding telecommuting.

Telecommuting for Eligibility employees is strictly for processing Medicaid applications. The employee must work a full schedule during the day (at least 37.5 hours per week) to qualify for telecommuting outside typical working hours. Designated days and hours for working at home must be approved by the supervisor in advance. The supervisor and regional performance manager are responsible for monitoring performance and insuring quality performance and productivity are maintained. The ability to telecommute can be revoked at any time.

**Network Access:**

For personal computers and agency issued laptops, telecommuters must obtain VDI software in order to access DHHS eligibility programs, including MEDS and OnBase. (VDI software must be requested through Service Manager.)

Agency-owned equipment is for agency use only. VDI may be run on a personal computer. However, no entity within SCDHHS will make any attempt to troubleshoot or support a non-agency owned machine. Telecommuter computers are subject to audit at will without prior notification

**HIPAA/Privacy Policy:**

Refer to SC DHHS Policy for HIPAA and privacy guidelines.

Reminders: Always lock (control+alt+delete) computer before stepping away from it when working offsite.

**Contacting Applicants, Beneficiaries and Third Parties:**

Personal telephones are not to be used for agency business. Any telephone or face-to-face interaction with applicants, beneficiaries, authorized representatives or third parties is to take place during normal business hours in an SC DHHS office/sponsored specialist location.

**Application Processing and Printing Documents:**

Do not print any documents related to Medicaid or the Medicaid application when working offsite.

Do not carry printed documents related to application processing outside of onsite office.

Do not save any work related documents on your desktop.

For any forms that need to be printed and mailed to an applicant, beneficiary or third party:

* 1. All printing should take place in the office following an offsite work session.
  2. For printing needs identified during an offsite work session, keep a running list of what needs to be printed and mailed to continue processing an application.
  3. Print necessary forms and mail the very next working day from the office. Do not take printed documents home or to another location off site.

The specialist is responsible for insuring that the offsite work environment is physically secure and that case related information is not accessible to any other individuals such as household members and guests.

The specialist is responsible for having adequate Internet access to access systems necessary to conduct job functions identified for telecommuting purposes.

**101.21 Person Composite Service**

(Rev. 11/01/18)

The Person Composite Service (PCS) is a web-based portal used to validate and verify applicant information from multiple sources. The PCS must be used in Google Chrome. DO NOT use the Person Composite Service in Internet Explorer. The pages will not display correctly.

Sources and available information include:

* Social Security Administration (SSA)
  + Social Security Number (SSN) Verification
  + Citizenship Verification
  + Quarters of Coverage Verification (Work Quarters)
* South Carolina Department of Employment and Workforce (SCDEW)
  + Wage Payments
  + Unemployment Compensation Payments
* Person Composite Service (PCS) Wage Income
  + Employment History
  + Annual Compensations
  + Pay Periods (including employer, pay date, pay period end date, hours/week, gross income, net payment)
* SCDHHS Cúram and MEDS
  + Eligibility History (Full Benefits Only at this time.)
* SSA Income
  + SSN Verification
  + Title II Monthly Income Verification (if Yes, then displays month, gross/net amounts and overpayment deduction)
  + Payments Suspended
  + Death Recorded
  + Disability Confirmed by SSA
  + Payments Ongoing

**NOTE:**

Until further notice, the “Check Address” is listed as an option but will not return any information.

The information is used to verify evidence on an Insurance Affordability Application Case (Application Case) or an Insurance Affordability Case (Integrated Case) such as Income, SSN Details and Citizenship. PCS is one tool that can be used to electronically verify information. If a member of the household has outstanding verifications, check electronic sources before requesting any documentation from an applicant or beneficiary.

A specialist’s security role determines his or her ability to use the Person Composite Service and which systems may be accessed or queried. The specialist can only access the types of information necessary to fulfill his/her assigned job functions.

The specialist must follow the process described in the Job Aid: [Using the Person Composite Service](https://team.scdhhs.gov/OPS/EES/ACA%20%20Access%20Training/67_Using%20the%20Person%20Composite%20Services.pdf)for each person listed as an applicant on the case. **Use the Person Composite Service:**

1. After a paper application has been entered and submitted in Cúram (Only if no automated verification results are returned from the Federal Hub and/or SCDEW);
2. Before adding a new person to an Insurance Affordability case;
3. When completing a case review;
4. When there is a Change of Circumstance (COC);
5. When two cases are already approved and you need to obtain Eligibility History for the reconciliation process.

The applicant’s First Name, Last Name, Date of Birth and Social Security Number (SSN) are required to retrieve information from the PCS.

**When using the Person Composite Service:**

* ONLY Request information needed for an application to be processed.
* ONLY Request information for applicants on the application to be processed. (The specialist must NOT search for information on an individual who is not part of an application he/she is processing.)
* Verification requests are tracked. If information is accessed inappropriately, the specialist will incur a security violation per agency policy and may be subject to progressive disciplinary action.

Do not make multiple requests for SSA data. If SSN or Citizenship data has already been requested and verified using the Federal Hub or other verification sources, DO NOT request the information again via the Person Composite Service.

**101.22 Reserved for Future Use**

(Deleted 06/01/21)

**101.23 Non-Financial and Income Verification Matrix**

(Rev. 08/01/15)

The Non-Financial and Income Verification Matrix can be found at MPPM 105.01.01.

**101.24 Resource Verification Matrix**

(Rev. 08/01/15)

The Resource Verification Matrix can be found at MPPM 105.01.02.

**101.25 Long Term Care Verification Matrix**

(Rev. 08/01/15)

The Long Term Care Verification Matrix can be found at MPPM 105.01.03

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102.01 Introduction

(Eff. 10/01/05)

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

102.01.01 Verification of Non-Financial Requirements

(Eff. 10/01/05)

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

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

102.02 Identity

(Eff. 07/01/06)

[CFR §435.407](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-E/section-435.407); [CFR §435.949](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-J/subject-group-ECFRc649656b2ed45a8/section-435.952)

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

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102.03 State Residency

(Rev. 04/01/16)

[CFR §435.403](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-E/section-435.403)

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

**Note**

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

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

102.03.01 Individuals Receiving a State Supplementary Payment

(Rev. 03/01/07)

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

102.03.02 Individuals Receiving a Title IV-E Payment

(Rev. 04/01/16)

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

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102.03.03 Individuals Aged 21 and Older

(Rev. 04/01/16)

Not in an Institution

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

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

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

The State of Residence is:

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

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

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

Any Other Individual in an Institution

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

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

(Rev. 04/01/16)

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

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

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

**Anyone Else Not in an Institution**

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

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

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

The State of Residence is:

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

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102.03.05 State Placement in an Out-of-State Institution

(Eff. 10/01/05)

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

These actions are not considered state placement:

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

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

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

102.03.06 Individual Moving to SC Previously Eligible in Another State

(Rev. 10/01/23)

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

PARIS stands for Public Assistance Reporting Information System.

The PARIS Interface provides information from three sources:

* The Interstate Match provides payment information and the related participants from participating states. The details include potential duplicate public assistance payments from Temporary Assistance for Needy Families (TANF), Medicaid, Supplemental Security Income (SSI), Food Stamps, General Assistance, Child Care, and Workers Compensation.
* The Veteran’s Administration Match provides benefit amounts currently paid for Veteran or spousal benefits, paid by the Veterans Administration.
* The Federal Match provides federal and military wage or retirement payments to participants.

PARIS information is requested quarterly from the Defense Manpower Data Center (DMDC).

* Each quarter the system will generate a file of participants from Cúram and MEDS called the request file.
* DMDC compares the participant list to their database and returns the PARIS Response File
* The response file is processed, and the corresponding information is displayed by the participant in Cúram for each participant that was matched in the DMDC database.

**Cúram/CGIS**

**PARIS Interstate Match**

The PARIS Interstate file contains information about Medicaid eligible members who are receiving benefits in any state other than South Carolina.

For the following benefit types:

* Medicaid
* TANF
* Food Stamps
* General Assistance
* Child Care
* SSI
* Worker Compensation

Cúram processes the member with active benefits in another state when the PARIS Interstate response file contains all of the following:

* An SSN match to the member
* Indicates a “Y” for any of the previously listed benefit types
* Contains a valid eligibility start date
* Contains an eligibility end date that is ongoing (blank with no end date), or future dated (in another state)

**Auto Processing When Member Has Active Coverage In Another State**

When Cúram determines that a beneficiary receiving active coverage in South Carolina has existing coverage in another state (and the Integrated Case does not have an annual review status):

* Cúram automatically generates the "Relocation Out Of State” Cover Letter for that member.

**Note**

* If more than one member of a household is identified on the PARIS Interstate file, Cúram only generates and sends one "Relocation Out Of State” Cover Letter that lists the applicable household members.
* The "Relocation Out Of State” Cover Letter is not sent if South Carolina eligibility is ending at the end of the current or next month (according to the eligibility dates in Cúram).
* When the "Relocation Out Of State” Cover Letter is generated, Cúram also sets and starts the Residency timer with a timer expiration of 20 days.
* The due date on the cover letter will be set to 15 days from the current date (PARIS Interstate processing date).
* The "Relocation Out Of State” Cover Letter will have a due date of 15 days, but the Cúram timer expiration will be 20 days to compensate for any delays in communications, holidays, emergencies, network outages, etc.
* When the Residency timer expires due to NO response from the member, Cúram automatically begins the closure process for the member(s).
  + Adverse Action rules are used.
  + For members receiving HCR coverage in Cúram, Cúram end dates the Application Details with the reason ‘Moved State/Country’ and applies the change.
  + For members receiving CGIS coverage in Cúram, Cúram end dates the Household Member evidence and applies the change. Additionally, Cúram closes the PDC with the reason ‘Out of State Medicaid’.
  + A Closure notice with the following text is generated: "Based on the information provided, it appears that you are not a resident of South Carolina. Only legal residents are eligible for Medicaid in South Carolina."
  + A note is added to the Contact tab: "Residency Information not returned” (for each applicable member).

If the member returns the residency information confirming they are not a South Carolina resident before the Residency timer expires, confirmation must be added manually from the beneficiary's home page in CGIS, and the Adverse Action rules will not apply. Refer to the [PARIS Interface Job Aid](https://schhs.sharepoint.com/:b:/r/sites/EES/Training/Curam/CGIS/Job%20Aids/PARIS_Interface_JA.pdf?csf=1&web=1&e=fSRIiM) for further instructions.

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

102.03.07 Individual Previously Eligible in SC Moving to Another State

(Eff. 10/01/05)

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

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102.03.08 Residency Disputes

(Eff. 10/01/05)

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

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

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

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

102.03.09 Interstate Agreements

(Eff. 10/01/05)

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

102.03.10 Migrant/Seasonal Farm Specialists

(Eff. 10/01/05)

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

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

102.03.11 Visitors to the United States (US)

(Eff. 03/01/11)

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

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102.03.12 Verification

(Eff. 01/01/14)

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

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

102.04 United States Citizens

(Eff. 05/01/11)

[CFR §435.949](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-J/subject-group-ECFRc649656b2ed45a8/section-435.952)

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

102.04.01 Citizenship

(Eff. 01/01/14)

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

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

102.04.02 Identity

(Eff. 01/01/14)

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

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

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102.04.03 Exemption for Non-Applicants

(Eff. 05/01/11)

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

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

102.04.04 Reasonable Opportunity to Prove Citizenship and/or Identity

(Rev. 10/01/23)

An applicant can be approved for Medicaid for a period of up to 90 days from the date of application. Citizenship and Identity must be verified within this period or Medicaid eligibility must be terminated. Citizenship and Identity includes a beneficiary’s Social Security Number as it can be used to verify both Citizenship and Identity under Person Composite (PCS). For a beneficiary who has previously been approved for Medicaid for up to 90 days while awaiting verification of Citizenship and/or Identity and is re-applying, the individual cannot be approved until all verifications, including Citizenship and/or Identity, have been received.

Verification of citizenship and identity is a one-time requirement. Once citizenship and identity are verified, subsequent changes in eligibility will not require repeating the verification process. If Physical Documents are used, the Eligibility Specialist must maintain verification of citizenship and identity in the permanent verification section of the case record. Refer to SC MPPM Chapter 102, Appendix C.

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

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

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

| **Procedure for Verifying Citizenship and Identity** |
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| **MEDS Procedure:**   * When pending an application, the Proof of Citizenship and Identity indicators and <SRC DOCUMENT> Fields for Citizenship and Identity on HMS91, HH MBR Parental/ Citizenship/Identity Detail Screen (HMS91 C&I SCREEN) must remain blank except when one of the following conditions exist:   + - If valid verification is already coded in the Citizenship and/or Identity fields, do not change the information     - If the applicant presented Original Documents at the time of application, enter the appropriate coding in the field(s)     - If the application is to be approved the same day based on assumptive eligibility or 90-day reasonable opportunity, enter “WKRVER” in the <SRC DOCUMENT> Fields.   Note**:** For all verification methods except SVES, the Eligibility Specialist will be responsible for updating HMS91 C&I SCREEN and ELD01 as the information is received.   * To close the member(s) for which Citizenship and/or Identity was not provided; the Eligibility Specialist should access ELD00 and change the pass/fail indicator to Fail for Citizenship and/or Identity depending upon which verification was not provided.   Note**:** If the appropriate pass/fail indicators are protected, the Eligibility Specialist will need to enter RC004 in the RC1 field on ELD01 to cause those fields to become updateable. The Eligibility Specialist will also need to enter RC004 on the RC1 field on ELD01 to initiate a closure for a child in a protected period.   * After adjusting the pass/fail indicators and removing PPED if necessary, the Eligibility Specialist should call Make Decision on ELD01. Make Decision will close those members who have not provided proof of Citizenship and/or Identity with the appropriate reason codes (RC061 if proof of citizenship was not provided, RC043 if proof of identity was not provided, or RC012 if proof of citizenship nor identity were provided). If the entire budget group is being closed, the reason code(s) will appear on ELD01. If only certain members are being closed, those reason codes will appear on the individual ELD02 screens. The specialist should check to ensure the correct members are closing before calling Act on Decision to complete the closure. * If an application is approved allowing a reasonable opportunity but verification of Citizenship and/or Identity has been not provided within the 90 days and all avenues of verification have been exhausted, the budget group must be closed using Reason Code 061, You did not provide proof of citizenship; Reason Code 043, You did not provide proof of identity; or Reason Code 012, You did not provide proof of Citizenship and/or Identity. * If an application is denied solely for failure to provide information and the applicant provides all needed verifications within 30 days from the date on the denial notice, the date of the previous application must be used to determine the effective date of Medicaid eligibility.   If the closure is for one or more individuals and not the entire budget group, go to ELD00 in MEDS and FAIL that individual(s) on Citizenship and/or Identity. The remaining budget group members will remain eligible  **Note**  Citizenship and Identity do not have to be verified if the applicant is not otherwise eligible. Refer to SC MPPM Chapter 101.09.03. |

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

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102.04.05 Verification of Citizenship and Identity by the Federal Data Hub

(Eff. 01/01/14)

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

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

102.04.06 Verification of Citizenship and Identity by SVES

(Eff. 05/01/11)

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

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

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

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102.04.07 Verification of Citizenship and Identity by VCME

(Eff. 01/01/17)

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

102.04.08 Verification of Citizenship and Identity by DMV Web Tool

(Rev. 01/01/17)

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

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

The DMV System will:

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

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

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102.04.09 Verification of Citizenship and Identity with Physical Documents

(Rev. 10/01/23)

If verification of citizenship cannot be obtained through SVES and citizenship and/or identity is needed, the Eligibility Specialist must give the applicant a [DHHS Form 3293](chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https:/medsweb.scdhhs.gov/EligibilityForms/FM%203293.pdf), Request for Verification of Citizenship and/or Identity

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

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

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

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

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

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

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

| **Procedure for Verifying Citizenship and Identity** |
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| **MEDS Procedure**:   * If an applicant does not provide verification of Citizenship and/or Identity or the specialist is unable to verify using SVES:  1. For an applicant required to submit documentation of Citizenship and/or Identity for the first time:    1. If all verifications other than Citizenship and/or Identity have been provided and Citizenship and/or Identity are not questionable, approve the application for Medicaid. Refer to the MEDS procedures below.    2. The Eligibility Specialist will send a [DHHS Form 3293](chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https:/medsweb.scdhhs.gov/EligibilityForms/FM%203293.pdf), to the applicant, requesting the needed information. The applicant will have up to 90 days from the date the application is pended to provide verification of Citizenship and/or Identity. Enter the <Reasonable Opportunity Expiration Date> shown on HMS91 C&I SCREEN as the date by which the applicant must return verification of Citizenship and/or Identity.    3. On ELD01 set the ACD to the <Reasonable Opportunity Expiration Date> shown on HMS91 C&I SCREEN    4. If verification of Citizenship and/or Identity has not been provided within 90 days, the Eligibility Specialist must close each member for whom citizenship and identity has not been verified.    5. If prior to the end of the 90-day reasonable opportunity period, the applicant contacts the specialist to request additional time to obtain the required verification:       1. The Eligibility Specialist must document what steps the applicant has taken to secure the requested information       2. The Eligibility Specialist must discuss the case with her supervisor       3. If the supervisor agrees with the specialist, a ticket must be sent through Service Manager requesting approval to allow Medicaid eligibility to continue. The e-mail must describe the steps the applicant is taking to obtain the verification and the reason for the delay       4. Medical Support will review the e-mail, make a determination, and inform the supervisor.       5. If Medical Support approves the request for an extension in Medicaid benefits, the Eligibility Specialist must update ACD to 90 days from the date of the request by the applicant. If the information is not provided by that date, the case must be closed.       6. If Medical Support does not approve the request for an extension of Medicaid benefits, eligibility must be terminated. 2. For a beneficiary who has previously been approved for Medicaid for up to 90 days while awaiting verification of Citizenship and/or Identity and is re-applying, the individual cannot be approved until all verifications, including Citizenship and/or Identity, have been received.   **Cúram Procedure**:   * Citizenship and Identity can be verified from either the Application Case or the Integration Case. * The Integrated Case may be used if case is approved within ninety (90) days reasonable opportunity. If the case is processed outside of the ninety (90) day window, the Application Case should be used. * Under the Application Case/ Integration Case, the Eligibility Specialist should click on “Verifications” link. * Next click on the “Action” icon for “Citizen Status Code” for individual needing to be verified. * The specialist would then enter the verification source into Cúram. |

102.04.10 Exceptions to Verification of Citizenship and Identity

(Eff. 05/01/11)

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

102.04.11 Foreign-Born Children

(Eff. 05/01/17)

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

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

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

**Note**

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

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

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

102.04.12 Qualified Aliens

(Rev. 12/01/21)

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

A qualified alien is:

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

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

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

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

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

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

| **Document Type** | **Required Field** |
| --- | --- |
| I-327 | Alien Number |
| I-551 | Alien Number, Card /Receipt Number |
| I-571 | Alien Number |
| I-766 | Alien Number, Card /Receipt Number, Document Expiration Date |
| Certificate of Citizenship | Citizenship Number |
| Naturalization Certificate | Naturalization Number |
| Machine Readable Immigrant Visa with Temporary/I-551 Language | Alien Number, Passport Number, Country of Issuance |
| Temporary I-551 Stamp | Alien Number |
| I-94 (Arrival/Departure Record) | I-94 Number |
| I-94 (Arrival/Departure Record) in Unexpired Foreign Passport | I-94 Number, Passport Number, Country of Issuance, Document Expiration Date |
| Unexpired Foreign Passport | Passport Number, Country of Issuance, Document Expiration Date |
| I-20 | SEVIS ID |
| DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status) | SEVIS ID |
| Other | Alien Number, Document Description |
| Other | I-94 Number, Document Description |
| Note: Cúram will make an applicant eligible for a 90-day period while paper documentation is pending. | |

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

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

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| **Procedure for Approving Application while Qualified Alien Status Pending**: |
| If an applicant does not provide verification of Alien Status and/or Identity:   1. For an applicant required to submit documentation of Alien Status and/or Identity for the first time: 2. If all verifications other than Alien Status and/or Identity have been provided and Alien Status and/or Identity is not questionable, approve the application for Medicaid. Refer to the MEDS procedures below. 3. The Eligibility Specialist will send a [DHHS Form 1233](http://medsweb.scdhhs.gov/EligibilityForms/FM%201233%20ME.pdf), Medicaid Eligibility Checklist, to the applicant, requesting the needed information. The applicant will have up to 90 days from the date of approval to provide verification of Alien Status and/or Identity. 4. If verification of Alien Status and/or Identity has not been provided within 90 days, the Eligibility Specialist must close each member for whom Alien Status and/or Identity has not been verified. 5. For a BG Member who has previously been approved for Medicaid for 90 days while awaiting verification of Alien Status and/or Identity and is re-applying, the individual cannot be approved until all verifications, including Alien Status and/or Identity, have been received. 6. Complete a DHHS Form 1233 requesting all needed information, including Alien Status and/or Identity, and allow at least 21 days for the applicant to submit the information to allow the application to be processed within the federal standard of 45/90 days. Refer to MPPM Section 101.08. 7. If the applicant requests additional time to obtain verification, the Eligibility Specialist can request an Extension of Promptness in MEDS. Refer to MPPM Section 101.08.03. The Eligibility Specialist must verify that the applicant is trying to obtain the necessary verification with a telephone call or other contact. The telephone call or other contact should be documented on the MEDS NOTES screen.  * On ELD01 set the ACD to 90 Days from the Application Effective Date (AED).   **Note**   * ACD can be monitored in MEDS through alert 582 * The Eligibility Specialist will be responsible for updating ELD01 as the information is received. * If verifications are not received within 90 days, the Eligibility Specialist must close the case.   Note**:** If the closure is on a child who is in a protected period, the specialist will have to enter 004 in the RC1 field on ELD01. The specialist will then put the appropriate reason code in the RC1 field before calling Act on Decision to close the budget group.  If an application is denied solely for failure to provide information and the applicant provides all needed verifications within 30 days from the date on the denial notice, the date of the previous application must be used to determine the effective date of Medicaid eligibility.   * If an application is denied solely because the individual has not provided verification of Alien Status and/or Identity and all avenues of verification have been exhausted, the application must be denied using Reason Code 061, You did not provide proof of citizenship; Reason Code 043, You did not provide proof of identity; or Reason Code 012, You did not provide proof of Citizenship and/or Identity.   If the denial is for one or more individuals and not the entire budget group, go to ELD00 in MEDS and FAIL that individual(s) on Citizenship and/or Identity. The remaining budget group members will be eligible, and an approval notice will be generated. MEDS will generate the appropriate notices.  **Note**  Citizenship and Identity do not have to be verified if the applicant is not otherwise eligible. Refer to MPPM 101.09.03. |

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102.04.13 40 Qualifying Quarters of Work

(Eff. 05/01/11)

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

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

**Verification of Quarters of Coverage**

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

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

102.04.14 Undocumented and Illegal Aliens

(Eff. 05/01/11)

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

102.04.14A Deferred Action for Childhood Arrivals (DACA)

(Eff. 04/01/17)

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

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

102.04.15 Visitors to the United States (US)

(Rev. 10/01/23)

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

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| **Procedure for Determining Non-Citizen Qualifies for Services** |
| If the applicant provides the Eligibility Specialist with a copy of their passport, visa or any other form of documentation or ID, the specialist should ask the individual if they have established residence in South Carolina with no intention of returning to their country.   * + If the visitor indicates they plan to remain in this country, regardless of the status of their documentation, they may be eligible for emergency services if all other eligibility criteria are met.   + If the visitor has no intentions of remaining in this country and has not established a residence, they are not eligible for any services (including emergency services).   The applicant’s intent to remain in SC may be documented in the SOR notes screen and documentation template. If the intent is unknown to the Eligibility Specialist, the Eligibility Specialist must attempt to contact the applicant by phone to determine their intent. If the Eligibility Specialist is unable to reach the applicant by phone, assume that the applicant intends to remain in the United States and establish residency in South Carolina because the applicant has applied for emergency services. |

102.04.16 Non-Qualified Aliens

(Eff. 05/01/11)

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

102.04.17 Ineligible Aliens

(Eff. 05/01/11)

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

Ineligible aliens are:

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

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102.04.18 Alien Status

(Eff. 05/01/18)

The chart in MPPM 102 Appendix D identifies each alien group, whether the group can receive the full range of Medicaid benefits or just emergency services, and acceptable documentation used to establish alien status. The Systematic Alien Verification for Entitlement (SAVE) program procedures must be used to validate alien documentation presented by each individual in these groups. SAVE procedures are also used to verify the date of entry to the US for lawful permanent residents, parolees, and conditional residents to determine if an individual in one of these qualified alien groups is entitled to full benefits or emergency services only.

**Note**

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

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

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

(Eff. 05/01/11)

[CFR §435.603](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-G/section-435.603)

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

102.04.20 Criteria for Approval of Emergency Services

(Rev. 12/01/21)

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

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

**NOTE**

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

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

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

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

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

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| **Procedure for Determining Emergency Services** |
| **MEDS Procedure**:  When an applicant/beneficiary is approved for emergency services the Eligibility Specialist must enter “E” for Emergency Services in the Service Type field on ELD02.  Individuals will be eligible for payment of Emergency Services only for up to one year from the date of approval if he or she remains categorically eligible. This does not prevent the individual from applying for and being approved for payment of services at a future date. Individuals are responsible for reporting changes and completing an annual review. If the individual loses eligibility for any reason:   * Go to ELD01 in MEDS and put enter reason code 016, “You are no longer eligible for Emergency Services” * Enter a secondary reason code to show why the individual is losing eligibility, such as 051, “Your Income is more than policy allows,” or 060, “You have no minor child in the home.” * Before Acting on Decision, go to ELD02 to make sure the eligibility beginning and end dates are correct. * Act on Decision to close the Budget Group.   **Note**  Non-citizens found in need of treatment for breast or cervical cancer or pre-cancerous lesions (CIN 2/3 or atypical hyperplasia), may be eligible for BCCP. If the applicant is approved, coverage will continue if eligibility criteria are met, and the beneficiary is receiving treatment. Refer to SC MPPM 501.03.03 for MEDS Procedures.  **Note**  Individuals approved for Parent/Caretaker Relative (PCR) eligible for payment of Emergency Services only cannot be moved to Transitional Medicaid Assistance (TMA) if there is a change in earned income.  **Cúram Procedure**:  If a service is an emergency, it will be determined automatically under Cúram.  **Note**  Individuals will be eligible for payment of Emergency Services only for up to one year from the date of approval if he or she remains categorically eligible. This does not prevent the individual from applying for and being approved for payment of services at a future date. |

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102.04.21 Case Processing for Aliens Eligible for Emergency Medicaid Services Only

(Rev 09/01/15)

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

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

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

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

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

(Eff. 05/01/11)

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

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102.04.23 Systematic Alien Verification for Entitlement (SAVE) Program

(Eff. 05/01/18)

[CFR §435.949](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-J/subject-group-ECFRc649656b2ed45a8/section-435.952)

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

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

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

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

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| **Procedure for Accessing VIS** |
| Access the system by entering the following Web address into the address line of your Web browser: <https://save.uscis.gov/Web/>. If logging into the system for the first time, you will be required to enter your user ID and password that will be provided to you by your supervisor. After completion of the initial login, you will be prompted to change your password. Keep in mind that your new password must contain all four (4) of the following password characteristics:   * Uppercase letters * Lowercase letters * Numbers * Special character ($, !, #, etc.)   To ensure that you have entered the correct password, you will be prompted to re-enter the password in the ‘Re-type New Password’ field.  The system is user-friendly; however, it is advisable that you take the time to visit the tutorial link found on the title navigation links bar. The tutorial is a Web-based, self-paced, role-sensitive tutorial. It is divided into lessons that focus on each major section of the navigation menu. Each lesson is comprised of topics that focus on each of the functions that can be performed in the system. |

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

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102.05 Social Security Number (SSN)

(Rev. 01/01/21)

[CFR §435.910](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-J/subject-group-ECFR9b4bff9082050a1/section-435.910)

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

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

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

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

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

102.05.01 Application for an SSN

(Rev. 10/01/23)

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

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

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

1. Application at the county SSA office

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

1. Enumeration at birth

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

Should an applicant/beneficiary have more than one SSN or have the same SSN as another individual, he must be referred to the county SSA office to resolve the discrepancy.

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102.05.02 Verification

(Rev. 10/01/23)

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

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

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| **CÚRAM Procedure:**  Please see job aid: [Managing Evidence- Social Security Number](https://schhs.sharepoint.com/:b:/r/sites/EES/Training/Curam/HCR/Job-Aids/Evidence/Social%20Security%20Number.pdf?csf=1&web=1&e=o3cRMy)  If an applicant/beneficiary has furnished an SSN, the applicant/beneficiary CANNOT be denied assistance while awaiting verification of the number.   * If the furnished SSN cannot be verified through electronic sources, the beneficiary can be approved for the 90-day reasonable opportunity period while the eligibility specialist awaits documentation. * If the beneficiary has not returned verification at the time of a new application or review the beneficiary would not be approved for a 2nd 90-day reasonable opportunity period. |
| **MEDS Procedure:**  If the applicant/beneficiary has no documentation of the SSN, but can provide the number, the eligibility worker should accept the number. The computer match between Social Security and MEDS will validate the number. A "V" validation code will appear on the Household Member Detail Screen and the Recipient Detail Screen showing the SSN has been validated.  If no “V” appears after the match, the eligibility worker must verify the correct number with the individual. Should the individual be unable to provide verification, refer him/her to the SSA to resolve the matter. |

**MEDS Procedure**

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

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

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

102.05.03 SVES Verification of Social Security Number

(Rev. 10/01/23)

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

| **Procedure for Verifying Social Security Number** |
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| **MEDS Procedure:**   1. Eligibility Specialist receives Alert #264 or Alert #265. 2. Specialist must check the code on SVES13, SVES SSN Validation and C&I Verification Response. 3. If the Verification Code for Citizenship/Identity Validation Response is one of the following codes, the Eligibility Specialist must use other methods to verify Citizenship and Identity. Refer to SC MPPM 102.04.04.  * B – SSN is verified, No DOD, C&I not verified by SSA * D – SSN is verified, DOD present, C&I not verified by SSA  1. If there is no verification code under Citizenship/Identity Validation Response, check the Error Condition Code and Description under the SSN Validation Response section for the reason that the Social Security Number did not verify. 2. Compare the information provided by the applicant.    1. If the information in MEDS does not match the information provided by the applicant, make all appropriate corrections in MEDS. If the SSN, Name, Date of Birth, Sex, or Medicare Number are changed in MEDS, a new query will be generated to attempt to verify SSN, Citizenship, and Identity.    2. If the information in MEDS matches the information provided by the applicant, contact the applicant to confirm the provided information.       1. If the applicant provides new information, make the necessary corrections in MEDS.       2. If the applicant confirms that the information is correct, use other methods to verify Citizenship and/or Identity. Refer to SC MPPM 102.04.04.   **Cúram Procedure**  If known to the system, Social Security Number will be verified automatically in Healthy Connections Cúram. If not known, when the service becomes available, the specialist may use the Person Composite Service to verify SSN. Refer to the [Social Security Number (SSN)](https://schhs.sharepoint.com/sites/EES/Training/Curam/HCR/Job-Aids/Evidence/Social%20Security%20Number.pdf?csf=1&e=nguDrQ&cid=d4a01aab-1487-48dd-8c16-1cd261446d55) job aid for specific instructions. |

102.06 Categorical Relationship

(Eff. 10/01/05)

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

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

102.06.01 Aged/Age Verification

(Rev. 09/01/20)

[CFR §435.956](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-J/subject-group-ECFRc649656b2ed45a8/section-435.965)

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

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

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

102.06.01A Age Verification

(Eff. 10/01/13)

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

Examples of acceptable sources of age verification are:

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

102.06.02 Blindness/Disability

(Eff. 06/01/15)

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

102.06.02A Determination of Documented Blindness/Disability Status at Application

(Rev. 04/10/22)

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

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

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

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

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

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

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

| **Disability Determination Process** | |
| --- | --- |
| **Step** | **Action** |
| **Disability Check – Interfaces** | **STEP 1**  Check BENDEX (MPPM 102.06.02B), SDX (MPPM 102.06.02C) and SVES (MPPM 102.06.02D). Refer to [**Check** **System Interfaces**](#Interface)   * Has the applicant already been determined to be disabled, including all requested retroactive months?   + **YES** – Go to [**Process Application**](#Proc_App)   + **NO** – Go to [**Disability Check - OnBase**](#Dis_Chk_Step_2) |
| **Disability Check – OnBase** | * Is there an existing MAO99 that has not passed the diary date?   + **YES** – Go to [**MAO99 Return**](#MOA99_Ret)   + **NO** – Continue OnBase check * Is there a pending *Disability Packet* in OnBase for the current application?   + **YES** – Review the *Disability Packet* for completeness   **Note:** If the *Disability Packet* is incomplete, the missing pages/information will need to be requested via DHHS Form 1233.  Go to [**Process Application**](#Proc_App)   * + **NO** – Go to [**Applicant Contact**](#App_Con) |
| **Applicant Contact** | * Review the application and create a DHHS Form 1233 to show any additional information needed to complete an eligibility determination. * Attempt to contact the applicant by phone using the [**Disability Process Script**](#Dis_Proc_Scrpt) (MPPM 105.02.01)   + - * + Does the Applicant want to continue the disability process?   **YES** –  Confirm the applicant’s Name, Date of Birth, Social Security Number, Address and Phone Number  Go to [**Prepare Disability Packet**](#Prep_Dis_Pak)   * + - **NO** – Assess for Family Planning or other MAGI category. * If unable to contact the applicant by phone, go to [**Prepare Disability Packet**](#Prep_Dis_Pak) |
| **Prepare Disability Packet** | * On the *Disability Report*, type the applicant’s Name, Date of Birth, Social Security Number, Address, Phone Number and other Identification and Contact information.   Fill in the “For DHHS Use Only” box by typing the complete Household Number and Application Date and indicate whether it is a request for an Initial or Retro Only decision and the beginning Retro month.   * On the DHHS Form 921, fill in the “To Be Completed By SCDHHS” box by typing the Name, Social Security Number, Date of Birth and complete Household or Application ID number.   + A DHHS Form 921 is not necessary if the applicant is deceased and documentation was submitted with the date and cause of death, preferably the death summary or case notes from the hospital. * Update the DHHS Form 1233 to add the *Disability Packet*. * Mail the DHHS Form 1233 and *Disability Packet* to the applicant and Authorized Representative. Allow 15 days to return the required information. Reminder: When setting the follow-up date in OnBase, add an additional six (6) days to allow for scanning and task creation in PathOS.   **NOTE**: If the applicant is deceased, include documentation of the date and cause of death, preferably the death summary or case notes from the hospital. The death must be linked to the applicant’s underlying disability.   * Begin completion of the Disability Review Checklist in OnBase. Steps should be completed until a “Stop” is reached. * Go to [**Information Return**](#Info_Ret) |
| **Information Return**  If no information is returned within 15 days, deny the application for Failure to Return Information.  If information is returned, check Part 1 and Part 2. | **Part 1**  Is the *Disability Packet* returned within 15 days?   * **YES** –   + **Central Document Management (CDM)** – Scan the *Disability Packet* into OnBase (Document Type: MEDS-Disability Packet) with Trailing set to “YES.”   **NOTE:** Do not date stamp or make any other marks on the front of the DHHS Form 921   * + **Eligibility Specialist** – Go to [**Check Disability Report**](#Chk_Dis_Rep) * **NO** – Go to [**Second Contact**](#Sec_Cont) |
| **Part 2**  Is all other required information returned within 15 days?   * **YES** – Go to [**Eligibility Check**](#Elig_Chk) * **NO** – Go to [**Second Contact**](#Sec_Cont) |
| **Second Contact** | Contact the applicant and clarify that information is still missing.  Send a DHHS Form 1233 requesting the completion of the missing pages and any other necessary case information (i.e., income/resources).  **Note:** Because this is the second request for this information, give the applicant 10 days to return the information and put the case in Follow-Up for an additional 6 days.  Go to [**Second Contact Information Return**](#Sec_Cont_Info_Ret) |
| **Second Contact Information Return** | Did the applicant return the *Disability Packet* within 10 days?   * **YES** – Go to [**Information Return – Part 1**](#Info_Ret_Pt_1) * **NO** – Deny the Non-MAGI application and assess for Family Planning or other MAGI category in MEDS. |
| Did the applicant return other requested information within 10 days?   * **YES** – Go to [**Eligibility Check**](#Elig_Chk) * **NO** – Deny the application for Failure to Return Information |
| **Check Disability Report** | Access the *Disability Packet* in OnBase. Complete the Disability Process Checklist to evaluate the packet for completeness.  *Disability Report*   * Is the *Disability Packet* contact information complete and legible, and did the applicant sign the *Disability Report*?   + **YES**: Proceed to review the DHHS Form 921   **NOTE**: A *Disability Report* is still required with a posthumous application if a Disability Determination is required for eligibility.   * + **NO**:     - Search documentation and electronic systems to verify the information.     - Make a collateral call to the applicant/authorized representative to verify the information.       * If the discrepancy CAN be resolved make the change in the SOR (if needed) and on *the Disability Report*. Include a note in SOR and the Documentation Template of the error found. Add an OnBase sticky note of the change to the *Disability Report*.       * If the discrepancy CANNOT be resolved, make note of the verification needed and include on the DHHS Form 1233.   DHHS Form 921   * Is the MEDS-Disability Packet contact information complete and legible and did the applicant sign the DHHS Form 921? **NOTE**: Do not date stamp or make any other marks on the front of the DHHS Form 921   + **YES** –     - If all forms are complete and correct, re-index the *Disability Packet* from MEDS-Disability Packet to MEDS-Disability Application. While the re-index column is open, update the Disability Status Keyword with the dropdown value of “Pending DD Review.”     - Ensure the MEDS-Disability Application is in VR Workflow and exit date is blank. Right click the MEDS-Disability Application, choose “History,” then “Workflow Queues.” If the MEDS-Disability Application is not in “VR Workflow” or has an Exit Date, put the MEDS-Disability Application into VR Workflow by right clicking the MEDS-Disability Application, choose “Workflow,” then “Execute,” then “Ok.” Confirm that the MEDS-Disability Application is now in VR Workflow.     - Set the “Disability Packet sent to VR?” indicator to “No” on the Tracking Form. This shows the Disability Determinations Team has not reviewed the MEDS-Disability Application, and Vocational Rehabilitation has yet to receive the MEDS-Disability Application to make a Disability Determination.     - Set the follow-up date on the Tracking Form for 21 days to allow the Disability Determination Team to review the *Disability Application* and send to Vocational Rehabilitation.   **NOTE**: Be sure POA signs their name on behalf of the client, not the client’s name. Include POA document with *Disability Application* when submitting to Vocational Rehabilitation.   * + **NO** –     - A DHHS Form 921 is not necessary if the applicant is deceased and documentation was submitted with the date and cause of death, preferably the death summary or case notes from the hospital.     - Contact the applicant by phone regarding any incomplete or illegible information in the *Disability Packet*.   **NOTE**: If the *Disability Application* was sent to VR-Intake Workflow and the MEDS-Application Tracking Form has been pended twice for 21 days (placed in Follow-Up two times waiting for Disability Determination Team to review the packet and send to Vocational Rehabilitation), and there are no notes on the Documentation Template that the *Disability Application* was sent to VR, notify your supervisor to escalate the case and keep the task in Finish Later until a response is received.  **NOTE**: Be sure POA signs their name on behalf of the client, not the client’s name. Include POA document with the *Disability Application* when submitting to Vocational Rehabilitation. |
| **Eligibility Check** | Verify all other financial and non-financial eligibility criteria.   * Does the applicant meet all other financial and non-financial criteria?   + **YES** – Send the case to the Follow-Up Queue for 90 days or until [**MAO99 Return**](#MOA99_Ret).   + **NO** – Send the case to the Follow-Up Queue for 90 days to wait for the final disability decision. Do not deny the application at this time.   **Note:** A financial denial can only be made BEFORE a *Disability Report* has been requested/received from the applicant. Once a *Disability Packet* is received/requested, the case can no longer be denied for financial reasons until the Disability Determination is received.   * + - Contact the applicant   + Disability Determination Services at Vocational Rehabilitation will continue processing the *Disability Packet*. |
| **MAO99 Return** | **CDM** – Scan MAO99 into OnBase (Document Type: MEDS Form MAO99; Trailing Document – Yes)  **Eligibility Specialist** – Does the MAO99 establish disability?   * **YES** –   + Does the MAO99 indicate an Adopted or Coordinated decision?     - **YES** – Go to [**Process Application**](#Proc_App)     - **NO** – Check BENDEX, SDX and SVES to see if the applicant filed an application for benefits with the Social Security Administration.       * If an application with SSA was denied, determine the reason and the impact on the Medicaid decision. Go to [**Process Application**](#Proc_App)       * If there appears to be no application for SSA benefits, contact the applicant for an explanation.         + If the applicant provides a reasonable explanation, go to [**Process Application**](#Proc_App)         + If the applicant does not provide a reasonable explanation or indicates an application was not filed, deny the application for Failure to Apply for Other Benefits * **NO** – Assess for Family Planning or other MAGI category. |
| **Process Application** | Evaluate application for all eligibility criteria.  Does the applicant meet all eligibility criteria?   * **YES** – Approve the application for the appropriate category. * **NO** – Assess for Family Planning or other MAGI category in MEDS. |

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| **System of Record** |
| Prior to processing the application, it must be determined whether the person already has eligibility in either MEDS or Cúram. The following steps apply to most situations.  **Applications originating in Cúram**:   * + 1. Is the applicant Medicaid eligible?        1. Yes: Are they eligible in a full benefit category?           1. Yes: Treat the application like a reported change, apply changes.           2. No: Re-index to the SSI Non-Institutional Queue.   If the applicant is found eligible under the ABD category, eligibility in Cúram must be ended before approving the application in MEDS.   * + - 1. No: Re-index application to SSI Non-Institutional Queue.   **Applications originating in MEDS:**  Determine if the applicant is Medicaid eligible.  If they are eligible in a full benefit category, the disability decision may not be needed.  If the applicant is not currently eligible in a full-benefits category, assess the application for ABD.  If the applicant is not eligible for ABD, assess for Family Planning and other MAGI categories in MEDS.  If the person is not eligible in any full benefit Medicaid category and does not have Medicare, their information must be forwarded to the FFM. An email must be sent to [SP\_FFMTransfer@scdhhs.gov](mailto:SP_FFMTransfer@scdhhs.gov).   1. Subject Line of the email: Household Number 2. Body of the email: First and Last Name   **Applications originating in Cúram (CGIS):**  Determine if the applicant is Medicaid eligible.  If they are eligible in a full benefit category, the disability decision may not be needed.  If the applicant is not currently eligible in a full-benefits category, assess the application for ABD.  If the applicant is not eligible for ABD, assess for Family Planning and other MAGI categories.  If the person is not eligible in any full benefit Medicaid category and does not have Medicare, their information must be forwarded to the FFM. An email must be sent to [SP\_FFMTransfer@scdhhs.gov](mailto:SP_FFMTransfer@scdhhs.gov).   1. Subject Line of the email: Household Number 2. Body of the email: First and Last Name |

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

**Delayed Application Processing**

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

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

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

102.06.02B Check System Interface – BENDEX

(Eff. 11/01/23)

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| **Automated Process: Check System Interfaces-BENDEX MMA** |
| Beginning November 1, 2023, Cúram-CGIS will automatically assess the applicant’s/ beneficiary’s disability status based on the results from the BENDEX and MMA interfaces and clear the outstanding verifications for disability if the individual is disabled. Eligibility specialists are still required to perform the following tasks:   * Clear any task generated in Cúram-CGIS associated with Disability Evidence * Check Eligibility and Apply changes to the Disability evidence. |

The following procedure must be used to check BENDEX when manual processing is required.

| **Check System Interfaces – BENDEX** |
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| * From Household Member Detail (HMS06) screen use F9; or * From the Interfaces Menu, select IEVS Action Menu, then select BENDEX Menu, then select BENDEX Information Screen (IEV11)   1. If BENDEX record is not found, create a request      1. Press F16 to go to BENDEX Input Form (IEV05)      2. Enter “BDA” in Communication Code field      3. Enter “ADD” in the Action field      4. Press <ENTER>      5. The request will be returned in 2 to 3 days. An alert will not be sent when the response is received, so the Eligibility Specialist must check IEV11 to determine if the query request has been returned   2. If BENDEX record is found, check the date shown in the SSA PROCESS field      1. If the SSA PROCESS date is more than 12 months old, create a new request. Refer to the instructions in a. above      2. If the SSA PROCESS date is within the previous 12 months, check the Payment Status Code (PSC)         1. If PSC is CP (Current Pay), check the applicant’s age            1. If the applicant is age 18 through age 61, check to see if the applicant is receiving on his own record   If the claim number is the applicant’s Social Security Number with an “A” suffix, the applicant is disabled, and a disability referral is not needed  If the claim number is the applicant’s Social Security Number with a “T” suffix, go to [**SDX**](#SDX)  If the applicant’s claim number ends with any other suffix or uses someone else’s SSN, check Medicare eligibility on BENDEX INFORMATION page 2 (IEV02)  If the applicant is currently Medicare Part A eligible, the applicant is disabled, and a disability referral is not needed  If the applicant is not Medicare Part A eligible, go to [**SDX**](#SDX)   * + - * 1. If the applicant is age 62 through age 64, check to see if the applicant is receiving on his own record   If the claim number is the applicant’s Social Security Number with an “A” suffix, check Medicare eligibility on IEV02  If the applicant is currently Medicare Part A eligible, the applicant is disabled, and a disability referral is not needed  If the applicant is not currently Medicare Part A eligible, go to [**SDX**](#SDX)  If the claim number is the applicant’s Social Security Number with a “T” suffix, go to [**SDX**](#SDX)  If the applicant’s claim number ends with any other suffix or uses someone else’s SSN, check Medicare eligibility on IEV02  If the applicant is currently Medicare Part A eligible, the applicant is disabled, and a disability referral is not needed  If the applicant is not Medicare Part A eligible, go to [**SDX**](#SDX)   * + - 1. If PSC is not CP, go [**SDX**](#SDX) |

102.06.02C Check System Interfaces – SDX

(Eff. 06/01/15)

The following procedure must be used to check SDX.

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

102.06.02D Check System Interfaces – SVES

(Eff. 06/01/15)

The following procedure must be used to check SVES.

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

102.06.02E Disability Process Script

(Rev. 08/01/15)

The Disability Process Script can be found in MPPM 105.02.01.

102.06.02F Continuing Disability Review at Annual Review

(Rev. 12/01/21)

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

| **Procedures for Continuing Disability Review for Blind and Disabled Beneficiaries at Annual Review** |
| --- |
| **Eligibility Specialist Tasks:**  Upon receipt of the annual review form:  If the disability determination was based on an Adopted or Coordinated decision, the eligibility specialist must check interfaces to ensure the beneficiary is still in payment status for Social Security benefits. If they are, no CDR is required. Complete the annual review assuming continued disability.  If the beneficiary had Social Security benefits terminated within the last 12 months of the annual review date, as indicated by PSC codes N01, N02, N04, N05, or N22 without an Independent, disability determination, the specialist should not send a CDR packet to VR and should complete the annual review, assuming continued disability.  If the terminating SSA decision occurred more than 12 months prior to the annual review date or with any other PSC code, the specialist must complete the identifying information and “FOR DHHS USE ONLY” sections on the DHHS Form 3218 (adult) / 3218-D (child) and DHHS Form 921 and send it to the applicant. (This is considered a new application to Disability Determination Services.) If the applicant is otherwise eligible, the case remains open until the disability decision is received.  If a disability determination was previously done, the Eligibility Specialist must:   1. Check the case record for the MAO99 disability determination for the Diary Date or Date of Next Review:  * If the date is past due or is due within the next three (3) months, the specialist must complete (type) the identifying information and the FOR DHHS USE ONLY section on the DHHS Form 3266 (adult)/3266-D (child), as well as the DHHS Only section on DHHS Form 921. This is the CDR packet. Send a completed DHHS Form 1233 for any information needed to complete the financial determination and the CDR packet to the beneficiary/Authorized Representative. Provide 15 days to return the requested information. **Reminder:** When setting the follow-up date in OnBase, add an additional six (6) days to allow for scanning and task creation in Workload Pro.   + Complete the financial determination for the annual review.     - * If all information is not received in 15 days, contact the applicant, resend the completed DHHS Form 1233 and provide 10 additional days for follow up.   + If otherwise eligible keep the case open until a decision is received. * If the date is more than three (3) months in the future, no action needs to be taken regarding disability until the next annual review. Complete the annual review.   **Eligibility Specialist Tasks:**   * Retrieve the CDR Packet in OnBase. * Review the documents for completeness, legibility.   + Follow up with beneficiary/Authorized Representative for any needed information/clarification. * Retrieve the case file documents related to last favorable decision. This may be via OnBase, AppXtender, Appeals documents.   **Note:** AppXtender, also known as ApplicationXtender, is a database used to store documents from application files that are dated outside the storage capacity of OnBase.   * Print the CDR Packet and related documents. * **If no case file documents found related to last favorable decision, indicate this in the DHHS Only Section of Form 3266 ME/3266D-ME.** * Give the entire CDR Packet and related documents to VR staff.   Upon receipt of the MAO99 from VR, CDM will scan the MAO99 into OnBase.  **Eligibility Specialist Tasks:**   * Access MAO99 from OnBase. * Complete eligibility decision based on financial determination and disability decision for continuation of benefits. If the beneficiary is no longer eligible in this payment category, assess for eligibility in MAGI categories, including Family Planning. (Keep case in MEDS.) |

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

102.06.02G Child Aging Out of Disability Based Category

(Eff. 09/01/15)

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

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

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

(Eff. 10/01/05)

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

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

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

102.06.03 Child

(Eff. 10/13/13)

[CFR §435.4](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-A/section-435.4); [CFR §435.110](http://www.ecfr.gov/cgi-bin/text-idx?SID=1b8b9ef1f90fc64f896519015ec193ff&node=se42.4.435_1110&rgn=div8); [CFR §435.952](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-J/subject-group-ECFRc649656b2ed45a8/section-435.956)

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

102.06.04 Pregnant Women

(Eff. 04/22/22)

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

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

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

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

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

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

102.07 Medical Support Requirements

(Rev. 03/01/14)

Each legally able applicant/beneficiary is required to:

* + - 1. Assign to Medicaid any rights to payment for medical care from any third party;

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

Cooperation for Medical Support Requirement purposes is defined as:

· Providing information or evidence relevant to an investigation,

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

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

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

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102.07.01 Automatic Assignment

(Rev. 03/01/14)

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

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

102.07.01A Non-Cooperation with Assignment Requirements

(Rev. 03/01/14)

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

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

102.07.01B Good Cause for Non-Cooperation

(Rev. 03/01/14)

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

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

102.07.01C Verification

(Rev. 03/01/14)

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

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

102.07.02 Procedures for Third-Party Data Collection

(Rev. 02/01/22)

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

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

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

(Rev. 05/01/22)

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

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

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

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

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

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

South Carolina Department of Social Services

Integrated Child Support Services Division

Case Management Services

Post Office Box 1469

3150 Harden Street

Columbia, South Carolina 29202

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

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

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

102.07.04 Health Insurance Premium Payment (HIPP) Program

(Eff. 10/01/05)

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

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

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

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

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

Department of Health and Human Services

Attention: HIPP

Post Office Box 100127

Columbia, South Carolina 29202-3127

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

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

102.08 Application for Other Benefits

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

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

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

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

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

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

102.08.01 Unemployment Benefits

(Rev. 05/01/18)

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

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

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

A referral for Unemployment Benefits is not required for:

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

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

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

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

The base period is controlled by the effective date of a claim, not by the date the individual becomes unemployed. Using the table below, if a claim is effective during the January, February, or March of 2024 (Quarter 1), then the base period is Quarters 1, 2, and 3 from 2022 and Quarter 4 of 2021 as shown by the shaded area on the first line. This is true even if the claim is effective on March 31, 2024, the last day of the quarter. If a claim is effective during April, May, or June of 2024 (Quarter 2), the base period is Quarters 1, 2, 3, and 4 of 2022.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Quarter** | | | | | | | | |
| **4** | **1** | **2** | **3** | **4** | **1** | **2** | **3** | **4** |
| Oct  Nov  Dec | Jan  Feb  Mar | April  May  June | July  Aug  Sept |  | Jan  Feb  Mar |  | If claim’s effective date is in: | |
|  | Jan  Feb  Mar | April  May  June | July  Aug  Sept | Oct  Nov  Dec |  | April  May  June |  |  |
| 2021 |  | April  May  June | July  Aug  Sept | Oct  Nov  Dec | Jan  Feb  Mar |  | July  Aug  Sept |  |
|  |  | July  Aug  Sept | Oct  Nov  Dec | Jan  Feb  Mar | April  May  June |  | Oct  Nov  Dec |
| 2022 | | | | 2024 | | | |

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| **Procedure for Determining Unemployment Benefits** |
| 1. Check the application for any applicant who is currently not working nor receiving a retirement or disability benefit 2. Check SCDEW Wage Match to see if the applicant has wages. If the applicant/beneficiary has any wages, a copy of the SCDEW Wage Match screen must be printed for the record 3. Determine the base period assuming the claim effective date is in the current quarter 4. If the applicant/beneficiary has income in at least two quarters of the base period, the Eligibility Specialist must determine if a referral to the South Carolina Department of Employment and Workforce (SCDEW) is appropriate. The case record must be documented to show specialist’s determination and decision 5. The [DHHS Form 3301](http://medsweb.scdhhs.gov/EligibilityForms/FM%203301.doc), Unemployment Compensation Benefits Referral Worksheet, can be used to determine if a referral is appropriate and a printed copy of the form in the case record can serve as documentation 6. If the Eligibility Specialist determines that the applicant/beneficiary must be referred to SCDEW, complete a DHHS Form 1233 instructing the applicant/beneficiary to apply for benefits 7. If an applicant/beneficiary indicates she was working in another state prior to moving to South Carolina, refer to DEW for an interstate unemployment claim   Note**:** Once someone is entered into MEDS, information about South Carolina wages is immediately available on SCDEW Wage Match.  **Example 1**  Sarah Berry applies for Medicaid on May 15, 2024. On the application she indicates she is not currently working. Ms. Berry’s base period is January through December of last year. ESC Wage Match shows the following income:  Quarter 1/2022: 1,125.52 Quarter 2/2022: 925.25  Quarter 3/2022: 1,268.85 Quarter 4/2022: 1,365.98  Quarter 2/2022 is her highest quarter at $1,365.98, which is greater than $1,092.00. Her total income for the four quarters is $4,685.60, which is greater than $4,455.00; and the total is greater than 1 and one-half times the highest quarter ($1,365.98 × 1.5 = $2,048.97.) Ms. Berry is referred to SCDEW to apply for unemployment.  **Example 2**  Jean Green applies for Medicaid on August 31, 2024. On the application he indicates he is not currently working. Mr. Green’s base period is April through December of last year and January through March of this year. ESC Wage Match shows the following income:  Quarter 2/2022: 1,125.25 Quarter 3/2022: 512.12  Quarter 4/2022: 600.00 Quarter 1/2024: 552.36  Quarter 4/2022 is Mr. Green’s highest quarter at $1,125.00, which is greater than $1,092.00. His total income is $2,789.73, which is less than $4,455.00. Mr. Green ***is not*** referred to SCDEW to apply for unemployment. |

102.08.02 Social Security Benefits

(Eff. 10/01/05)

<http://www.ssa.gov>

Disability Related SSA

Disability Benefits off the Individual’s Own Record

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

Disabled Widow/Widower Drawing off Spouse’s Record

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

Disabled Child

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

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

Spouse/Minor Children of Disabled Individual Who Receives SSA

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

Survivor’s Benefits

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

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

Note

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

102.08.03 Veterans Benefits

(Rev. 11/01/07)

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

**Disability**

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

**Pension**

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

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

**Survivor’s Benefits**

Dependency and Indemnity Compensation (DIC)

The following individuals may qualify for benefits:

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

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102.09 Living Arrangements

(Eff. 10/01/05)

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

102.09.01 Inmates of a Public Institution

(Rev. 02/01/23)

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

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

Definition of an Inmate

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

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

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

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

Note

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

Special Considerations

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

**Inmate Residency**

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

Inmate Applications

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

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

All inmate applications must be sent to:

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

Post Office Box 211695

Columbia, SC 29221

**Courier Address:** SC DHHS

7499 Parklane Road, Suite 176 and Suite 180

Columbia, SC 29223

**Note**

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

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

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

| **Procedure for Processing an Inmate Application:** |
| --- |
| * The Specialty Unit Inmate Specialist checks MEDS to determine if the inmate is currently eligible. * The specialist attaches the “I” indicator or (“C” indicator if eligible for Emergency Services only) in the first full month that an individual is both eligible and an inmate. * If not already eligible, the specialist enters the application in MEDS. * On HMS04 (Primary Individual Screen), the specialist must enter the Sponsor Code of 4010 (Richland County SCDC), 0000 (Richland County Miscellaneous Correctional Facility) or 4013 (Richland County DJJ). The sponsor code is a designation given to each facility to capture Medicaid work. * On HMS04, enter “40” (Richland County Code) as the applicant’s county, regardless of which facility the inmate is in. * On HMS04 (Primary Individual Screen) the specialist must enter the address of the correctional facility in the Residence Address and enter the mailing address as:   South Carolina Department of Corrections  COA Attn: Medical  4542 Broad River Road  Columbia SC 2910   * All correspondence must be sent to the mailing address listed on HMS04 (Primary Individual Screen). Note**:** For DJJ detainees, the HMS05 (Authorized Representative) screen is completed. * The Inmate Reason for Application on HMS04 must be “Y”. * On HMS06, the Living Arrangement of CORF (Correctional Facility) must be entered. * Note: For DJJ detainees, category ‘88’ must be entered in the CAT1 field on the HMS07 (Household Members) screen. * If an application is withdrawn due to specialist error, the inmate specialist should ALWAYS enter “W” at the WITHDRAW APPLICATION (W/C/N) prompt on HMS04. This will not generate a notice unnecessarily. * Once the application is locked in MEDS, the specialist will proceed to ELD00 to determine eligibility for the inmate. * The specialist will ensure that the Sponsor Code on ELD00 (Medicaid Eligibility Decision) is 4010 (Richland County SCDC), 0000 (Richland County Miscellaneous Correctional Facility) or 4013 (Richland County DJJ). * Set the next review date on ELD01 for one (1) year from the current date. The inmate cases will be reviewed annually as long as the individual is incarcerated. * Do not set an anticipated closure date. * The Specialty Unit Inmate Specialist will ensure that the appropriate indicator is entered on the ELD02 screen in SERVICE TYPE. Enter an “I” for Inmate and a “C” for a non-citizen Inmate. * The Specialty Unit Inmate Specialist must enter/update the Service Type on ELD02 before AOD (pf24) even if the BG is being denied. * Do not change the eligibility date to a date prior to July 1, 2004, nor submit corrections to change the eligibility. The Helpdesk will be notified not to key MEDS corrections if the Benefits Code = I, or C and the request is to add eligibility prior to July 1, 2004. * Do not establish eligibility for an inmate in categories 48, 50, 52, 56, or 90. The only acceptable category for a DJJ Inmate is 88. * MMIS will edit claims to ensure only in-patient claims are paid.   **Cúram Procedure:**   * Reduce benefits by adding the “I” indicator for full months the individual is both incarcerated and eligible.   + If a beneficiary who is currently eligible for benefits becomes incarcerated, the reduced benefits should begin on the first day of the month after the beneficiary became incarcerated.   + If an individual who does not have current eligibility applies for and becomes eligible for benefits while incarcerated, the reduced benefits should begin on the first day of the first full month that the applicant was both incarcerated and eligible.   + When an individual applies prior to incarceration and is found eligible after he/she is incarcerated, he/she can receive full benefits prior to incarceration and reduced benefits starting the first full month of incarceration. * See Job Aid:   + MAGI: [Processing Incarceration Evidence and Inmate Applications](https://schhs.sharepoint.com/sites/EES/Training/Curam/HCR/Job-Aids/Evidence/Processing%20Incarceration%20Evidence%20and%20Inmate%20Applications.pdf?csf=1&e=MB7hlk&cid=77004982-1991-4c2d-8c6d-f211abe8c4ef)   + CGIS: [Process\_Incarcerated\_Members\_JA.pdf](https://schhs.sharepoint.com/:b:/r/sites/EES/Training/Curam/CGIS/Job%20Aids/Process_Incarcerated_Members_JA.pdf?csf=1&web=1&e=aDhs42) |

| **Procedure when an Inmate is Released** |
| --- |
| **MEDS Procedure**:   * If the incarcerated beneficiary with reduced benefits is released at any time during the month, the benefits will be regained on the first day of the month that the beneficiary is released.   + The specialist removes the “I” or “C” indicator, so the individual’s benefits are no longer limited to inpatient services.   **Cúram Procedure:**   * If the incarcerated beneficiary with reduced benefits is released at any time during the month, the benefits will be regained on the first day of the month that the beneficiary is released.   + The specialist removes the “I” or “C” indicator. * The specialist encourages the individual to report any change of circumstance after release. |

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102.09.02 In a Public Institution

(Rev. 04/01/16)

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

Institution for Mental Diseases

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

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

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

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

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

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

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

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

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

Correctional or Holding Facilities

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

102.09.03 Not In a Public Institution

(Eff. 10/01/05)

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

Medical Institution

A medical institution:

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

Intermediate Care Facility for the Intellectually Disabled

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

Publicly Operated Community Residence

A publicly operated community residence:

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

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

**Childcare Institution**

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

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

Public Educational or Vocational Training Institution

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

Temporary Arrangement While Awaiting Permanent Placement

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

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

102.10 Marital Status

(Eff. 08/01/19)

[CFR §435.603](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-G/section-435.603)

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

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

|  |
| --- |
| **Procedure for Evaluating Marital Status** |
| **NOTE:** South Carolina does not recognize common-law marriages established on or after July 25, 2019.  **Common Law Marriage – Considerations and Treatment**   * If they consider themselves common law and the above applies, accept their statements, and consider them as married. * If they agree they are not married at common law, and there is no evidence to the contrary, do not consider them as married. * If they disagree, or there is evidence to the contrary, refer to [POMS SI 00501.152](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500501152) for further instructions.   **Separated Spouses**   * The separation is considered the month following the month the separation began. * If the separation is questionable, obtain corroborating verification such as:   + Landlord statements   + Utility bills   + Collateral statements from two non-relatives, to include their address and phone numbers   + Refer to SC MPPM 304.08 for specific instructions for Nursing Home, Waivered Services, and General Hospital.   **Legally Divorced Individuals Who Reside Together**   * Request a copy of the divorce decree. |

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102 Appendix A Primary Evidence of Citizenship and Identity

(Eff. 01/01/14)

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

Acceptable documents include, but are not limited to:

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

102 Appendix B Evidence of Citizenship

(Eff. 01/01/14)

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

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

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

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

102 Appendix C Evidence of Identity

(Eff. 01/01/14)

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

102 Appendix D Alien Status Chart

(Rev. 03/01/24)

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

| MEDICAID TREATMENT OF NON-CITIZENS | | |
| --- | --- | --- |
| VERIFICATION DOCUMENTATION | ALIEN STATUS | ELIGIBILITY STATUS |
| * **I-551** (Alien Registration Receipt Card) commonly referred to as the “green card” * **Foreign passport** stamped with an un-expired temporary I-551 stamp * **I-94** annotated stamped with a temporary I-551 stamp (for recent arrivals or aliens who have applied for a replacement I-551) | LAWFULLY ADMITTED  FOR PERMANENT  RESIDENCE (LPR) | Eligible for full Medicaid benefits if entered the US before August 22, 1996.  If admitted August 22, 1996, or after, ineligible for full Medicaid benefits for 5 years from the date they entered the country or obtained qualified status, whichever is later. Eligible for emergency services only during the disqualification period.  Eligible for full Medicaid benefits after the 5-year disqualification period **IF** they have 40 quarters of income that required payment of Social Security taxes. |
| * **I-94** stamped showing admission under section 207 of the INA and date of entry to the United States * **I-688B** (Employment Authorization Card) annotated 274a.12(a)(3) * **I-766** (Employment Authorization Document) annotated “A3” * **I-571** (Refugee Travel Document) **I-551** (Alien Registration Receipt Card) with a status code of RE6, RE7, RE8, or RE9. | **REFUGEE** | 5-Year Disqualification period does not apply.  Can qualify for full benefits up to 7 years if meets all requirements for any Medicaid category.  After 7 years, must meet citizenship requirements (40 work quarters) to establish eligibility.  If they do not meet Medicaid categorical requirements, then they are eligible for full benefits for 12 months beginning with the month of entry. (Refer to MPPM Chapter 503) |
| * **I-94** stamped showing grant of asylum under section 208 of the INA and date of entry * **A grant letter** from the Asylum Office of the USCIS * **I-688B** (Employment Authorization Card) annotated “274a.12(a)(5)” * **I-766** (Employment Authorization Document) annotated “A5” * **Court order** of an immigration judge showing asylum granted under section 208 of the INA | **ASYLEE** | 5-Year disqualification period does not apply.  Can qualify for full benefits up to 7 years if meets all requirements for any Medicaid category.  After 7 years, must meet citizenship requirements (40 work quarters) to establish eligibility.  If they do not meet categorical requirements, then they are eligible for full benefits for 12 months beginning with the month of entry. (Refer to MPPM Chapter 503) |
| * **Order** of an immigration judge showing deportation withheld under section 243(h) of INA as in effect prior to April 1, 1997, or removal withheld under Sec. 241(b)(3) of the INA and date of grant * **I-688B** (Employment Authorization Card) annotated 274a.12(a)910) * **I-766** (Employment Authorization Document) annotated “A10” | **DEPORTATION**  **WITHHELD** | 5-Year disqualification period does not apply.  Eligible for any Medicaid category if they meet all other eligibility criteria. |
| * **I-94** annotated with stamp showing grant of parole under 212(d)(5) and a date showing granting of parole for at least one year * **I-94** or **Foreign Passpor**t with a parole stamp that has the Code of Admission of:   + **NHP** (Nicaraguan Family Reunification)   + **RCO** (Columbia Family Reunification)   + **RED** (Ecuadorian Family Reunification)   + **RGT** (Guatemala Reunification)   + **RHN** (Honduras Family Reunification)   + **RSV** (El Salvador Family Reunification)   + **VHP** (Venezuelan Family Reunification) | **PAROLEE**  (Refer to **IRAQI /AFGHAN SPECIAL IMMIGRANTS** for Special Immigrant Parolees with an I-94 form showing SQ or SI Parole)  (Refer to **UKRAINIAN HUMANITARIAN PAROLEE**) | Eligible for full Medicaid benefits if entered the US prior to August 22, 1996  If admitted August 22, 1996, or after, ineligible for full Medicaid benefits for 5 years from the date they entered the country or obtained qualified status, whichever is later. Eligible for emergency services only during the disqualification period  Eligible for full Medicaid benefits after the 5-year disqualification period **IF** they have 40 quarters of income that required payment of Social Security taxes. |
| * **I-94** with stamp showing admission under 203(a)(7) of the INA, refugee-conditional entry * **I-688B** (Employment Authorization Card) annotated 274a.12(a)(3) * **I-766** (Employment Authorization Document) annotated “A3” | **CONDITIONAL ENTRANT** | Eligible for full Medicaid benefits if entered the US prior to August 22, 1996  If admitted August 22, 1996, or after, ineligible for full Medicaid benefits for 5 years from the date they entered the country or obtained qualified status, whichever is later. Eligible for emergency services only during the disqualification period.  Eligible for full Medicaid benefits after the 5-year disqualification period **IF** they have 40 quarters of income that required payment of Social Security taxes. |
| * **Green Form DD-2** marked “ACTIVE”   OR   * **Current orders** showing the individual is on full-time duty in the US Army, Navy, Air Force, Marine Corps, or Coast Guard (Reserves are not considered active duty.) | ACTIVE-DUTY MILITARY  **Includes spouse and unmarried dependent children under 21** | 5-Year disqualification period does not apply.  Eligible for any Medicaid category if they meet all other eligibility criteria. |
| * **DD-214** indicating honorable discharge,   OR   * **Discharge papers** indicating honorable discharge | VETERAN **Includes spouse and unmarried dependent children under 21** | Eligible  5-Year disqualification period does not apply. |
| * **I-551** (Alien Registration Receipt Card) with the code CU6, CU7, or CH6 * **Foreign passport** stamped with an unexpired temporary I-551 stamp with the code CU6 or CU7, CHP, HHP, RCU, or RHT * **I-94** stamped with an unexpired temporary I-551 stamp with the code CU6 or CU7 * **I-94** with stamp showing parole as “Cuban/Haitian Entrant” under Section 212(d)(5) or the INA. * **I-766** Employment Authorization Document with a C11 category | **CUBAN/HAITIAN ENTRANT** | 5-Year disqualification period does not apply.  Can qualify for full benefits up to 7 years if meets all requirements for any Medicaid category.  After 7 years, must meet citizenship requirements (40 work quarters) to establish eligibility.  If they do not meet categorical requirements, then they are eligible for full benefits for 12 months beginning with the month of entry. (Refer to MPPM Chapter 503) |
| * **I-551** with code AM6, AM7, or AM8 * **Foreign passport** stamped with an unexpired temporary I-551 stamp with the code AM1, AM2, or AM3 * **I-94** stamped with an unexpired temporary I-551 stamp with the code AM1, AM2, or AM3 | **AMERASIAN IMMIGRANTS** | 5-Year disqualification period does not apply.  Can qualify for full benefits up to 7 years if meets all requirements for any Medicaid category.  After 7 years, must meet citizenship requirements (40 work quarters) to establish eligibility.  If they do not meet categorical requirements, then they are eligible for full benefits for 12 months beginning with the month of entry. (Refer to MPPM Chapter 503) |
| * Foreign passport with CBP PAROLED stamp and/or parole COA notation * EAD with C11 parolee category * Electronic Form I-94 with OAR, PAR, or DT COA (may be able to obtain print copy from CBP I-94 website) | **NON-SPECIAL IMMIGRANT AFGHAN PAROLEE (Non-SI Parolee)**  **Includes spouse and unmarried children under 21 years of Age** | 5-year disqualification period does not apply.  Afghan nationals who enter the United States as parolees on or between July 31, 2021, and September 30, 2023, are eligible for Medicaid or CHIP to the same extent as refugees, without a five-year waiting period.  Afghan nationals who are paroled into the U.S. after September 30, 2023, and are the spouse, child, parent, or legal guardian of a parolee described above, will also be eligible for Medicaid and CHIP to the same extent as refugees, without a five-year waiting period.  If they do not meet Medicaid categorical requirements, then they are eligible for full benefits for 12 months beginning with the month of entry. (Refer to MPPM Chapter 503)  Note: If an Afghan’s parole has been terminated and does not have another satisfactory immigration status, the individual would no longer be eligible for full Medicaid benefits. Afghans whose parole has terminated and meet all other eligibility requirements for Medicaid, except for satisfactory immigration status, are eligible for Emergency Medicaid. |
| * **Iraqi or Afghan passport** with an immigrant visa stamp noting that the individual has been admitted under IV (Immigrant Visa)   **Category SI1 or SQ1**-Principal Applicant Iraqi/Afghan Special Immigrant  **Category SI2 or SQ2**-Spouse of Principal Applicant Iraqi/Afghan Special Immigrant  **Category SI3 or SQ3**-Unmarried child under 21 years of age of Iraqi/Afghan Special Immigrant   * **DHS Form I-551 (green card) showing Iraqi or Afghan nationality (or Iraqi or Afghan passport), with an IV (immigrant visa) code of:**   **SI6 or SQ6-** Principal Applicant Iraqi/Afghan Special Immigrant  **SI7 or SQ7**- Spouse of Principal Applicant Iraqi/Afghan Special Immigrant  **SI9 or SQ9**- Unmarried child under 21 years of age of Iraqi/Afghan Special Immigrant   * **Foreign-issued passports** with a DHS or CBP admission stamp admitting them with:   + **CQ1** – Principal Afghan applicant   + **CQ2** – Spouse of Principal Afghan Applicant (CQ1)   + **CQ3** – Child of Principal Afghan Applicant (CQ1) * **I-94 form showing SQ or SI Parole (per section 602(B)(1) AAPA/Sec 1059(a) NDAA 2006) with a SQ4 or SQ5 Class of Admission code** | **IRAQI /AFGHAN SPECIAL IMMIGRANTS**  **Includes spouse and unmarried children under 21 years of Age** | 5-year disqualification period does not apply.  Afghan nationals who enter the United States as parolees on or between July 31, 2021, and September 30, 2023, are eligible for Medicaid or CHIP to the same extent as refugees, without a five-year waiting period.  Afghan nationals who are paroled into the U.S. after September 30, 2023, and are the spouse, child, parent, or legal guardian of a parolee described above, will also be eligible for Medicaid and CHIP to the same extent as refugees, without a five-year waiting period.  If they do not meet Medicaid categorical requirements, then they are eligible for full benefits for 12 months beginning with the month of entry. (Refer to MPPM Chapter 503)  **Note**  The date of eligibility for benefits of the Iraqi/Afghan Special Immigrant is the date the immigrant was admitted to the U.S. as an Iraqi or Afghan Special Immigrant, not the date of application for benefits and services.  **Note**  If an Afghan’s parole has been terminated and does not have another satisfactory immigration status, the individual would no longer be eligible for full Medicaid benefits. Afghans whose parole has terminated and meet all other eligibility requirements for Medicaid, except for satisfactory immigration status, are eligible for Emergency Medicaid. |
| * **Form I-94** noting humanitarian parole (per INA section 212(d)(5) or 8 U.S.C. §1182(d)(5)) * **Foreign passport** with DHS/CBP admission stamp noting “DT” * **Foreign passport** with DHS/CBP admission stamp noting Uniting for Ukraine or “U4U” * **Foreign passport** with DHS/CBP admission stamp noting Ukrainian Humanitarian Parolee or “UHP” * **Form I-765** Employment Authorization Document (EAD) receipt notice with code C11 * **Form I-766** Employment Authorization Document (EAD) with the code C11 | **UKRAINIAN HUMANITARIAN PAROLEE** | Ukrainian nationals who enter the United States as parolees on or between February 24, 2022, and September 30, 2023, are eligible for Medicaid or CHIP to the same extent as refugees, without a five-year waiting period, if they meet other eligibility requirements (e.g., income, state residency) for coverage.  Eligibility for full benefits can begin no earlier than **June 1, 2022.** Prior to this date, eligibility is limited to Emergency Services Only.  Five-year disqualification period does not apply.  These Ukrainian parolees are considered “qualified non-citizens” for purposes of Medicaid and CHIP eligibility since they are eligible for the same benefits as refugees, without a five-year waiting period.  Ukrainian nationals who are paroled into the U.S. after September 30, 2023, and are the spouse or child of a parolee described above, or who is the parent, legal guardian, or primary caregiver of a parolee described above who is determined to be an unaccompanied child will also be eligible for Medicaid and CHIP to the same extent as refugees, without a five-year waiting period.  Eligible parolees can also include individuals other than Ukrainian nationals (i.e., individuals who are stateless or have another nationality) who last habitually resided in Ukraine.  Ukrainian Parolees who are ineligible for Medicaid or CHIP are also eligible for Refugee Medical Assistance (RMA) for up to 12 months following the date of entry to the same extent as refugees if they meet the RMA income and eligibility requirements. RMA benefits generally mirror Medicaid coverage and are administered through state Medicaid programs in nearly all states. |
| * **I-797** indicating filing under one of the provisions listed below and approval of the petition or a finding that a prima facie case has been established. * **Case Type: I-130** petition approved * **Case Type: I-360** petition approved * **I-551** with one of the following COA codes stamped on the lower left side of the back of a pink card demonstrates approval of a petition under C.3.j.(1)3. Above: IB1-IB3, IB6-IB8, B11, B12, B16, B17, B20-B29, B31-B33, B36-B38, BX1-BX3, or BX6-BX8 * **Order** from an immigration judge (EOIR) or the Board of Immigration Appeals granting suspension of deportation or cancellation of removal under VAWA (EOIR) Form 42B or an order from an immigration judge (EOIR) or Board of Immigration | **BATTERED ALIEN**  **Includes battered alien’s child and parent of a battered alien child** | Eligible if entered the US prior to August 22, 1996  If admitted August 22, 1996, or after, ineligible for 5 years from the date they entered the country or obtained qualified status, whichever is later.  Eligible after the 5-year disqualification period **IF** they have 40 quarters of income that required payment of Social Security taxes. |
| * **I-94** arrival/departure record, * **I-94** arrival/departure record and foreign passport, or * **I-766** Employment Authorization Document. | **Compact of Free Association (COFA) Migrants**  COFA is an agreement between the United States and the three Pacific Island sovereign states of Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau—known as Freely Associated States. | **For coverage in December 2020 or after:**  5-Year disqualification period does not apply.  Eligible for any Medicaid category if they meet all other eligibility criteria.  **For coverage before December 2020:**   * Pregnant women and children are eligible for full Medicaid coverage, * Medicaid coverage for other COFA migrants is limited to Emergency Services only |

| **ALIEN GROUPS LISTED BELOW ARE INELIGIBLE FOR ANY SERVICES**  **(Including Emergency Services)** | |
| --- | --- |
| Foreign Students  Visitors  Tourists  Foreign government representatives on official business and their families and servants  Crewmen on shore leave  International organization representatives and their families and servants  Temporary specialists (individuals allowed entry temporarily for employment purposes)  Members of the foreign press, radio, film, etc., and their families  Short-term parolees | Visa, Passports or Form I-766  OR  Form I-94, Arrival/Departure Record annotated with A to M  OR  Form I-688, Temporary Resident Card annotated with Section 210 or 245A  OR  Form I-688 A and B, Employment Authorization Card  OR  Form I-185, Canadian Border Crossing Card  OR  Form I-186, Mexican Border Crossing Card  OR  Form SW 434, Mexican Border Visitor’s Permit  OR  Form I-95-A, Crewman’s Landing Permit |

CHAPTER 103—Program Financial Limits

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103.01 Family Planning (FP) & Pregnant Women and Infants (PW)

(Eff. 03/01/24)

| Family Size | 194% of Federal Poverty Level | | 194% + 5% of  Federal Poverty Level | |
| --- | --- | --- | --- | --- |
| Monthly Income | Annual Income | Monthly Income | Annual Income |
| 1 | 2,434.70 | 29,216.40 | 2,497.45 | 29,969.40 |
| 2 | 3,304.46 | 39,653.60 | 3,389.63 | 40,675.60 |
| 3 | 4,174.23 | 50,090.80 | 4,281.81 | 51,381.80 |
| 4 | 5,044.00 | 60,528.00 | 5,174.00 | 62,088.00 |
| 5 | 5,913.76 | 70,965.20 | 6,066.18 | 72,794.20 |
| 6 | 6,783.53 | 81,402.40 | 6,958.36 | 83,500.40 |
| 7 | 7,653.30 | 91,839.60 | 7,850.55 | 94,206.60 |
| 8 | 8,523.06 | 102,276.80 | 8,742.73 | 104,912.80 |
| Each Additional  Member | 869.76 | 10,437.20 | 892.18 | 10,706.20 |

103.02 Partners for Healthy Children

(Eff. 03/01/24)

| Family Size | 208% of Federal Poverty Level | | 208% + 5% of  Federal Poverty Level | |
| --- | --- | --- | --- | --- |
| Monthly Income | Annual Income | Monthly Income | Annual Income |
| 1 | 2,610.40 | 31,324.80 | 2,673.15 | 32,077.80 |
| 2 | 3,542.93 | 42,515.20 | 3,628.10 | 43,537.20 |
| 3 | 4,475.46 | 53,705.60 | 4,583.05 | 54,996.60 |
| 4 | 5,408.00 | 64,896.00 | 5,538.00 | 66,456.00 |
| 5 | 6,340.53 | 76,086.40 | 6,492.95 | 77,915.40 |
| 6 | 7,273.06 | 87,276.80 | 7,447.90 | 89,374.80 |
| 7 | 8,205.60 | 98,467.20 | 8,402.85 | 100,834.20 |
| 8 | 9,138.13 | 109,657.60 | 9,357.80 | 112,293.60 |
| Each Additional  Member | 932.53 | 11,190.40 | 954.95 | 11,459.40 |

103.03 Parent/Caretaker Relative (PCR)   
*(formerly Low-Income Families – LIF)*

(Eff. 03/01/24)

| Family Size | 62% of Federal Poverty Level | | 62% + 5% of  Federal Poverty Level | |
| --- | --- | --- | --- | --- |
| Monthly Income | Annual Income | Monthly Income | Annual Income |
| 1 | 778.10 | 9,337.20 | 840.85 | 10,090.20 |
| 2 | 1,056.06 | 12,672.80 | 1,141.23 | 13,694.80 |
| 3 | 1,334.03 | 16,008.40 | 1,441.61 | 17,299.40 |
| 4 | 1,612.00 | 19,344.00 | 1,742.00 | 20,904.00 |
| 5 | 1,889.96 | 22,679.60 | 2,042.38 | 24,508.60 |
| 6 | 2,167.93 | 26,015.20 | 2,342.76 | 28,113.20 |
| 7 | 2,445.90 | 29,350.80 | 2,643.15 | 31,717.80 |
| 8 | 2,723.86 | 32,686.40 | 2,943.53 | 35,322.40 |
| Each Additional  Member | 277.96 | 3,335.60 | 300.38 | 3,604.60 |

103.03A Transitional Medicaid (TMA)

(Eff. 03/01/24)

| Family Size | 185% of Federal Poverty Level | |
| --- | --- | --- |
| Monthly Income | Annual Income |
| 1 | 2,321.75 | 27,861.00 |
| 2 | 3,151.16 | 37,814.00 |
| 3 | 3,980.58 | 47,767.00 |
| 4 | 4,810.00 | 57,720.00 |
| 5 | 5,639.41 | 67,673.00 |
| 6 | 6,468.83 | 77,626.00 |
| 7 | 7,298.25 | 87,579.00 |
| 8 | 8,127.66 | 97,532.00 |
| Each Additional Member | 829.41 | 9,953.00 |

103.04 Regular Foster Care – RFC  
Subsidized Adoption

(Eff. 03/01/24)

|  | Monthly Income Limit |
| --- | --- |
| March 2024 | $ 840.85 |

Historic Income Limit

| Effective Month | Monthly Income Limit |
| --- | --- |
| March 2023 | $ 814.05 |
| March 2022 | $ 758.77 |
| March 2021 | $ 719.13 |
| March 2020 | $ 712.43 |
| March 2019 | $ 697.35 |
| March 2018 | $ 677.81 |
| March 2017 | $623.10 |
| March 2016 | $ 613.80 |
| March 2015 | $ 608.12 |
| March 2014 | $ 602.95 |
| January 2014 | $ 593.65 |
| October 2013 | $ 479 |
| October 2012 | $ 466 |
| November 2011 | $ 454 |
| November 2009 | $ 452 |
| October 2008 | $ 434 |
| October 2007 | $ 425 |
| October 2006 | $ 408 |
| October 2005 | $ 398 |
| October 2004 | $ 387 |

103.05 Aged, Blind and Disabled (ABD),   
Qualified Medicare Beneficiary (QMB),  
Specified Low Income Beneficiaries (SLMB),  
Qualifying Individual (QI)

(Eff. 03/01/24)

| Family Size | ABD, QMB  100% | | SLMB  120% | | QI  135% | |
| --- | --- | --- | --- | --- | --- | --- |
|  | Monthly | Annual | Monthly | Annual | Monthly | Annual |
| 1 (Individual) | 1,255 | 15,060 | 1,506 | 18,072 | 1,695 | 20,331 |
| 2 (Couple) | 1,704 | 20,440 | 2,044 | 24,528 | 2,300 | 27,594 |

103.06 Federal Poverty Level Chart

(100% of Federal Poverty Level. Used to calculate eligibility limits for poverty-based programs)

(Eff. 03/01/24)

| Family Size | Annual |
| --- | --- |
| 1 | 15,060.00 |
| 2 | 20,440.00 |
| 3 | 25,820.00 |
| 4 | 31,200.00 |
| 5 | 36,580.00 |
| 6 | 41,960.00 |
| 7 | 47,340.00 |
| 8 | 52,720.00 |
| Each Additional Person | 5,380.00 |

103.07 General Hospital (GH),   
Nursing Home (NH),   
Katie Beckett (TEFRA),   
Home and Community Based Services (HCBS)

(300% of Federal Benefit Rate)

(Eff. 01/01/24)

| Family Size | Monthly Income Limit |
| --- | --- |
| Individual | $2,829.00 |
| Spousal Allocation (NH and HCBS only) | $3,853.50 |
| Medicare Part D Premium Benchmark for South Carolina | $45.73 |

103.07A Current Average Monthly Private Pay Rate

(Eff. 01/01/24)

|  |  |
| --- | --- |
| Current Average Monthly Private Pay Rate | $9,243.32 ($303.89 daily) |

103.08 Breast and Cervical Cancer Program (BCCP)  
Qualified Disabled Working Individuals (QDWI)

(200% of Federal Poverty Level)

(Eff. 03/01/24)

| FAMILY SIZE | MONTHLY INCOME | ANNUAL INCOME |
| --- | --- | --- |
| 1 | 2,510.00 | 30,120.00 |
| 2 | 3,407.00 | 40,880.00 |
| 3 | 4,304.00 | 51,640.00 |
| 4 | 5,200.00 | 62,400.00 |
| 5 | 6,097.00 | 73,160.00 |
| 6 | 6,994.00 | 83,920.00 |
| 7 | 7,890.00 | 94,680.00 |
| 8 | 8,787.00 | 105,440.00 |
| Each Additional Member | 897.00 | 10,760.00 |

For family sizes over 8, add the amount shown for each additional person to income limit for 8.

103.09 Working Disabled – WD

(250% of Federal Poverty Level)

(Eff. 03/01/24)

| Family Size | Monthly Income | Annual Income |
| --- | --- | --- |
| 1 | 3,138.00 | 37,650.00 |
| 2 | 4,259.00 | 51,100.00 |
| 3 | 5,380.00 | 64,550.00 |
| 4 | 6,500.00 | 78,000.00 |
| 5 | 7,621.00 | 91,450.00 |
| 6 | 8,742.00 | 104,900.00 |
| 7 | 9,863.00 | 118,350.00 |
| 8 | 10,984.00 | 131,800.00 |
| Each Additional Member | 1,121.00 | 13,450.00 |

If applicant’s household meets income requirement of 250% FPL, it must also be determined whether the applicant has unearned income equal to or less than 100% FPL.

|  |  |
| --- | --- |
| Applicant’s Unearned Income | |
| Monthly Income | Annual Income |
| $1,255 | $15,060 |

103.10 Optional State Supplementation – OSS

(Eff. 01/01/24)

|  |
| --- |
| **Monthly Net Income Limit:** $1,753.00  **Personal Needs Allowance:** $81.00 (Receives SSI **only**)  $101.00 (Receives any income from other sources) |

103.11 Substantial Gainful Activity – SGA

(Eff. 01/01/24)

|  |  |
| --- | --- |
| Blind Individual | $2,590 |
| Non–Blind Individual | $1,550 |

103.12 Student Earned Income Exclusion

(Eff. 01/01/24)

|  |  |
| --- | --- |
| Per Month Limit | $2,290 |
| Maximum Annual Limit | $9,230 |

103.13 Tuberculosis Services – TB

*(133% of Federal Poverty Level)*

*The TB Only Program is not a separate Medicaid eligibility category   
but is an additional benefit added to an existing eligibility category.*

(Eff. 03/01/24)

| Family Size | Monthly Income | Annual Income |
| --- | --- | --- |
| 1 | 1,669.15 | 20,029.80 |
| 2 | 2,265.43 | 27,185.20 |
| 3 | 2,861.71 | 34,340.60 |
| 4 | 3,458.00 | 41,496.00 |
| 5 | 4,054.28 | 48,651.40 |
| 6 | 4,650.56 | 55,806.80 |
| 7 | 5,246.85 | 62,962.20 |
| 8 | 5,843.13 | 70,117.60 |
| Each Additional Member | 596.28 | 7,155.40 |

For family sizes over 8, add the amount shown for each additional person to income limit for 8.

103.14 Program Resource Limits

(Eff. 01/01/24)

[CFR §435.603](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-G/section-435.603)

| Program | Individual Limit | Couple Limit |
| --- | --- | --- |
| Chapter 303  ABD, QMB, SLMB | $9,430 | $14,130 |
| Chapter 304  Nursing Home, HCBS, General Hospital | $2,000  Home Equity Limit: $713,000 | $66,480  Spousal share for  community spouse.  Refer to MPPM 304.14 |
| Chapter 305  TEFRA | $2,000 | N/A |
| Chapter 307  Working Disabled | $9,430 | N/A |
| Chapter 308  Qualified Disabled Working Individual | $4,000 | $6,000 |
| Chapter 403  Optional State Supplementation | $2,000 | N/A |
| Chapter 404  Pass–along | $2,000 | $3,000 |
| Chapter 405 Retroactive SSI | $2,000 | $3,000 |

103.15 Federal Income Tax Filing Threshold for Dependents

(Eff. 01/01/24)

| Tax Year | Yearly Taxable Income |
| --- | --- |
| 2023 | $13,850 |
| 2022 | $12,950 |
| 2021 | $12,550 |
| 2020 | $12,400 |
| 2019 | $12,200 |
| 2018 | $10,400 |
| 2017 | $10,400 |

103.16 Social Security Cost–of–Living Adjustment – COLA and Supplemental Security Income – SSI Federal Benefit Rate

(Eff. 01/01/24)

| **Effective Date** | **Cost of Living Adjustment (COLA)** | **Individual** | | | **Couple** | | | **Child Allocation** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Federal Benefit Rate (FBR) in Own Household** | **Value of the 1/3 Reduction (VTR)** | **Presumed Maximum Value (PMV)** | **Federal Benefit Rate (FBR) in Own Household** | **Value of the 1/3 Reduction (VTR)** | **Presumed Maximum Value (PMV)** |
| Jan-2024 | 3.2% | 943.00 | 314.33 | 334.33 | 1,415.00 | 471.67 | 491.67 | 472.00 |
| Jan-2023 | 8.7% | 914.00 | 304.67 | 324.67 | 1,371.00 | 457.00 | 477.00 | 457.00 |
| Jan-2022 | 5.9% | 841.00 | 280.33 | 300.33 | 1,261.00 | 420.33 | 440.33 | 420.00 |
| Jan-2021 | 1.3% | 794.00 | 264.66 | 284.66 | 1,191.00 | 397.00 | 417.00 | 397.00 |
| Jan-2020 | 1.6% | 783.00 | 261.00 | 281.00 | 1,175.00 | 391.66 | 411.66 | 392.00 |
| Jan-2019 | 2.8% | 771.00 | 257.00 | 277.00 | 1,157.00 | 385.66 | 405.66 | 386.00 |
| Jan-2018 | 2.0% | 750.00 | 250.00 | 270.00 | 1,125.00 | 375.00 | 395.00 | 375.00 |
| Jan-2017 | 0.3% | 735.00 | 245.00 | 265.00 | 1,103.00 | 367.66 | 387.66 | 368.00 |
| Jan-2015 | 1.7% | 733.00 | 244.33 | 264.33 | 1,100.00 | 366.66 | 386.66 | 367.00 |
| Jan-2014 | 1.5% | 721.00 | 240.33 | 260.33 | 1,082.00 | 360.66 | 380.66 | 361.00 |
| Jan-2013 | 1.7% | 710.00 | 236.66 | 256.66 | 1,066.00 | 355.33 | 375.33 | 355.00 |
| Jan-2012 | 3.6% | 698.00 | 232.66 | 252.66 | 1,048.00 | 349.33 | 369.33 | 350.00 |
| Jan-2009 | 5.8% | 674.00 | 224.66 | 244.66 | 1,011.00 | 337.00 | 357.00 | 337.00 |
| Jan-2008 | 2.3% | 637.00 | 212.33 | 232.33 | 956.00 | 318.66 | 338.66 | 319.00 |
| Jan-2007 | 3.3% | 623.00 | 207.66 | 227.66 | 934.00 | 311.33 | 331.33 | 311.00 |
| Jan-2006 | 4.1% | 603.00 | 201.00 | 221.00 | 904.00 | 301.33 | 321.33 | 301.00 |
| Jan-2005 | 2.7% | 579.00 | 193.00 | 213.00 | 869.00 | 290.00 | 310.00 | 290.00 |
| Jan-2004 | 2.1% | 564.00 | 188.00 | 208.00 | 846.00 | 282.00 | 302.00 | 282.00 |
| Jan-2003 | 1.4% | 552.00 | 184.00 | 204.00 | 829.00 | 276.33 | 296.33 | 277.00 |
| Jan-2002 | 2.6% | 545.00 | 181.66 | 201.66 | 817.00 | 272.33 | 292.33 | 272.00 |

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104 Appendix A Acronyms

(Rev. 11/01/18)

| Acronym | Definition |
| --- | --- |
| ABD | Aged, Blind and Disabled |
| ABD-NH | Aged, Blind and Disabled – Nursing Home |
| ACD | Anticipated Closure Date |
| ACE | Assistance for Coaching Excellence |
| AIDS | Acquired Immune Deficiency Syndrome |
| ALJ | Administrative Law Judge |
| AR | Authorized Representative |
| AV | Actual Value |
| BCCP | Breast and Cervical Cancer Program |
| BCCPTA | Breast and Cervical Cancer Prevention and Treatment Act of 2000 |
| BCIS | Bureau of Citizenship and Immigration Services |
| BCN | Best Chance Network |
| BEERS | Beneficiary Earnings Exchange Record System |
| BENDEX | Beneficiary Earnings Data Exchange |
| BEA | Bureau of Eligibility Administration |
| BG | Budget Group |
| BGP | Budget Group Period |
| BIA | Bureau of Indian Affairs |
| BL | Black Lung |
| BUS | Department of Beneficiary User Services |
| BWE | Blind Work Experience |
| CCDBGA | Child Care and Development Block Grant Act |
| CCEDC | Continuum of Care for Emotionally Disturbed Children |
| CD | Certificate of Deposit |
| CEP | Central Eligibility Processing |
| CHIP | Children’s Health Insurance Program |
| CI | Countable Income |
| CIU | Central Institutional Unit |
| CLTC | Community Long-Term Care |
| CMA | Clothing Maintenance Allowance |
| CMS | Centers for Medicare and Medicaid Services |
| CMV | Current Market Value |
| CNCS | Corporation for National and Community Services |
| COBRA | Consolidated Omnibus Budget Reconciliation Act (1985) |
| COLA | Cost-of-Living Adjustment |
| CRCF | Community Residential Care Facilities |
| CSD | Client Status Document |
| CSV | Cash Surrender Value |
| CV | Cash Value |
| DAA | Drug Addiction or Alcoholism |
| DAC | Disabled Adult Children |
| DB | Deemed Baby |
| DCEP | Division of Central Eligibility Processing |
| DDD | Department of Disability Determinations |
| DDSN | Department of Disabilities and Special Needs |
| DHEC | Department of Health and Environmental Control |
| DHHS | Department of Health and Human Services |
| DEW | Department of Employment and Workforce |
| DJJ | Department of Juvenile Justice |
| DMH | Department of Mental Health |
| DOB | Date of Birth |
| DOD | Date of Death |
| DOD | Department of Defense |
| DOI | Department of Insurance |
| DOL | Department of Labor |
| DSS | Department of Social Services |
| DWW | Disabled Widows/Widowers |
| EFT | Electronic Funds Transfer |
| EITC | Earned Income Tax Credit |
| EODDA | Employment Opportunities for Disabled Americans Act |
| EPSDT | Early Periodic Screening, Diagnosis and Treatment Program |
| EQA | Eligibility Quality Assurance |
| ES | Essential Spouse |
| ESC | Employment Security Commission |
| EW | Eligibility Specialist |
| EWW | Early Widows/Widowers |
| FAD | Final Administrative Decision |
| FBR | Federal Benefit Rate |
| FEMA | Federal Emergency Management Agency |
| FERS | Federal Employee Retirement System |
| FFC | Former Foster Care |
| FFM | Federally Facilitated Marketplace |
| FFP | Federal Financial Participation |
| FI | Family Independence |
| FMSHA | Federal Mine Safety and Health Act |
| FMV | Fair Market Value |
| FP | Family Planning |
| FPL | Federal Poverty Level |
| FV | Face Value |
| GED | General Educational Development |
| GH | General Hospital |
| GIT | Gross Income Test |
| HASCI | Head and Spinal Cord Injured Waiver |
| HCBS | Home and Community Based Services |
| HEA | Home Energy Assistance |
| HEAP | Home Energy Assistance Payment |
| HIPAA | Health Insurance Portability and Accountability Act |
| HIPP | Health Insurance Premium Payment Program |
| HIV | Human Immunodeficiency Virus |
| HUD | Office of Housing and Urban Development |
| IBON | Income Based on Need |
| ICAMA | Interstate Compact on Adoption and Medical Assistance |
| ICF | Intermediate Care Facility |
| ICF/ID | Intermediate Care Facility/Intellectual Disabilities |
| ID | Identification |
| ID/RD | Intellectual Disabilities and Related Disabilities |
| IDT | Interdisciplinary Team |
| IEVS | Income Eligibility and Verification System |
| IHSS | In-Home Supportive Services |
| IMD | Institution for Mental Disease |
| INS | Immigration and Naturalization Services |
| IRA | Individual Retirement Account |
| IRS | Internal Revenue Service |
| IRWE | Impairment-Related Work Experience |
| ISM | In-Kind Support and Maintenance |
| IT | Income Trust |
| IV-E | Title IV-E (refers to Foster Care or Adoptions) |
| IVRS | Interactive Voice Response System |
| JTPA | Job Training Partnership Act |
| KB | Katie Beckett |
| LE | Life Estate |
| LEP | Limited English Proficiency |
| LEP | Local Eligibility Processing |
| LIF | Low Income Families |
| LOC | Level of Care |
| LPR | Lawful Permanent Resident |
| MAGI | Modified Adjusted Gross Income |
| MAO | Medical Assistance Only |
| MAO-NH | Medicaid Assistance Only-Nursing Home |
| MCCA | Medicare Catastrophic Coverage Act of 1988 |
| MEDS | Medicaid Eligibility Determination System |
| MIVS | Medical Insurance Verification Services |
| MIW | Minimum Income Level Widows of Veterans |
| MMIS | Medicaid Management Information System |
| MOD | Modify (MEDS) |
| MPPM | Medicaid Policy and Procedures Manual |
| MR/RD | Refer to ID/RD |
| NA | Not Applicable |
| NADA | National Automobile Dealers’ Association |
| NBCCEDP | National Breast & Cervical Cancer Early Detection Program |
| NCCC | National Civilian Community Corps |
| NEN | New Eyes for the Needy Program |
| NESE | Net Earnings from Self-Employment |
| NF | Nursing Facility |
| NH | Nursing Home |
| NIT | Net Income Test |
| OBRA | Omnibus Budget Reconciliation Act |
| OCSE | Office of Child Support Enforcement |
| OCWI | Optional Coverage for (Pregnant) Women and Infants |
| OPM | Office of Personnel Management |
| OSS | Optional State Supplementation |
| PAC | Pass-Along Children |
| PASALG | Pass Along |
| PASS | Plan for Achieving Self-Support (“Pickle”) |
| PCAT | Payment Category |
| PCR | Parent/Caretaker Relative |
| PCS | Person Composite Service |
| PHC | Partners for Healthy Children |
| PMV | Presumed Maximum Value |
| POA | Power of Attorney |
| POMS | Program Operations Manual System |
| POS | Point of Sale device |
| PPED | Protected Period End Date |
| PRWOA | Personal Responsibility and Work Opportunity Act |
| PSC | Palmetto Senior Care |
| PW | Pregnant Women |
| QC | Quality Control |
| QDWI | Qualified Disabled and Working Individuals |
| QMB | Qualified Medicare Beneficiaries |
| RAP | Refugee Assistance Program |
| RECTF | Radiation Exposure Compensation Trust Fund |
| RFC | Regular Foster Care |
| RHB | Retired Health Benefit |
| RR | Responsible Relative |
| RRB | Railroad Retirement Board |
| RSDI | Retirement, Survivors and Disability Insurance |
| RSFPP | Retired Serviceman’s Family Protection Plan |
| RSVP | Retired Senior Volunteer Program |
| SABON | State Assistance Based on Need |
| SAVE | Systematic Alien Verification for Entitlement |
| SC | South Carolina |
| SC DHHS | South Carolina Department of Health and Human Services |
| SCF | Skilled Care Facility |
| SC MPPM | South Carolina Medicaid Policy and Procedures Manual |
| SCRS | South Carolina Retirement System |
| SCVRD | South Carolina Vocational Rehabilitation Department |
| SDE | State Department of Education |
| SDX | State Data Exchange |
| SGA | Substantial Gainful Activity |
| SLMB | Specified Low-Income Medicare Beneficiaries |
| SMA | Support and Maintenance Assistance |
| SOP | Standard of Promptness |
| SSA | Social Security Administration |
| SSI | Supplemental Security Income |
| SSI-NH | Supplemental Security Income-Nursing Home |
| SSI-OSS | Supplemental Security Income-Optional State Supplementation |
| SSN | Social Security Number |
| SVES | State Verification and Exchange System |
| TANF | Temporary Assistance for Needy Families |
| TEFRA | Tax Equity and Fiscal Responsibility Act (Katie Beckett children) |
| TMA | Transitional/Extended Medicaid |
| TPL | Third Party Liability |
| UC | Unemployment Compensation |
| UNC | Unemployment Compensation |
| USA | United States of America |
| UYA | University Year of Action |
| VA | Veterans Administration |
| VENT | Ventilator Waiver |
| VISTA | Volunteers in Service to America |
| VR | Vocational Rehabilitation |
| VRDDS | Vocational Rehabilitation Disability Determination Service |
| VTR | Value of 1/3 Reduction |
| WC | Specialists’ Compensation |
| WD | Working Disabled |
| WIC | Women, Infants and Children Program (DHEC) |
| WS | Waiver Services |
| WTPY | Wire Third Party |

104 Appendix B Basic Application Process

(Eff. 10/01/13)

[CFR §435.907](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-J/subject-group-ECFR9b4bff9082050a1/section-435.907); [CFR §435.908](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-J/subject-group-ECFR9b4bff9082050a1/section-435.908)

Applications Accepted to Collect Necessary Information

* [SC DHHS Form 3400](https://www.scdhhs.gov/sites/default/files/Form%203400%20Application.pdf), Healthy Connections Application for Medicaid and/or Affordable Health Coverage
* [SC DHHS Form 3401](https://scdhhs.gov/sites/default/files/3401_HealthyConnections_Inst_OSS.pdf), Application for Nursing Home, Residential, or In-Home Care
* [SC DHHS Form 3400-01](https://scdhhs.gov/sites/default/files/Form3400-01-ExtraPerson.pdf), Additional Person in Household

*(Refer to SC MPPM 101.03 for information on the application form and SC MPPM 101.04.01 for the recommended application for each program.)*

Method of Application

Applications may be accepted via the Healthy Connections web portal, established community partners, telephone, mail, in person, Application assistance must be provided online and by phone, and it must be accessible to individuals with limited English proficiency and disabilities. Individuals of the applicant’s choice must be allowed to assist in the application process.

There is no requirement for a face-to-face interview although it may be beneficial for some types of cases like Nursing Home or Home and Community-Based Services. *(Refer to SC MPPM 101.04 for information on the application process.)*

· If a face-to-face interview is conducted, either the applicant or the authorized representative is interviewed. During the interview the Eligibility Specialist must:

* + Ask relevant questions needed to determine eligibility, and
  + Share information about the eligibility process, including:
    - Verifications that are needed and why,
    - Interaction with Nursing Home and Community Long Term Care,
    - Rights and Responsibilities, and
    - Standard of Promptness:
      * 45 days for all categories (SC MPPM 101.08.01 and 101.08.02)
      * 90 days if a blindness/disability determination is required (SC MPPM 101.08.02)

· If no face-to-face interview is conducted, the Eligibility Specialist must ensure all necessary information is gathered.

* + Contact the applicant/authorized representative if there are:
    - Any unanswered questions, and/or
    - Any discrepancies found on the application or between the current and past applications.
  + Share information about the eligibility process.

104 Appendix C Reserved for Future Use

(Rev. 08/01/19)

104 Appendix D Certificate of Creditable Coverage (COCC)

(Eff. 10/01/05)

The Health Insurance Portability and Accountability Act (HIPAA) requires that group plans and health insurance issuers, including Medicaid, who offer group coverage furnish Certificates of Creditable Coverage when an individual ceases to be covered by the plan. The purpose of the Certificate of Creditable Coverage is to present evidence that the individual had prior creditable coverage that will reduce or eliminate pre-existing exclusions under subsequent health coverage. Health plans that impose pre-existing condition exclusions must reduce the length of an exclusion period by an individual's creditable coverage.

The issuance of the certificates is automated when a beneficiary is terminated from Medicaid. Beneficiaries as well as former beneficiaries contacting the Eligibility Specialist because of receipt of a COCC or who need to request a COCC, should be referred to the Medicaid Managed Care Enrollment Unit at 1-888-549-0820.

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104 Appendix E Welvista of SC (formerly known as CommuniCare)

(Rev. 02/01/21)

Hope and Wellness for the Uninsured

Call 1-800-763-0059 or 803-933-9183

<www.welvista.org>

Welvista is a non-profit, mail order pharmacy that provides free prescription medication to uninsured South Carolinians who qualify. There is no fee to apply or cost for any medications. Welvista does not provide healthcare services.

To Qualify:

* You must live in South Carolina and provide proof of where you live.
* You must be a legal resident (in the United States legally per US Immigration Laws).
* You cannot have any form of medical health insurance (*private health insurance/Affordable Care Act, Medicaid (except for Medicaid Family Planning/SC Healthy Check Up program), Medicare, VA health benefits or other medical health insurance).*
* You must provide proof of income for everyone in your home who has income (*Paycheck Stubs, W-2 or 1099, Tax Return, Child Support, Alimony, Pension, Social Security Documentation, Unemployment, Specialists’ Compensation)*. If no one in your home has income, contact Welvista.

The total gross income for everyone living in your home must be below 200% of the Federal Poverty Level for the household size.

* Our current drug list is on our website. Welvista does not stock any controlled substance medications.

For more information, an application package, or a current drug list, call Welvista or visit our website, [www.welvista.org](http://www.welvista.org).

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104 Appendix F Community Health Centers of SC

(Eff. 01/01/14)

RURAL HEALTH CENTERS

CONTRACTED WITH SOUTH CAROLINA MEDICAID

|  |  |  |  |
| --- | --- | --- | --- |
| APPALACHIA I HEALTH DISTRICT *(Anderson, Oconee)* | | | |
| Oconee County  Michael Parrino, M.D.  457-B North Park; Highway 123 Bypass  Seneca, SC 29678  (864) 888-4464 | | | |
| APPALACHIA II HEALTH DISTRICT *(Greenville, Pickens)* | | | |
| APPALACHIA III HEALTH DISTRICT (*Cherokee, Spartanburg, Union*) | | | |
| CATAWBA HEALTH DISTRICT (*Chester, Lancaster, York*) | | | |
| Lancaster County  Kershaw Family Medical Center  216 East Marion Street  Kershaw, SC 29009  (803) 334-6551 | | Macky Family Practice  1025 West Meeting Street, #2  Lancaster, SC 29720  (803) 285-7414 | |
| EDISTO SAVANNAH HEALTH DISTRICT (Aiken, Allendale, Bamberg, Barnwell, Calhoun, Orangeburg) | | | |
| Aiken County  Wagener Medical Center  120 Louie Street  Wagener, SC 29164  (803) 564-6497 | | Family Health Care  120 Darlington Street  Aiken, SC 29803  (803) 641-1404 | |
| Allendale County  Laffitte & Warren Medical Center  623 North Memorial Avenue  Allendale, SC 29810  (803) 584-2128 | | | |
| Bamberg County  R. Dale Padgett, M.D.  526 North Street  Bamberg, SC 29003-0524  (803) 245-2433 | F. Marion Dwight, M.D., PA  450 North Street  Bamberg, SC 29003-0120  (803) 245-5168 | | Michael C. Watson RHC  498 North Street  Bamberg, SC 29003-0528  (803) 245-5144 |
| Barnwell County  Blackville Medical Center  218 Main Street  Blackville, SC 29817  (803) 284-0020 | Williston Medical Center  Williston, SC 29853  (803) 266-5740 | | Barnwell Family Medicine  86 Wren Street  Barnwell, SC 29812  (803) 259-5752 |
| Calhoun County  St. Matthews Family Practice  725 S. Harry C. Raysor Drive South  St. Matthews, SC 29135  (803) 874-3902 | | | |
| Orangeburg County  William E. O’Quinn, M.D.  215 Dorange Road  Branchville, SC 29432  (803) 274-8400 | Family Diagnostic Associates  922 Holly Street  Holly Hill, SC 29059-0488  (803) 496-7174 | | Family Practice Associates  187 Bunch Ford Road  Holly Hill, SC 29003  (803) 496-3312 |
| Orangeburg County (cont.)  Medical Center of North  4631 Savannah Hwy  North, SC 29112  (803) 247-3900 | R. Dale Padgett, MD RHC  1499 John C. Calhoun Drive  Orangeburg, SC 29115  (803) 533-0007 | | Singleton Health Center  1773 Village Park Drive  Orangeburg, SC 29118  (803) 535-3600 |
| LOW COUNTRY HEALTH DISTRICT (Beaufort, Colleton, Hampton, Jasper) | | | |
| Beaufort County  Beaufort Family Practice  974 Ribaut Road  Beaufort, SC 29902  (843) 524-3344 | | | |
| Colleton County  Walterboro Family Practice  107 Church Street  Walterboro, SC 29488  (843) 549-1558 | | Cottageville Medical Center  370 Sally Ackerman Drive  Cottageville, SC 29435  (843) 835-2121 | |
| Hampton County  Harrison Peoples Health Care Center  441 Second Street, East  Estill, SC 29918  (803) 625-0161 | | Harrison Peoples Health Care Center  1000 Pine Street  Varnville, SC 29944  (803) 943-5228 | |
| Jasper County  Coastal Medical Associates  43 Coastal Highway  Hardeeville, SC 29927  (843) 784-3101 | Family Health Center/Ridgeland  Ridgeland, SC 29936  (843) 717-2600 | | Coastal Medical Associates  Ridgeland, SC 29936  (843) 717-2590 |
| PALMETTO HEALTH DISTRICT (Fairfield, Lexington, Newberry, Richland) | | | |
| Fairfield County  Fairfield Medical Associates  880 West Moultrie Street, Suite 200  Winnsboro, SC 29180  (803) 635-6461 | | | |
| Lexington County  Lexington Medical Center – Swansea  935 West Second Street  Swansea, SC 29160  (843) 568-2000 | | Lexington Medical Center – Batesburg-Leesville  338 E. Columbia Avenue  Batesburg-Leesville, SC 29070  (803) 604-0066 | |
| PEE DEE HEALTH DISTRICT (Chesterfield, Darlington, Dillon, Florence, Marlboro, Marion) | | | |
| Darlington County  Griffin Family Practice  121 E. Main Street  Lamar, SC 29069  (843) 326-5860 | McLeod Family Medicine Center  701 Cashua Ferry Road  Darlington, SC 29532  (843) 398-8500 | | Pee Dee Health Center, PA  201 Cashua Street  Darlington, SC 29532  (843) 799-1700 |
| Dillon County  Latta Internal Medicine  3263 Highway 301 South  Latta, SC 29565  (843) 752-2091 | | | |
| Florence County  Pee Dee Family Practice  625 S. Georgetown Hwy  Johnsonville, SC 29555  (843) 386-3106 | Lake City Medical Center  101 John Street  Lake City, SC 29560  (843) 394-2031 | | Pee Dee Family Practice  325 W. Mercy Street  Lake City, SC 29560  (843) 394-5471 |
| Lake City Family Medicine  334 Mercy Street  Lake City, SC 29560  (843) 374-8380 | Olanta Family Medicine  103 Park Avenue  Olanta, SC 29114  (843) 396-9730 | | Coleman Family Practice  217 3rd Street  Pamplico, SC 29583  (843) 493-5252 |
| McLeod Family Medicine-Johnsonville  355 S. Georgetown Hwy  Johnsonville, SC 29555  (843) 380-2000 | McLeod Family Medicine – Lake City  276 North Ron McNair Blvd.  Lake City, SC 29561  (843) 394-1051 | | McLeod Family Medicine – Timmonsville  755 E. Smith Street  Timmonsville, SC 29161  (843) 346-3900 |
| Marlboro County  Bennettsville Internal Medicine  1076 Marlboro Way, Suite 2  Bennettsville, SC 29512  (843) 454-1082 | | Clio Medical Center  Cheraw Hwy  Clio, SC 29525  (843) 586-2292 | |
| Marion County  Fowler Associates, PA  1106 Lombardy Street  Marion, SC 29571  (843) 423-4044 | Marion Medical Group  1115 North Main Street  Marion, SC 29571  (843) 423-0760 | | Campbell Family Practice  2835 Hwy 76 E.  Mullins, SC 29574  (843) 341-9862 |
| Drs. Thourani & Dawani  511 S. Main Street  Mullins, SC 29574  (843) 464-8244 | Independent Physicians Group  1004 S. Main Street  Mullins, SC 29574  (843) 464-1201 | | Marion County Family Practice  2845 E. Hwy. 76  Mullins, SC 29574  (843) 431-2710 |
| McLeod Family Practice  3032 E. Hw. 76  Mullins, SC 29574  (843) 292-7300 | | | |
| TRIDENT HEALTH DISTRICT (Berkeley, Charleston, Dorchester) | | | |
| Berkeley County  Berkeley Medical Center  106 W. Main Street  Moncks Corner, SC 29461  (843) 761-1995 | | | |
| UPPER SAVANNAH (Abbeville, Edgefield, Greenwood, Laurens, McCormick, Saluda) | | | |
| Abbeville County  Family Medicine Associates  901 W. Greenwood Street S-9  Abbeville, SC 29620  (864) 366-9681 | | Due West Family Medicine  6 College Street  Due West, SC 29639  (864) 379-2345 | |
| Laurens County  Laurens Family Practice – Gray Court  670 Hwy 14  Gray Court, SC 29645  (864) 876-4888 | | Laurens Family Practice - RHC  106 Parkview Drive  Laurens, SC 29360  (864) 984-0571 | |
| McCormick County  Savannah Lakes Medical Center  207 Holiday Road  McCormick, SC 29835  (864) 330-6008 | | | |
| Saluda County  Riley Family Practice  121 N. Newberry Hwy.  Saluda, SC 29138  (864) 445-36-32 | | | |
| WACCAMAW HEALTH DISTRICT (Georgetown, Horry, Williamsburg) | | | |
| Georgetown County  Andrews Medical Center  701 S. Morgan Ave  Andrews, SC 29510  (843) 264-5653 | Medical Building, PA #1  1530 Highmarket Street  Georgetown, SC 29440  (843) 546-5128 | | Waccamaw Medical Center  1075 North Fraser  Georgetown, SC 29440  (843) 264-5253 |
| Horry County  Family Health Center - Mt. Olive  5250 Hwy 9  Green Sea, SC 29545  (843) 392-9222 | Loris Community Hospital/ Clinic  3204 Casey Street  Loris, SC 29569  (843) 756-9194 | | Loris Medical Center  3612 Mitchell Street  Loris, SC 29569  (843) 756-1582 |
| Williamsburg County  Medical Building, PA #2  456 N. Main Street  Hemingway, SC 29554  (843) 558-9319 | Kingstree Family Medicine  512 Nelson Blvd., Suite 200  Kingstree, SC 29556  (843) 354-5459 | | Williamsburg Medical Associates  500 Thurgood Marshall Rd.  Suite F  Kingstree, SC 29556  (843) 355-7461 |
| WATEREE HEALTH DISTICT (Clarendon, Kershaw, Lee, Sumter) | | | |
| Clarendon County  Manning Internal Medicine  50 Hospital Street, #4  Manning, SC 29102  (803) 435-5250 | | McLeod Family Medicine – Manning  22 Bozard Street  Manning, SC 29102  (803) 435-8828 | |
| Robert S. Eagerton, MD  200 E. Hospital Drive  Manning, SC 29102  (803) 435-0439 | | East Clarendon Medical Center  944 Smith Street  Turbeville, SC 29162  (843) 659-2114 | |
| Kershaw County  Healthcare Place @ Bethune  103 South Main Street  Bethune, SC 29009  (843) 334-6551 | | | |
| Lee County  Pate Medical Associates  116 Hospital Square  Bishopville, SC 29010  (803) 484-9425 | | | |

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FEDERALLY QUALIFIED HEALTH CENTERS

MAIN ADMINISTRATION NUMBERS

|  |  |  |  |
| --- | --- | --- | --- |
| APPALACHIAI HEALTH DISTRICT *(Anderson, Oconee)* | | | |
| APPALACHIAII HEALTH DISTRICT *(Greenville, Pickens)* | | | |
| Greenville County  New Horizon Family Health Services, Inc.  130 Mallard Street  P.O. Box 287  Greenville, SC 29602-0287  (864) 233-1534 | | | |
| APPALACHIAIII HEALTH DISTRICT *(Cherokee, Spartanburg, Union)* | | | |
| CATAWBAHEALTH DISTRICT *(Chester, Lancaster, York)* | | | |
| York County  Community Medicine Foundation  North Central Family Medical Center  1131 Saluda Street  P.O. Box 28  Rock Hill, SC 29730  (803) 325-7744 | | | |
| EDISTO SAVANNAH HEALTH DISTRICT *(Aiken, Allendale, Bamberg, Barnwell, Calhoun, Orangeburg)* | | | |
| Aiken County  Rural Health Services  Post Office Box 27  Clearwater, SC 29822  (803) 593-9283 | | | |
| Allendale County  Low Country Health System  Post Office Box 990  Fairfax, SC 29827  (803) 632-2533 | | | |
| Orangeburg County  Family Health Center, Inc. (Main Site)  3310 Magnolia Street, NE  P.O. Box 1806  Orangeburg, SC 29115  (803) 531-6900 | | | |
| LOW COUNTRY HEALTH DISTRICT *(Beaufort, Colleton, Hampton, Jasper)* | | | |
| Beaufort County  Port Royal Medical Center  1320 South Ribaut Road  Port Royal, SC 29935  (843) 987-7400 | | Elijah Washington Medical Center  211 Palge Point Road  Sheldon, SC 29942  (843) 987-7400 | |
| Colleton County  Sea Island Medical Center of Colleton  600 Padget Loop  Walterboro, SC 29488  (843) 549-6853 | | | |
| Jasper County  Beaufort-Jasper-Hampton Comprehensive Health Services  P.O. Box 357  Ridgeland, SC 29936  (843) 987-7400 | | | |
| PALMETTOHEALTH DISTRICT *(Fairfield, Lexington, Newberry, Richland)* | | | |
| Richland County  Richland Community Health Care  1520 Laurel Street  Columbia, SC 29201  (803) 251-1779 | | Eau Claire Cooperative Health Center  4605 Monticello Road  Columbia, SC 29203  (803) 252-5432 | |
| PEE DEE HEALTH DISTRICT *(Chesterfield, Darlington, Dillon, Florence, Marlboro, Marion)* | | | |
| Chesterfield County  Sandhills Medical Foundation  409 E. Church Street  P.O. Box 249  Jefferson, SC 29718  (843) 658-3005 | | | |
| Darlington County  CareSouth Carolina  P.O. Box 1090  Hartsville, SC 29550  (843) 857-0111 | | | |
| TRIDENT HEALTH DISTRICT *(Berkeley, Charleston, Dorchester)* | | | |
| Charleston County  Franklin C. Fetter Family Health Ctr  51 Nassau Street  Charleston, SC 29403  (843) 722-4112 | St. James–Santee Family Health Ctr  P.O. Box 131  McClellanville, SC 29458  (843) 887-3274 | | Sea Island Medical Center  Post Office Box 689  Johns Island, SC 29457  (843) 559-4137 |
| UPPER SAVANNAH HEALTH DISTRICT *(Abbeville, Edgefield, Greenwood, Laurens, McCormick, Saluda)* | | | |
| Greenwood County  Carolina Health Centers  311 UL Main Street  Greenwood, SC 29646  (864) 388-0301 | | | |
| WACCAMAW HEALTH DISTRICT *(Georgetown, Horry, Williamsburg)* | | | |
| Georgetown County  North Santee Site  41145 Powell Road  P.O. Box 608  Georgetown, SC 29440  (843) 887-3274 | | | |
| Horry County  Health Care Partners of South Carolina  1608 North Main Street  P.O. Box 2100  Conway, SC 29526  (843) 248-4700 | | Little River Medical Center  4303 Live Oak Drive  P.O. Box 547  Little River, SC 29568  (843) 249-3424 | |

|  |
| --- |
| WATEREE HEALTH DISTRICT *(Clarendon, Kershaw, Lee, Sumter*) |
| Clarendon County  Black River Healthcare  Post Office Box 578  Manning, SC 29102  (803) 433-6790 |
| Sumter County  Sumter Family Health  100 W. Liberty Street  Sumter, SC 29150  (843) 773-0032 |

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104 Appendix G Cost-of-Living Adjustments (COLA)

(Eff. 10/01/05)

Cost-of-living adjustments are effective in January of each year for beneficiaries receiving Supplemental Security Income and Social Security income. These COLAs result in an increase of the SSI Federal Benefit Rate (FBR) for individuals and couples. Since the Medicaid cap is three times the FBR for an individual, the Medicaid Cap increases accordingly. COLA increases also raise the Value of One-Third Reduction (VTR), used when an SSI beneficiary lives in someone else’s household, and the child allocation amounts. (Refer to SC MPPM 103.12, Program Financial Limits, for a table of COLAs, Federal Benefit Rates, and Value of One-Third Reduction for the past several years.)

For many Medicaid cases, a re-budget of the budget group’s income must be completed before February of the new year. In preparation, Medicaid Eligibility Determination System (MEDS) files are matched to BENDEX cost-of-living adjustments files as well as the SDX cost-of-living files. The data is automatically updated to the MEDS Unearned Income Detail Screen (MEDHMS15) in late November and early December.

MEDS re-budgets cases in the following payment categories:

* 10 Nursing Home (MAO-NH)
* 14 General Hospital (MAO-GH)
* 15 Waivered Services (MAO-WV)
* 40 Working Disabled (WD)
* 54 SSI Nursing Home (SSI-NH) - *beneficiary receives SSI benefits*
* 57 Katie Beckett (TEFRA)
* 59 Low Income Families (LIF)/Parent/Caretaker Relative (PCR)
* 85 Optional State Supplementation (OSS) - *beneficiary does not receive SSI*
* 86 Optional State Supplementation (SSI-OSS) - *beneficiary receives SSI*
* 33 ABD Nursing Home (ABD-NH) – Note: *MEDS will only re-calculate the recurring income since re-budgets on ABD cases will not occur until the Federal Poverty Level (FPL) increases in April of each year.*

MEDS updates, but does not re-budget the following payment categories:

* 16 Pass-along Eligibles (PASALG)
* 17 Early Widow/Widower (EWW)
* 18 Disabled Widow/Widower (DWW)
* 20 Pass-along Children (PAC)
* 80 Supplemental Security Income (SSI)

PCATs 16, 17, 18, and 20 will be reported on Report MSC4300 with the exception message “UNABLE TO REBUDGET - INSUFFICIENT INFORMATION.”

After MEDS re-budgets the cases, the Eligibility Specialist is able to access reports in View Direct that will identify cases re-budgeted by MEDS and cases that must be re-budgeted by the Eligibility Specialist. These reports are identified below:

Report Number MSC4000R02, Recipients with VA Benefits/Income

This report will identify cases with VA benefits. The Eligibility Specialist must verify the correct benefit amounts and re-budget cases that appear on this report.

Report Number MSC4200R02, Mass Change Updates for County

This report will list the cases re-budgeted by MEDS. The Eligibility Specialist should check the information for accuracy.

Report Number MSC4300R02, Mass Change Exceptions for County

This report will identify cases that were NOT re-budgeted by MEDS as well as identify the reason the case was not re-budgeted. The Eligibility Specialist must verify the correct benefit amounts and re-budget cases that are on this report. If a BG appears on this report and the exception message was “BG in a Review,” the re-budget was completed and notices created for PCATs 10, 33, 54, 85, and 86, but Act on Decision was not completed because it would take the BG out of review status. This report only includes Households for which a BENDEX record was received, but MEDS was unable to complete the re-budget for the reason listed on the report.

|  |
| --- |
| Note  Two sets of Reports MSC4200 and MSC4300 will be generated. The first report is generated from the IEV/BENDEX Mass Change run and the second report is generated from the SDX Mass Change run. |

Report Number MSC5000R02, Recipients on MEDS with SSA,

but Not on BENDEX COLA for County

This report lists cases in which MEDS shows a Social Security benefit for an individual but BENDEX does not. The Eligibility Specialist must verify the benefit amounts and re-budget cases appearing on this report. The Eligibility Specialist should request a SSA and/or SSI query on SVE11 (Request SVES Query) under the SVES Menu, under the Interface Menu. The Eligibility Specialist should also ask their supervisor to complete screen IEV05 (BENDEX Input Form), if a BENDEX record on this person has not been received in over a year and it has been verified that he/she receives SSA.

Remember the following when verifying the re-budgets and new recurring incomes:

1. If HMS15 (Unearned Income Detail Screen) does not have a new SSA amount, review the BENDEX record. If there is SSA information, look at the bottom of IEV01 (BENDEX Information Screen) to determine the date of the transaction, and update HMS15, if necessary. If there is not a recent SSA record, request a SVES query to verify the new SSA amount.
2. Some beneficiaries have multiple BENDEX records. In the top right-hand corner of IEV01 (BENDEX Information Screen) you will see displayed Row X of X. If Row 1 of 1 is displayed, that is the only record associated with this Social Security Number that we have received. However, if Row 1 of 2, 3, etc., is displayed, you should press F8 to see the next record. To go back to the previous record press F7. This will enable you to see all of the claim numbers associated with this beneficiary.
3. On the IEV04 (BENDEX History Screen), the EFF DATE field is not the effective date of the payment but the date that the change was updated to MEDS.
4. If you believe this person has SSA income, but the HMS15 (Unearned Income Detail Screen) indicates $0 for the New Year, review the BENDEX record. There may be multiple BENDEX records and the wrong one updated HMS15. After the correct income is verified, update HMS15.
5. If you believe the beneficiary to have SSA or SSI income and there is an "I" indicator on HMS14 (Unearned Income Screen) for that particular kind of income, change the indicator to X and F3 forward to the HMS15 (Unearned Income Detail Screen). You should see there is current income for this person. If not, refer to BENDEX for the correct income amount and update HMS15.
6. If a PCAT 54 BG has SSA income, the beneficiary should be switched to PCAT 10 or 33 if the person is in a nursing home. If not residing in a nursing home, look at other categories. PCAT 54 is for Nursing Home beneficiaries that only receive $30 SSI.
7. If a PCAT 86 BG is not receiving SSI, the beneficiary should be switched to PCAT 85 if the person is still in the boarding home; or, if not residing in a boarding home, look at other categories. PCAT 86 is for Boarding Home residents receiving SSI.
8. If the person has a dual or triple entitlement and the matching record was not on the BENDEX file, his/her income on HMS15 was not updated.
9. If Mass Change re-budgeted or attempted to re-budget a BG, the new year’s income limits will be used. If the Eligibility Specialist then Makes Decision, the income limit will revert to the current year’s limits because the decision is being made in the current year. In order to keep the new income limit, Act on Decision only.

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104 Appendix H Courthouse/Property Searches

(Eff. 07/01/15)

Reasons why the Agency conducts Courthouse/Property Searches:

* Determine personal and real Property ownership Auditor, Assessor

*(SSI-related program requirement)*

* Verify value of Resources Auditor, Assessor

*(SSI-related program requirement)*

* Check for Transfers within the past 60 months Clerk of Court

*(Institutional case requirement)* Register of Mesne Conveyance

* Check for Divorces Clerk of Court

*(Possible tool for SSI-related or MAGI-related programs)*

* Check for Marriages Probate Court

*(Possible tool for SSI-related or MAGI-related programs)*

* Check Wills for possible estate property Probate Court

*(SSI-related programs)*

* Check Child Support payments Family Court

*(Possible tool for either MAGI- or SSI-related programs)*

* Check Alimony payments Family Court

*(Possible tool for either MAGI- or SSI-related programs)*

The above examples represent reasons to conduct these searches. Historically, the Eligibility Specialist completed DHHS Form 1255 ME and submitted it to the appropriate county eligibility office for completion by the designated eligibility specialist.

This is still necessary for some counties, but approximately 32 of the 46 counties in SC offer on-line courthouse searches at: [www.netronline.com](http://www.netronline.com/frameset.asp?StateID=42). Currently, the counties that may be accessed on-line are: *Abbeville, Aiken, Anderson, Barnwell, Beaufort, Berkeley, Charleston, Chesterfield, Clarendon, Colleton, Darlington, Dillon, Dorchester, Edgefield, Florence, Georgetown, Greenville, Greenwood, Hampton, Horry, Kershaw, Lancaster, Laurens, Lexington, Marion, Newberry, Orangeburg, Pickens, Richland, Spartanburg, Sumter, and York.* (Refer to the county Web site addresses listed on the next page.)

Typically, most counties only provide access to real property and vehicle information; however, a number of counties do provide for verification of marriages, county inmates, and other records that may warrant your investigation.

|  |
| --- |
| Note: Are you trying to process an application that will require an out-of-state property search? Check the Internet. Other states are listed at [http://publicrecords.netronline.com](http://publicrecords.netronline.com/). It may save you valuable processing time not to mention the cost of a stamp and a return envelope. |

**County Web Site Addresses for On-Line Property Searches**

|  |  |
| --- | --- |
| County | Web Address |
| Abbeville | [www.abbevillecountysc.com](http://www.abbevillecountysc.com/) |
| Aiken | [cxap2.aikencountysc.gov/EGSV2Aiken/index.jsp](http://cxap2.aikencountysc.gov/EGSV2Aiken/index.jsp) |
| Anderson | [acpass.andersoncountysc.org/index.htm](http://acpass.andersoncountysc.org/index.htm) |
| Barnwell | http://www.qpublic.net/sc/barnwell/ |
| Beaufort | [www.bcgov.net](http://www.bcgov.net/) |
| Berkeley | <https://www.berkeleycountysc.gov/drupal/?q=property_search> |
| Charleston | [taxweb.charlestoncounty.org/connect?](http://taxweb.charlestoncounty.org/connect?) |
| Chesterfield | <http://chesterfieldcountysc.com/assessor.aspx> |
| Clarendon | [www.clarendoncountysctax.com](http://www.clarendoncountysctax.com/) |
| Colleton | [tax.colletoncounty.org](http://tax.colletoncounty.org/) |
| Darlington | [darcosc.com/onlinetaxes/](http://darcosc.com/onlinetaxes/) |
| Dillon | www.dilloncountysctaxes.com |
| Dorchester | [www.dorchestercounty.net](http://www.dorchestercounty.net/) |
| Edgefield | [www.edgefieldcountysc.com](http://www.edgefieldcountysc.com/search.aspx) |
| Florence | [web.florenceco.org/cgi-bin/ta/tax-inq.cgi](http://web.florenceco.org/cgi-bin/ta/tax-inq.cgi) |
| Georgetown | [www.georgetowncountysc.org](http://www.georgetowncountysc.org/) |
| Greenville | [www.greenvillecounty.org/vrealpr24/clrealprop.asp](http://www.greenvillecounty.org/vrealpr24/clrealprop.asp) |
| Greenwood | [www.co.greenwood.sc.us](http://www.co.greenwood.sc.us/) |
| Hampton | http://www.qpublic.net/sc/hampton/ |
| Horry | [www.horrycounty.org/gateway/disclaimer/idx\_real.html](http://www.horrycounty.org/gateway/disclaimer/idx_real.html) |
| Kershaw | [www.kershawcountysctax.com](http://www.kershawcountysctax.com/) |
| Lancaster | [lancastercountysc.net/onlinetaxes/](http://lancastercountysc.net/onlinetaxes/) |
| Laurens | [www.laurenscountysctaxes.com/](http://www.laurenscountysctaxes.com/) |
| Lexington | [www.lex-co.com/GIS/GISDisclaimerAssessor.html](http://www.lex-co.com/GIS/GISDisclaimerAssessor.html) |
| Marion | [www.marionsc.org/](http://www.marionsc.org/) |
| Orangeburg | [www.orangeburgcounty.org/Assessor/disclaimer.html](http://www.orangeburgcounty.org/Assessor/disclaimer.html) |
| Pickens | [pickensassessor.org](http://pickensassessor.org/) |
| Richland | [www.richlandonline.com/services/assessorsearch/assessorsearch.asp](http://www.richlandonline.com/services/assessorsearch/assessorsearch.asp) |
| Spartanburg | [www.spartanburgcounty.org](http://www.spartanburgcounty.org/) |
| Sumter | [www.sumtercountysc.org](http://www.sumtercountysc.org/) |
| York | [www.yorkcountygov.com](http://www.yorkcountygov.com/) |

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**Completion of the SC DHHS Form 1255 ME**

**Verification of Real and Personal Property**

1. Complete the information regarding the county, specialist, primary individual, and household number. Check the Property Search County Contacts list on [SharePoint](https://team.scdhhs.gov/OPS/EES/Shared%20Documents/Forms/AllItems.aspx) to identify the designated staff member(s) for each county.
2. Complete all identifying information to include the name(s) of spouse, parents, or other relatives, including the dates of death for spouse, parents or other individuals from whom an inheritance was received within the five (5) years prior to application. This information is necessary to complete a thorough check of probate records. Also, include any known information pertaining to the property.
3. When completing a courthouse check, verify:
   * Current property ownership (Auditor’s and Assessor’s Offices);
   * Transfers within the past 60 months (Clerk of Court or Register of Conveyance); and
   * Probate record (Probate Court Office) if an inheritance has been received by the applicant and/or spouse within five (5) years prior to the application date (Effective for all decisions on or after July 1, 2015).

The form is not complete unless all three are verified. When completing the verification check, sign page two (2) of the form.

1. If an administrative specialist completes the property checks for your county, be sure that this person is trained to complete thorough checks for:

* Current ownership;
* Transfers within the past 60 months; and
* Probate records.

1. For institutional case, forms should be completed for:

* County of residence, and
* Other counties where the individual and/or his spouse:
  + In-state
    - Alleges current or previous property ownership, and/or
    - Resided for long periods in their adulthood.
  + Out-of-state
    - Alleges current or previous property ownership, and/or
    - Alleges ownership of property within the past five (5) years. Send a DHHS Form 1255 but do not wait for the return of the form to make a decision on the application.
* If the applicant and/or spouse has received an inheritance within five (5) years prior to the application date, probate must be checked in the county where the estate was probated.

1. When sending a SC DHHS Form 1255 ME to other counties in South Carolina, indicate at the top of the form, an attached memo, or cover letter that you need verification of:

* Current property ownership,
* Transfers within the past 60 months, and
* Probate records.

Include a self-addressed envelope for reply.

1. When you receive requests for completion of forms from other counties, give these requests the same attention and consideration that you would give your own. Complete all requested information and return the form in a timely manner.

**Courthouse Records**

1. Auditor – Current listing for real and personal property

1. Real property – Real estate tax rolls alphabetic listing by name and address and gives legal description. Life estate may be found in applicant/beneficiary’s name with a notation of LE.
2. Personal property – Vehicle listings grouped by month of registration.

2. Assessor – Current listings of appraised value of property

1. Derivation cards – Show history of ownership of property
2. Plat books – Show location, size, and name of owner of each piece of land in a stated area.
3. Maps – show aerial view of property.

3. Register of Mesne Conveyance (RMC or Clerk of Court)

1. Grantor (may be listed as direct)/grantee (may be listed as indirect) index – property transfers listed by name. Listing gives volume, page number of deed that may be located or files or deed books.
2. Mortgage register – Mortgage listed alphabetically.
3. Affidavit books – Records affidavits from deeds that show “other consideration.” Listings are usually by date or month deed was recorded.
4. Trusts – Found in grantor (may be listed as direct)/grantee (may be listed as indirect) index.

Note: Trusts that are established by wills are found in Probate Court listed under the deceased individual’s name.

4. Clerk of Court

1. Foreclosures – Found in index of Lis Pendens.
2. Suits – Found in index to common plies docket by plaintiff (brings suit) and defendant (brought against).
3. Judgments – Found in index of judgments by plaintiff (creditor) and defendant (debtor).
4. Divorces – Divorce decrees before approximately 1975 are found in general index, defendant or plaintiff books.

5. Probate Court

1. Marriages – Licenses may be found in the Probate Court or a separate Marriage License Division. Listed in the bride’s and/or groom’s name with a number. The licenses are then filed by these numbers.
2. Wills (deceased estates), committeeships, guardianships found in general index lists names alphabetically and gives a box, package or file number.

6. Family Court

1. Divorce Decrees – Divorce decrees after 1975 are found in the general index, defendant, or plaintiff books.
2. Child Support – Usually listed in the name of the parent paying child support.
3. Alimony – Usually listed in the name of the spouse paying alimony.

**Common Court House Terms**

Contiguous Adjacent; in actual contact; touching; near.

Conservator One who is responsible for the person and the property of an incompetent individual.

Grantee One who receives a transfer of real property by deed; the buyer.

Grantor One who transfers real property by deed; the seller.

Intestate Legal designation of a person who has died without leaving a will.

Judgment Decree of a court declaring that one individual is indebted to another and fixing the amount of such indebtedness.

Lessee Person who leases property; the tenant.

Lessor Person from whom property is leased; the landlord.

Lien A security interest or legal right acquired in one’s property by a creditor.

Lis Pendens Suit pending; usually recorded to give constructive notice of pending litigation.

Mortgagee The person or business who makes a loan to the mortgagor, secured by the mortgagor’s property; the lender.

Mortgagor The person who has borrowed money and pledged their property as security for the mortgagee; the borrower.

Plat Plan or map of certain piece or pieces of land.

Plat Book Record showing the location, size, and name of owner of each plot of land in a stated area.

Testate Legal designation of a person who has died and left a legally valid will.

**Special Types of Deeds**

Quit-Claim Deed – From time to time, because of deficiencies in prior deeds such as inadequate or deficiencies in the records of title, there may arise question as to whether an individual has a legal interest in title to real estate. In some instances, that individual executing a “quit claim deed” can remove the question. By executing this type of deed, an individual relinquishes all his right, title intent, and estate, if any, in the property. He does not claim an interest in the property, does not warrant the title, and assumes no liability.

Trust Deed – A deed of trust conveys title in real estate to a trustee. The legal title vests in the trustee, but the trustee takes title for the benefits of someone else. The terms of the trust and powers, duties and authority of the trustee may be contained in a separate trust agreement. If there is a separate trust agreement, it need not be recorded.In all cases, the powers, duties and authority of the trustee, such as whether or not he has power to convey, mortgage, lease, or otherwise dispose of the property, is controlled by the terms of the instrument creating the trust.

Warranty-Deed or Full Covenant – A full and complete conveyance, with pledge that the property is free from encumbrance or encumbered only as stated by the conveyor and understood by the new owner. It is the most indisputable conveyance possible.

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104 Appendix I Definitions

(Rev. 10/01/13)

| Term | Definition | Program Area |
| --- | --- | --- |
| 529 Plan | A State-sponsored investment program that parents can fund to pay for their child’s college education. The state sets up the plan with an asset management company, and the parents open a 529 account with this asset management company. | SSI |
| Accelerated Life Insurance Payments | Proceeds paid to a policyholder before the insured’s death. | SSI |
| Actuarially Sound | The return on a promissory note or annuity is expected within the lifetime of the individual. | SSI |
| Adequate Notice | A notice that must be received before the effective date of the change that informs the applicant/beneficiary or the Authorized Representative of action taken. | All |
| Advanced Notice | Notice of planned action must be mailed to the beneficiary or authorized representative at least 10 days before the date of action, or 5 days prior in the case of fraud. | All |
| Aged | As defined by the SSA, a person who is 65 years of age or older. An individual is considered aged the month he turns age 65. | SSI |
| Alien | An alien is an individual who lives in the U.S. but is not a citizen. | All |
| Annuity | A sum paid yearly or at other specific times in return for the payment of a fixed sum. Annuities may be purchased by an individual or by an employer. | All |
| Appeal | An appeal is a request of an applicant/ beneficiary or his representative for a review of the action taken on his case. | All |
| Appeal Decision | A decision reached by the Fair Hearing Officer. | All |
| Appeal Summary | A detailed summary of case situation, including supporting documents. | All |
| Applicant | A person who signs under penalty of perjury a written application for Medicaid or on whose behalf a written application is made and signed by an authorized representative. | All |
| Application | An application for Medicaid signed by the applicant or his authorized representative. | All |
| Application Process | A series of actions leading to a determination of eligibility or ineligibility for Medicaid. | All |
| Appraisal | A comprehensive estimate of property value. | SSI |
| Assisted Living | Group Care for a person who cannot remain in his own home but does not yet meet Skilled or Intermediate Level of Care. | SSI |
| Authorization Period | Period for which all factors of eligibility have been established and the beneficiary is authorized to receive a Medicaid card. | All |
| Authorized Representative | Any individual who alleges that he is acting on behalf of an applicant/beneficiary. | All |
| Automated Notice | A notice produced and mailed by MEDS or Cúram to an applicant/beneficiary based on codes entered by the Eligibility Specialist. | All |
| Award Letter | A statement to an individual from a governmental or private agency indicating benefits for which he/she is eligible. | All |
| Bed Hold | Ability for Medicaid to continue vendor payment to a Long Term Care facility for a limited time if certain criteria are met. | SSI |
| BENDEX | Beneficiary Data Exchange System, a computer printout listing the amount of an individual's Social Security benefits. | All |
| Beneficiary | A term used to refer to an individual who is eligible for Medicaid. | All |
| Black Lung | Payments to a disabled specialist, dependents, or survivors resulting from exposure to coal dust. | All |
| Blue Book Value | An official car valuation by the NADA or Kelly Blue Book | SSI |
| Boarder | A person who lives with the applicant/beneficiary and pays a set amount for a room and meals. | All |
| Brown Lung Benefits | Payments made to persons disabled by lung disease resulting from exposure to raw cotton dust. | All |
| Budget Group | Persons, who are related by blood, adoption or marriage, and whose needs, income and/or resources, are considered in the eligibility determination of one or more persons in the group. | All |
| Bureau of Citizenship and Immigrations Services (BCIS) | Part of the Department of Homeland Security. As of November 1, 2003, the name has been changed to US Citizenship and Immigration Services (USCIS). Most of the functions it performed were formerly in the jurisdiction of the Immigration and Naturalization Service (INS) that was part of the Department of Justice. | All |
| Burial Funds | Funds clearly designated for burial related expenses. May include: burial contracts, cash, bank accounts, stocks, bonds, or CD. | SSI |
| Burial Insurance | Contract whose terms preclude the use of its proceeds for anything other than payment of the insured’s burial expenses. | SSI |
| Burial Spaces | A cemetery plot, niche, casket, urn, mausoleum, or other traditionally used for bodily remains. May also be vaults, markers, or opening and closing of the gravesite. | SSI |
| Caretaker Relative | The natural or adoptive parent or the specified relative living in the household with the child who is eligible for Medicaid and providing the child's day-to-day care and supervision. | MAGI |
| Case Record | A file containing the application and all documents verifying initial and continuing eligibility for members of the assistance unit. | All |
| Cash Surrender Value | A form of equity value a life insurance policy acquires over time. The amount of money a person may receive if they surrender their Life Insurance Policy before its maturity or the insured’s death. Gross Cash Value less any outstanding loans and surrender charges. | SSI |
| Categorical  Eligibility | All persons applying for Medicaid must be categorically eligible. To be categorically eligible for Medicaid, an individual must be: receiving cash assistance such as SSI or Optional State Supplementation (OSS); aged; blind; disabled; a child under age 19; a pregnant woman; a family with a dependent child(ren); or screened for breast or cervical cancer under the Best Chance Network program and found to need treatment for either breast or cervical cancer or pre-cancerous lesions. | All |
| Category Change | The process of transferring from one payment category of assistance to another. | All |
| Certification period | The period of time for which assistance is requested and in which all eligibility factors except need and reserve (when applicable) must be met. | All |
| Certified Level of Care | Medical determination of need for Skilled or Intermediate Nursing Care. It is recommended by a physician. Community Long Term Care (LONG TERM CARE FACILITY) must certify for Medicaid Eligibility. Intermediate Care for the Intellectually Disabled is certified through the Dept of Disability and Special Needs (DDSN) | SSI |
| Change in Situation | A change in a beneficiary’s circumstances that may affect eligibility for assistance. | All |
| Child Support | Money or in-kind goods given for a child by a parent for the child’s care. | All |
| Child’s Allocation | A deduction from the income of an eligible parent that is considered set aside for the support of the child. | SSI |
| Children’s Health Insurance Program (CHIP) | The national title for the expansion and separate health insurance programs program authorized by Title XXI of the Social Security Act. | MAGI |
| Choice of Category | Applicant/beneficiary’s right to have their eligibility determined in the Medicaid program of their choice. | All |
| Closing Date | The last day of the month in which the beneficiary is eligible for benefits. | All |
| Collateral | Any individual, employee, or person representing an agency, firm, organization, etc., whom the Eligibility Specialist approaches to obtain verification of information provided by the budget group. | All |
| Commissions | Percentage of money made on sales and given in pay, in addition to salary or wages. | All |
| Community Residential Care Facility (CRCF) | Refer to Assisted Living | SSI |
| Community Spouse | An institutionalized person’s spouse who remains living in a community setting (Refer to, home, relative’s home, Residential Care Facility) | SSI |
| Community Spouse Allocation | The amount of income protected from an Institutionalized spouse’s income for the community spouse’s use. | SSI |
| Compensation | Something received as payment for a resource. | SSI |
| Confidentiality | Safeguarding applicant/beneficiary information. | All |
| Conservatorship Accounts | Established by a court and administered by a court-appointed conservator for the benefit of an individual. | SSI |
| Conserved Funds | Funds, or other property, which are being held for an individual by someone else. | SSI |
| Contested Decision | A tentative State hearing decision with which a county or the applicant/beneficiary disagrees. | All |
| Continuous Eligibility | Once a child under age 19 has qualified for Medicaid, he can receive for up to 12 months regardless of financial changes that affect eligibility. | MAGI |
| Contribution | Donation of cash or in-kind made by an individual to or on behalf of a member of the budget unit. | All |
| Corporate Bond | Obligation of private Corporation | SSI |
| Countable Resources | Those resources remaining after all exclusions have been applied. The FMV must be verified and the equity value considered when determining eligibility. | SSI |
| Coverage Group | The category under which an individual is determined eligible for assistance. | All |
| Creditable Health Insurance | Health insurance that at minimum hospitalization, doctor visits, X-ray, and lab coverage. | MAGI |
| Date of Application | The date that the signed, dated application is received by the Agency. | All |
| Deduction | Mandatory and allowable work related expense subtracted from gross earned income for members of the budget group. | All |
| Deemed | The process of considering income and reserve of persons in the household, or sponsors of lawfully admitted aliens as available to the applicant/ beneficiary. | All |
| Deemed Baby | An infant that is eligible for Medicaid at birth because of the mother’s eligibility for Medicaid in any Medicaid category. Eligibility continues for one year regardless of changes in income. | MAGI |
| Default | Failure to meet the requirements of a loan or note. | SSI |
| Denial | Rejection of benefits of the applicant. | All |
| Dependent | An individual who is financially dependent upon another for his wellbeing as defined by financial responsibility regulations for the program. | All |
| Determination of Eligibility | The process of verifying eligibility factors for applicants/beneficiaries to accurately decide eligibility. | All |
| Disability | As defined by the Social Security Administration (SSA), a physical or mental impairment of such severity that it prevents the applicant from engaging in Substantial Gainful Activity (SGA) for at least a year or is expected to result in death. For a child under 18, it is an impairment of comparable severity. | SSI |
| Disability Determination | The process of determining if a person meets the SSA’s definition of disability. | SSI |
| Disabled Adult Child | An individual who is blind or permanently and totally disabled who is unable to become self-supporting after age 18. | SSI |
| Discretionary Trust | The trustee has full discretion as to the time, purpose and amount of all distributions. The beneficiary has no control over the trust. | SSI |
| Disregard of Earned Income | Exemption of a portion of earned income for applicants/beneficiaries. | All |
| Disregard of Income | The procedure for exempting certain portions of income when determining benefits. | All |
| Documentation | Record data substantiating all points of eligibility. | All |
| Earned Income | Wages, earnings from Self Employment. | All |
| Earned Income Tax Credit | Supplement to the earnings of the working poor. An eligible individual can choose to receive the credit in advance payments added to his paycheck or in a lump sum when he files his income tax return. | All |
| Effective Date | The first day of the authorization period for Medicaid. | All |
| Elective Share | South Carolina Probate Code provides that the spouse is entitled to 1/3 of the estate after deductions and expenses, even if the Deceased spouse’s will left the spouse a lesser or no amount. | SSI |
| Eligibility | The status of an individual qualifying for Medicaid. | All |
| Eligibility Quality Assurance | A management tool used to determine the accuracy of eligibility and evaluation of needed corrective action. | All |
| Emancipated Minors | Children who are no longer legally dependent upon their parents/guardians. | MAGI |
| Emergency Services Medicaid | Eligibility for Medicaid by non-qualified aliens is limited to receipt of Medicaid on the day an emergency existed. An emergency is defined as labor and delivery or treatment after the sudden onset of a medical condition manifesting itself by acute systems of sufficient severity, including severe pain, such that absence of immediate medical attention could reasonably be expected to result in placing the patient’s health in serious jeopardy, or serious impairment to bodily function, or serious dysfunction of any bodily organ or part. | All |
| Enumeration | The process of obtaining a Social Security Account Number. | All |
| Equity | The Fair Market Value of a resource owned by a person, minus the amount of debts, liens, or other encumbrances. | All |
| Equitable Ownership | No legal title for property exists for an individual; however, an informal agreement exists with the actual titleholder because the individual has invested money in the property or in improvements to the property, which he can verify. | SSI |
| Estate Recovery | A claim filed against the estate of a deceased Medicaid beneficiary when Medicaid has paid for long-term care services provided either in a Nursing Home or through Home and Community Based Services Waiver. | SSI |
| Ex Parte | A re-determination of Medicaid eligibility without the assistance of the beneficiary. | All |
| Face Value | Amount of basic death benefit contracted for at the time a life insurance policy is purchased. | SSI |
| Fair Market Value (FMV) | The amount for which property can be sold on the open market in a particular geographical area. Also called, Current Market Value (CMV). | All |
| Family Planning (FP) | Limited Medicaid coverage for individuals whose family income is at or below 194% of poverty. Men and women of any age can be approved for FP. | MAGI |
| Father, Alleged | The man who is said, without proof, to be the father of the child when the courts have not established paternity. | MAGI |
| Father, Legal | (1) The man who is married to the mother at the time of the child's birth; or (2) A man who has been determined by the courts to be the father; or (3) A man who has legally adopted the child; or (4) A man who has signed affidavits legitimating the child. | MAGI |
| Father, Natural | The biological father of the child. | MAGI |
| Father, Putative | Same as Alleged Father. | MAGI |
| FBR (Federal Benefit Rate) | The maximum benefit amount paid by the Federal Government for SSI. Rate changes annually with the Cost of Living Raises. | SSI |
| Federally Facilitated Marketplace | A resource where individuals, families, and small businesses can learn about their health coverage options; compare health insurance plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage. | All |
| FI (Family Independence) | A cash payment and Medicaid for children and parents who meet the income and asset limits for the program. This program is known as Temporary Assistance for Needy Families (TANF) at the national level. | FI |
| Final Decision | A decision by the State hearing office, after all non-judicial appeal rights have been exhausted. | All |
| Financially Responsible Person | A parent or spouse whose income and resources are considered available to the Medicaid applicant/beneficiary as long as the applicant/beneficiary and the parent or spouse live together in the same household. | All |
| Forgery | Signing someone else's name without proper authorization. | All |
| Fraud | A criminal act in which a applicant/beneficiary or authorized representative makes a false statement and/or withholds information willfully, knowingly, and with deceitful intent and, as a result, obtains or attempts to obtain assistance for which he is not eligible. | All |
| Garnishment | A withholding of an amount from earned or unearned income in order to satisfy a debt or legal obligation. | All |
| Government Bond | Transferable obligation issued or backed by the Federal Government, with the exception of Savings Bonds. | SSI |
| Grantor Trust | The Grantor/Settlor is also the sole beneficiary of the trust. | SSI |
| Guardian | A person appointed by a court to be legally in charge of the affairs of a minor, or of someone incapable of taking care of his own needs. | All |
| Healthy Connections Kids | A separate State Children’s Health Insurance Program providing a special benefits package for uninsured children with incomes greater than 150% and less than or equal to 200% FPL. This program ended October 2010. | MAGI |
| Hearing | A review requested by an applicant/beneficiary to establish whether an adverse action taken by the county was correct. (Refer to [Appeal](#Appeal).) | All |
| Heir Property | Ownership of property passed by will or intestate succession. | SSI |
| Home Maintenance Allowance | The amount of money “protected” from an institutionalized person’s cost of care if a physician certifies they are expected to return home within 6 months of admission. It is used to keep their home going, IF no one else is living there, and is the smaller of the FBR or actual expenses. | SSI |
| Home Property | The land, or mobile home, where a person resides, or would reside if they were able (Refer to: out of home due to illness). In the case of land, home property is the land the home is on and all connecting land. | SSI |
| Household | Group of related individuals sharing common living quarters; functioning as a single economic unit; and whose needs, income and resources are considered to determine eligibility for one or more Medicaid categories of assistance. | All |
| Household Goods | Items of personal property customarily found in the home and used in connection with the maintenance, use, and occupancy of the premises as a home. | SSI |
| Household Number | The number that MEDS assigns to a group of related individuals sharing common living quarters and whose needs, income and resources are considered to determine eligibility for one or more Medicaid categories. | All |
| Illegal Alien | Aliens who entered the US without knowledge of BCIS or were admitted for a limited period and did not leave the US when the period expired. These aliens may be known or unknown in BCIS but are not in a satisfactory status with BCIS. | All |
| Income | Cash or in-kind resources received for labor, services, government or private benefits, or any money available to members of the budget unit for their maintenance. | All |
| Income Trust | Special trust funded by an institutionalized individual’s income designed to allow eligibility when the countable income exceeds the Medicaid Cap but all other eligibility factors have been met. Also known as Miller Trust. Provided for under OBRA 93. | SSI |
| Income, Earned | Money received because of employment. | All |
| Income, Gross | Total income before allowable deductions. | All |
| Income, Net | Income after all allowable deductions. | All |
| Income, Unearned | Money received from any source other than employment. | All |
| Incur | Become liable for, regardless of whether the expense is paid or expected to be paid by insurance, including Medicare or some other source. | All |
| Inheritance | Cash, non-cash item, or property received as the result of someone’s death. | SSI |
| In-kind Income | Non-monetary assistance such as food, clothing, shelter or something the individual can use or convert to obtain food, clothing or shelter. | All |
| Inmate of a Public Institution | A person who is living in a public institution. | All |
| Inquiry | A request for information regarding assistance or other services. | All |
| Institutionalized Spouse/Individual | Person residing in a Skilled or Intermediated Nursing Facility or receiving services through a Home and Community Based Services Waiver. | SSI |
| Institutionalized Spouse | An individual who is in a Skilled Nursing Facility, an Intermediate Care Facility, an Intermediate Care Facility for the Intellectually Disabled, a Swing Bed, been hospitalized for 30 days or longer, or receiving Home and Community Based Services. | SSI |
| Intake | An initial interview. | All |
| Intermediate Care Facility (ICF) | A long-term care facility that provides eight hours per day of nursing supervision by either an RN or LPN. | SSI |
| Intermediate Care Facility for Intellectual Disability  (ICF-ID) | An ICF for the intellectually disabled. | SSI |
| Investigation | A thorough examination of all eligibility factors. | All |
| Irrevocable Burial Contract | A burial agreement that cannot be reversed (that is, money cannot be returned to the owner) after 30 days. | SSI |
| Irrevocable Trust | A contract in which the terms cannot be altered. | All |
| Katie Beckett | Medicaid Program that allows disabled children who are at risk for institutionalization to receive Medical Care at home, if appropriate. Also known as TEFRA. | SSI |
| Knowledgeable Source | A person or entity familiar with property/vehicle values in the area. | SSI |
| Lawful Permanent Resident | An alien who is legally admitted to the US by the BCIS to live and work on a permanent basis. | All |
| Legal Parent | Natural or adoptive parent after the final order of adoption is issued. | All |
| Legal Representative | A person acting for and legally authorized to execute a contract for the applicant/beneficiary, such as, but not limited to: a legal guardian, parent of a minor child, holder of power of attorney, fiduciary (agent), conservator or any trustee managing the applicant/beneficiary’s resources. Legal authorization requires a separate legal document except for parents of minor children. | All |
| Legal Temporary Residents | These are aliens who have applied for legalization and been granted lawful temporary resident status (LTR) and eventually granted lawful permanent residence. | All |
| Life Estate | An individual(s) are given certain property rights for the duration of his life, or someone else’s life. Some restrictions may apply (Refer to, until remarriage). The life estate owner has the right to possess, use, and obtain profits form the property but can only sell the life estate interest. | SSI |
| Life Insurance | A contract where an individual pays premiums to a company, which agrees to pay a specified sum to a beneficiary upon the death of the insured. | SSI |
| Liquid Resource | Cash or item that can be converted to case, generally within 20 days (Refer to, bank accounts, promissory notes, stocks, or bonds). | SSI |
| Loans | Money given with the intention of repayment. | All |
| Long Term Care Facility | An intermediate care facility (ICF), a skilled nursing facility (SNF), an Intermediate care facility for the intellectually disabled (ICF-ID) or general hospital (after being admitted for 30 consecutive days). | SSI |
| Look back Period | The 36-month (or 60 in the cases of trusts) period that must be reviewed to see if a LONG TERM CARE FACILITY applicant or their community spouse transferred assets out of their names. | SSI |
| Lump Sum Payment | Money received with no anticipated recurrence (Refer to retroactive SSA payments, life insurance proceeds.) | All |
| Mandatory Trust | The trustee is mandated to pay trust earnings or principal to, or for the benefit of, the beneficiary at certain times. | SSI |
| Manual Notices | In certain situations, the Eligibility Specialist must complete and mail the appropriate notice informing the applicant/beneficiary of changes or adverse actions to be taken in his case. | All |
| Means Tested Program | An assistance program in which an applicant’s financial circumstances are considered. | All |
| Medicaid Cap | An amount equal to 3 times the Federal Benefit Rate for SSI. This is a special income limit used for Institutional Medicaid Programs. | SSI |
| Medicaid Eligible | Enrolled in the South Carolina Medicaid program. | All |
| Medicare | A program of health insurance for aged and disabled individuals who meet the program’s eligibility requirements. Title XVIII of the Social Security Act. | All |
| Migrant Farm Specialist | A person who moves with the migrant stream in order to follow seasonal farm work employment, and does not return to his permanent home each night. | All |
| Military Allotments | Benefits received by dependents of military personnel. | All |
| Miller Trust | (Refer to [INCOME TRUST](#Income_Trust).) | SSI |
| Minor Mother | A mother below a certain age (18) as defined by a specific program. | MAGI |
| Misrepresentation | An intentional or unintentional statement giving incomplete, false, or misleading information. | All |
| Misutilization | Improper use of services provided under Medicaid | All |
| Modified Adjusted Gross Income (MAGI) | The figure used to determine eligibility for lower costs in the Marketplace and for Medicaid and CHIP. Generally, modified adjusted gross income is your adjusted gross income plus any tax-exempt Social Security, interest, or foreign income you have. | All |
| Mortgage | A pledge or security of particular real estate for the payment of a debt or the performance of some other obligation within a specified period. | SSI |
| Multi-generational Family | Household comprised of a child, the mother and grandmother. Budget Group composition depends on who is applying for coverage. | MAGI |
| Multiple Household | A household made up of more than one family unit. This does not include room and board situations, as persons in such living arrangements are considered separate households. | All |
| Municipal Bond | Obligation of a State or a locality (county, city, town, village or special purpose authority such as a school district). | SSI |
| Mutual Fund | A pool of assets (stocks, bonds, etc.) managed by an investment company. A mutual fund share represents ownership interest in this pool as opposed to a particular stock or bond. | SSI |
| Name | The name entered in MEDS or Cúram that matches verification records. | All |
| Need Standard | The amount of money the State determines essential to meet minimal standard of living for a family of a specified size. | All |
| Net Profit | The income received from self-employment, farming, roomers, boarders, or small business, minus allowable expenses. | All |
| Newborn Coverage | Medicaid coverage for children under one who were born to Medicaid eligible mothers or into families whose income is less than or equal to 194% of poverty. | MAGI |
| Non Home Property | Consists of land and buildings or immovable objects (including some mobile homes) that are attached permanently to the land and that do not meet the definition of a home. | SSI |
| Non-cooperation | Failure of a budget group member to comply with program requirements. | All |
| Non-immigrant Aliens (temporary residents) | Aliens who are not permanently residing in the US. These aliens are lawfully admitted but only for a specified period, such as foreign students, and are in a satisfactory status with BCIS. These aliens are ineligible for full Medicaid. | All |
| Non-liquid resource | Resources that are not cash and cannot be easily converted to cash (Refer to: real property, vehicles.) | SSI |
| Non-qualified Alien | An alien who does not meet the alien requirements to receive full Medicaid coverage. Nonqualified aliens potentially are eligible for emergency services only. Nonqualified aliens include illegal aliens, non-immigrants legally admitted to the US but only for a temporary or specified period, and/or aliens admitted legally to the US but who do not fall into one of the specified qualified alien categories. | All |
| Ombudsman | An advocacy program to assist LONG TERM CARE FACILITY patients and their families with problems and questions related to LONG TERM CARE FACILITY. | SSI |
| Partners for Healthy Children (PHC) | A health insurance program for uninsured children under the age of 19 whose family income is at or below 200% of the Federal Poverty Limit. This program is known as Children’s Health Insurance Program (CHIP) at the national level. | MAGI |
| Patient Trust Accounts | Small accounts maintained by facilities for individuals to provide them with sundries. Also known as Personal Needs Accounts. | SSI |
| Payee | The individual to whom the benefits are written. | All |
| Payee | The person in whose name the assistance is made. | All |
| Payment Category | The category of assistance for which the beneficiary applies or receives Medicaid. | All |
| Perjury | The voluntary violation of an oath or vow by swearing to what is untrue or by omission to do what was promised under oath. A signed application is a signed oath. | All |
| Personal Effects | Items of personal property that are worn or carried by an individual or that have an intimate relation to him or her. | SSI |
| Personal Representative | A substitute payee appointed by the court when the specified relative payee is unwilling or unable to manage the assistance payment in the best interest of the children. | All |
| Plan for Achieving Self Support (PASS) - Also known as “Pickle” | A plan that allows blind and disabled (but not aged) individuals to set aside income and/or resources necessary for the achievement of its goals. | SSI |
| Pooled Trust | Similar to a Special Needs trust. Applies only to disabled individuals. Must be established and managed by a non-profit organization with a separate account for each individual. | SSI |
| Postpartum Period | Sixty-day period following birth or termination of pregnancy. Medicaid coverage continues until the end of the month in which the 60th day falls. | MAGI |
| Posthumous Application | Medicaid application for a deceased person. Must be filed by the end of the 3rd calendar month before death. | All |
| Poverty Level | A Federally established income guideline used to define persons who are economically disadvantaged. | All |
| Preneed Burial Contract | An agreement whereby the buyer pays in advance for a burial that the seller agrees to furnish upon the death of the buyer or other designated individual. | SSI |
| Prepaid Burial Contract | An agreement whereby the buyer pays in advance for a burial that the seller agrees to furnish upon the death of the buyer or other designated individual. | SSI |
| Presumptive Disability or Blindness | Conditions under which SSA presumes that requirements are met and makes payment for a period of up to 6 months awaiting a final determination. | SSI |
| Private Disability or Unemployment Benefits | Includes benefits paid by private insurance plans for persons incapacitated/unemployed. | All |
| Program Transfer | The process of transferring from one category of assistance to another. | All |
| Promissory Note | A written unconditional agreement whereby one party promises to pay a specified sum of money at a specified time (or on demand) to another party. It may be given in return for goods, money loaned, or services rendered. | SSI |
| Property Agreement | A pledge or security of particular property for the payment of a debt or the performance of some other obligation within a specified period. Property agreements on real estate generally are referred to as mortgages but also may be called land contracts, contracts for deed, deeds of trust, etc. Personal property agreements (Refer to, pledges of crops, fixtures, inventory, etc.) are commonly know as chattel mortgages. | SSI |
| Prospective Budgeting | Computing income and resources based on a representative amount of income received to determine Medicaid eligibility. | All |
| Public Institution | An institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. | All |
| Qualified Alien | An individual who meets the non-citizenship requirements to receive full Medicaid coverage. Qualified aliens potentially are eligible for full Medicaid just like US citizens. | All |
| Reapplication | A subsequent application when a case has been terminated or suspended. | All |
| Recertification | A review of all factors of eligibility. | All |
| Recoupment | Action to recover overpayments/over issuances made to beneficiaries. | All |
| Recurring Income | The amount of money an Institutionalized person must contribute toward their cost of care. | SSI |
| Redetermination of Eligibility | A complete review of all eligibility factors. | All |
| Refund | Return of a person’s own money | All |
| Remainder Interest | Interest in a property over and above a life estate holder’s share. | SSI |
| Renter | An individual who pays for separate living quarters. | All |
| Residence | Requirement that an applicant/beneficiary live in South Carolina voluntarily with the intent to remain in the state. | All |
| Residual Beneficiary | Is not a current beneficiary but will receive the residual benefit of the trust contingent upon the occurrence of a certain event (Refer to, the death of the primary beneficiary). | SSI |
| Resource | Those assets, including real and personal property, which an individual or couple owns; can apply, either directly or by sale or conversion, to the basic needs of food, clothing, and shelter; and is not legally restricted from use for support and maintenance. May be liquid or non liquid. | SSI |
| Resource Exclusions | Resources whose value, or part of the value, is not included in the eligibility determination process. | SSI |
| Resource Limit | The limit on the value of countable resources an individual or couple may own and still be eligible for Medicaid. The limit varies as to Payment Category. | SSI |
| Retirement Funds | Annuities or work-related plans for providing income when employment ends. | SSI |
| Retirement, Survivors, Disability Insurance (RSDI) | A program administered under Title II of the Social Security Act through the Social Security Administration which pays benefits to persons who have contributed enough quarters to the Social Security System, or who are the dependents of one who has contributed to the system, when they are aged or retired, are a surviving spouse or dependent child, or are disabled. | All |
| Retroactive period | 3 calendar months before the month in which the Medicaid application was filed. | All |
| Retrospective Budgeting | Computing income and resources, if applicable, for the benefit month based on actual income in a previous month. | All |
| Revocable Burial Contract | An agreement which can be reversed and money returned or that can be sold. | SSI |
| Revocable Trust | A contract in which terms can be altered. | All |
| Right of Recovery (Third Party Liability) | The responsibility of an individual, institution, corporation, or public or private agency to pay for all or part of medical costs of an applicant/beneficiary. | All |
| Roomer | A person who lives with the applicant/beneficiary and pays a set amount for a room. | All |
| Sanctionable Transfer | A change of ownership for compensation of less than Fair Market Value. | SSI |
| Seasonal Employment | Employment that is engaged in for a portion of year, at a predictable time each year. The employment may cover a few weeks or several months. | All |
| Self-Employment | Net Income of a person from a business enterprise or trade controlled by oneself, such as produce sales, farm rental, farming, craft sales, baby-sitting in one’s own home. | All |
| Self-Supporting | Maintaining one’s self without financial assistance from others. | All |
| Settlor | A person who creates a trust. | SSI |
| Shared Ownership | Two or more people own a resource concurrently. | SSI |
| Social Security Administration (SSA) | The agency of the federal government that issues regulations for the RSDI and SSI programs, as well as Medicare and Medicaid, under the Social Security Act. | All |
| Sole Ownership | Only one person may sell, transfer, or otherwise dispose of property. | SSI |
| Special Needs Trust | Contains resources of a disabled person under age 65 and established solely for their benefit. At the disabled person’s death, the state will receive all amounts remaining up to the amount of Medicaid funds paid on the person’s behalf. | SSI |
| Specified Relative | A relative who provides care and supervision of a child with whom the child lives. | MAGI |
| Sponsor | A person who signed an Affidavit of Support on behalf of an alien as a condition of the alien’s entry or admission to the US. An alien may have more than one sponsor. This does not apply to organizations and institutions, such as churches or service clubs. | All |
| Sponsored Alien | An alien admitted lawfully for permanent residence sponsored by an individual who has signed an Affidavit of Support. | All |
| Spousal Impoverishment Provisions | Provisions regarding the treatment of income and resources of an “Institutionalized” individual who has a spouse in the community. Designed to prevent the spouse from becoming impoverished. | SSI |
| Spousal Resource Assessment | The procedure for determining the community spouse’s share of resources owned by the couple at the time of institutionalization. | SSI |
| Spouse | An individual who is married to another person. Marriage may be Legal or Common Law | All |
| State Data Exchange (SDX) | A computer file listing the amount of an individual’s Supplemental Security Income benefits and which reflects Social Security amounts for individuals who receive both SSI and Social Security. This file is available as an on-line inquiry. | All |
| Stepparent | A person married to a child’s natural parent who is not the legal parent of the child. | All |
| Stocks | Shares of stock represent ownership in a business corporation. Their value shifts with demand and may fluctuate widely. | SSI |
| Subpoena | A written summons requiring appearance in court to give testimony. | All |
| Substantial Gainful Activity (SGA) | For disability purposes, gross earnings equal to or exceeding an amount set by Social Security | SSI |
| Supplemental Security Income (SSI) | A Federal assistance program administered by the Social Security Administration for aged, blind, and disabled persons under Title XVI of the Social Security Act to guarantee a certain level of income. SSI beneficiaries have contributed nothing or not enough to the Social Security System to be able to receive benefits on their own accounts. | All |
| Support Payments | Money paid by an absent parent. | All |
| Suspected Fraud | Basis for belief that an intentional misrepresentation may have occurred. | All |
| TANF (Temporary Assistance for Needy Families) | The federal block grant that funds the Family Independence (FI) program administered by the Department of Social Services. | FI |
| Tax Assessed Value | Value that the local tax office has placed upon real or personal property | SSI |
| TEFRA (Tax Equity and Fiscal Responsibility Act) | Program to allow disabled children who are at risk for institutionalization to receive medical care at home. Also called Katie Beckett. | SSI |
| Tentative Decision | A preliminary decision. | All |
| Terminated Case | When assistance has been previously terminated. | All |
| Termination | The ending of specific benefits. | All |
| Third Party Liability | (Refer to [Right of Recovery](#Right_of_Recovery).) | All |
| Third Party Payment | A monetary payment made on behalf of a household/ individual by an outside party. | All |
| Third Party Recovery | Recovery of all or part of a beneficiary’s medical cost from a responsible source such as private insurance. | All |
| Timely Notice | A written notice to inform the beneficiary of intended action. | All |
| Tips | Gratuities or sums of money in excess of $20 per month given voluntarily for services rendered | All |
| Totten Trust | A tentative trust in which a settlor makes himself trustee of his/her own funds for the benefit of another. Revocable. If the trustee dies without revoking the trust, ownership passes to the beneficiary. | SSI |
| Transfer | The conveyance of title, property, or money from one person to another. | SSI |
| Transfer Month | The calendar month in which resources were legally transferred. | SSI |
| Transfer of Assets | Changing of ownership. | SSI |
| Transfer Penalty | The period of time in which a person could be ineligible for Medicaid to pay the Vendor Payment at a SNF or ICF or for payment of Home and Community Based Services. | SSI |
| Transitional Medicaid (TM) | Four Months Transitional Medicaid: The up to 4 month period of time that a family may receive Medicaid.  OR  Eighteen Months Transitional Medicaid: The 18 month period of Medicaid for which a family qualifies if PCR is terminated for increased earnings or loss of disregards and income remains less than or equal to 185% of poverty. At the end of this period, a review is conducted to determine if income remains less than or equal to 185% of poverty. If so, the family qualifies for an additional 6 months of Transitional Medicaid.  OR  Six Months Transitional Medicaid: The six month period for which a family qualifies if PCR is terminated for increased earnings or loss of disregards and income exceeds 185% of poverty. | TMA |
| Treasury Bills | Also known as T-Bills. Short‑term obligations that require a minimum investment of $10,000. Certificates are not issued for T‑Bills; they are registered in book form at the Treasury Department and receipts are provided as proof of purchase. T‑Bills can be sold before maturity. | SSI |
| Treasury Notes and Securities | Treasury notes and bonds are similar to T‑Bills but have longer maturities and a lower minimum investment requirement. They have been registered in book entry form since July 1986 but were sometimes issued as bearer bonds before then. | SSI |
| Trust | A property interest whereby property is held by and individual subject to a fiduciary duty to use the property for the benefit of the trust’s beneficiary. | SSI |
| Trust Beneficiary | A person for whose benefit a trust exists. A beneficiary does not hold legal title to trust property but does have an equitable ownership interest in it. | SSI |
| Trust Earnings | Amounts earned by the trust principal. These amounts are unearned income to the person legally able to use them for personal support and maintenance. | SSI |
| Trust Grantor | A person who creates a trust. | SSI |
| Trust Principal | The property placed in trust by the Settlor plus any earnings paid into the trust and left to accumulate. | SSI |
| Trustee | A person or entity that holds legal title to property for the use or benefit of another. | SSI |
| Uncompensated Value | For liquid resources, the FMV less any payment for consideration received for the resource.  For real and personal property, the equity less any payment or consideration received for the property. | SSI |
| Unearned Income | All income that is not earned. Refer to, pension Social Security, alimony and child support, interest. | SSI |
| Unemployment Insurance (UI) | Income received by an individual as compensation for loss of employment due to layoff, suspension, and firing; may include additional amounts paid by unions or employers. | All |
| Unknown Assets | Assets in which an individual may be unaware of his ownership. | SSI |
| US Savings Bonds | Obligations of the Federal Government which are not transferable; they can only be sold back to the Federal Government. | SSI |
| Vendor Payment | Medicaid Payment of the Room and Board cost at a Nursing Facility. | SSI |
| Verification | The confirmation of information by direct contact with collateral source or personal review of documented information such as a receipt, ledger, or signed statement. | All |
| Verification Date | The date verifying information is received by the SC DHHS | All |
| Wages/Salary | Compensation paid regularly for services rendered, such as babysitting in the home of another, and sales clerk. | All |
| Specialists’ Compensation | Benefits resulting from loss of employment due to injury on the job. | All |

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104 Appendix J Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program

(Eff. 10/01/05)

The Early Periodic Screening, Diagnosis and Treatment (EPSDT) service is Medicaid’s comprehensive and preventive child health program for individuals under the age of 21. EPSDT is defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) legislation and includes periodic screening, vision, dental and hearing services. In addition, Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed in Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State’s Medicaid Plan to the rest of the Medicaid population.

How often should check ups be scheduled for children?

* Birth
* Two months
* Four months
* Six months
* Nine months
* One year
* 15 months
* 18 months
* Ages 2 through 6 – annually
* Ages 7 up through the month of the child’s 21st birthday - every other year

The EPSDT benefit, in accordance with Section 1905(r) of the Act, must include the following screening services:

* Comprehensive health and developmental history
* Comprehensive unclothed physical exam
* Appropriate immunizations
* Laboratory tests
* Health Education
* Vision services
* Dental services
* Diagnosis
* Treatment
* Lead Poisoning Prevention

Call 1-800-868-0404, if you do not have a doctor or dentist.

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104 Appendix K Race Code Values

(Eff. 04/01/11)

The 1996 Health Insurance Portability and Accountability Act (HIPAA) mandated that covered entities (health plans, health care clearinghouses, and certain health care providers) must use specific standards when conducting electronic transactions.

As a health plan, SC DHHS is required by Federal law to use appropriate race code values. The race code values allow for more accuracy in the collection of data and the processing of Medicaid claims.

The following race code values are valid for South Carolina:

|  |
| --- |
| 01 = White/Caucasian |
| 02 = Black/African American |
| 03 = Multi Race |
| 04 = Federally Recognized Native American |
| 05 = Other Native American |
| 06 = Alaska Native |
| 07 = Asian |
| 08 = Other/Unknown |
| 09 = Native Hawaiian/Pacific Islander |
| 10 = Hispanic |

104 Appendix L IRS Form 1095-B Documentation of Health Coverage

(Eff. 2/1/16)

([26 CFR 1.5000A-1](http://www.ecfr.gov/cgi-bin/text-idx?SID=ae356a1db1480b6d8c6f2d271de56efc&mc=true&node=se26.15.1_15000a_61&rgn=div8); [26 CFR 1.5000A-2](http://www.ecfr.gov/cgi-bin/text-idx?SID=ae356a1db1480b6d8c6f2d271de56efc&mc=true&node=se26.15.1_15000a_62&rgn=div8); [26 CFR 1.6055-1](http://www.ecfr.gov/cgi-bin/text-idx?SID=ae356a1db1480b6d8c6f2d271de56efc&mc=true&node=se26.15.1_16055_61&rgn=div8))

**Introduction**

Starting in 2016 the Affordable Care Act (ACA) requires health coverage providers, including Medicaid, to report certain information to the IRS. The ACA requires most US Citizens and resident aliens to have health coverage that meets Minimum Essential Coverage (MEC). MEC includes coverage under health plans offered on the individual market, grandfathered health plans, government-sponsored programs (including most Medicaid coverage), employer-sponsored plans, and health coverage designated by the United States Department of Health and Human Services as MEC. If you do not have MEC and do not qualify for an exemption, you must make an individual shared responsibility payment when you file your federal income tax return. Form 1095-B represents health coverage for the Medicaid household for the past tax year. SCDHHS reports the household’s months of coverage directly to the IRS and sends the Medicaid beneficiary a copy of the Form 1095-B for his or her records. The tax filer uses the Form 1095-B to complete his or her tax return but does not need to send a copy of the form to the IRS.

Note: Although most Medicaid coverage satisfies MEC, Family Planning (FP) does not.

Information on Form 1095-B Form

Part I lists information about the primary contact or responsible individual for the Medicaid household. Part III lists information about SCDHHS, the coverage provider. Part IV lists information about the members of the household who received health coverage from Medicaid and the months the coverage was provided. For an example of Form 1095-B, see Figure 1 below.

Corrections

If information on the Form 1095-B is incorrect, the Medicaid beneficiary should call 844-730-4003. SCDHHS will send a corrected version of the form and correct the information with the IRS.

Additional Copies

If an individual did not receive a Form 1095-B or needs another copy, the individual may call 844-730-4003. SCDHHS will send a copy of the form to the individual.

Questions about Form 1095-B

If an individual has questions about the Form 1095-B, he or she should be directed to the FAQs located on [scdhhs.gov](https://www.scdhhs.gov) or to call 844-730-4003.

Figure 1

****

104 Appendix M Forms

(Eff. 10/01/05)

Medicaid eligibility forms may be viewed, downloaded and printed from the following public Web site addresses:

* South Carolina Department of Health and Human Services (SC DHHS)

[http://www.scdhhs.gov](http://www.scdhhs.gov/)

* Medicaid Eligibility Determination System (MEDS)

<http://medsweb.scdhhs.gov/formslisting.htm>

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104 Appendix N Free Medical Clinics of SC

(Rev. 04/01/10)

Free medical clinics in South Carolina provide indigent residents with basic medical care, including prescription medicines, wellness education and, in some cases, dental or chiropractic care and psychological counseling. The clinics are as diverse as the communities that support them are. One operates in a homeless shelter, another operates within a university school of nursing, and several are closely associated with congregations or multi-denominational religious organizations, or community hospitals. Please contact the nearest facility by telephone and make an advance appointment before visiting any clinic. The current list of free medical clinics can also be found at: [www.scfreeclinics.org](http://www.scfreeclinics.org)

| County | Clinic Name | Address | Phone | Fax |
| --- | --- | --- | --- | --- |
| Aiken | Community Medical Clinic of Aiken County | [244 Greenville St Aiken, SC 29801](http://maps.google.com/maps?oe=utf-8&client=firefox-a&q=244+Greenville+Street+Aiken,+SC+29801&ie=UTF8&hq=&hnear=244+Greenville+St+NW,+Aiken,+SC+29801&gl=us&ei=diHBSsWIAcPd8QbtyJmeAQ&z=16&iwloc=A) | 803.226.0631 |  |
| Anderson | Anderson Free Clinic | [414 N. Fant St. Anderson, SC 29621](http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=414+N.+Fant+St.+Anderson,+SC+29621&sll=34.447125,-82.393186&sspn=0.012103,0.01929&gl=us&ie=UTF8&z=16&iwloc=A)  Mail- PO Box 728 Anderson, SC 29622 | 864.226.1294 dir –.261.4542 | 864.261.4543 |
|  | Honea Path (satellite) | [34 N. Main St. Anderson, SC 29654](http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=34+N.+Main+St.+Anderson,+SC+29654&sll=32.434549,-80.677444&sspn=0.012387,0.01929&gl=us&ie=UTF8&z=16&iwloc=A)  Mail- PO Box 728 Anderson, SC 29622 | 864.226.1294 | 864.261.4543 |
| Beaufort (Hilton Head) | Volunteers in Medicine Clinic | [15 Northridge Drive Hilton Head Island, SC 29926](http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=15+Northridge+Drive+Hilton+Head+Island,+SC+29926&sll=33.565297,-81.723687&sspn=0.012766,0.01929&gl=us&ie=UTF8&z=17&iwloc=A) | 843.681.6612 | 843.681.6614 |
| Beaufort | Good Neighbor Free Medical Clinic of Beaufort | [1402 King Street Beaufort, SC](http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=1402+King+Street+Beaufort,+SC&sll=33.463232,-79.116648&sspn=0.012244,0.01929&gl=us&ie=UTF8&z=16&iwloc=A) | 843.470.9088 |  |
| Charleston (St John & Wadmalaw Island) | Barrier Islands Free Medical Clinic | [3226 Maybank Highway, Suite A Johns Island, SC 29455](http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=3226+Maybank+Highway,+Suite+A+Johns+Island,+SC+29455%09&sll=32.218072,-80.706405&sspn=0.012508,0.01929&gl=us&ie=UTF8&ll=32.731444,-80.060956&spn=0.012888,0.01929&z=16&iwloc=A) | 843.266.9800 | 843.266.9801 |
| Charleston | Crisis Ministries Health Clinic | [573 Meeting St PO Box 20038 Charleston, SC 29413-0038](http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=573+Meeting+Street+PO+Box+20038+Charleston,+SC+29413-0038%09&sll=32.731444,-80.060956&sspn=0.012888,0.01929&gl=us&ie=UTF8&z=17&iwloc=A) | 843.723.9477 | 843.723.7563 |
| Charleston (North Charleston) | Dream Center Clinic | [5505 N. Rhett Avenue North Charleston, SC 29406](http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=5505+N.+Rhett+Avenue+North+Charleston,+SC+29406%09&sll=32.800496,-79.943725&sspn=0.006439,0.009645&gl=us&ie=UTF8&z=17&iwloc=A) | 843.375.1099 | 843.767.7563 |
| Charleston (North Charleston) | Harvest Free Medical Clinic | [1670 Drydock Avenue Bldg 10B N. Charleston, SC 29405](http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=1670+Drydock+Avenue+North+Charleston,+SC+29405&sll=32.861206,-79.964406&sspn=0.051477,0.077162&gl=us&ie=UTF8&ll=32.861493,-79.958625&spn=0.024837,0.038581&z=15&iwloc=B) | 843.747.3526 | 843.747.3527 |
| Chester | Good Samaritan Medical Clinic | [139 Church St.  Chester, SC 29706](http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=139+Church+Street+Chester,+SC+29706%09&sll=32.861493,-79.958625&sspn=0.024837,0.038581&gl=us&ie=UTF8&ll=34.703094,-81.21171&spn=0.012595,0.01929&z=16&iwloc=A) | 803.385.6332 | 803.385.3243 |
| Chesterfield | Mercy In Me Free Medical Clinic | [32 Foundry Hill Road  Cheraw, SC 29520](http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=32+Foundry+Hill+Road+Cheraw,+SC+29520%09&sll=34.703094,-81.21171&sspn=0.012595,0.01929&gl=us&ie=UTF8&z=17&iwloc=A) |  |  |
| Darlington | Free Medical Clinic of Darlington County | [203 Grove St Darlington, SC 29532](http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=203+Grove+Street+Darlington,+SC+29532%09&sll=34.693356,-79.901798&sspn=0.006298,0.009645&gl=us&ie=UTF8&z=17&iwloc=A) | 843.398.0060 | 843.398.0401 |
|  | Hartsville (satellite) | [500 W. Carolina Ave  PO Box 520 Hartsville, SC 29550](http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=500+W.+Carolina+Ave+PO+Box+520+Hartsville,+SC+29550%09&sll=34.301019,-79.871254&sspn=0.006328,0.009645&gl=us&ie=UTF8&z=17&iwloc=A) | 843.332.0422 | 843.332.5445 |
| Edgefield | Peachtree Medical Center | [200 Ridge Medical Plaza Rd  Edgefield, SC 29824](http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=200+Ridge+Medical+Plaza+Road+Edgefield,+SC+29824&sll=34.370572,-80.082784&sspn=0.006323,0.009645&gl=us&ie=UTF8&z=17&iwloc=A) | 803.637.3630 |  |
| Florence | Mercy Medicine Clinic | [514E S Dargan St Florence, SC 29506](http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=514E+South+Dargan+Street+Florence,+SC+29506%09&sll=33.778504,-81.929307&sspn=0.006367,0.009645&gl=us&ie=UTF8&z=17&iwloc=A) | 843.667.9947 dir – 667.5023 | 843.667.0455 |
| Florence | Lake City Free Medical Clinic | [124 Epps Street Lake City, SC 29560](http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=124+Epps+Street+Lake+City,+SC+29560%09&sll=34.1901,-79.765418&sspn=0.006337,0.009645&gl=us&ie=UTF8&z=17&iwloc=A) | 843.374-2085 | 843.374.2089 |
| Georgetown (Pawleys Island) | Smith Medical Clinic at Baskervill | [116 Baskerville Dr Pawleys Island, SC](http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=116+Baskerville+Dr+Pawleys+Island,+SC&sll=34.842346,-82.417995&sspn=0.012046,0.01929&gl=us&ie=UTF8&z=16&iwloc=A)  Mail- PO Box 1740 Pawleys Island, SC 29585 | 843.237.2672 | 843.237.0369 |
| Greenville | Greenville Free Medical Clinic | [600 Arlington Ave Greenville, SC](http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=600+Arlington+Ave+Greenville,+SC&sll=34.484326,-81.938221&sspn=0.012098,0.01929&gl=us&ie=UTF8&z=16&iwloc=A)  Mail- PO Box 8993 Greenville, SC 29604 | 864.232.1470 (dir – ext 25) | 864.233.4599 |
|  | Northwest Crescent Free Clinic (satellite) | [925 N Franklin Road Greenville, SC 29617](http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=925+N+Franklin+Road+Greenville,+SC+29617+&sll=34.937719,-82.226445&sspn=0.00628,0.009645&gl=us&ie=UTF8&z=17&iwloc=A) | 864.232.1470 ext 60 |  |
|  | Greer Free Clinic (satellite) | [J Verne Smith Human Service Center  202 Victoria St Greer, SC 29650](http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=+202+Victoria+Street+Greer,+SC+29650&sll=34.892349,-82.422236&sspn=0.006283,0.009645&gl=us&ie=UTF8&z=17&iwloc=A) | 864.232.1470 ext 65 |  |
|  | Golden Strip Free Clinic (satellite) | [Golden Strip Child & Family Center  1102 Howard Street Simpsonville, SC 29681](http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=1102+Howard+Street+Simpsonville,+SC+29681&sll=34.746728,-82.237037&sspn=0.10071,0.154324&gl=us&ie=UTF8&z=17&iwloc=A) | 864.232.1470 ext 55 |  |
| Greenville (Taylors) | Taylors Free Medical Clinic | [400 W Main St Taylors, SC 29687](http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=400+W+Main+Street+Taylors,+SC+29687+&sll=34.720422,-82.218278&sspn=0.006296,0.009645&gl=us&ie=UTF8&z=17&iwloc=A)  Mail– PO Box 1266  Taylors, SC 29687 | 864.244.1134 | 864.244.1135 |
| Greenwood | Greenwood Free Clinic | [1404 Edgefield Street Greenwood, SC 29646](http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=1404+Edgefield+Street+Greenwood,+SC+29646&sll=34.919459,-82.309972&sspn=0.006281,0.009645&gl=us&ie=UTF8&z=17&iwloc=A) | 864.942.0500 | 864.229.0332 |
| Greenwood | Clinica Gratis at Community Initiatives, Inc | [647 Grier Street Greenwood, SC 29646](http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=647+Grier+Street+Greenwood,+SC+29646%09&sll=34.176982,-82.155891&sspn=0.006337,0.009645&gl=us&ie=UTF8&z=17&iwloc=A) | 864.223.7472 |  |
| Horry | Friendship Free Medical Clinic and Pharmacy | [1396 Hwy 544  Conway, SC 29526](http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=1396+Highway+544+Conway,+SC+29526%09&sll=34.160198,-82.143152&sspn=0.006339,0.009645&gl=us&ie=UTF8&z=16&iwloc=A) | Main 843.347.7199 Patient line 843.347.7178 | 843.347.7180 |
| Kershaw | Community Medical Clinic of Kershaw County | [110 E DeKalb St Camden, SC 29020](http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=110+E+DeKalb+Street+Camden,+SC+29020%09&sll=33.805468,-79.016363&sspn=0.012731,0.01929&gl=us&ie=UTF8&z=17&iwloc=A) | 803.713.0806 | 803.713.0526 |
| Laurens | Good Shepherd Free Medical Clinic of Laurens County | [245 Human Services Road Clinton, SC](http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=245+Human+Services+Road+Clinton,+SC&sll=33.981392,-81.236494&sspn=0.01217,0.01929&gl=us&ie=UTF8&z=16&iwloc=A)  Mail- PO Box 1535 Clinton, SC 29325 | 864.833.0017 | 864.833.0709 |
| Lexington | Clinica El Buen Samaritano | [1303 Sunset Boulevard West Columbia, SC 29169](http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=1303+Sunset+Boulevard+West+Columbia,+SC+29169+&sll=34.247225,-80.596059&sspn=0.006332,0.009645&gl=us&ie=UTF8&z=17&iwloc=A) | 803.790.0239 |  |
| Lexington County | Med Mission | PO Box 1661 Lexington, SC 29071 |  |  |
| Marion | Helping Hands Free Medical Clinic | [518 South Main Street Mullins, SC 29574](http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=518+South+Main+Street+Mullins,+SC+29574%09&sll=33.997726,-81.081006&sspn=0.006351,0.009645&gl=us&ie=UTF8&z=17&iwloc=A) | 843.464.0938 |  |
| Newberry | Free Medical Clinic of Newberry County | [2568 Kinard St  PO Box 783  Newberry, SC 29108](http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=2568+Kinard+Street+PO+Box+783+Newberry,+SC+29108&sll=34.199826,-79.253061&sspn=0.006336,0.009645&gl=us&ie=UTF8&z=17&iwloc=A) | 803.276.6665 | 803.276.6667 |
| Orangeburg-Calhoun | Orangeburg-Calhoun Free Medical Clinic | [800 Holly St.  Orangeburg, SC](http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=800+Holly+St.++Orangeburg,+SC&sll=34.688941,-82.826767&sspn=0.012068,0.01929&gl=us&ie=UTF8&z=16&iwloc=A)  Mail- PO Box 505 Orangeburg, SC 29116 | 803.534.8847 |  |
| Pickens (Clemson) | Clemson Free Clinic | [105 Anderson Hwy Clemson, SC 29633](http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=105+Anderson+Hwy+Clemson,+SC+29633%09&sll=34.841974,-82.602408&sspn=0.012046,0.01929&gl=us&ie=UTF8&z=16&iwloc=A)   Mail- PO Box 941 Clemson, SC 29633 | 864.654.8277 |  |
| Pickens | Samaritan Health Clinic of Pickens County | [303 Dacusville Hwy. Easley, SC](http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=303+Dacusville+Hwy.+Easley,+SC&sll=34.940892,-81.927806&sspn=0.012031,0.01929&gl=us&ie=UTF8&z=16&iwloc=A)  PO Box 1452 Pickens, SC 29671 | 864.855.0853 ext 26 | 864.855.5582 |
| Richland | Clinica El Buen Samaritano | [7915 Old Percival Rd Columbia, SC 29223](http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=7915+Old+Percival+Rd+Columbia,+SC+29223+&sll=34.289051,-81.605149&sspn=0.006329,0.009645&gl=us&ie=UTF8&z=17&iwloc=A) | 803.790.0239 |  |
| Richland | The Free Medical Clinic | [1875 Harden Street Columbia, SC 29204](http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=1875+Harden+Street+Columbia,+SC+29204%09&sll=34.062971,-80.91051&sspn=0.006346,0.009645&gl=us&ie=UTF8&z=17&iwloc=A) | 803.765.1503 | 803.779.6178 |
| Spartanburg | St Luke’s Free Medical Clinic | [411 S. Church St. Spartanburg, SC](http://maps.google.com/maps?q=411+S.+Church+St.+Spartanburg,+SC&oe=utf-8&client=firefox-a&ie=UTF8&hq=&hnear=411+S+Church+St,+Spartanburg,+SC+29306&gl=us&ei=9fXISv_vIJGntgeeuZHuDg&z=16&iwloc=A)  PO Box 3466 Spartanburg, SC 29304 | 864.542.2273 | 864.597.0413 |
| York | The Early Learning Partnership of York County | [403 Withers Building, Winthrop Univ.  Rock Hill, SC 29733](http://maps.google.com/maps?f=d&source=s_d&saddr=&daddr=Winthrop+Univ.+Withers+Bldg+@34.941506,-81.028397&hl=en&geocode=&gl=us&mra=mi&sll=34.949835,-81.026659&sspn=0.024236,0.038581&ie=UTF8&ll=34.949413,-81.026659&spn=0.025116,0.038581&z=15) | 803.323.2180 | 803.323.4960 |
| York | Palmetto Volunteers in Medicine Clinic | [235 S Herlong Ave Rock Hill, SC 29732](http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=235+S+Herlong+Ave+Rock+Hill,+SC+29732%09&sll=34.949413,-81.026659&sspn=0.025116,0.038581&gl=us&ie=UTF8&z=17&iwloc=A) | 803.366.6337 | 803.324.4819 |

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104 Appendix O Health Insurance Premium Payment (HIPP) Program

(Rev. 04/01/09)

What is the Health Insurance Premium Payment (HIPP) program?

The HIPP program was created to assist families of Medicaid beneficiaries with the cost of health insurance that covers the client. The goal of the program is to help beneficiaries maintain their private insurance. Private plans pay first for medical services and Medicaid is secondary. This savings benefits all South Carolinians.

In order to be approved, HIPP program cost effectiveness guidelines must be met. Once approved, a cost effectiveness re-evaluation is done every six (6) months to determine continued program eligibility.

Who qualifies for HIPP?

Applicants must be receiving South Carolina Medicaid benefits and have access to medical health insurance coverage. Premiums must be cost effective. Cost effective means that the anticipated medical cost of the client are greater that the cost of the private health insurance. Medicaid beneficiaries with a chronic medical condition requiring long-term or short-term treatment that will result in high medical cost usually qualify for the program.

How to apply?

A referral form should be completed and returned indicating client’s diagnosis and other requested information. Providers, other state agencies and departments, self or family members, and support groups or organizations can make referrals. Referral forms can also be obtained by calling 803-933-1800. Case approval or denial is usually completed within 30 days.

Who receives premium payments?

Checks are mailed to beneficiaries, employers, or the insurance company. HIPP staff will determine the proper payee.

What are the beneficiary’s responsibilities?

* Furnish HIPP staff with copies of EOBs (Explanation of Benefits) or paid claims to support medical condition, medical and drug expenses, and documentation of ongoing treatment, to determine cost effectiveness.
* Notify staff of any changes with insurance policy or premium amount.
* Give providers both Medicaid and health insurance benefit cards at time of service.
* If requested, send copies of proof of payment each month. Proof of payment could include pay stubs, bank drafts, or letters from a human resources department.

What are the benefits of the HIPP program?

All South Carolinians will experience benefits from the program. It saves taxpayers dollars by making Medicaid the payer of last resort. Medicaid beneficiaries are able to maintain their private health insurance, which may increase their accessibility to medical care. Insurance companies’ reimbursement rates are higher than the Medicaid-allowed amount; therefore, by billing the third-party carrier first, providers will receive maximum amount of payment for services rendered.

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104 Appendix P Income Eligibility and Verification System (IEVS)

(Rev. 08/01/19)

A State plan under Title I, IV-A, X, XIV or XVI (AABD) of the Social Security Act must provide that there be an Income and Eligibility Verification System (IEVS) in the state through which the State agency:

(1) Coordinates data exchanges with other Federally-assisted benefit programs covered by Section 1137(b) of the Act;

(2) Requests and uses income and benefit information as specified in Section 1137(a)(2) of the Act; and

(3) Adheres to standardized formats and procedures in exchanging information with the other programs and agencies and in providing such information as may be useful to assist federal, state and county/local agencies in the administration of the child support program and the Social Security Administration in the administration of the Title II and Title XVI (SSI) programs.

|  |
| --- |
| **IEVS Procedure** |
| Procedure in MEDS:  The IEVS Action Menu in MEDS includes BENDEX and SCDEW (South Carolina Department of Employment and Workforce) information. To access the IEVS Action Menu in MEDS from the Main Menu:  Select Interface Menu; then <ENTER>. Select IEVS Action Menu, then <ENTER>.  The BENDEX inquiry and update screens may be accessed from the Interface Menu.  Select IEVS Action Menu and press <ENTER>. Then, select BENDEX and press <ENTER>.  The BENDEX information screens provide SSA benefit information and Medicare data received from SSA through the BENDEX exchange. (See MEDS User Training Manual-Section 16.3.2.3.)  The ESC screens may also be accessed from the Interface Menu.  Select IVES Action Menu and press <ENTER>. Then, select ESC and press <ENTER>.  The ESC screens provide information on wage inquiries and Unemployment Compensation benefit verifications. |
| **Procedure in Cúram:**  Income eligibility and verification will be determined automatically in Cúram by referencing the SCDEW and the Federal Hub. |

The maintenance of the confidentiality of the information available through IEVS is vital. Each Eligibility Specialist who has access to IEVS information will be asked to sign a confidentiality statement, confirming that he/she understands the responsibility of handling confidential information, the importance of not sharing the USERID/ PASSWORD, and that he/she agrees to adhere to the requirement of keeping information confidential.

SCDHHS prohibits printing of SSA data. Any exceptions to this policy must be approved by the Privacy Official in the SCDHHS Civil Rights Division and must meet the SSA paper handling requirements at a minimum. IEVS information is to be released to no other agency or person, except as allowed by federal law, unless clearance for release has been received from the SCDHHS Privacy Official.

The Eligibility Specialist must indicate in the case record that system matches have been completed. IEVS matches can be virtually printed into OnBase. Do not print a hard copy of any IEVS matches without approval from the SCDHHS Privacy Official. A notation in the electronic budget workbook or on the Documentation Template is satisfactory documentation.

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104 Appendix Q Translation Services

(Rev. 08/01/21)

Refer to MPPM Chapter 802, Appendix B

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104 Appendix R Life Insurance Verification

(Eff. 01/01/14)

The SSI-related Medicaid programs require a resource test in the financial determination process. In some cases, The Eligibility Specialist will need to verify only the Face Value (FV) of a life insurance policy. In other cases, the Cash Value (CV) may be used in the resource test.

There are a number of ways to obtain the necessary documentation for the case record:

* Copy the face sheet (the front page) of the life insurance policy. This page should verify the name of the company, the policy number, the owner, the insured, and the face value of the policy.
* Copy the cash value tables if the information is needed to verify the CV.
* In the event that the applicant/beneficiary cannot locate the life insurance policy, or it has been determined that the cash value is needed, the SC DHHS Form 1280 ME, Verification of Life Insurance Values, should be mailed to the appropriate company.
* To access the list of life insurance companies licensed to do business in South Carolina, visit the SC Department of Insurance (DOI) Web site. The online list provides insurance company addresses and telephone numbers. Here is a link to the DOI Web site address: <https://doi.sc.gov/>

|  |
| --- |
| Procedure for Using the State DOI Web Site:   * Click on the link above or enter the DOI Web address in your Internet address box. * The DOI Home Page will open. Place your cursor on the word “Insures” on the blue toolbar and click. * Select “Company Information” * For a list of companies currently licensed in South Carolina, click on “[List of Insurance Companies and HMOs Authorized to Transact Business Within the State of South Carolina](http://doi.sc.gov/DocumentCenter/View/7165).” * For a list of companies no longer licensed in South Carolina, click on “[List of Insurers No Longer Licensed in South Carolina](http://doi.sc.gov/documentcenter/view/2383) |

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104 Appendix S Lifeline Assistance Program

(Rev. 01/01/14)

The Lifeline Assistance Program assists qualified residential telephone customers. It is designed to ensure that basic telephone connection (hook-up) and service remain affordable to low-income South Carolina residents.

The Lifeline Assistance Program provides a discounted rate (for one line only, landline or cellular) on the monthly residential telephone bill. Medicaid beneficiaries may qualify for Lifeline Assistance.

Medicaid beneficiaries may complete the [Lifeline & Link-Up Telephone Assistance Application](http://www.regulatorystaff.sc.gov/TTWWW/LifeLine/SC%20Universal%20Application%202013.pdf) located on-line at the Office of Regulatory Staff web site, at their county Medicaid office, or local telephone company. The application will serve as notice that the individual is receiving Medicaid benefits and the telephone is listed in the beneficiary’s name. The telephone company will verify that the individual in Medicaid eligible and determine the discount available to the beneficiary.

The completed application must be mailed to:

Office of Regulatory Staff

1401 Main St., Suite 900

Columbia, S.C. 29201

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104 Appendix T Reserved for Future Use

(Rev. 08/01/17)

This section is reserved for future use.

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104 Appendix U Medicaid Policy Requests Through Service Manager

(Eff. 11/01/11)

* If you have a question about policy or procedures, refer to the Medicaid Policy and Procedures Manual (SC MPPM)
* If the answer to your question is not in the SC MPPM, ask your supervisor for help
* If your supervisor cannot answer your question, s/he should create a Service Manager ticket to submit the question to Medicaid Eligibility for a policy clarification. The question will then be assigned for a response
  + The Service Manager ticket should include a clear description of the case situation
  + If documents need to be included with the request, the items can be scanned and attached to the ticket, or can be faxed to the attention of Betty Moses in the Division of Policy and Planning at 803-255-8350. Make sure to include the Service Manager ticket number with the fax
* Other Medicaid Policy requests, such as promissory notes, annuities, overpayment summaries, etc., can be submitted by either specialists or supervisors through Service Manager

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104 Appendix V National Voter Registration Act (NVRA)

(Rev. 06/01/14)

This appendix has been deleted. Refer to MPPM 101.18.

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104 Appendix W New Eyes for the Needy Program

(Rev. 06/01/09)

**Introduction**

New Eyes for the Needy, Inc., is a nonsectarian volunteer organization in Short Hills, New Jersey. This organization has been in existence since 1932 and provides eyeglasses for people who meet financial and visual criteria. It is funded entirely from donations such as used metal eyeglass frames, unbroken plastic frames with lenses and hearing aids. It also accepts precious metal scrap such as old watches, broken or outdated real, costume or antique jewelry. Since New Eyes for the Needy funds are limited, eligibility criteria have been established for this service program in South Carolina. The Bureau of Eligibility Administration is notified bimonthly of the number of referrals for vision services that can be made to the organization or if the number of referrals previously allotted must be reduced.

**Available Medical Coverage for Eyeglasses and Eye Examination**

One eye examination and one pair of eyeglasses every 365 days are covered services under the Medicaid Program for beneficiaries under the age of 21. Beneficiaries aged 21 and older receive one eye examination every 365 days and one pair of glasses every two years following cataract surgery. If eyeglasses can be obtained for an individual through the Medicaid Program, a referral for New Eyes for the Needy services for that individual is not appropriate.

**Eligibility Criteria**

The individual makes the request for eyeglasses or the Eligibility Specialist recognizes individual’s need for eyeglasses. The Eligibility Specialist establishes that individual is not financially able to purchase eyeglasses and that there is no local resource exists to obtain eyeglasses. The EW sends the request via letter or memorandum to the Bureau of Eligibility Administration (BEA). The request is reviewed by BEA and if accepted a voucher is sent to the EW to be given to the individual. The EW sends the individual to a cooperating dispenser.

To qualify for New Eyes for the Needy (NEN), an individual must meet the following requirements:

* The individual must be financial need (income at or below 100% of the Federal Poverty Level).
* No other source is available for purchasing eyeglasses. The NEN voucher is not to be used for partial payment. If the individual has funds, he is not entitled to NEN services.
* The eyeglasses have not been ordered or purchased and will not be ordered or purchased before receipt of the NEN voucher.
* The individual has not received a NEN voucher within the past year.

**Referral to Commission for the Blind**

An individual whose distance vision is 20/200 or worse in both eyes must first be referred to the Commission for the Blind because they are considered legally blind. However, since the Commission for the Blind is limited in services it can provide for individuals whose near vision is 20/200, New Eyes for the Needy forms may be requested for individuals in this category.

**Initiating Requests for New Eyes for the Needy Program Services**

Requests for the New Eyes for the Needy services are made by the EW only when the individual is not financially able to purchase eyeglasses and no local resources exist through which eyeglasses can be obtained. The Eligibility Specialist sends a request via letter or memorandum form to the BEA, along with the New Eyes for the Needy application, which should include the following information:

1. The name, address, and age of the individual;
2. The number of people in the household;
3. Types and amounts of income;
4. Employment status;
5. Fixed expenses;
6. A copy of the prescription from a recent eye examination.
7. A statement verifying that no resources for obtaining the eyeglasses are available, including religious organizations and private sector groups; and
8. The name and address of the eyeglass dispenser. The optometrist or optician who is providing the eyeglasses must be informed of the current New Eyes for the Needy price list and must agree to adhere to this list before being sent the New Eyes for the Needy voucher. (See New Eyes for the Needy Program Price List below.)

If an individual is determined eligible, a New Eyes for the Needy Voucher will be issued to the individual by the EW in order to purchase eyeglasses. The optician must have the New Eyes for the Needy Inc. voucher before he makes the glasses. The optician should be contacted before the individual arrives to assure that optician will accept New Eyes for the Needy price guidelines. The Eligibility Specialist may need to help find a willing optician. Once the EW issues the voucher to the individual, he/she should be informed to use the voucher before the expiration date.

For additional information on New Eyes for the Needy, contact (803) 898-2635.

**New Eyes for the Needy Program Price List**

|  |  |  |
| --- | --- | --- |
|  | Single Vision Lenses | Bifocal Lenses |
| Lenses | $24.00/pair | $43.00/pair |
| Frame – add | $20.00/pair | $20.00/pair |

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104 Appendix X Healthy Connections (Medicaid) Insurance Card

(Eff. 03/01/08)

The following is an example of a Healthy Connections (Medicaid) Insurance Card.





104 Appendix Y Prescription Assistance Programs

(Rev. 04/01/10)

There are several specialized programs sponsored by pharmaceutical companies, business associations or non-profit organizations to assist low-income or needy individuals in obtaining necessary prescription medicines at little or a substantially reduced cost. The following is a list of some of these programs and contact information for those who may want to apply for assistance:

Generic Drug Programs

Regardless of someone’s prescription insurance provider, several pharmacies, including Wal-Mart, Target, Kroger and Publix, offer generic drugs for as little as $4 for a 1 month supply and $10 for a 3 month supply. Publix also offers several antibiotics for free with a valid prescription. Other pharmacies offer prescription assistance programs so ask your doctor to prescribe generic drugs whenever possible.

GlaxoSmithKline

1-866-475-3678

[www.gskforyou.com](http://www.gskforyou.com)

Various programs sponsored by GSK help patients save money on prescriptions. Assistance is available for individuals of all ages who meet categorical requirements to include being diagnosed with cancer, enrolled in a Medicare Part D drug plan and having no private or public Rx coverage. Must be a US citizen and meet set income limits.

Lilly Medicare Answers

1-877-795-4559

[www.lillytruassist.com](http://www.lillytruassist.com/Pages/index.aspx)

Provides eligible Medicare Part D recipients access to affordable medications outside their Part D plan. Patients eligible will receive their prescriptions through the mail. Must meet set income limits and not be eligible for Medicaid or Low-Income Subsidy through the Social Security Administration.

Needy Meds

[www.needymeds.com](http://www.needymeds.com)

Needy Meds is a 501(c)(3) non-profit organization, according to its website, with the mission of helping people who cannot afford medicine or healthcare costs. The information at NeedyMeds is available anonymously and free of charge. Unfortunately, at this time, NeedyMeds does not have a phone help line. All NeedyMeds information is available on their website. Mailing Address: NeedyMeds, Inc., 120 Western Ave. Gloucester, MA 01930.

Partnership for Prescription Assistance

1-888-477-2669

[www.pparx.com](http://www.pparx.com)

This organization is a centralized source of information on many prescription assistance programs and their requirements.

Pfizer Helpful Answers

1-866-706-2400

[www.pfizerhelpfulanswers.com](http://www.pfizerhelpfulanswers.com)

Pharmaceutical company program offering several options for free or reduced cost prescriptions of their products through doctors and community health centers for low-income patients. Must meet set income limits and have no private or public prescription (Rx) coverage.

Together RX Access

1-800-444-4106

[www.TogetherRxAccess.com](http://www.TogetherRxAccess.com)

Savings of 25-40% on approximately 275 brand-name prescriptions. Must meet specific income levels, have no private or public prescription insurance coverage, be a legal US resident and not be eligible for Medicare.

Welvista

1-800-763-0059 ext. 100

[www.welvista.org](http://www.welvista.org)

Twelve pharmaceutical companies have donated over 200 name-brand medications to be dispensed to working, uninsured SC residents under the age of 65 with an income at or below 200% of the Federal Poverty Level. Eligibility is for one year and requires a $20 refundable application-processing fee. There is never a charge for the medication. An application may be obtained online. Mailing address:

Welvista

2700 Middleburg Drive-Suite 104

Columbia, SC 29204.

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104 Appendix Z Program Operations Manual System (POMS) on Internet

(Eff. 10/01/05)

The Program Operations Manual System (POMS) is used for SSI-Related categories to determine the treatment of income and resources.

The Web site address is: <http://policy.ssa.gov/poms.nsf/aboutpoms>

The way to navigate is to:

1. Go to the SSA Online <http://www.ssa.gov/>
2. On the right side, under Our Agency, click on Program Rules, Laws, Regulations and Rulings,
3. On this page, scroll down to Employee Operating Instructions, (shown on the screen) and select Program Operations Manual System
4. Once in the Program Operations Manual System, click on “Table of Contents.”

The site may also be accessed directly at: <http://policy.ssa.gov/poms.nsf/partlist?OpenView>

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104 Appendix AA Toll-Free Numbers at SC DHHS

(Eff. 01/01/14)

Staff in the Healthy Connections Member Services Center man the toll-free telephone line (1-888-549-0820) so that customers may obtain service on a wide range of Medicaid-related issues. SC DHHS customers include applicants, beneficiaries, members of the legislature or other state agencies. Services offered include, but are not limited to, the following:

* Provide information and referral services to individuals who may not be Medicaid beneficiaries, but who are interested in receiving Medicaid benefits in South Carolina. Appropriate Medicaid forms are mailed to individuals upon request;
* Provide basic technical support for applicants using the Healthy Connections online application portal;
* Provide consumer information to callers regarding South Carolina Medicaid covered services. For example, beneficiaries often call because they wish to know if a particular service is covered, such as prescription drugs, transportation, medical procedures or durable medical equipment;
* Provide beneficiary information regarding hospital and doctor bills, often related to balances due on their billing statements, or coverage of out-of-state emergency services;
* Provide responses to inter-agency requests regarding beneficiaries who may be receiving services from a state agency;
* Assist with insurance-related calls. When recipients no longer have a private insurance carrier and Medicaid becomes the primary insurer for the beneficiary, the cancelled insurance may remain in the individual’s file until the insurance indicator has been removed;
* Provide referrals, if applicable, to county/local eligibility offices;
* Provide referrals to appropriate offices within SC DHHS regarding Third Party Liability, Estate Recovery, and other Medicaid issues.
* The automated Call Center menu also routes beneficiaries to third-party managed care provider resources. Through this menu option, beneficiaries may enroll or dis-enroll with managed care providers for medical services and access the full range of supportive services.

Provider-related issues should NOT be referred to the Healthy Connections Call Center.

*INSTEAD*

Refer provider-related calls to the Provider Service Center at:

(888) 289-0709

Provider-related calls usually fall into the following three categories:

1. Verification of beneficiary eligibility for Medicaid
2. Covered services
3. Procedure codes and payments

Since November 2001, the SC DHHS has provided medical providers in South Carolina with a system to verify Medicaid eligibility:

Other helpful toll-free numbers:

Civil Rights 1-800-368-1019

Fraud 1-888-364-3224

Healthcare.gov 1-800-318-2596

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104 Appendix BB Verification of Car Values

(Eff. 11/01/05)

SSI-related programs require that the individual’s/couple’s resources be considered in the financial determination. The current market value (CMV) or a portion of the CMV of a vehicle could be counted in the resource test. There are a number of ways to verify vehicle values.

* Knowledgeable source statement
* NADA Older Car Guide-more than 25 years old
* NADA Used Car Guide-if hard copy still available to you
* On-line NADA- <http://www.nadaguides.com/>

This site provides information on new and used cars as well as the values of classic cars, recreational vehicles, motorcycles, boats, and manufactured housing.

* Kelley Blue Book-if hard copy still available to you
* On-line Kelley Blue Book - http://kbb.com

This site provides information on new and used cars as well as the values of motorcycles, watercraft, and snowmobiles.

The steps for either the NADA or Kelley site are very similar.

1. Enter your preferred site in the Address box. (Add to your list of Favorites.)
2. The site’s Home Page will appear. Click on the link of your choice. (New car, used car, motorcycle, etc.)
3. Click on Value by category of vehicle-SUV, Coupe, Sedan, etc.
4. Click on Make of Vehicle-Ford, GMC, Chevrolet, etc.
5. Click on Model-Explorer, Taurus, Monte Carlo, etc.
6. Click on the Year of the Vehicle and enter the owner’s zip code.
7. Click on Trade-In Value as Policy instructs Trade-In Value = CMV. (The next selections will require some additional information from the owner.)
8. Select engine type, transmission and enter mileage. (Contact applicant/ beneficiary for additional information)
9. Identify any extras such as sunroofs, CD players. (Contact applicant/ beneficiary for additional information)
10. Get pricing report. Print the report for documentation purposes.

The on-line used car guides only allow for a limited number of quotes per day per inquirer. Currently, you will only be allowed five per day. Additionally, they only provide values of used cars that are no older than twenty years. However, if an applicant/beneficiary owns a vehicle more than twenty years old the NADA site prompts you to check The Classic Cars site.

If the Eligibility Specialist does not have the details of a vehicle, but has the VIN, this information can be used to obtain more information on the automobile. On the first page of the NADA website, find Tips/Advice and select. On the resulting page under Other Resources, select Get Free VIN Check. Find the area of the page as shown below, and enter the VIN.

|  |
| --- |
| getStarted_headlet |
| |  | | --- | | I have a VIN number:   Get a FREE record summary now! | |
| |  |  |  | | --- | --- | --- | | clear | How do I find my VIN? |  | |
| |  | | --- | | I don't have a VIN number:   Select an AutoCheck vehicle history option below, then login anytime within 60 days and enter your VIN to get your report. | |

This will return information that can be used to help determine the value of the vehicle.

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104 Appendix CC Women, Infants and Children (WIC) at DSS

(Eff. 10/01/05)

I. BACKGROUND

WIC is a targeted Special Supplemental Food Program established by Congress in 1972 and federally-funded (USDA) through monetary grants to assist states in safeguarding the health and nutritional wellbeing of our low-income women, infants, and children during critical growth periods. The State Department of Health and Environmental Control (DHEC) has been designated to administer the program in South Carolina.

II. HOW SERVICES ARE PROVIDED

Application for WIC is made available at 165 health departments, primary care centers and physicians offices. In most cases, eligibility is determined at the time of application. Applicants must: (1) live within the state; (2) have a household income below 185% of the Federal Poverty Level; and (3) be certified as having a “nutritional risk” by a nurse, doctor, nutritionist, etc. “Income” is defined as cash income such as wages, unemployment compensation or cash welfare. “Nutritional risk” is defined as abnormal weight gain during pregnancy; a history of high-risk pregnancies, growth problems, iron-deficiency anemia, an inadequate dietary pattern, or other similar problems.

Eligible applicants are “certified” for the program for a set length of time. Guidelines are as follows: pregnant women are certified for the length of their pregnancy and up to six weeks postpartum; postpartum women are certified for six-month periods ending with their breast-fed Infant’s 1st birthday; infants are certified for six-month periods or for the time period up until their 1st birthday; children are certified for six-month periods up until the end of the month in which they turn five years old.

*Participation in the WIC program has no effect on eligibility for other entitlement programs such as AFDC, Food Stamps, and Medicaid. Applicants who present ID cards for these programs are considered to be adjunctively income-eligible for WIC.*

III. SERVICES OFFERED

At a minimum, the applicant is *weighed, measured for height,* and assessed for iron deficiency anemia by a *blood test* in order to determine nutritional risk. In addition, an evaluation of the diet of the applicant is completed.

Following a health assessment, the program provides specific nutritious foods (such as milk, cheese, cereal, fruit juices, eggs, beans, infant formula) in quantities tailored to meet the needs of the participant.

Participants obtain these foods by use of vouchers in their local grocery store. Participants are never required to pay for their benefits. Visits to the health department to receive food vouchers also serve as an opportunity to provide follow-up for health problems.

IV. NUTRITION EDUCATION

Nutrition education must be offered to each participant at least twice in one-on-one counseling or in a group setting. In most cases participants with the most serious nutrition/health problems receive individual counseling, where the information is specifically related to the participant’s dietary needs, and health problems. Group education sessions are designed to encourage discussion and interaction between the nutrition educator and the participants. Receipt of the food package is not conditional on participation in nutrition education sessions. The supplemental foods in the WIC food package were specifically chosen to provide protein, iron, calcium and vitamins A and C -- the nutrients most often missing from the diets of low-income women and children.

Prenatal and postpartum women are counseled on the benefits and advantages of breastfeeding and are offered classes, referral to community resources, support groups and educational materials.

V. WIC FARMERS’ MARKET NUTRITION PROGRAM (FMNP)

The South Carolina WIC Farmers’ Market Nutrition Program (FMNP) is sponsored jointly by the South Carolina Department of Agriculture and the WIC program. In counties that have a viable and authorized farmers’ market, WIC clinics provide coupons on a one-time basis to women and children enrolled in WIC. Clients not only purchase fresh fruits and vegetables at the market, but also learn how to select, store, and prepare fresh produce during WIC education classes.

VI. VENDOR MANAGEMENT

Grocery stores (vendors) are monitored for program compliance. Although these activities are not “healthcare services,” they are important. If voucher redemptions transpire according to procedures, participants are best able to realize the full intended benefit of the program and program funds are less likely to be lost through fraud and abuse.

VII. WIC’s HEALTH IMPACT AND COST-EFFECTIVENESS

The WIC program has often been called the “gateway” to health care and serves to enhance participants’ access to medical care. In South Carolina, this is facilitated through an integrated Maternal and Children’s Health Service approach allowing clinics to schedule WIC appointments in conjunction with medical appointments, Refer to, immunizations, family planning, prenatal care and child health exams.

The WIC program has been found to be very effective. The results of numerous federal, state and local studies conducted both by government and citizen groups point to the positive impact of the WIC program. Specific findings include an increase in early (first trimester) prenatal care, increased length of gestation, decreased rate of pre-term delivery, significant increases in birth weight, reduced late fetal deaths and increased infant head circumferences. WIC participation has also been associated with improved dietary intakes of protein, calories and other nutrients that often are inadequate in the diets of low-income pregnant women and children.

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104 Appendix DD Reserved for Future Use

(Eff. 11/01/18)

104 Appendix EE Web Address Index

(Rev. 03/01/08)

Chapter 101

SC MPPM 101.04 Application Process - [County Offices Contact Info](https://www.scdhhs.gov/site-page/dhhs-county-offices)

Chapter 102

SC MPPM 102.04.14 Systematic Alien Verification for Entitlement (SAVE) Program - <https://www.vis-dhs.com/WebOne>

SC MPPM 102.05.01 Application for a SSN - [SS-5](http://www.socialsecurity.gov/online/ss-5.pdf)

SC MPPM 102.07.02 Referral to DSS Office of Child Support Enforcement (OCSE) <http://www.state.sc.us/dss/csed/contact.htm>

SC MPPM 102.08.01 Unemployment Benefits - <http://www.sces.org/>

SC MPPM 102.08.02 Social Security Benefits - <http://www.ssa.gov>

SC MPPM 102.08.03 Veterans Benefits - <http://www.vba.va.gov>

Chapter 207

SC MPPM 207.09 Interstate Compact on Adoption and Medical Assistance (ICAMA) - <http://aaicama.aphsa.org/who.html>

Chapters 302 and 402

SC MPPM 302.16 and 402.17.01 Automobiles - <http://www.nadaguides.com/>

SC MPPM 302.16 and 402.17.01 Automobiles - <http://www.kbb.com/>

SC MPPM 302.26.08 and 402.27.08 US Savings Bonds - [www.publicdebt.treas.gov](http://www.publicdebt.treas.gov)

Miscellaneous

List of Nursing Facilities in SC - <http://www.asisvcs.com/publications/pdf/074109.pdf>

List of Residential Care Facilities - <http://www.scdhhs.gov/internet/pdf/OSS%20Providers%20by%20County.pdf>

Lists of Licensed Medical Facilities in SC - <http://www.scdhec.gov/health/licen/hrtypfac.htm>

MEDS Online Manuals - <http://medsweb.scdhhs.gov/index2.htm>

MEDS Online References - <http://medsweb.scdhhs.gov/index3.htm>

Ombudsman - <http://aging.sc.gov/seniors/ombudsman/Pages/default.aspx>

South Carolina Secretary of State - <http://www.scsos.com>

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104 Appendix FF Federal Qualified Health Centers

(Eff. 09/01/06)

|  |
| --- |
| Beaufort-Jasper-Hampton Comprehensive Health Services  PO Box 357  Ridgeland, SC 29936  843-987-7457 |
| Black River Healthcare  PO Box 578  Manning, SC 29102-0578  803-433-1211 |
| CareSouth Carolina  PO Box 1090  Hartsville, SC 29550  843-332-3422 |
| Carolina Health Centers  313 Main Street  Greenwood, SC 864-396-0207 |
| Community Medical Foundation  PO Box 28  Rock Hill, SC 29731  803-325-7744 ext. 216 |
| Eau Claire Cooperative Health Center (8 locations in Columbia area)  4605 Monticello Road  Columbia, SC 29203  803-733-5969 ext. 4129 |
| Family Health Centers  PO Box 1806  Orangeburg, SC 29116-1806  803-531-8976 |
| Franklin C. Fetter Family Health Center  51 Nassau Street  Charleston, SC 29403  843-722-4112 ext. 3999 |
| Health Care Partners of South Carolina  PO Box 2100  Conway, SC 29526  843-248-4700 ext. 6034 |
| Little River Medical Center  PO Box 547  Little River, SC 29566  843-663-1013 ext. 24 |
| Low Country Health System  PO Box 990  Fairfax, SC 29827  803-632-2533 ext. 131 |
| Margaret J. Weston Community Health Center  PO Box 27  Clearwater, SC 29822  803-593-9283 |
| New Horizon Family Health Services  PO Box 287  Greenville, SC 29602.0287  864-233-1534 ext. 160 |
| Richland Community Health Care Association  1520 Laurel Street  Columbia, SC 29201  803-799-8407 |
| Sandhills Medical Foundation  PO Box 249  Jefferson, SC 29718  843-658-3005 ext. 17 |
| Sea island Medical Center  PO Box 689  Johns Island, SC 29457  843-559-3676 |
| St. James-Santee Rural Health Program  PO Box 608  McClellanville, SC 29458  843-887-3274 |
| Sumter Family Health  1278 North Lafayette Drive  Sumter, SC 29150  803-774-4531 |

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104 Appendix GG Children’s Rehabilitative Services

(Eff. 12/01/06)

The South Carolina Department of Health and Environmental Control offers a program called Children’s Rehabilitative Services (CRS) as a statewide organization assuring that the best possible medical services are available for special children. The CSR System of Care provides nursing intervention, social work services, nutrition services, parent-to-parent support, in and out-patient hospitalizations, braces, hearing aids, specialized medical equipment, physical, occupational, and speech therapies, and genetic services. To participate is the CRS program, a child must be a legal resident of the United States, live in South Carolina, be under the age of 21, be diagnosed with a covered medical condition, and the family must meet certain income guidelines.

For additional information regarding the CRS program, visit the South Carolina DHEC website at: [DHEC: Children?s Rehabilitative Services (CRS)](http://www.scdhec.gov/Health/ChildTeenHealth/ServicesforChildrenwithSpecialHealthCareNeeds/ChildrensRehabilitativeServices/)

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104 Appendix HH About Reverse Mortgages

(Eff. 01/01/07)

The following information was copied from the National Reverse Mortgage Lenders Association website, [www.reversemortgage.org](http://www.reversemortgage.org).

About Reverse Mortgages

A reverse mortgage enables older homeowners (62+) to convert part of the equity in their homes into tax-free income without having to sell the home, give up title, or take on a new monthly mortgage payment. The reverse mortgage is aptly named because the payment stream is “reversed.” Instead of making monthly payments to a lender, as with a regular mortgage, a lender makes payments to you. Below are some common questions asked by consumers about reverse mortgages.

What are My Payment Plan Options?

You can choose to receive the money from a reverse mortgage all at once as a lump sum, fixed monthly payments either for a set term or for as long as you live in the home, as a line of credit, or a combination of these. The most popular option – chosen by more than 60 percent of borrowers – is the line of credit, which allows you to draw on the loan proceeds at any time.

My Understanding is that the Unused Balance in the Line of Credit Option Has a Growth Feature. Does that Mean I'm Earning Interest?

No, you're not earning interest like you do with a savings account. The growth factor is taking into consideration that your home has appreciated in value over the past 12 months and that you are one year older. And just to clarify, the growth feature only applies to the FHA Home Equity Conversion Mortgage program.

How Much Money Will I Get?

No matter which reverse mortgage product you choose, the amount of funds you are eligible to receive will depend on your age (or the age of the youngest spouse in the case of couples), appraised home value, current interest rates, and the lending limit in your area. In general, the older you are and the more valuable your home (and the less you owe on your home), the more money you can get.

Does My Home Qualify?

Eligible property types include single-family homes, 2-4 unit properties, manufactured homes (built after June 1976), condominiums, and townhouses. In general, co-ops are not allowed. Only the Financial Freedom "Cash Account" program is available on co-ops in New York City.

How Can I Use the Proceeds from a Reverse Mortgage?

The proceeds from a reverse mortgage can be used for anything, whether its to supplement retirement income to cover daily living expenses, repair or modify your home (such as widening halls or installing a ramp), pay for health care, retire existing debts, buy a new car or take a "dream" vacation, cover property taxes, and prevent foreclosure.

Are There Any Special Requirements to Get a Reverse Mortgage?

As long as you own a home, are at least 62, and have enough equity in your home, you can get a reverse mortgage. There are no special income or medical requirements.

What If I Have An Existing Mortgage?

You may qualify for a reverse mortgage even if you still owe money on an existing mortgage. However, the reverse mortgage must be in a first lien position, so any existing mortgage must be paid off. You can pay off the existing mortgage with a reverse mortgage, money from your savings, or assistance from a family member or friend.

For example, let's say you owe $100,000 on an existing mortgage. Based on your age, home value, and interest rates, you qualify for $125,000 under the reverse mortgage program. Under this scenario, you will be able to pay off ALL the existing mortgage and still have $25,000 left over to use as you wish.

If, however, you only qualify for $85,000, then you would need to come up with $15,000 from your savings to get the reverse mortgage. Even then, all the money from the reverse mortgage will have been used to pay off the existing mortgage. On the other hand, you won't have a monthly mortgage payment.

What Is the Service Fee Set-Aside?

Under most reverse mortgage programs, you will be charged a monthly servicing fee that ranges from $30-$35 to manage your account once the loan closes. The SFSA is an estimate of what the total servicing fees will be over the life of the loan, by multiplying your life expectancy (converted from years into months) multiplied by either $30 or $35.

Although it's not considered a closing cost, the SFSA can equal several thousand dollars, which is deducted from your available loan proceeds. You do not have access to that money, nor do you earn interest.

Will I Lose My Government Assistance If I Get a Reverse Mortgage?

A reverse mortgage does not affect regular Social Security or Medicare benefits. However, if you are on Medicaid, any reverse mortgage proceeds that you receive must be used immediately. Funds that you retain would count as an asset and could impact Medicaid eligibility. For example, if you receive $4,000 in a lump sum for home repairs and spend it all the same calendar month, everything is fine. Any residual funds remaining in your bank account the following month would count as an asset. If the total liquid resources (including other bank funds and savings bonds) exceed $2,000 for an individual or $3,000 for a couple, you would be ineligible for Medicaid. To be safe, you should contact the local [Area Agency on Aging](http://www.eldercare.gov/) or a Medicaid expert.

Why Do I Need to Get Counseling?

Counseling is one of the most important consumer protections built into the program. It requires an independent third party to make sure you understand the program, and review alternative options, before you apply for a reverse mortgage.

You can seek counseling from a local [HUD-approved counseling agency](http://www.hud.gov/offices/hsg/sfh/hecm/hecmlist.cfm), or a national counseling agency, such as AARP (800-209-8085), National Foundation for Credit Counseling (866-698-6322), and Money Management International (877-908-2227). Counseling is required for all reverse mortgages and may be conducted face-to-face or by telephone.

By law, a counselor must review (i) options, other than a reverse mortgage, that are available to the prospective borrower, including housing, social services, health and financial alternatives; (ii) other home equity conversion options that are or may become available to the prospective borrower, such as property tax deferral programs; (iii) the financial implications of entering into a reverse mortgage; and, (iv) the tax consequences affecting the prospective borrower’s eligibility under state or federal programs and the impact on the estate or his or her heirs.

When Do I Pay Back My Loan?

No monthly payments are due on a reverse mortgage while it is outstanding. The loan is repaid when you cease to occupy your home as a principal residence, whether you (the last remaining spouse, in cases of couples) pass away, sell the home, or permanently move out. The amount owed can never exceed the value of your home. Furthermore, if the home is sold and the sales proceeds exceed the amount owed on the reverse mortgage, the excess money goes to you or your estate.

Under What Circumstances Should I Not Consider a Reverse Mortgage?

Because of the upfront costs associated with a reverse mortgage, if you intend to leave your home within 2-3 years, there may be other less expensive options to consider, such as home equity loans, no-interest loans or grants that may be offered by your county government or a local non-profit to repair your home, or a tax deferral program, if you're having problems paying your property taxes.

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104 Appendix II Verify Direct

(Eff. 06/01/13)

Verify Direct is a free service offered to Government agencies that verify wages via the Government portal. The portal was created to enable credentialed government requestors to electronically fulfill verification requests. A User ID and password has been created for DHHS, so it’s not necessary to create one on your own. The User ID and password can be provided by your supervisor. To access Verify Direct, please follow the steps below:

1. From your internet browser, go to [www.verifydirect.com](http://www.verifydirect.com)
2. Click the “Login” link under the “Government Requestor” section
3. To sign in, Type in User Name and Password. Select “Login”
4. Select “Request Report”
5. Complete the required fields (including Employer Name), under “Social Security Number Selection”. Note: Under “Permissible Purpose”, select “Determining Eligibility for benefits”. The SSN is for the person who you are requesting the information. If you are requesting information on more than one applicant/ beneficiary, you can select the “Bulk Applicant View” and enter the appropriate Social Security numbers and select the current employer name(s) for which you would like to run a report.
6. All verifications will be confirmed electronically. If a match is found, the applicant/ beneficiary’s current employment status as well as a breakdown by pay periods will be displayed. The system will also tell you if a match is not found, based on the employer and/or SSN that was entered.

104 Appendix JJ Medically Indigent Assistance Program (MIAP) County Designees

(Eff. 05/01/23)

The following list shows the person or entity responsible for processing applications for the Medically Indigent Assistance Program (MIAP) as reported by local counties. This information is subject to change and therefore may not be complete or up-to-date.

|  |  |
| --- | --- |
| Abbeville  Ms. Lynn Soplosky  903 W. Greenwood St., Ste. 2800  Abbeville SC 29620  Telephone: (864) 366-6690 (Ext. 2236) | Aiken  Ms. Deena Smart  Aiken County Finance Department  828 Richland Avenue, West  Aiken, South Carolina 29801  Telephone: (803) 642-2071  [Dsmart@aikencountysc.gov](mailto:Dsmart@aikencountysc.gov) |
| Allendale  Ms. Elisha McMillian  Allendale County Courthouse  Post Office Box 351  Allendale, South Carolina 29810  Telephone: (803) 584-7053  [emcmillian@allendalecounty.com](mailto:emcmillian@allendalecounty.com) | Anderson  Ms. Kathleen Surratty  An-Med Health Business Services  800 N. Fant Street  Anderson, South Carolina 29621  Telephone: (864) 512-2163  [Latisha.richardson@anmedhealth.org](mailto:Latisha.richardson@anmedhealth.org) |
| Bamberg  SCDHHS – MIAP Unit  Central Mail Center  P. O. Box 100101  Columbia, SC 29202-3101  Fax: (803) 255-8220  (Hospital closed 04.30.12) | Barnwell  SCDHHS – MIAP Unit  Central Mail Center  P. O. Box 100101  Columbia, SC 29202-3101  Fax: (803) 255-8220  (Hospital closed in 2016) |
| Beaufort  SCDHHS – MIAP Unit  Central Mail Center  P. O. Box 100101  Columbia, SC 29202-3101  Fax: (803) 255-8220 | Berkeley  Ms. Christie Jackson  Berkeley County  Post Office Box 6122  Moncks Corner, South Carolina 29461  Telephone: (843) 719-4193  [Christie.Jackson@berkeleycountysc.gov](mailto:Christie.Jackson@berkeleycountysc.gov) |
| Calhoun  Ms. Elaine Golden  102 Courthouse Drive, Suite 105  St. Matthews, South Carolina 29135  Telephone: (803) 874-2679  [Egolden@calhouncounty.sc.gov](mailto:Egolden@calhouncounty.sc.gov) | Charleston  Ms. Carolyn Smalls  County of Charleston, MIAP  4045 Bridge View Drive  North Charleston, SC 29405  Telephone: (843) 202-6986  Fax: (843) 202-6961  [Casmalls@charlestonscounty.org](mailto:Casmalls@charlestonscounty.org)  Reconsideration Designee  Ms. Gwendolyn Parilla  County of Charleston, MIAP  4045 Bridge View Drive  North Charleston, SC 29405  Telephone: (843) 202-6976  Fax: (843) 202-6961  [grtgvp@charlestoncounty.org](mailto:grtgvp@charlestoncounty.org) |
| Cherokee  SCDHHS – MIAP Unit  Central Mail Center  P. O. Box 100101  Columbia, SC 29202-3101  Fax: (803) 255-8220 | Chester  SCDHHS – MIAP Unit  Central Mail Center  P. O. Box 100101  Columbia, SC 29202-3101  Fax: (803) 255-8220 |
| Chesterfield  SCDHHS – MIAP Unit  Central Mail Center  P. O. Box 100101  Columbia, SC 29202-3101  Fax: (803) 255-8220 | Clarendon  SCDHHS – MIAP Unit  Central Mail Center  P. O. Box 100101  Columbia, SC 29202-3101  Fax: (803) 255-8220 |
| Colleton  SCDHHS – MIAP Unit  Central Mail Center  P. O. Box 100101  Columbia, SC 29202-3101  Fax: (803) 255-8220 | Darlington  Mr. Sean Adams  Darlington County DSS  106 North Main Street  Darlington, South Carolina 29532  Telephone: (843) 398-4420 |
| Dillon  SCDHHS – MIAP Unit  Central Mail Center  P. O. Box 100101  Columbia, SC 29202-3101  Fax: (803) 255-8220 | Dorchester  SCDHHS – MIAP Unit  Central Mail Center  P. O. Box 100101  Columbia, SC 29202-3101  Fax: (803) 255-8220 |
| Edgefield  SCDHHS – MIAP Unit  Central Mail Center  P. O. Box 100101  Columbia, SC 29202-3101  Fax: (803) 255-8220 | Fairfield  SCDHHS – MIAP Unit  Central Mail Center  P. O. Box 100101  Columbia, SC 29202-3101  Fax: (803) 255-8220 |
| Florence  Ms. Jannie Mae Fleming  Pee Dee Community Action Agency  Post Office Box 12670/2685 S. Irby Street  Florence, South Carolina 29504  Telephone: (843) 678-3400, Ext. 122  [Cheynne@hotmail.com](mailto:Cheynne@hotmail.com) | Georgetown  Ms. Deborah Thomas  Georgetown Memorial Hospital  Post Office Box 421718  Georgetown, South Carolina 29442  Telephone: (843) 527-7154  Fax: (843) 520-8403  [Dthomas@georgetownhospitalsystem.org](mailto:Dthomas@georgetownhospitalsystem.org) |
| Greenville  Ms. Jacqueline Glenn  Greenville Hospital System  701 Grove Road  Greenville, South Carolina 29605-4295  Telephone: (864) 454-8545  [Jturner@ghs.org](mailto:Jturner@ghs.org) | Greenwood  SCDHHS – MIAP Unit  Central Mail Center  P. O. Box 100101  Columbia, SC 29202-3101  Fax: (803) 255-8220 |
| Hampton  Ms. Erin Hiller  Hampton Regional Medical Center  598 West Carolina Avenue  Post Office Box 338  Varnville, South Carolina 29944  Telephone: (803) 943-1213  [Selfpay1@hamptonregional.org](mailto:Selfpay1@hamptonregional.org) | Horry  Dr. Dwayne Graham – Carol Wisester  Horry County  1515 Fourth Avenue  Conway, South Carolina 29526  Telephone: (843) 915-7032  [Dwayne@horrycounty.org](mailto:Dwayne@horrycounty.org) |
| Jasper  Ms. Georgia DeLoach  Jasper County Council  Post Office Box 1509  Ridgeland, South Carolina 29936  Telephone: (843) 726-7607  Fax: (843)726-7966  [Gdeloach@jaspercountysc.gov](mailto:Gdeloach@jaspercountysc.gov) | Kershaw  SCDHHS – MIAP Unit  Central Mail Center  P. O. Box 100101  Columbia, SC 29202-3101  Fax: (803) 255-8220 |
| Lancaster  Ms. Lisa Smith  Springs Memorial Hospital  800 West Meeting Street  Lancaster, South Carolina 29720  Telephone: (803) 286-1481 | Laurens  Ms. Brenda Carter  Laurens County DHHS  Post Office Box 388  Laurens, South Carolina 29360  Telephone: (864)833-9260  [Brenda.Carter@scdhhs.gov](mailto:Brenda.Carter@scdhhs.gov) |
| Lee  SCDHHS – MIAP Unit  Central Mail Center  P. O. Box 100101  Columbia, SC 29202-3101  Fax: (803) 255-8220 | Lexington  SCDHHS – MIAP Unit  Central Mail Center  P. O. Box 100101  Columbia, SC 29202-3101  Fax: (803) 255-8220 |
| Marion  SCDHHS – MIAP Unit  Central Mail Center  P. O. Box 100101  Columbia, SC 29202-3101  Fax: (803) 255-8220 | Marlboro  SCDHHS – MIAP Unit  Central Mail Center  P. O. Box 100101  Columbia, SC 29202-3101  Fax: (803) 255-8220  (Hospital closed 4/30/2015) |
| McCormick  Ms. Sandra Anthony  McCormick County Government  326 Airport Road  McCormick, South Carolina 29835  Telephone: (864) 852-0434  [Santhony@mccormickcountysc.org](mailto:Santhony@mccormickcountysc.org) | Newberry  SCDHHS – MIAP Unit  Central Mail Center  P. O. Box 100101  Columbia, SC 29202-3101  Fax: (803) 255-822 |
| Oconee  Ms. Donna Smith  Oconee Memorial Hospital  298 Memorial Drive  Seneca, South Carolina 29672-9499  Telephone: (864) 885-7147  (864) 482-3100  [Donna.smith@oconeemed.org](mailto:Donna.smith@oconeemed.org) | Orangeburg  SCDHHS – MIAP Unit  Central Mail Center  P. O. Box 100101  Columbia, SC 29202-3101  Fax: (803) 255-8220 |
| Pickens  Pickens County Administration  PO Box 407  Liberty, SC 29657  Telephone: (864) 512-2163 | Richland  SCDHHS – MIAP Unit  Central Mail Center  P. O. Box 100101  Columbia, SC 29202-3101  Fax: (803) 255-8220 |
| Saluda  Ms. Ruth Padgett  111 Law Range  Saluda, South Carolina 29138  Telephone: (864) 445-4000 ext. 2200  [rf.padget@saludacounty.sc.gov](mailto:rf.padget@saludacounty.sc.gov) | Spartanburg  Ms. Susan Hicks  Spartanburg County Indigent Care Services  PO Box 566  Spartanburg, South Carolina 29304  Telephone: (864) 562-4745  Fax: (864) 560-3445  [Shicks@spartanburgcounty.org](mailto:Shicks@spartanburgcounty.org)  Reconsideration Designee:  Lynn McClure  Spartanburg County Indigent Care Services  101 East Wood Street  Spartanburg, South Carolina 29303  Telephone: (864) 596-3638  [lmcclure@spartanburgcounty.org](mailto:lmcclure@spartanburgcounty.org) |
| Sumter  SCDHHS – MIAP Unit  Central Mail Center  P. O. Box 100101  Columbia, SC 29202-3101  Fax: (803) 255-8220 | Union  SCDHHS – MIAP Unit  Central Mail Center  P. O. Box 100101  Columbia, SC 29202-3101  Fax: (803) 255-8220 |
| Williamsburg  SCDHHS – MIAP Unit  Central Mail Center  P. O. Box 100101  Columbia, SC 29202-3101  Fax: (803) 255-8220 | York  Ms. CherylDuncan  Ms. Ruth Evans  Ms. Loretta Puglise-Williams  Sindy Kattan  Piedmont Medical Center  1731 Frank Gaston Boulevard  Rock Hill, South Carolina 29732  Telephone: (803) 329-6784  Fax: (803) 323-2809  [Ruthi.evans@coniferhealth.com](mailto:Ruthi.evans@coniferhealth.com)  [cheryl.duncan@coniferhealth.com](mailto:cheryl.duncan@coniferhealth.com) |

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105.01 Verification Matrices

(Eff. 08/01/15)

Verification matrices are designed to provide high level guidance concerning verification. The goal is to help eligibility specialists to verify eligibility criteria at the appropriate level to prevent over or under documentation and to aid in consistent determinations.

105.01.01 Non-Financial and Income Verification Matrix

(Rev. 04/17/20)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  | **Acceptable Sources**  Only **one** data source is needed to verify an element | |
|  | **Element** | | **Primary Data Sources**  (If unable to verify, use a Secondary Source) | **Secondary Data Sources**  (Not all data sources are listed) |
| **Non-Financial** | **Citizenship** | | * **SVES** * **Federal Hub** * **Person Composite Service (PCS)** * **DMV** | * **Passport** * **Certificate of Naturalization** * **Birth Certificate** |
| **Identity** | | * **SVES** * **Federal Hub** * **Person Composite Service (PCS)** * **DMV** | * **Passport** * **Certificate of Naturalization** * **Driver’s License** |
| **Social Security Number (SSN)** | | * **SVES** * **BENDEX** * **Federal Hub** * **Person Composite Service (PCS)** | * **Social Security Card** * **Social Security Letter** * **SS-5** |
| **Age/Date of Birth** | | * **SVES** * **BENDEX** * **Federal Hub** * **Person Composite Service (PCS)** | * **Birth Certificate** * **Driver’s License** |
| **Lawful Presence**  (Alien Status, Lawful Permanent Resident) | | * **SAVE** * **Federal Hub** * **Person Composite Service (PCS)** * **SVES (40 Work Quarters)** | * **USCIS Document** |
| **Residency** | | **Client Statement** |  |
| **Out-of-State Benefits** | | **Client Statement** |  |
| **Marital Status** | | **Client Statement** |  |
| **Relationship** | | **Client Statement** |  |
| **Household Composition/**  **Tax Filing Status** | | **Client Statement** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Income** | **Unearned Income** | * **BENDEX** * **SDX** * **UCB** * **State Retirement System** | * **Collateral Call** * **Award Letter** * **Check Stub** * **DHHS Verification Forms** |
| **Earned** | * **Wage Match** * **Person Composite Service (PCS) Wage Verification** * **VerifyDirect** * **CHIP** | * **Collateral Call** * **Check Stub** * **DHHS Form 1245 or other written statement from employer** |
| **Self-Employment** | * **Tax Return** |  |
| **Contributions** | **Client Statement** |  |
| **Category Specific** | **Pregnancy**  (Pregnant Woman) | **Client Statement** |  |
| **School Attendance**  (If the only Qualifying Child for a PCR is Age 18) | **Client Statement** |  |
| **Disability**  (Non-MAGI with Applicant under age 65) | * **BENDEX** * **SDX** | * **SSA/SSI Award Letter** * **MAO99** |

|  |  |  |
| --- | --- | --- |
| **Electronic Source** | **Client Statement** | **Hard Copy** |

105.01.02 Resource Verification Matrix

(Rev. 09/01/23)

|  |  |  | **Acceptable Sources**  Only consider resources for non-MAGI programs | |
| --- | --- | --- | --- | --- |
|  | **Resource** | | **Verification Sources** | **Instruction** |
| **Bank** | **Checking Account Savings Account Certificate of Deposit** | | * **Documented call to Financial Institution** * **Asset Verification System (AVS)** * **Bank Statement** * **Account Information from Bank website** | * **Verify:**   + **Name of Bank**   + **Account Number**   + **Account Balance** * **Obtain balance for month of application** * **Obtain balance for each Retroactive month** |
| **IRA, 401-K, Retirement Account** | | * **Documented call to Financial Institution** * **Asset Verification System (AVS). Does not include brokerage firms** * **Financial Institution Statement** | * **Verify:**   + **Name of Institution**   + **Account Number**   + **Account Balance** |
| **DirectExpress**  (Direct deposit account for U.S. government benefits) | | * **Client Statement** | * **Accept client statement of account balance** |
| **Property** | **Homestead Property**  **Non-Homestead Property** | | * **County Tax Assessor**   + **Use county website if available**   + **Send DHHS Form 1255 if the county does not have property records online** * **Property Tax Notice** | * **Liberalized: MPPM 302.14.01** * **Verify if the client alleges property:**   + **Owner(s)**   + **Location/Address**   + **Map/block/parcel number**   + **Value** * **Accept client statement if no real property is alleged\***   **\*Exception: Long Term Care MPPM 304.05.03** |
| **Vehicle** | | * **County Tax Assessor**   + **Use county website if available**   + **Send DHHS Form 1255 if the county does not have property records online** * **Property Tax Notice** * **DMV Webtool** | * **Accept client statement if no vehicles are alleged** |
| * **Liberalized: MPPM 302.16** * **Accept client statement if one or two vehicles are alleged** * **Verify if three or more vehicles are alleged** |
| * **Strict: MPPM 402.17.01** * **Accept client statement if one vehicle is alleged** * **Verify if two or more vehicles are alleged** |
| **Life Insurance** | **Life Insurance Policy**  (Do not verify term life insurance provided through employment) | | * **Documented call or written statement by agent** * **Documented call to insurance company (automated system or call center)** * **Copy of policy** * **DHHS Form 1280** * **Applicant** | * **Accept attestation if no insurance is alleged** * **Accept attestation if life insurance is alleged with a total face value of all policies for each insured person is less than or equal to $10,000** * **Items to verify if client alleges life insurance with a total face value of all policies for each insured person is greater than $10,000:**   + **Name of Company**   + **Policy Number**   + **Type – Whole or Term**   + **Face Value**   + **Cash Value**   + **Dividends, if any** |

105.01.03 Long Term Care Verification Matrix

(Eff. 09/01/16)

| **Look-Back** | | |
| --- | --- | --- |
| **Element** | **Policy Reminder** | **Verification/Documentation** |
| **Bank/Financial Accounts**  MPPM 302.26.02  MPPM 304.09.02C | * Review bank statements for Month of Application and Three Months prior to Application if provided. Do not request from the applicant * Create Financial Institution (FI) and Geosearch AVS requests. If a transfer is indicated, wait for response * Look for unusual withdrawals/deposits which exceed income * Compare Monthly interest earned to Year to Date interest earned | * Hard copy from applicant * Collateral Phone call with financial institution * Asset Verification System (AVS) * DHHS Form 1253 or bank specific form (Only if unable to verify with AVS) |
| **Property**  MPPM 302.14.01  MPPM 304.05.03  MPPM 304.09.02C | * Complete property check for applicant’s county of residence and where lived within the past five years * If applicant lived out of state, complete/send property check but do not wait for a response unless the applicant indicates current property or transfer. | * Always use On-line property check if available (In-State or Out-of-State) * Hard copy from applicant * DHHS Form 1255 ME |
| **Probate**  MPPM 302.13  MPPM 304.09.02C | * Complete a probate search only if the applicant indicates an inheritance within the past 5 years | * DHHS Form 1255 ME * Copy of will, estate accounting form, deed of distribution or other court documents |
| **Eligible Out-of-State Applicant** | * If an applicant who is Medicaid eligible in another state for LTC moves in-state, a new look-back must not be completed | * Written or verbal statement from the state Medicaid agency * Written or verbal statement from LTC facility |
| **Previous Look-Back completed within past 5 years** | * If an applicant who is Medicaid eligible in another state for LTC moves in-state, a new look-back must not be completed | * Written or verbal statement from the state Medicaid agency * Written or verbal statement from LTC facility that the individual transferred from a Medicaid facility in another state |

| **Deductions** | | |
| --- | --- | --- |
| **Element** | **Policy Reminder** | **Verification/Documentation** |
| **Health Insurance Premium** | * Health insurance premiums which are paid by an institutionalized individual can be deducted from income; AND * A deduction can only be given for the part of the premium which provides coverage for the institutionalized person | * Hard copy of bill or receipt from the insurance company * Documented phone call with the insurance company or agent * Deduction on a bank statement (if the insurance coverage is only for the institutionalized person) |
| **Home Maintenance Allowance** | * Allowance can be given for up to six full calendar months for necessary household expenses * Six month count begins the first full calendar month the applicant is in an institutional setting (Hospital or Nursing Facility) * Allowance is for actual household expenses not to exceed the current SSI limit * Deduction is applied during recurring income calculation * Deduction can be requested at any point within the six month period and applied retroactively | * Letter from physician certifying the applicant is expected to return home within six months * Written or verbal statement of household expenses. Must detail the type and amount of expenses * Only request copies if the reported expense is excessive and is needed to give the full allowance * Deduct household expenses in the following order until full allowance is used   + Mortgage or Rent   + Electricity, Water and Sewer   + Telephone and internet   + Cable and other utilities and expenses |
| **Spousal Allocation** | * An allocation can be given to a community spouse by the institutionalized spouse * The institutionalized spouse must agree to provide the allocation * The community spouse must cooperate and provide income and resource information to receive the allocation | * Question must be answered on DHHS Form 3401 or the DHHS Form 3400-B * Verification of spousal income/resources |
| **Dependent Allocation** | * An allocation can be given to a dependent relative by the institutionalized person * The institutionalized person must agree to provide the allocation * The dependent relative must cooperate by providing information to receive the allocation | * Written Statement which has the:   + Name of the dependent relative;   + Relationship of the dependent relative to the institutionalized person;   + Nature of the dependency of the dependent relative; and   + Name and relationship to the person with whom the dependent relative will be living |

| **Other** | | |
| --- | --- | --- |
| **Element** | **Policy Reminder** | **Verification/Documentation** |
| **Separated Spouse** | If a person who is separated but not divorced applies for an institutional program, the eligibility specialist MUST attempt to contact the community spouse and obtain resource information. | * If the community spouse receives SSI, no contact is required * If the location of the spouse is known, attempt contact:   + If spouse does not cooperate, document and treat Institutional Spouse as an individual     - If a DHHS 1233 is sent, continue processing the application. Process as a change if something is returned   Cooperating:   * Document income for spousal allocation * Document Resources   Non-Cooperating:   * Failure to respond to DHHS Form 1233 * Documented phone call * Written Statement of refusal |
| **Income Trust** | * Individuals with income over the income limit can establish an income trust * Income which is deposited into the trust does not count toward the income limit * All income received is used to calculate the cost of care * An Income Trust document must be completed before approving eligibility * There must be a separately designated account (can be an existing account). No other income or resources can be deposited into the account * Income is not protected for the month of entry or discharge | * Copy of properly executed Income Trust document * Designated bank account for trust |

105.02 Scripts

(Eff. 08/01/15)

Scripts are designed for specialists to use when initiating phone calls to applicant’s to provide a framework for gathering information used in the eligibility process. The goal is to help eligibility specialists to verify eligibility criteria at the appropriate level to prevent over or under documentation and to aid in consistent determinations.

105.02.01 Disability Process Script

(Eff. 08/01/15)

The following Disability Process Script must be used to make contact with the applicant who may require a disability decision.

| Disability Process Script 105.02.01 | | |
| --- | --- | --- |
| Step | Script | Actions |
| **Call** |  | *Make call using the contact information on the application. 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, go to* **Prepare Disability Packet.**MPPM 102.06.02A*.* |
| **Call Back Message** | Hi, this is Name with the South Carolina Department of Health and Human Services, Healthy Connections. Someone recently contacted our agency and I am following up for more information. I will call back in the next 5 minutes. Thank you. | *After 3-5 minutes, attempt a second call to the applicant/ beneficiary.*  *If a person answers the call, go to* [**Introduction**](#Intro)**.**  *If there is no answer 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. | *Go to* **Prepare Disability Packet.**MPPM 102.06.02A |
| **Introduction** | Hi, this is Name with the South Carolina Department of Health and Human Services, Healthy Connections. May I speak with Mr./Ms. Applicant (or Authorized Representative)? | *If person on the phone says the applicant is not available, go to* [**Not Available**](#Not_Avail)*.*  *If able to speak with the applicant, go to* [**Available**](#Avail)*.*  *If applicant 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. Since we cannot speak with Mr./Ms. Last Name right now we will contact him/her by mail. Can we take a few moments to make sure we have the correct contact information for Mr./Ms. Last Name? | *If the person on the phone is willing, confirm the name (ask if it is the person’s legal name and check the spelling), date of birth if the person knows it, and contact information (address and phone number).*  **END CALL**  *Go to* ***Prepare Disability Packet.*** MPPM 102.06.02A |
| **Available** | Mr./Ms. Last Name, you recently contacted our agency to apply for benefits and we need to follow up to get some additional information. First I need to confirm I am speaking with the right person. | *If someone other than the applicant 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 application. Ask for additional elements such as address and the last four digits of the SSN. If confirmed, go to* [**Disability Script**](#Dis_Script)***.***  *If unable to confirm the identity of the applicant, indicate you will have to send the request by mail and go to Go to Prepare Disability Packet. MPPM 102.06.02A* |
| **Disability Script** | On your application for Medicaid, you checked that you may be disabled. We are trying to help make the process go a little more smoothly, so we want to give you some information about applying for Medicaid based on disability so you can make the best decision about what to do next. | Go to [**General Medicaid Information**](#Gen_Med_Info)**.** |
| **General Medicaid Information** | Medicaid is for people who have a financial need, but it is more than just how much money you may or may not have. You must also be part of a coverage group, or category. In addition to being disabled or aged 65 or older, there are four other broad categories. You can be a:   * Child under age 19; * Pregnant women; * Parent (or other caretakers of children) in families with dependent children; or * Person diagnosed with and receiving treatment for breast or cervical cancer.   Do you believe you may be part of one of these other groups? | *If the person indicates he/she may be eligible under one of the other categorical groups, explore possible eligibility in a MAGI group.*  *If the person does not indicate possible eligibility in a MAGI group, go to* [**Define**](#Define)***.*** |
| **Define** | Because you checked on the application that you have a disabling physical, mental, or emotional health condition that causes limitations in activities, we want to talk about what that means and explain the disability determination process.  Medicaid uses the same definition of disability as the Social Security Administration (SSA). This definition is different than that used by other programs. This may be different than you receiving disability from work or the VA or your doctor telling you that you are disabled and need special medical treatment or some kind of accommodation, such as handicap parking. You are only eligible for Social Security if you have a permanent and total disability. You will not receive benefits if your disability is partial or short-term. Because Medicaid has the same rule, you must be totally disabled to be eligible as part of this coverage group.  Social Security's disability definition is based on your inability to work. You may be considered disabled under Social Security rules if:   * You cannot do work that you did before; * It is determined that you cannot adjust to other work because of your medical condition(s); and * Your disability lasts or is expected to last for at least one year.   Disability is more than just having a serious medical problem. Your age, education, work history and how long your problem is expected to last all make a difference. For instance, an individual may not be able to go back to a past job requiring heavy lifting and standing but might be able to work at a different job that requires light lifting and mostly sitting. | ***If example is needed to explain:***  A 32 year old office specialist with a college degree who is no longer able to walk may not be disabled. On the other hand, a 59-year-old construction specialist who did not finish high school who has the same condition may be disabled.  ***If person indicates condition is terminal:***  I’m sorry to hear that. This is something that is taken into consideration in making the decision.  Go to [**SSA Screening**](#SSA_Screen)**.** |
| **SSA Screening** | Applying for disability can be a long process.  Normally the best first step is to apply for disability with the Social Security Administration (SSA). There are a couple of different programs with SSA based on your work history, marital status, your living arrangement (for instance, are you living with someone or living by yourself) and what you may own.  Have you already applied for SSA disability? | *If the applicant answers yes, go to* [***SSA Status***](#SSA_Stat)***.***  *If the applicant answers no, go to* [**Disability Process**](#Dis_Proccess)***.***  *If the applicant wants contact information for SSA:*  You can go to the Social Security website to get more information and to apply for benefits at [www.ssa.gov](http://www.ssa.gov).  *If the applicant wants a phone number for SSA:*  You can get more information by calling SSA at  1-800-772-1213  (TTY 1-800-325-0778) |
| **SSA Status** | Has SSA approved or denied your application? | *If approved, ask for verification then go to* [**Process Application**](#Proc_App)*.*  *If denied, go to* [**Disability** **Process**](#Dis_Proccess)**.** |
| **Disability Process** | In South Carolina, Medicaid and Social Security use the same agency to make disability decisions. If you are waiting on a decision from Social Security, we will ask you to fill out the disability forms. When Disability Determination Services (DDS) gets the paperwork, they will match it with your Social Security application and work both at the same time. Getting a disability decision can take a long time, but providing all the requested information can prevent unnecessary delays. By applying for Social Security, if you are eligible you may be able get a monthly check.  We can send a request for a disability determination if you have not already filed with Social Security. It will still take about the same amount of time that it takes to get a decision for Social Security. | *Go to* [**Application for Other Benefits**](#App_Other_Bene)***.*** |
| **Application for Other Benefits** | One of the Medicaid eligibility rules is you must apply for any income benefits for which you may be eligible. This does not include programs that are based on need, such as SNAP (Food Stamps), Family Independence (at DSS), Supplemental Security Income (SSI) or some VA programs.  What this means is if we get a decision back from DDS and they say you are disabled, we have to check to see if you applied for Social Security Disability benefits. If you have not applied and you do not have a good reason, we will have to deny your application for Medicaid until you can show us that you have applied for Social Security. | *Go to* [**Next Step**](#Next_Step)***.*** |
| **Next Step** | Based on what we have talked about today, do you feel that your disability meets the Social Security requirements? | *If applicant says Yes and wants to pursue disability, go to* [**Continue Process**](#Cont_Proc)***.***  *If applicant says No and does not want to pursue disability, go to* [**Other Category**](#Other_Cat)***.*** |
| **Continue Process** | If you think you may have a disability that meets Social Security’s requirements, we will send you some forms to fill out. The questions on the form will ask about the following:   1. Medical information – a description of the problems you are having, the doctors you have seen, hospital visits, tests 2. Education history – grade completed, school attended 3. Work history – Jobs worked in the past 15 years and the kind of work you did   You will also have space to give any other information you think may help.  There will also be a second form that you will need to sign and date that will allow us to obtain medical records needed to make the disability decision. Do not write any other information on the form.  You will need to send the whole packet back to us within 15 days so we can continue the process. An envelope is included but you must put the postage on it. | *Discuss any other information that needs to be requested on the DHHS Form 1233 ME.*  *Go to*[**End Call**](#End_Call) |
| **Other Category** | Based on what we have talked about, If you decide that your disability is not likely to meet Social Security’s requirements, then we can use your application to see if there is anything else that you may be eligible for. Depending on your situation, you may be eligible for another full Medicaid category, a limited benefit Medicaid program, or you may not be eligible at all. | *Discuss any other information that needs to be requested on the DHHS Form 1233 ME.*  *Go to* [**End Call**](#End_Call) |
| **End Call** | Thank you for your time today. If you think of any questions after this call, you can call the Healthy Connections Member Services Call Center at 1-888-549-0820 and they can help you. |  |

105.02.01A MAGI to Non-MAGI/LTC Disability Process Script

(Eff. 10/01/23)

The following Disability Process Script must be used to make contact with the applicant who may require a disability decision during the MAGI to Non-MAGI/LTC Ex Parte process.

| Ex Parte Disability Process Script 105.02.01A | | |
| --- | --- | --- |
| Step | Script | Actions |
| Call |  | *Make call using the contact information on the application. 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, go to* **Prepare Disability Packet.**MPPM 102.06.02A*.* |
| Call Back Message | Hi, this is Name with the South Carolina Department of Health and Human Services, Healthy Connections. Someone recently contacted our agency, and I am following up for more information. I will call back in the next 5 minutes. Thank you. | *After 3-5 minutes, attempt a second call to the applicant/ beneficiary.*  *If a person answers the call, go to* [**Introduction**](#Intro)**.**  *If there is no answer, 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. | *Go to* **Prepare Disability Packet.**MPPM 102.06.02A |
| Introduction | Hi, this is Name with the South Carolina Department of Health and Human Services, Healthy Connections. May I speak with Mr./Ms. Member (or Authorized Representative)? | *If person on the phone says the applicant is not available, go to* [**Not Available**](#Not_Avail)*.*  *If able to speak with the applicant, go to* [**Available**](#Avail)*.*  *If applicant 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. Since we cannot speak with Mr./Ms. Last Name right now we will contact him/her by mail. Can we take a few moments to make sure we have the correct contact information for Mr./Ms. Last Name? | *If the person on the phone is willing, confirm the name (ask if it is the person’s legal name and check the spelling), date of birth if the person knows it, and contact information (address and phone number).*  **END CALL**  *Go to* ***Prepare Disability Packet.*** MPPM 102.06.02A |
| Available | Mr./Ms. Last Name, you recently returned your review and we need to follow up to get some additional information. First I need to confirm I am speaking with the right person. | *If someone other than the member 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 and in the system of record. Ask for additional elements such as address and the last four digits of the SSN. If confirmed, go to* [**Disability Script**](#Dis_Script)***.***  *If unable to confirm the identity of the member, indicate you will have to send the request by mail and go to Go to Prepare Disability Packet. MPPM 102.06.02A* |
| MAGI to Non-MAGI Disability Script | On your Annual Review for Medicaid benefits, you checked that you may be disabled. We are trying to help make the process go a little more smoothly. We want to give you some information about applying for Medicaid based on disability so you can make the best decision about what to do next. | Go to [**General Medicaid Information**](#Gen_Med_Info)**.** |
| General Medicaid Information | Medicaid is for people who have financial needs, but it is more than just how much money you may or may not have. You must also be part of a coverage group, or category. Because you no longer meet the eligibility criteria for your current coverage group, and to qualify in another category, you must meet the age or disability requirement. There are two other broad categories.   * Non-MAGI which includes either full Medicaid benefits for Doctor and hospital visits or coverage for your Medicare part B premiums only for individuals who are disabled. * Long-Term Care which includes full benefits for institutional coverage such as residential care, nursing home facilities, and in-home care for individuals who are disabled.   Do you believe you may be part of one of these other groups; Or do you have Breast or Cervical Cancer? | *If the person indicates he/she may be eligible under one of the other categorical groups, explore possible eligibility and go to* [**Define**](#Define)***.***  *If the person does not indicate he/she may be eligible under one of the other categorical groups, go to Offer Family Planning.* |
| Define | Because you checked on the Annual Review Form that you have a disabling physical, mental, or emotional health condition that causes limitations in activities, we want to talk about what that means and explain the disability determination process.  Medicaid uses the same definition of disability as the Social Security Administration (SSA). This definition is different than that used by other programs. This may be different than you receiving disability from work or the VA or your doctor telling you that you are disabled and need special medical treatment or some kind of accommodation, such as handicap parking. You are only eligible for Social Security if you have a permanent and total disability. You will not receive benefits if your disability is partial or short-term. Because Medicaid has the same rule, you must be totally disabled to be eligible as part of this coverage group.  Social Security's disability definition is based on your inability to work. You may be considered disabled under Social Security rules if:   * You cannot do work that you did before; * It is determined that you cannot adjust to other work because of your medical condition(s); and * Your disability lasts or is expected to last for at least one year.   Disability is more than just having a serious medical problem. Your age, education, work history and how long your problem is expected to last all make a difference. For instance, an individual may not be able to go back to a past job requiring heavy lifting and standing but might be able to work at a different job that requires light lifting and mostly sitting. | ***If example is needed to explain:***  A 32-year-old office worker with a college degree who is no longer able to walk may not be disabled. On the other hand, a 59-year-old construction worker who did not finish high school who has the same condition may be disabled.  ***If person indicates condition is terminal:***  I’m sorry to hear that. This is something that is taken into consideration in making the decision.  Go to [**SSA Screening**](#SSA_Screen)**.** |
| SSA Screening | Applying for disability can be a long process.  Normally the best first step is to apply for disability with the Social Security Administration (SSA). There are a couple of different programs with SSA based on your work history, marital status, your living arrangement (for instance, are you living with someone or living by yourself) and what you may own.  Have you already applied for SSA disability? | *If the applicant answers yes, go to* [***SSA Status***](#SSA_Stat)***.***  *If the applicant answers no, go to* [**Disability Process**](#Dis_Proccess)***.***  *If the applicant wants contact information for SSA:*  You can go to the Social Security website to get more information and to apply for benefits at [www.ssa.gov](http://www.ssa.gov).  *If the applicant wants a phone number for SSA:*  You can get more information by calling SSA at  1-800-772-1213  (TTY 1-800-325-0778) |
| SSA Status | Has SSA approved or denied your application?  If Yes ask:  Have you been disabled for two years or more?   * If Yes, are you receiving Medicare benefits?   + If Yes, do you know the Medicare Number on your card     - Medicare ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * If no, do not ask about Medicare benefits. | *If approved, ask for verification then go to* [**Process Application**](#Proc_App)*.*  *If denied, go to* [**Disability** **Process**](#Dis_Proccess)**.** |
| Disability Process | If you are waiting on a decision from Social Security, we will ask you to fill out the disability forms. When Disability Determination Services (DDS~~)~~ gets the paperwork, they will match it with your Social Security application and work both at the same time. Getting a disability decision can take a long time, but providing all the requested information can prevent unnecessary delays. By applying for Social Security, if you are eligible you may be able get a monthly check.  We can send a request for a disability determination if you have not already filed with Social Security. It will still take about the same amount of time that it takes to get a decision for Social Security. | *Go to* [**Application for Other Benefits**](#App_Other_Bene)***.*** |
| Application for Other Benefits | One of the Medicaid eligibility rules is you must apply for any income benefits for which you may be eligible. This does not include programs that are based on need, such as SNAP (Food Stamps), Family Independence (at DSS), Supplemental Security Income (SSI) or some VA programs.  What this means is if we get a decision back from DDS and they say you are disabled, we have to check to see if you applied for Social Security Disability benefits. If you have not applied and you do not have a good reason, we will have to deny your application for Medicaid until you can show us that you have applied for Social Security. | *Go to* [**Next Step**](#Next_Step)***.*** |
| Next Step | Based on what we have talked about today, do you feel that your disability meets the Social Security requirements? | *If applicant says Yes and wants to pursue disability, go to* [**Continue Process**](#Cont_Proc)***.***  *If applicant says No and does not want to pursue disability, go to* [**Other Category**](#Other_Cat)***.*** |
| Continue Process | If you think you may have a disability that meets Social Security’s requirements, we will send you some forms to fill out. The questions on the form will ask about the following:   1. Medical information – a description of the problems you are having, the doctors you have seen, hospital visits, tests 2. Education history – grade completed, school attended 3. Work history – Jobs worked in the past 15 years and the kind of work you did   You will also have space to give any other information you think may help.  There will also be a second form that you will need to sign and date that will allow us to obtain medical records needed to make the disability decision. Do not write any other information on the form.  You will need to send the whole packet back to us within 15 days so we can continue the process. An envelope is included but you must put the postage on it.  Does your reported disability limit your ability to complete the paperwork? If so, would you like to go over the paperwork in this call? | *If yes, go over the disability application and fill in the form over the phone. Then Mail the completed form to the beneficiary.*  *If no, complete the top of the form and mail the form to the beneficiary.*  *Discuss any other information that needs to be requested on the DHHS Form 1233 ME.*  *Go to*[**End Call**](#End_Call) |
| Other Category | Based on what we have talked about, if you decide that your disability is not likely to meet Social Security’s requirements, then we can use your review to see if you qualify for Family Planning which does not meet the Minimum Essential Coverage Requirement under the Affordable Care Act. Family Planning provides limited-benefit coverage provides coverage for preventive health care, family planning services, and family planning-related services.  You also have the option to apply for Federal Marketplace coverage through the HealthCare.gov website, which may lead to lower costs for health insurance. | *Discuss any other information that needs to be requested on the DHHS Form 1233 ME.*  *Go to* [**End Call**](#End_Call) |
| End Call | Thank you for your time today. If you think of any questions after this call, you can call the Healthy Connections Member Services Call Center at 1-888-549-0820 and they can help you. |  |

105.02.02 Long Term Care Call Initiation Script

(Eff. 08/01/15)

| Long Term Care Call Initiation Script 105.02.02 | | |
| --- | --- | --- |
| Step | Script | Actions |
| **Call Preparation** |  | Review the application and make notes of any information that may be missing, needs clarification or requires verification/documentation.  Check all online verification sources which may be available including completion of online property checks. |
| **Call** |  | Make call using the contact information on the application. 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, prepare a DHHS Form 1233 and request required information. |
| **Call Back Message** | *→* Hi, this is Name with the South Carolina Department of Health and Human Services, Healthy Connections. Someone recently contacted our agency and I am following up for more information. I will call back in the next 5 minutes. Thank you. | After 3-5 minutes, attempt a second call to the applicant/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. | Prepare a DHHS Form 1233 and request required information. Document attempted contact. |
| **Introduction** | *→* Hi, this is Name with the South Carolina Department of Health and Human Services, Healthy Connections. May I speak with Mr./Ms. Applicant (or Authorized Representative)? | If person on the phone says the applicant/authorized representative is not available, go to [**Not Available**](#Not_Avail).  If able to speak with the applicant/authorized representative, go to [**Available**](#Avail).  If applicant/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 contacted our agency to apply for benefits 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 applicant 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 application. Ask for additional elements such as address and the last four digits of the SSN. If confirmed, go to [**Interview Script**](#Interview_Script)**.** |
| **Interview Script** | *→* We received your application for Long Term Care Services and we want to go over it with you to make sure we have a good idea of the situation and to let you know about any else you may need to send in. Once we finish this call we will mail you a list of everything we are asking you to return as a reminder. | Go to [**Application Script**](#App_Script) |

105.02.01A Update Disability Packet Script

(Eff. 03/01/16)

The following Disability Process Script must be used to make contact with the applicant when an application requiring a disability decision has not been processed timely and the DHHS Form 921, Release for Information, is expired or about to expire. Refer to MPPM 102.06.02A.

| Update Disability Packet Script | | |
| --- | --- | --- |
| Step | Script | Actions |
| Call |  | *Make call using the contact information on the application. 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, go to* [**Prepare Update Disability Packet**](#Prep_Update)**.** |
| Call Back Message | Hi, this is Name with the South Carolina Department of Health and Human Services, Healthy Connections. Someone contacted our agency and I am following up for more information. I will call back in the next 5 minutes. Thank you. | *After 3-5 minutes, attempt a second call to the applicant/ beneficiary.*  *If a person answers the call, go to* [**Introduction**](#Intro)**.**  *If there is no answer 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 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. | *Go to* [**Prepare Update Disability Packet**](#Prep_Update) |
| Introduction | Hi, this is Name with the South Carolina Department of Health and Human Services, Healthy Connections. May I speak with Mr./Ms. Applicant (or Authorized Representative)? | *If person on the phone says the applicant is not available, go to* [**Not Available**](#Not_Avail)*.*  *If able to speak with the applicant, go to* [**Available**](#Avail)*.*  *If applicant is the person on the phone, go to* [**Available**](#Avail)*.* |
| Not Available | Mr./Ms. Last Name contacted our agency and we need to speak with him/her to get some more information. Since we cannot speak with Mr./Ms. Last Name right now we will contact him/her by mail. Can we take a few moments to make sure we have the correct contact information for Mr./Ms. Last Name? | *If the person on the phone is willing, confirm the name (ask if it is the person’s legal name and check the spelling), date of birth if the person knows it, and contact information (address and phone number).*  **END CALL**  *Go to* [**Prepare Update Disability Packet**](#Prep_Update)***.*** |
| Available | Mr./Ms. Last Name, you contacted our agency to apply for benefits and we need to follow up to get some additional information. First I need to confirm I am speaking with the right person. | *If someone other than the applicant 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 application. Ask for additional elements such as address and the last four digits of the SSN. If confirmed, go to* [**Update Disability Packet Script**](#Dis_Script)***.***  *If unable to confirm the identity of the applicant, indicate you will have to send the request by mail and go to Go to* [**Prepare Update Disability Packet**](#Prep_Update)**.** |
| Update Disability Packet Script | On your application for Medicaid, you checked that you may be disabled. You filled out a disability packet with your original application but due to a delay, the Information Release Form is more than 10 months old and needs to be updated. I would like to send you a packet so that we can get updated information. | *Go to* [**Update Cover Letter**](#Gen_Med_Info)***.*** |
| Update Cover Letter | The packet will contain several things. The first is a letter that will repeat many of the same things we will talk about today. It will explain that we need to update the information we have on file and give you the instructions on what needs to be done. | *Go to* [**DHHS Form 921**](#Form_921)***.*** |
| DHHS Form 921 | I am sending you a DHHS Form 921, Authorization to Disclose Health Information (Request for Medical Records). This form gives your doctors and other medical providers permission to give Vocational Rehabilitation the needed information to make a decision about your disability. It is important that you send this form back. | *Go to* [**Review Disability Report**](#Rev_Dis_Rep)***.*** |
| Review Disability Report | I am also including a copy of the original Disability Report that you sent in with your application. We want to give you a chance to look over what you told us so you can make any changes, such as a new doctor or medical problem. | *Go to* [**Report Changes**](#Rep_Chan)***.*** |
| Report Changes | If there are any changes you want to tell us about, you can add it on the blank copy of the Disability Report included in this packet. You do not have to fill out the entire form again. You only have to fill out that part where there is a change. For instance, if you have a new doctor you want to add, you can add his or her information on page 2. You would not have to fill out anything else. If you do not have any new information, you do not have to fill out anything on this form. | *Go to* [**Return Envelope**](#Ret_Env)***.*** |
| Return Envelope | We are including an addressed envelope for you to use to return everything to us. Please remember to put a stamp on the envelope or we will not get to us. We ask that you send everything to us within 15 days. Please call the number shown on the letter for the Healthy Connections Member Services Call Center if you will not be able to return everything within 15 days. | *Go to* [**End Call**](#End_Call)***.*** |
| End Call | Thank you for your time today. If you think of any questions after this call, you can call the Healthy Connections Member Services Call Center at 1-888-549-0820 and they can help you. |  |

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| --- | --- |
| **Prepare Update Disability Packet**   * Cover Letter * Copy of original DHHS Form 3218 ME * DHHS Form 3218 ME * DHHS Form 921 | * Complete the DHHS Form 3218-J ME, Update Disability Packet cover letter * Print a copy of the applicant’s original completed Disability Report * On a new Disability Report, type the applicant’s Name, Date of Birth, Social Security Number, Address, Phone Number and other Identification and Contact information * Fill in the “For DHHS Use Only” box by typing the complete Household Number and Application Date and indicate whether it is a request for an Initial or Retro Only decision and the beginning Retro month * On the DHHS Form 921, fill in the “To Be Completed By SCDHHS” box by typing the Name, Social Security Number, Date of Birth and complete Household or Application ID number * Update the DHHS Form 1233 ME to add the Disability Packet * Mail the DHHS Form 1233 ME and Update Disability Packet to the applicant and give 15 days to return the required information |

105.02.03 Long Term Care Application Script

(Eff. 08/01/15)

| **Application Script 105.02.03**  Specialist ID:       Applicant:  Call Date:       HH/Application Number: | |
| --- | --- |
| **Element**  Script  Adjust as appropriate if speaking with an Authorized Representative **Confirmation/Correction** | **Action** |
| **Applicant Name**  *→* You entered your name as Full Name. Is this the way that your name is on your Social Security Card? |  |
| Correct  Change: |
| **Date of Birth**  *→* What is your date of birth? |  |
| Correct  Change: |
| **Social Security Number**  *→* You show your Social Security Number as Social Security Number? Is this correct? |  |
| Correct  Change: |
| **Home Address**  *→* You show your home address as Home Address. Is this correct? Do you also receive your mail at this address? |  |
| Correct  Change: |
| **Mailing Address**  *→* You entered your mailing address as Mailing Address. Is this correct? |  |
| Correct  Change: |
| **Household Members**  *→* You listed the following people on your application as living with you:  Names. Is this correct?  *→* Is there anyone else we should add such as a spouse living somewhere else?  Record Name, Relationship, Date of Birth and other information as needed |  |
| Correct  Change/Addition: |
| **Legal Documents**  → Does anyone have a Conservatorship, Guardianship or Power of Attorney for you? | Copy in File  1233 – Copy Requested |
| None  Conservatorship  Guardianship  Power of Attorney  Name: |
| **Requested Service Type**  *→* On your application you indicated you are interested in Service Type. Is this correct? | Level of Care Request (NH/HCBS)  Slot Request (OSS) |
| Nursing Home  In Home Care (HCBS)  OSS |
| **Current Location**  *→* Are you currently at home, in a hospital, or at some other facility such as a nursing facility or residential care facility? |  |
| Home (Own home or with a relative or friend)  Nursing Home  Hospital  CRCF  Facility Name:  Date Entered:  If applicant is currently in a nursing facility:  → Did you live at home at any time during the month you entered the nursing facility?  Yes  No |
| **Categorical** | If Disability is not established, go to **Disability Script** |
| Aged (Age 65 or older)  Blind or Disabled  Disability not established |
| **Retroactive**  *→* Have you received any medical services in the three months prior to the application? | 1233 – Retro info requested |
| Retro requested on application  Retro requested on call  Retro not requested |
| **Other Benefits**  *→* Have you or your spouse ever served in the military?  *→* Have you or your spouse ever worked somewhere which has a retirement benefit? | 1233 – Refer to apply for other benefits |
| No other potential income  Currently receive  Other potential income |
| **Income** – Applicant  Complete before call. Make any notes or corrections as necessary: |  |
| *→* You listed the following income on your application: | 1233 – Income Verification Requested |
| Source Amount  SSA/Railroad  Veterans Benefits  Retirement/Pension  Other:   |  |  | | --- | --- | |  |  | |  |  | |
| *→* Is there any other income that may not have been listed? | 1233 – Income Verification Requested    Total Reported Income:  0.00  If reported income is greater than $2000, go to **Income Trust** script. If Income Trust script is not required, continue **Application Script** |
| None  Additional Income:  Source Amount   |  |  | | --- | --- | |  |  | |  |  | |  |  | |  |  | |
| *→* Do you have any deductions taken out of your check? Anything such as health/dental insurance premiums or taxes withheld? If you have medical deductions, we may be able to not count the premiums.  No Deductions  Deductions (List all deductions) | 1233 – Verification Requested  *→* If taxes are being withheld, you have the option to ask whoever is paying the income to stop withholding taxes.  Medicaid must use the full amount even if taxes are being deducted. |
| **Income** – Spouse or other dependent relative  Complete before call. Make any notes or corrections as necessary: |  |
| *→* You listed the following income on your application:  Source Amount  SSA/RRB  Veterans Benefits  Retirement/Pension  Other:   |  |  | | --- | --- | |  |  | |  |  | | 1233 – Income Verification Requested |
| *→* Is there any other income that may not have been listed? | 1233 – Income Verification Requested |
| None  Additional Income:  Source Amount   |  |  | | --- | --- | |  |  | |  |  | |  |  | |  |  | |
| **Resources**  Complete on-line property check  Complete before call. Make any notes or corrections as necessary.  Follow up on discrepancies |  |
| *→* You listed the following resources on your application: | 1233 – Resource verification requested    If an applicant reports a Trust Fund or Trust Account, request a copy of the trust documents.  If an applicant reports a Direct Express account, ask for the balance but do not request any hard copy verification. |
| Homestead Property  Intent to Return Home  Yes  No  Other Real Property    Checking Account    Savings Account    Vehicles    Life Insurance    Trust Fund or Trust Account    Burial Fund/Contract    Direct Express account    Other |
| If the applicant lists home property but either did not answer the intent to return home question or answered no:  *→* Normally when you have property we have to count its value. With homestead property you can decide if we have to count it or not.  If you tell us that you want to return to your home if you ever get better, then we would not count the value of the home. If you say that you do not want to go back home even if you got better, then we would have to count the value of the home.  *→* Even if you think you will never be able to go home, would you want to go back to your home if you could? | Declined Intent to Return Home  Requested change for Intent to Return Home. DHHS Form 1277 sent. |
| If there is a checking or savings account listed, ask either:  *→* Which account is your Social Security check (or other income) deposited into?  *→* Is your Social Security check (or other income) deposited into this account? | 1233 – Resource verification requested |
| Account listed above  Other Account(s) |
| *→* Are there any other resources that may not have been listed? | 1233 – Resource verification requested |
| None  Additional Resources |
| **Medical Insurance**  *→* Are you currently covered by medical insurance? | If Yes, confirm the details shown on the application or request the company and policy number.  1233 – Requested Verification of coverage and premium |
| No  Yes  Details: |
| **Allocation**  If the allocation question is blank or No and the person is going into a nursing home:  *→* Would you like to allocate, or give, part of your income to your:   * Spouse, * Child, or * Other dependent relative who was living with the applicant prior to admission? |  |
| No Change  Allocation Change |
| **Other Financial Accounts**  *→* Does anyone have any financial accounts for you or is holding money for you that has not been listed? Have you added any names to any accounts? | 1233 – Verification Requested |
| No  Yes  Details: |
| **Closed Financial Accounts**  *→* In the past five years have you or your spouse closed or transferred any type of financial account such as bank, investment, or retirement accounts? | 1233 – Verification Requested |
| No  Yes  Details: |
| **Real Property**  *→* In the past five years have you or your spouse sold or given away your home or any other property? This includes transferring your home into a life estate.  No  Yes  If a transfer is indicated:  *→* When did you transfer the property and in what county and state did the transfer take place?  Or  *→* Where have you lived in the past five years? | 1233 – Verification Requested |
| Details: |
| **Vehicles**  *→* In the past five years have you or your spouse given away any motor vehicles including cars, boats, RVs, etc.? | 1233 – Verification Requested    The transfer of one vehicle that is otherwise excluded is not subject to the transfer of assets penalty and no further verification is needed. |
| No  Yes  Details: |
| **Other Transfers**  *→* In the past five years have you given away money or anything else to anyone in the past five years that we may not have asked about? | 1233 – Verification Requested |
| No  Yes  Details: |
| **Inheritance**  *→* Have you received an inheritance from anyone within the past five years? | 1233 – Verification Requested |
| No  Yes – Person, when and where probated, and description  Details: |

105.02.04 Income Trust Script

(Eff. 08/01/15)

|  | Income Trust Script 105.02.04 | | |
| --- | --- | --- | --- |
|  | Step | Script | Actions |
| **INCOME TRUST SCRIPT** | **Why an Income Trust is needed** | Based on the income information you have given us, it appears the gross income before deductions may be at or above the Income Limit or Medicaid Cap of $\_\_\_\_.  The applicant may still qualify for Medicaid by setting up a special Income Trust for their income to flow through.  If an Income Trust is set up, the income deposited into the trust does not count toward the Medicaid Cap but is considered when determining how much he/she as to pay toward their cost of care each month. |  |
| **INCOME TRUST SCRIPT** | **Income Trust paperwork** | You do not have to have an attorney to set up this trust. We will send you a packet. It needs to be completed as soon as possible. The earliest possible date of eligibility is the first day of the month the document is signed.   * The packet you receive will include: Income Trust Document to fill out and sign. * Instructions on how to fill it out.   + You do not have to have an attorney unless you want to.   + It does have to be signed, witnessed and notarized.   Mr/Mrs Last Name sign themselves or their Power of Attorney or Conservator can sign for them. | If the applicant is unable to sign and does not have a Power of Attorney or Conservator, explain someone may need to pursue obtaining conservatorship. They will need an attorney. |
| **INCOME TRUST SCRIPT** | **Trustee** | Someone will need to serve as trustee for you or the applicant. This person will be responsible for putting the money in the trust and paying the cost of care. It can be a:   * Spouse * Child * Friend * Legal Representative * Nursing Home   Do you or Mr/Mrs Last Name have someone who can do this? |  |
| **INCOME TRUST SCRIPT** | **Separate account** | A separate account must be designated or opened to have Mr/Mrs Last Name’s income to flow through.  It can be a regular checking account. You do not need to set up an account with the Bank’s Trust Department.  The information you receive will explain how the account needs to:   * Must have applicant and trustee’s names only on the account * Only the applicant’s income can be deposited into the account. * Only allowed expenses can be paid from the account. * The information you receive will explain how to use the account. |  |
| **INCOME TRUST** | **Cost of Care** | **Nursing Home:**  Depending on the amount of your income and the deductions we are able to give you may have to pay the Nursing Home. If we are able to approve your application, we will let you know how much you will have to pay to the nursing home for the medical services and care you receive. | 1233 – Income Trust Information and Forms sent |
| **INCOME TRUST** |  | **Waiver Services:**  Depending on the amount of your income and the deductions we are able to give, you may have to pay part of your income. If we are able to approve your application, we will let you know how much you will have to pay. You will get a bill each month. |  |

105.02.05 Release of Application/Case Information

(Eff. 11/01/15)

| Step | Script | Action |
| --- | --- | --- |
| Provider Request  Provider is making a request for specific case information about an individual such as if an application has been filed or the status of an application. | Please hold one moment while I check the record to see if Individual has filled out the proper documentation giving us permission to share this information with you. | Check OnBase, MEDS notes and Access Notes. Is a DHHS Form 1282 on file?  **Yes –** Does the 1282 name the provider as AR or in the release of information section?  **Yes –** Go to **Provide Information**  **No –** Go to **1282 Explanation**  **No –** Go to **1282 Explanation** |
| Provide Information | I see we have documentation on file which gives us permission to share information with you. How can I help you? | Help the provider with the information needed. |
| 1282 Explanation | When someone applies for or is receiving Medicaid, that person can name someone to act as an Authorized Representative. We use the DHHS Form 1282 for this designation. This form allows the individual to give a trusted person permission to:   * Talk with DHHS staff about an application, * See the applicant’s information, * Get information about the application, and * Act on behalf of the applicant during the application, appeals, review or managed care process.   Another option for the applicant is to give permission for a more limited role where the agency can release information to a person or organization. The DHHS Form 1282 is also used for this designation. If the applicant selects this option, the agency is able to share information with the person or organization, such as the status of an application, but the person or organization cannot act on behalf and does not receive notices or other client communication.  We use this process to help protect the individual’s private information by adhering to HIPAA requirements and Medicaid confidentiality laws.  As a provider, you have an excellent opportunity to assist the individual and their family. | Go to **Offer** |
| Offer | We can send you a copy of the DHHS Form 1282 and you can discuss with the individual about how they may want you to help them. Would you like me to tell you how you can get a copy from our website or would you rather I send you a copy? | **Yes –**  **Website**  Go to <www.scdhhs.gov>. Select [Getting Medicaid](https://www.scdhhs.gov/members/getting-started). Near the bottom of the page, select the link [For additional forms, please click here](https://www.scdhhs.gov/members/forms).  **Mail**  Get the provider’s contact information and send a DHHS Form 1282.  **No – End Call** |

105.03 Documentation Template

(Rev. 02/10/21)

The documentation template is a tool used to consistently document an application or redetermination from the time it is received until a final disposition is completed. The template must be completed in OnBase for all applications and redeterminations except for cases that are processed straight through without any specialist.

105.03.01 Instructions for Completing Documentation Template

(Eff. 07/01/16)

Below are general instructions for the template by each section. A single instance will be shown where there may be multiple lines or rows and formatting may be slightly altered for display purposes in the manual.

105.03.01A Header and General Information

(Rev. 11/01/18)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| The header of the document is used to show the cycle for the template, identifying information, and if a ticket has been submitted. A documentation is intended to be active for an application or review cycle. A template is started at application and remains active until the next review. Reported changes and other contacts are saved near the end of the document.  This section has a checkbox to document that an applicant has requested a retroactive determination for themselves or another household member on the application. This section also shows any tickets sent to Technical Assistance or the Helpdesk. If there is a ticket, refer to the scanned copy of the ticket in OnBase before creating a new ticket to prevent duplicate requests. When a specialist creates a Technical Assistance or Helpdesk ticket, record the Ticket Number and select the type of request under Ticket Type. Record the date the ticket is created and the Specialist ID. When an answer is scanned into OnBase and placed into Workflow, the eligibility specialist picking up the case will record the date of the answer and his or her Specialist ID. Medicaid Eligibility Date corrections will be marked as resolved by the individual making the change in the system  The date a template is created, either at application or at review   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Documentation Template** Start a new template at application and at each annual review  o Initial Application o Review Application/Review Date: Template Start Date:  o Retro Requested Template End Date:  The date a template is replaced by a new template  **HH Information**   |  |  |  | | --- | --- | --- | | **HH#/App ID** | **Primary Individual First Name** | **Primary Individual Last Name** | |  |  |  |   Pick from a list to show the type of ticket submitted  Enter when an answer is provided or issue is resolved  **Technical Assistance/Helpdesk Tickets**   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Ticket Number** | **Ticket Type** | **Created** | | **Resolved/Completed** | | | **Date** | **Specialist ID** | **Date** | **Specialist ID** | |  | ò |  |  |  |  | |  |  |  |  |  |  | | |

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| **General – Authorized Representative/Power of Attorney/Information Release** |
| This section is used to document an Authorized Representative, Power of Attorney, Guardianship or someone for whom the Applicant/beneficiary has given permission to release information   * **Authority**ò   + **1282 – Authorized Representative**   + **1282 – Information Release Only**   + **Power of Attorney**   + **Guardianship**  |  |  |  |  | | --- | --- | --- | --- | | **General – Authorized Representative/Power of Attorney/Information Release** | | | | | **Name** | **Authority** | **Start Date** | **End Date** | |  | ò |  |  | |

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| **General – Voter Registration** |
| This section is used to document that Voter Registration was offered to applicants and beneficiaries according to policy detailed in MPPM 101.18. Check   * **Voter Registration Application (VRA)**   + Checked when an eligibility specialist gives or mails a Voter Registration form to an applicant or beneficiary * **Voter Registration Declination (VRD)**   + Checked when an eligibility specialist receives a completed declination form from an applicant or beneficiary  |  | | --- | | **General – Voter Registration** | | o Voter Registration Application (VRA) o Voter Registration Declination (VRD) | |

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| **General – Categorical Eligibility** |
| This section is used to indicate the categorical basis for individuals applying for coverage. Check all that apply for any member of the household. For instance, if a pregnant woman with a child is applying for Medicaid, you would check both Under Age 19 (for the child) and Pregnant, filling in the Expected Date of Delivery and the Number of Children Expected. Include any notes that may be needed to explain special situations   |  | | --- | | **General – Categorical Eligibility** | | Check all that applies to members of the household   |  |  | | --- | --- | | o Under Age 19  o Dependent Child in Home  o Pregnant  Expected Date of Delivery:  Number Expected:  o Former Foster Care | o Aged 65 or Older  o Blind/Disabled  o MAO99 o System Match/ SSA Letter  o Breast and Cervical Cancer  o Tuberculosis  o Form 3400-E – Tuberculosis (TB) Referral | | **Notes:** | | | |

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| **General – HH Composition** |
| This section is used to document the composition of the household applying to coverage.   * **Number of Adults**   + Used to document the number of adults in the household * **Number of Children**   + Used to document the number of children under age 19 in the household * **Has Tax Filing Status Been Determined?**   + Used for MAGI determinations * **Filing Status**   + Used for MAGI determinations * **List Other Household Members and Relationship**   + Used to document other household members such as a spouse or child     - Include the relationship if known     - For MAGI determinations, show individuals who are not listed on the application or do not live in the household who may have an impact on an eligibility decision     - For Non-MAGI cases, show other individuals for whom an allocation has been considered * **Immigration Status Details**   + Used to document the immigration status or other citizenship and identity information about an applicant or beneficiary. Items such as Document Type, Alien Number, Classification Code, and SAVE Results should be documented below in General – Electronic Verifications  |  | | --- | | **General – HH Composition** | | |  |  | | --- | --- | | **Number of Adults** | **List Other Household Members and Relationship** | | **Number of Children** |  | | **Has Tax Filing Status Been Determined?** (MAGI Only) | | o Yes o No | | **Filing Status** (MAGI Only) | | o Married Filing Jointly o Single  o Married Filing Separately o Non-Tax Filer | | **Immigration Status Details:** | | | |

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| **General – Electronic Verifications** |
| This section is used to document the system matches that have been completed. Include any notes related to the information found that may not be documented elsewhere or that may require additional explanation. Document any details used to validate an alien’s status in SAVE, such as Document Type, Alien Number, Classification Code, and SAVE Result.   |  | | --- | | **General – Electronic Verifications** |  |  |  |  | | --- | --- | --- | | ESC – Wage Match  o Hit o No Hit o N/A | BENDEX – Social Security  o Hit o No Hit o N/A | SDX – SSI | | o Hit o No Hit o N/A | | SC State Retirement System  o Hit o No Hit o N/A | SVES – Citizenship  o Hit o No Hit o N/A | Unemployment Compensation | | o Hit o No Hit o N/A | | PCS Wage Verification  o Hit o No Hit o N/A | MMIS/TPL – Health Insurance  o Hit o No Hit o N/A | SAVE – Immigration Status | | o Hit o No Hit  o Required o Not Required | | CHIP – DSS Eligibility System  o Hit o No Hit o N/A | MMIS/RSP – Waiver/Special Programs | | o Hit o No Hit o N/A | \* Some verifications may be part of PCS | | Notes: | | | |

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| **General – Action Summary (One through Six)** |
| This section is used to document who has worked on a case, the date and the type of action completed   * **Action Taken**ò   + **Eligibility Decision** means that the specialist has made a decision (Approval, Denial, Continued Eligible, Terminated)   + **Pended–1233 Given** means the specialist has requested additional information from the applicant or beneficiary that is required before a decision can be completed   + **Pended–3rd Party Verification** means the specialist has requested additional information from a third party that is required before a decision can be completed   + **Pended–Admission/Enrollment** means the specialist is waiting for the applicant to be admitted to a facility or be enrolled in waiver services   + **Pended–30 Day Requirement** means to specialist must wait for the applicant to be admitted to a hospital, nursing facility, waiver or combination for 30 consecutive days * Include any notes or other explanation related to the action  | **General – Action Summary** | | --- | | **Action One**   |  |  | | --- | --- | | **Specialist ID** | **Action Taken**  ò | |  |  | | **Date** | |  | | |

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| **General – Collateral Calls (One through Five)** |
| This section is generally used to document collateral calls to collect information. Document the date and time the call is made. Include the name of the person who provides the information. Examples are:   * Requesting information from an applicant or beneficiary before sending a DHHS 1233 * Completing a LTC Application Script or VR Script * Clarifying information that has been received * Documenting a failed attempt to verify income or resources. If a specialist is able to verify income or resource with a collateral call, it will be documented in the income or resource section.  | **General – Collateral Calls** (Do Not use for Successfully Verified Income and Resources) | | --- | | **Call One Specialist ID:**   |  |  |  | | --- | --- | --- | | **Date** | **Time** | **Call Details** | |  |  |  | | **Person Contacted** | **Phone** | |  |  | | |

105.03.01B Financial Information – Income and Resources

(Eff. 07/01/16)

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| **Financial – Income (One through Six)** |
| This section is used to document income received in the household   * **Income Verification is Complete** is checked by the specialist once an income source has been appropriately verified either through a collateral call, electronic data source, hard copy verification or client statement * **Specialist ID** is the specialist who completes the verification of an income * **Whose Income?** Used to document to whom the income belongs. If income is received by someone for another person, show the name of the person for whom the income is intended. * **Income Type**ò is a drop list of different types of income, such as wages and Social Security * **Source of Income** is used to document where the income comes from. For instance, if the applicant reports wages, this is the name of the employer. If the source is the same as the payer, Social Security for instance, this field does not have to be completed * **Income Verified (List Dates)** is the date the income is verified * **Income Amount** is the gross income * **Frequency**ò is used to show how often an income is received * **Verified w/ Collateral Call** is checked when a specialist is able to verify income with a collateral call. Enter the name of the person, the name of the company or agency (include the person’s title if it would be helpful to identify the verification source) the phone number, and the date and time of the call * **Verification Details and Comments** is used to document any additional details related to the income source. Include the source of the verification if a collateral call was not used. This could be an electronic data source (such as BENDEX), copies of paychecks (including the paid dates), or an award letter. If multiple members of the household receive income from the same source, the specifics for each person could be documented in this field if the space is needed  |  | | --- | | **Financial – Income** | | **Income Source One** o **Income Verification Complete Specialist ID:**   |  |  |  |  | | --- | --- | --- | --- | | **Whose Income?** | **Income Type** | **Source of Income** | | |  | ò |  | | | **Income Verified (List Dates)** | **Income Amount** | **Frequency** | | |  |  | ò | | | o **Verified w/ Collateral Call** | **Person & Business:** | | **Call Date:** | | **Phone Number:** | **Call Time:** | | **Verification Details and Comments:** | | | | | |

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| --- |
| **Financial – Resources (One through Twelve)** |
| This section is used to document resources in the household   * **Resource Verification Complete** is checked by the specialist once a resource has been appropriately verified either through a collateral call, electronic data source, hard copy verification or client statement * **Specialist ID** is the specialist who completes the verification of a resource * **Whose Resource?** Used to document to whom the resource belongs. If a resource is held by someone for another person, show the name of the person to whom the resource belongs and enter the additional details in the comments. * **Type (General Description)**ò is a general description of a resource, such as checking account, savings account, life insurance policy, property, etc. * **Source/Name/Location/Account** is the location of the resource, the name of the bank, brokerage, Life Insurance Company, account numbers, etc. * **Resource Verified (List Dates)** is the date the resource is verified * **Resource Requested (List Dates)** is the date(s) verification is requested from the individual/AR or third party * **Verified Value** is the current market value of the resource * **Countable Value** is the amount to be budgeted in the eligibility determination. The resource could be excluded or the value reduced due to an outstanding loan * **Verified w/ Collateral Call** is checked when a specialist is able to verify a resource with a collateral call. Enter the name of the person, the name of the company or agency (include the person’s title if it would be helpful to identify the verification source) the phone number, and the date and time of the call * **Verification Details and Comments** is used to document any additional details related to the resource. This may include how a resource is verified when a collateral call is not used, or detailing an exclusion or other reduction in value of a resource.  |  | | --- | | **Financial – Resources** | | **Resource Item One** o **Resource Verification Complete Specialist ID:**   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Whose Resource?** | | **Type (General Description)** | | **Source/Name/Location/Account** | | |  | | ò | |  | | | **Resource Verified (List Dates)** | | **Resource Requested (List Dates)** | | | | |  | |  | | | | | **Verified Value** | **Countable Value** | o **Verified w/ Collateral Call** | | | **Phone Number:** | |  |  | **Person & Business:** | | | | | **Verification Details & Comments** | | **Call Date:** | **Call Time:** | | | |  | | | | | | | |

105.03.01C Long Term Care and OSS Information

(Eff. 07/01/16)

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| **Long Term Care/Optional State Supplementation** |
| This section is used to document details related to Long Term Care and Optional State Supplementation (OSS)   * **Type of Care** documents the type of care received by the individual   + **Nursing Home** – Must meet 30-day requirement unless eligible under another full Medicaid benefit category. A 60 month look-back is required   + **In-Home Care (Waiver)** – Home and Community Based (Waivered) Services. Must meet 30-day requirement unless eligible under another full Medicaid benefit category. A 60 month look-back is required   + **PACE** –   + **General Hospital** – Must meet the 30-day requirement but a 60 month look-back is not required   + **Optional State Supplementation (OSS)/Community Residential Care Facility (CRCF)** * **Hospital/Nursing Facility/Waiver Program/CRCF** is the name of the hospital, nursing facility, waiver program or community residential care facility where the individual has been admitted or enrolled. Up to three consecutive admissions can be documented * **Date of Entry/Enrollment Date** is when the individual is admitted to a facility or enrolled into a waiver * **Level of Care**ò is used to document the individual’s Level of Care (Intermediate, Skilled, Medicare Skilled, or Hospital) and the effective date. This is required for Nursing Home and Waiver * **OSS Slot Date** is the date an OSS slot is assigned to an individual * **Must Meet 30 Consecutive Day** is selected when an individual must meet the 30 Consecutive Day requirement in order to be approved * **30 Consecutive Days Met** is selected when an individual has satisfied the 30 Consecutive Day requirement if necessary for approval * **Phoenix Checked** is selected when a specialist has checked the Phoenix system to see the individual’s involvement with CLTC * **Phoenix Updated** is selected when a specialist has updated Phoenix as appropriate * **Transfer of Assets** documents if a sanctionable transfer was discovered. If there is a transfer, details can be entered in the **Notes** field * **Look-Back** documents if the 60 month look-back has been completed OR is not required   + **Specialist ID** records the specialist who completes the 60 month Look-Back   + **Status**òrecords the progress of the Look-Back     - **In Progress** is selected when a specialist has begun the look-back but not able to complete it because additional information had to be requested. Record the details in the **Notes** field     - **Completed** is selected when a specialist has all of the information required to complete the look-back and can make a decision     - **Not required** is selected when a look-back is not required. For instance, the individual may be SSI eligible or be moving from a facility out-of-state and the look-back has already been completed   + **Transfer of Assets**ò records the results of the look-back     - **No Transfer** – No transfer of assets was found     - **Transfer-Penalty** – A transfer occurred and a penalty is assessed. Record the details of the transfer and the penalty calculation in the **Notes** field     - **Transfer-No Penalty** – A transfer occurred but no penalty is assessed because it meets an exception. Record the details of the transfer and the reason for the exception in the **Notes** field   + **Penalty Period** shows the start and end date of a transfer penalty     - **Start**     - **End** * **Spousal Allocation** and **Dependent Relative Allocation** is used to indicate if an allocation is allowed from the individual’s income. Details can be entered in the **Notes** field * **Health Insurance Premium** is used to show if health insurance premiums are being deducted from the individual’s income and the amount. Additional details can be entered in the **Notes** field * **Home Maintenance Allowance** is selected if being budgeted for an individual. The **Start** and **End** dates are also recorded. Additional details can be entered in the **Notes** field * **Income Trust** is selected if an income trust is required to establish eligibility * **Trust Document Approved** is selected if there is a valid signed and dated income trust document that has been approved by Policy and Planning * **Effective Date** is the date the income trust is effective * **Account Designated** means that an specific account has been selected as the trust account * **Account Funded** means the income specified in the income trust is/has been deposited into the designated account  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **LONG TERM CARE/OPTIONAL STATE SUPPLEMENTATION** | | | | | | | | | | | | | **Type of Care**  o Nursing Home o In-Home Care (Waiver) o PACE o General Hospital  o Optional State Supplementation (OSS)/Community Residential Care Facility (CRCF) | | | | | | | | | | | | | **Hospital/Nursing Facility/**  **Waiver Program/CRCF** | | | **Date of Entry/ Enrollment Date** | | **Level of Care**  (For Nursing Home and In-Home Care only) | | | | | **OSS Slot Date** | | |  | | |  | | ò Eff. Date: | | | | |  | | | o Must Meet 30 Consecutive Day o 30 Consecutive Days Met o Phoenix Checked o Phoenix Updated | | | | | | | | | | | | | **Notes:** | | | | | | | | | | | | | **Look-Back** | | | | **Transfer of Assets** | | | **Penalty Period** | | | | | | **Specialist ID:**  **Status:** ò | | | | ò | | | **Start:**   **End:** | | | | | | **Notes:** | | | | | | | | | | | | | o **Spousal Allocation** | o **Dependent Relative Allocation** | | | o **Health Insurance Premium Deduction** | | | | o **Home Maintenance Allowance** | | | |  |  | | | **Amount:** | | | | **Start:**  **End:** | | | | **Notes:** | | | | | | | | | | | | o **Income Trust** | | o **Trust Document Approved** | | | | **Effective Date:** | | | o **Account Designated** | | | **Notes:** | | | | | | | | | o **Account Funded** | | |

105.03.01D Disability Information

(Eff. 07/01/16)

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| **Disability Report** |
| This section is used to document the process for a disability determination   * **Collateral Call Completed** is used to document that the eligibility specialist has contacted the individual and completed the Disability Script. Also, document the **Date** the call was completed, and the Disability Packet was sent to the applicant. * **Requested Via 1233** is checked if the eligibility specialist was unable to contact the applicant and complete the Disability Script. Also document the **Date** the Disability Packet was sent to the applicant |
| **MAO99**  This section is used to document the result of the disability determination by Vocational Rehabilitation Disability Determination Services.   * **Result** – Record the result shown on the MAO99.   + **Denied**   + **Approved**     - **Coordinated** – Means that there is a decision for the Social Security Administration. Check BENDEX and SDX for income     - **Independent** – Means there has not been a decision for SSA. Contact the applicant for an explanation. If there is a reasonable explanation or documentation, record the **Diary Date** |
| |  | | --- | | **Complete The Following If A VR Disability Determination Is Needed** | | **Disability Report:**   |  |  | | --- | --- | | o **Collateral Call Completed (VR Script)** | o **Requested Via 1233** | | **Date:** | **Date:** | | **Notes** | | |  | | | | **MAO99:**  **Result**   |  |  | | --- | --- | | o Denied | o Approved  o **Coordinated** o **Independent Diary Date:** | | |

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| **SCDHHS Support Staff at Vocational Rehabilitation** |
| This section is used by the SCDHHS support staff located at Vocational Rehabilitation to record the receipt of the Disability Packet from an applicant.   * **Is Disability Packet Complete?** Support staff are responsible for ensuring that the Disability Packet has been completed by the applicant with all identifying and contact information provided and legible and a signed DHHS Form 921.   + **If Yes: Date Given to VR** Record the date the packet is printed and sent to VR   + **If No: Why Incomplete?** Enter what items need to be completed in the Disability Packet * **Incomplete – Information Requested** Support staff will indicate the method used to request the required information/form to complete a disability packet   + **Collateral Call** – Provide the details of the collateral call in the **Notes** field   + **DHHS Form 1233** – Indicate the date the DHHS Form 1233 is sent to the applicant * **Follow-Up Completed** – Indicates how the Support Staff member obtained the information to complete the Disability Packet   + **Completed via Collateral Call** – Missing information was obtained through the collateral call   + **Completed via Paper Verification** – Missing information was obtained by hardcopy verification |
| |  | | --- | | **To Be Completed By SCDHHS Support Staff at Voc Rehab Only:** | | |  |  |  | | --- | --- | --- | | **Is Disability Packet Complete?** | **If YES: Date Given to VR** | | | o Yes o No |  | | |  | **If NO: Why Incomplete?** | | |  |  | | | o **Incomplete – Information Requested** | | o **Follow-Up Completed** | | o Collateral Call | | o Completed Via Collateral Call | | o Additional 1233 Sent | | o Completed Via Paper Verification | | Date: | | Date: | | Notes: | | | |  | | | | |

105.03.01E Comments and Escalations

(Rev. 11/01/18)

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| **General Comments/Reported Changes/Contact Center/Other Contacts** |
| This section is used to capture general comments, reported changes and other information provided to a SCDHHS Staff Member. **Date** and **Specialist ID** will be entered by the SCDHHS staff member. |
| | **General Comments/Reported Changes/Contact Center/Other Contacts** | | | --- | --- | | Date:  Specialist ID: | Note/Comment: | |

| **Escalations**  **For Member Relations, Member Services Center Escalations Team and State Office Use Only** |
| --- |
| This section is used by Member Relations, Member Services Center Escalations Team and other State Office Staff to record the circumstances and details around escalating a case. |
| | **Escalations**  **For Member Relations, Member Services Center Escalations Team and State Office Use Only** | | | | --- | --- | --- | | Date:  Specialist ID: | | Note/Comment: | |

105.03.02 Documentation Template

(Eff. 11/01/18)

**Documentation Template** Start a new template at application and at each annual review

Initial Application  Review Application/Review Date:      Template Start Date:

Retro Requested Template End Date:

**HH Information**

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **HH#/App ID** | | **Primary Individual First Name** | | | **Primary Individual Last Name** | | |
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|  | | | | | | | |
| **Technical Assistance/Helpdesk Tickets** (Please Check Existing Tickets Before Submitting a New Ticket) | | | | | | | |
| **Ticket Number** | **Ticket Type** | | **Created** | | | **Resolved/Completed** | |
| **Date** | **Specialist ID** | | **Date** | **Specialist ID** |
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| --- | --- | --- | --- |
| **General – Authorized Representative/Power of Attorney/Information Release** | | | |
| **Name** | **Authority** | **Start Date** | **End Date** |
|  |  |  |  |
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| **General – Voter Registration** (MPPM 101.18) |
| Voter Registration Application (VRA)  Voter Registration Declination (VRD) |

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| **General – Categorical Eligibility** |
| Check all that applies to members of the household   |  |  | | --- | --- | | Under Age 19  Dependent Child in Home  Pregnant  Expected Date of Delivery:  Number Expected:  Former Foster Care | Aged 65 or Older  Blind/Disabled  MAO99  System Match/SSA Letter  Breast and Cervical Cancer  Tuberculosis  Form 3400-E – Tuberculosis (TB) Referral | | **Notes:** | | |

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| --- |
| **General – HH Composition** |
| |  |  | | --- | --- | | **Number of Adults** | **List Other Household Members and Relationship** | | **Number of Children** |  | | **Has Tax Filing Status Been Determined?** (MAGI Only) | | Yes  No | | **Filing Status** (MAGI Only) | | Married Filing Jointly  Single  Married Filing Separately  Non-Tax Filer | | **Immigration Status Details:** | | |

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| **General – Electronic Verifications** |
| |  |  |  | | --- | --- | --- | | **ESC – Wage Match**  Hit  No Hit  N/A | **BENDEX – Social Security**  Hit  No Hit  N/A | **SDX – SSI** | | Hit  No Hit  N/A | | **SC State Retirement System**  Hit  No Hit  N/A | **SVES – Citizenship**  Hit  No Hit  N/A | **Unemployment Compensation** | | Hit  No Hit  N/A | | **PSC Wage Verification**  Hit  No Hit  N/A | **MMIS/TPL – Health Insurance**  Hit  No Hit  N/A | **SAVE – Immigration Status** | | Hit  No Hit  Required  Not Required | | **CHIP – DSS Eligibility System**  Hit  No Hit  N/A | **MMIS/RSP – Waiver/Special Programs** | | Hit  No Hit  N/A | **\***Some verifications may be part of PCS | | **Notes:** | | | |

| **General – Action Summary** |
| --- |
| **Action One**   |  |  | | --- | --- | | **Specialist ID** | **Action Taken** | |  |  | | **Date** | |  | |
| **Action Two**   |  |  | | --- | --- | | **Specialist ID** | **Action Taken** | |  |  | | **Date** | |  | |
| **Action Three**   |  |  | | --- | --- | | **Specialist ID** | **Action Taken** | |  |  | | **Date** | |  | |
| **Action Four**   |  |  | | --- | --- | | **Specialist ID** | **Action Taken** | |  |  | | **Date** | |  | |
| **Action Five**   |  |  | | --- | --- | | **Specialist ID** | **Action Taken** | |  |  | | **Date** | |  | |
| **Action Six**   |  |  | | --- | --- | | **Specialist ID** | **Action Taken** | |  |  | | **Date** | |  | |

| **General – Collateral Calls** (Do Not use for Successfully Verified Income and Resources) |
| --- |
| **Call One Specialist ID:**   |  |  |  | | --- | --- | --- | | **Date** | **Time** | **Call Details** | |  |  |  | | **Person Contacted** | **Phone** | |  |  | |
| **Collateral Call Two Specialist ID:**   |  |  |  | | --- | --- | --- | | **Date** | **Time** | **Call Details** | |  |  |  | | **Person Contacted** | **Phone** | |  |  | |
| **Collateral Call Three Specialist ID:**   |  |  |  | | --- | --- | --- | | **Date** | **Time** | **Call Details** | |  |  |  | | **Person Contacted** | **Phone** | |  |  | |
| **Collateral Call Four Specialist ID:**   |  |  |  | | --- | --- | --- | | **Date** | **Time** | **Call Details** | |  |  |  | | **Person Contacted** | **Phone** | |  |  | |
| **Collateral Call Five Specialist ID:**   |  |  |  | | --- | --- | --- | | **Date** | **Time** | **Call Details** | |  |  |  | | **Person Contacted** | **Phone** | |  |  | |

| **Financial – Income** |
| --- |
| **Income Source One  Income Verification Complete Specialist ID:**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Whose Income?** | | **Income Type** | **Source of Income** | | |  | |  |  | | | **Income Verified (List Dates)** | | **Income Amount** | **Frequency** | | |  | |  |  | | | **Verified w/ Collateral Call** | **Person & Business:** | | | **Call Date:** | | **Phone Number:** | **Call Time:** | | **Verification Details and Comments:** | | | | | |
| **Income Source Two  Income Verification Complete Specialist ID:**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Whose Income?** | | **Income Type** | **Source of Income** | | |  | |  |  | | | **Income Verified (List Dates)** | | **Income Amount** | **Frequency** | | |  | |  |  | | | **Verified w/ Collateral Call** | **Person & Business:** | | | **Call Date:** | | **Phone Number:** | **Call Time:** | | **Verification Details and Comments:** | | | | | |
| **Income Source Three  Income Verification Complete Specialist ID:**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Whose Income?** | | **Income Type** | **Source of Income** | | |  | |  |  | | | **Income Verified (List Dates)** | | **Income Amount** | **Frequency** | | |  | |  |  | | | **Verified w/ Collateral Call** | **Person & Business:** | | | **Call Date:** | | **Phone Number:** | **Call Time:** | | **Verification Details and Comments:** | | | | | |
| **Income Source Four  Income Verification Complete Specialist ID:**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Whose Income?** | | **Income Type** | **Source of Income** | | |  | |  |  | | | **Income Verified (List Dates)** | | **Income Amount** | **Frequency** | | |  | |  |  | | | **Verified w/ Collateral Call** | **Person & Business:** | | | **Call Date:** | | **Phone Number:** | **Call Time:** | | **Verification Details and Comments:** | | | | | |
| **Income Source Five  Income Verification Complete Specialist ID:**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Whose Income?** | | **Income Type** | **Source of Income** | | |  | |  |  | | | **Income Verified (List Dates)** | | **Income Amount** | **Frequency** | | |  | |  |  | | | **Verified w/ Collateral Call** | **Person & Business:** | | | **Call Date:** | | **Phone Number:** | **Call Time:** | | **Verification Details and Comments:** | | | | | |
| **Income Source Six  Income Verification Complete Specialist ID:**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Whose Income?** | | **Income Type** | **Source of Income** | | |  | |  |  | | | **Income Verified (List Dates)** | | **Income Amount** | **Frequency** | | |  | |  |  | | | **Verified w/ Collateral Call** | **Person & Business:** | | | **Call Date:** | | **Phone Number:** | **Call Time:** | | **Verification Details and Comments:** | | | | | |

| **Financial – Resources** |
| --- |
| **Resource Item One  Resource Verification Complete Specialist ID:**   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Whose Resource?** | | **Type (General Description)** | | **Source/Name/Location/Account** | | | |  | |  | |  | | | | **Resource Verified (List Dates)** | | **Resource Requested (List Dates)** | |  | | | |  | |  | | | | | **Verified Value** | **Countable Value** | | **Verified w/ Collateral Call** | | **Phone Number:** | | | |  |  | | **Person & Business:** | | | | | | **Verification Details and Comments** | | | **Call Date:** | | **Call Time:** | | |  | |  | | | | | | | | |
| **Resource Item Two  Resource Verification Complete Specialist ID:**   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Whose Resource?** | | **Type (General Description)** | | **Source/Name/Location/Account** | | | |  | |  | |  | | | | **Resource Verified (List Dates)** | | **Resource Requested (List Dates)** | |  | | | |  | |  | | | | | **Verified Value** | **Countable Value** | | **Verified w/ Collateral Call** | | **Phone Number:** | | | |  |  | | **Person & Business:** | | | | | | **Verification Details and Comments** | | | **Call Date:** | | **Call Time:** | | |  | |  | | | | | | | | |
| **Resource Item Three  Resource Verification Complete Specialist ID:**   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Whose Resource?** | | **Type (General Description)** | | **Source/Name/Location/Account** | | | |  | |  | |  | | | | **Resource Verified (List Dates)** | | **Resource Requested (List Dates)** | |  | | | |  | |  | | | | | **Verified Value** | **Countable Value** | | **Verified w/ Collateral Call** | | **Phone Number:** | | | |  |  | | **Person & Business:** | | | | | | **Verification Details and Comments** | | | **Call Date:** | | **Call Time:** | | |  | |  | | | | | | | | |
| **Resource Item Four  Resource Verification Complete Specialist ID:**   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Whose Resource?** | | **Type (General Description)** | | **Source/Name/Location/Account** | | | |  | |  | |  | | | | **Resource Verified (List Dates)** | | **Resource Requested (List Dates)** | |  | | | |  | |  | | | | | **Verified Value** | **Countable Value** | | **Verified w/ Collateral Call** | | **Phone Number:** | | | |  |  | | **Person & Business:** | | | | | | **Verification Details and Comments** | | | **Call Date:** | | **Call Time:** | | |  | |  | | | | | | | | |
| **Resource Item Five  Resource Verification Complete Specialist ID:**   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Whose Resource?** | | **Type (General Description)** | | **Source/Name/Location/Account** | | | |  | |  | |  | | | | **Resource Verified (List Dates)** | | **Resource Requested (List Dates)** | |  | | | |  | |  | | | | | **Verified Value** | **Countable Value** | | **Verified w/ Collateral Call** | | **Phone Number:** | | | |  |  | | **Person & Business:** | | | | | | **Verification Details and Comments** | | | **Call Date:** | | **Call Time:** | | |  | |  | | | | | | | | |
| **Resource Item Six  Resource Verification Complete Specialist ID:**   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Whose Resource?** | | **Type (General Description)** | | **Source/Name/Location/Account** | | | |  | |  | |  | | | | **Resource Verified (List Dates)** | | **Resource Requested (List Dates)** | |  | | | |  | |  | | | | | **Verified Value** | **Countable Value** | | **Verified w/ Collateral Call** | | **Phone Number:** | | | |  |  | | **Person & Business:** | | | | | | **Verification Details and Comments** | | | **Call Date:** | | **Call Time:** | | |  | |  | | | | | | | | |
| **Resource Item Seven  Resource Verification Complete Specialist ID:**   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Whose Resource?** | | **Type (General Description)** | | **Source/Name/Location/Account** | | | |  | |  | |  | | | | **Resource Verified (List Dates)** | | **Resource Requested (List Dates)** | |  | | | |  | |  | | | | | **Verified Value** | **Countable Value** | | **Verified w/ Collateral Call** | | **Phone Number:** | | | |  |  | | **Person & Business:** | | | | | | **Verification Details and Comments** | | | **Call Date:** | | **Call Time:** | | |  | |  | | | | | | | | |
| **Resource Item Eight  Resource Verification Complete Specialist ID:**   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Whose Resource?** | | **Type (General Description)** | | **Source/Name/Location/Account** | | | |  | |  | |  | | | | **Resource Verified (List Dates)** | | **Resource Requested (List Dates)** | |  | | | |  | |  | | | | | **Verified Value** | **Countable Value** | | **Verified w/ Collateral Call** | | **Phone Number:** | | | |  |  | | **Person & Business:** | | | | | | **Verification Details and Comments** | | | **Call Date:** | | **Call Time:** | | |  | |  | | | | | | | | |
| **Resource Item Nine  Resource Verification Complete Specialist ID:**   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Whose Resource?** | | **Type (General Description)** | | **Source/Name/Location/Account** | | | |  | |  | |  | | | | **Resource Verified (List Dates)** | | **Resource Requested (List Dates)** | |  | | | |  | |  | | | | | **Verified Value** | **Countable Value** | | **Verified w/ Collateral Call** | | **Phone Number:** | | | |  |  | | **Person & Business:** | | | | | | **Verification Details and Comments** | | | **Call Date:** | | **Call Time:** | | |  | |  | | | | | | | | |
| **Resource Item Ten  Resource Verification Complete Specialist ID:**   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Whose Resource?** | | **Type (General Description)** | | **Source/Name/Location/Account** | | | |  | |  | |  | | | | **Resource Verified (List Dates)** | | **Resource Requested (List Dates)** | |  | | | |  | |  | | | | | **Verified Value** | **Countable Value** | | **Verified w/ Collateral Call** | | **Phone Number:** | | | |  |  | | **Person & Business:** | | | | | | **Verification Details and Comments** | | | **Call Date:** | | **Call Time:** | | |  | |  | | | | | | | | |
| **Resource Item Eleven  Resource Verification Complete Specialist ID:**   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Whose Resource?** | | **Type (General Description)** | | **Source/Name/Location/Account** | | | |  | |  | |  | | | | **Resource Verified (List Dates)** | | **Resource Requested (List Dates)** | |  | | | |  | |  | | | | | **Verified Value** | **Countable Value** | | **Verified w/ Collateral Call** | | **Phone Number:** | | | |  |  | | **Person & Business:** | | | | | | **Verification Details and Comments** | | | **Call Date:** | | **Call Time:** | | |  | |  | | | | | | | | |
| **Resource Item Twelve  Resource Verification Complete Specialist ID:**   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Whose Resource?** | | **Type (General Description)** | | **Source/Name/Location/Account** | | | |  | |  | |  | | | | **Resource Verified (List Dates)** | | **Resource Requested (List Dates)** | |  | | | |  | |  | | | | | **Verified Value** | **Countable Value** | | **Verified w/ Collateral Call** | | **Phone Number:** | | | |  |  | | **Person & Business:** | | | | | | **Verification Details and Comments** | | | **Call Date:** | | **Call Time:** | | |  | |  | | | | | | | | |

| **LONG TERM CARE/OPTIONAL STATE SUPPLEMENTATION** | | | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Type of Care**  Nursing Home  In-Home Care (Waiver)  PACE  General Hospital  Optional State Supplementation (OSS)/Community Residential Care Facility (CRCF) | | | | | | | | | | | | |
| **Hospital/Nursing Facility/**  **Waiver Program/CRCF** | | | **Date of Entry/ Enrollment Date** | | | | **Level of Care**  (For Nursing Home and In-Home Care only) | | | | **OSS Slot Date** | |
|  | | |  | | | | Eff. Date:  Eff. Date:  Eff. Date: | | | |  | |
| Must Meet 30 Consecutive Day  30 Consecutive Days Met  Phoenix Checked  Phoenix Updated | | | | | | | | | | | | |
| **Notes:** | | | | | | | | | | | | |
| **Look-Back** | | | | | **Transfer of Assets** | | | | **Penalty Period** | | | |
| **Specialist ID:**       **Status:** | | | | |  | | | | **Start:**       **End:** | | | |
| **Notes:** | | | | | | | | | | | | |
| **Spousal Allocation** | **Dependent Relative Allocation** | | | **Health Insurance Premium Deduction** | | | | **Home Maintenance Allowance** | | | |
|  |  | | | **Amount:** | | | | **Start:**       **End:** | | | |
| **Notes:** | | | | | | | | | | | |
| **Income Trust** | | **Trust Document Approved** | | | | **Effective Date:** | | | | **Account Designated** | |
| **Notes:** | | | | | | | | | | **Account Funded** | |

|  |
| --- |
| **Complete The Following If A VR Disability Determination Is Needed** |
| **Disability Report:**   |  |  | | --- | --- | | **Collateral Call Completed (VR Script)** | **Requested Via 1233** | | **Date:** | **Date:** | | **Notes** | | |  | | |
| **MAO99:**  **Result**   |  |  | | --- | --- | | Denied | Approved  **Coordinated  Independent Diary Date:** | |
| **To Be Completed By SCDHHS Support Staff at Voc Rehab Only:** |
| |  |  |  | | --- | --- | --- | | **Is Disability Packet Complete?** | **If YES: Date Given to VR** | | | Yes  No |  | | |  | **If NO: Why Incomplete?** | | |  |  | | | **Incomplete – Information Requested** | | **Follow-Up Completed** | | Collateral Call | | Completed Via Collateral Call | | Additional 1233 Sent | | Completed Via Paper Verification | | Date: | | Date: | | Notes: | | | |  | | | |

| **General Comments/Reported Changes/Other Contacts** | | |
| --- | --- | --- |
| Date:  Specialist ID: | Note/Comment: | |
| Date:  Specialist ID: | Note/Comment: | |
| Date:  Specialist ID: | Note/Comment: | |
| Date:  Specialist ID: | Note/Comment: | |
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| **Escalations**  **For Member Relations, Member Services Center Escalations Team and State Office Use Only** | | |
| --- | --- | --- |
| Date:  Specialist ID: | | Note/Comment: |
| Date:  Specialist ID: | | Note/Comment: |
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