**Section 300—Non-MAGI Related Programs—Supplemental Security Income (SSI)—Liberalized**

[CHAPTER 301—Non-MAGI/Supplemental Security Income (SSI) Related Income Policy—Liberalized 2](#_Toc144817135)

[CHAPTER 302—Non-MAGI/Supplemental Security Income (SSI) Related Resource Policy—Liberalized 101](#_Toc144817136)

[CHAPTER 303—Medicare Saving Programs (MSP), Aged, Blind and Disabled (ABD) 196](#_Toc144817137)

[CHAPTER 304—Nursing Home, Home and Community-Based Services, and General Hospital 225](#_Toc144817138)

[CHAPTER 305—Katie Beckett (TEFRA) 403](#_Toc144817139)

[CHAPTER 307—Working Disabled 412](#_Toc144817140)

[CHAPTER 308—Qualified Disabled and Working Individual (QDWI) 420](#_Toc144817141)

# **CHAPTER 301—Non-MAGI/Supplemental Security Income (SSI) Related Income Policy—Liberalized**

[CHAPTER 301—Non-MAGI/Supplemental Security Income (SSI) Related Income Policy—Liberalized 2](#_Toc147074478)

[301.01 Introduction 6](#_Toc147074479)

[301.02 Income Limits 6](#_Toc147074480)

[301.03 Liberalized SSI Income Policy vs. Strict 6](#_Toc147074481)

[301.04 What Is Income? 7](#_Toc147074482)

[301.04.01 Relationship of Income to Resources 7](#_Toc147074483)

[301.04.02 Types of Income 7](#_Toc147074484)

[301.04.03 Forms of Income 8](#_Toc147074485)

[301.04.04 Effect of Garnishment or Seizure 8](#_Toc147074486)

[301.04.05 When Income Is Counted 8](#_Toc147074487)

[301.04.06 Income Determinations Involving Agents 9](#_Toc147074488)

[301.04.07 Income Derived from Joint Bank Accounts 9](#_Toc147074489)

[301.04.08 Computing Countable Income 10](#_Toc147074490)

[301.04.09 Infrequent or Irregular Income Exclusion 14](#_Toc147074491)

[301.04.10 Income of Members of Religious Orders 16](#_Toc147074492)

[301.04.11 Non-Representative Income 17](#_Toc147074493)

[301.04.12 Terminated/Reduced Income 18](#_Toc147074494)

[301.05 What is Not Income? 19](#_Toc147074495)

[301.06 Earned Income 21](#_Toc147074496)

[301.06.01 Sick Pay 21](#_Toc147074497)

[301.06.02 Wages 21](#_Toc147074498)

[301.06.03 Cafeteria Plans 22](#_Toc147074499)

[301.06.04 Wage Advances and Deferred Wages 23](#_Toc147074500)

[301.06.05 Verification of Wages 24](#_Toc147074501)

[301.06.06 Different Forms of Business 25](#_Toc147074502)

[301.06.07 Self-Employment Income 28](#_Toc147074503)

[301.06.08 Net Earnings from Self-Employment (NESE) 36](#_Toc147074504)

[301.06.09 Payments for Services Performed in a Sheltered Workshop or Work Activities Center 38](#_Toc147074505)

[301.06.10 Royalties and Honoraria 38](#_Toc147074506)

[301.06.11 Minister’s Gross Income 39](#_Toc147074507)

[301.07 Earned Income Exclusions 40](#_Toc147074508)

[301.07.01 Blind Work Expenses (BWE) 40](#_Toc147074509)

[301.07.02 Impairment-Related Work Expenses (IRWE) 41](#_Toc147074510)

[301.07.03 Earned Income Tax Credit (EITC) and Child Tax Credit (CTC) Payments Exclusions 45](#_Toc147074511)

[301.07.04 Census Bureau Income 46](#_Toc147074512)

[301.08 Unearned Income 46](#_Toc147074513)

[301.08.01 Unearned Income Exclusions 47](#_Toc147074514)

[301.08.02 Expenses of Obtaining Income 47](#_Toc147074515)

[301.08.03 Overpayment Involved - Income Counting 47](#_Toc147074516)

[301.08.04 Garnishment or Other Withholding 48](#_Toc147074517)

[301.08.05 Medicare Buy-In 48](#_Toc147074518)

[301.08.06 Verification and Documentation of Unearned Income 49](#_Toc147074519)

[301.09 Sources and Treatment of Unearned Income 49](#_Toc147074520)

[301.09.01 Annuities, Pensions, Retirement, or Disability Payments 49](#_Toc147074521)

[301.09.02 Title II/Retirement, Survivors and Disability Insurance (RSDI) Benefits 49](#_Toc147074522)

[301.09.02A Suspended SSA Income 51](#_Toc147074523)

[301.09.03 Black Lung Benefits 51](#_Toc147074524)

[301.09.04 Civil Service and Federal Employee Retirement System Payments 52](#_Toc147074525)

[301.09.05 Railroad Retirement Payments 53](#_Toc147074526)

[301.09.06 Unemployment Insurance Benefits 54](#_Toc147074527)

[301.09.07 Workers' Compensation 54](#_Toc147074528)

[301.09.08 Military Pensions 55](#_Toc147074529)

[301.09.09 Department of Veterans Affairs Payments 56](#_Toc147074530)

[301.09.09-A Pension Payments 57](#_Toc147074531)

[301.09.09-B Compensation Payments 58](#_Toc147074532)

[301.09.09-C VA Educational Benefits 58](#_Toc147074533)

[301.09.09-D VA Aid and Attendance and Housebound Allowances 59](#_Toc147074534)

[301.09.09-E VA Clothing Allowance 59](#_Toc147074535)

[301.09.09-F VA Payment Adjustment for Unusual Medical Expenses 59](#_Toc147074536)

[301.09.09-G Payments to Vietnam Veterans' Children with Spina Bifida 60](#_Toc147074537)

[301.09.09-H Dependency and Indemnity Compensation (DIC) 60](#_Toc147074538)

[301.09.10 Temporary Assistance For Needy Families (TANF) 61](#_Toc147074539)

[301.09.11 Support Payments - Spousal Support, Alimony 61](#_Toc147074540)

[301.09.12 Support Payments - Child Support 61](#_Toc147074541)

[301.09.13 Dividends and Interest 62](#_Toc147074542)

[301.09.14 Interest and Appreciation in Value of Excluded Burial Funds and Burial Space Purchase Agreements 64](#_Toc147074543)

[301.09.15 Rental Income 64](#_Toc147074544)

[301.09.16 Awards 65](#_Toc147074545)

[301.09.17 Gifts 65](#_Toc147074546)

[301.09.18 Gifts of Domestic Travel Tickets 65](#_Toc147074547)

[301.09.19 Prizes 65](#_Toc147074548)

[301.09.20 Work-Related Unearned Income 66](#_Toc147074549)

[301.09.21 Uniformed Services - Pay and Allowances 66](#_Toc147074550)

[301.09.22 Sick Pay as Unearned Income 68](#_Toc147074551)

[301.09.23 Death Benefits 68](#_Toc147074552)

[301.09.24 Inheritances 69](#_Toc147074553)

[301.09.25 Disaster Assistance – (Presidentially-Declared Disaster) 69](#_Toc147074554)

[301.09.25A COVID-19 Economic Impact Payments (EIPs) 70](#_Toc147074555)

[301.09.26 Federal Emergency Management Agency (FEMA) Emergency Food Distribution and Shelter Programs 71](#_Toc147074556)

[301.09.27 Federal Housing Assistance 71](#_Toc147074557)

[301.09.28 Food Programs with Federal Involvement 72](#_Toc147074558)

[301.09.29 Programs for Older Americans 72](#_Toc147074559)

[301.09.30 Refugee Cash Assistance, Cuban and Haitian Entrant Cash Assistance and Federally-Reimbursed General Assistance Payments to Refugees 73](#_Toc147074560)

[301.09.31 Refugee Reception and Placement Grants and Refugee Matching Grants 73](#_Toc147074561)

[301.09.32 Victims' Compensation Payments 73](#_Toc147074562)

[301.09.33 Payments in Foreign Currency 74](#_Toc147074563)

[301.09.34 Income Based on Need (IBON) 74](#_Toc147074564)

[301.09.35 State Assistance Based on Need (SABON) 74](#_Toc147074565)

[301.09.36 Work Relief (Workfare) Programs 75](#_Toc147074566)

[301.09.37 Foster Care and Adoption Assistance 75](#_Toc147074567)

[301.09.38 Child Care Payments 77](#_Toc147074568)

[301.09.39 Educational Assistance 77](#_Toc147074569)

[301.09.40 Grants, Scholarships, and Fellowships 78](#_Toc147074570)

[301.09.41 Royalties 78](#_Toc147074571)

[301.09.42 Job Training Partnership Act (JTPA) 79](#_Toc147074572)

[301.09.43 Workforce Investment Act (WIA) 79](#_Toc147074573)

[301.09.44 Job Corps 80](#_Toc147074574)

[301.09.45 AmeriCorps and National Civilian Community Corps (NCCC) Payments 81](#_Toc147074575)

[301.09.46 Low Income Energy Assistance 82](#_Toc147074576)

[301.09.47 Home Energy Assistance and Support and Maintenance Assistance (HEA/SMA) 82](#_Toc147074577)

[301.09.48 ACTION Programs/Corporation for National and Community Services (CNCS) (*Formerly Domestic Volunteer Services*) 82](#_Toc147074578)

[301.09.49 Community Service Block Grants 83](#_Toc147074579)

[301.09.50 Relocation Assistance 83](#_Toc147074580)

[301.09.51 Long-Term Care Insurance 84](#_Toc147074581)

[301.09.52 South Carolina Vocational Rehabilitation Job Readiness Vocational Training Center Services 84](#_Toc147074582)

[301.09.53 Other Unearned Income Exclusions 84](#_Toc147074583)

[301.09.54 Computing Unearned Income 86](#_Toc147074584)

[301.10 Plan for Achieving Self-Support (PASS) as an Income Exclusion 87](#_Toc147074585)

[301.11 Deeming of Income 87](#_Toc147074586)

[301.12 Income Computation Methods Used to Determine Medicaid Eligibility 88](#_Toc147074587)

[301 Appendix A Income Deeming Procedures 89](#_Toc147074588)

[301 Appendix B Definitions of Provisions 92](#_Toc147074589)

301.01 Introduction

(Eff. 10/01/05)

Eligibility for Medicaid programs is based on the rules used by the Social Security Administration (SSA) to decide eligibility for Supplemental Security Income (SSI). These rules are explained in the Program Operations Manual System (POMS). Links to sections in POMS are included in this manual for detailed explanations of policy and procedures. However, for individuals who are considered institutionalized (Nursing Home, Home and Community Based Services, General Hospital), the manner in which income is treated may differ. These differences are discussed in MPPM Chapter 304, Nursing Home, Waivered Services, and General Hospital.

The following sections explain how to treat income for SSI-related Medicaid programs.

An individual is eligible for Medicaid benefits if he or she:

* Is aged, blind, or disabled;
* Meets citizenship and residency requirements; and
* Meets the income and resource limits.

Income is counted on a monthly basis. An individual who has too much income in a particular month is not eligible in that month. Not all income counts in determining eligibility.

301.02 Income Limits

(Rev. 10/01/07)

Federal law establishes a limit on the amount of monthly countable income an individual may have and still be eligible for Medicaid. The limits vary according to the category of assistance. Refer to MPPM Chapter 103, Program Financial Limits.

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| **Note**  Income limits for poverty level groups change annually, usually in March. All other limits are changed effective January of each year. |

301.03 Liberalized SSI Income Policy vs. Strict

(Eff. 10/01/05)

The Social Security Act allows states the option of using more liberal income criteria than SSI in certain instances. South Carolina has received approval to exclude the value of In-kind Support and Maintenance (ISM) in determining eligibility for all categories except Optional State Supplementation, Pass-Along, and Retroactive SSI determinations.

[Table of Contents](#_top)

301.04 What Is Income?

(Eff. 10/01/05)

[POMS SI 00810.005](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500810005)

Income is anything an individual receives in cash that can be used to meet his needs for food or shelter. Income includes receipt of anything that can be applied, either directly or by sale or conversion, to meet the basic needs of food or shelter.

In-kind income is not cash, but is actually food or shelter, or something that can be used to get one of these basic needs. This type of income is not counted under liberalized eligibility rules.

301.04.01 Relationship of Income to Resources

(Rev. 08/01/19)

[POMS SI 00810.010](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500810010)

Income received during a month is evaluated under income rules. If an individual keeps part or all of the income into future months, it is counted as a resource. All other items are evaluated under resource rules. (Refer to MPPM Chapter 302)

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| **Example**  Mr. Jones receives his Social Security check in March. It is directly deposited into his checking account. Count the Social Security check as income in March, and subtract the deposit from the checking account to determine how much he has in resources. If he carries all or part of the check into April, you would not subtract the deposit from the checking account, but count the remaining amount as a resource.Refer to MPPM 302.26.02 for specific policy related to determining the countable value for checking and savings accounts. |

[Table of Contents](#_top)

301.04.02 Types of Income

(Eff. 10/01/05)

[POMS SI 00810.015](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500810015)

Income is either earned or unearned. Different rules apply to each.

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| **Earned Income** |
| [POMS SI 00810.015](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500810015)  Earned income consists of the following types of payments:   * Wages * Net earnings from self-employment * Payments for services performed in a sheltered workshop or work activities center; * Royalties earned by an individual in connection with any publication of his work and any honoraria received for services rendered. |
| **Unearned Income** |
| [POMS SI 00810.015](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500810015)  Unearned income is all income that is not earned income. Some types of unearned income are:   * Annuities, pensions, and other periodic payments * Alimony and support payments * Dividends, interest, and royalties * Rents * Benefits received as the result of another's death to the extent that the total amount exceeds the expenses of the deceased person's last illness and burial paid by the beneficiary * Prizes and awards * In-kind Support and Maintenance - ISM (Not counted in Liberalized policy categories.) |

301.04.03 Forms of Income

(Eff. 10/01/05)

[POMS SI 00810.020](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500810020)

Income may be received in either of two forms:

Cash – Currency, checks, money orders or Electronic Funds Transfers (EFT), such as:

* Social Security checks
* Unemployment Compensation checks
* Payroll checks
* Currency

In-kind **–** Items such as:

* Real property (including shelter)
* Food
* Clothing (Not after 03/09/05)
* Non-cash wages (such as, room and board as compensation for employment)

[Table of Contents](#_top)

301.04.04 Effect of Garnishment or Seizure

(Eff. 10/01/05)

[POMS SI 00810.025](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500810025)

A garnishment or seizure is a withholding of an amount from earned or unearned income in order to satisfy a debt or legal obligation. Amounts withheld from earned or unearned income to satisfy a debt or legal obligation is income for Medicaid purposes.

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| **Example**  Ms. Jones receives $900 monthly from Social Security. You determine Social Security is withholding $100 to pay back an overpayment. The amount withheld would be added back into her check, and her countable gross income is $1,000. |

301.04.05 When Income Is Counted

(Eff. 10/01/05)

[POMS SI 00810.030](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500810030)

Generally, count income in the earliest month it is:

* Received by an individual;
* Credited to an individual's account; or
* Set aside for an individual’s use.

Income is determined monthly and counted in the month it is received.

Occasionally, a regular periodic payment (such as wages, Title II, or VA benefits) is received in a month other than the month of normal receipt. As long as there is no intent to interrupt the regular payment schedule, the funds are considered to be income in the normal month of receipt.

The most common situations where this would apply are when:

* A payer advance dates a check because the regular payment date falls on a weekend or holiday – there is no intent to change the normal delivery date or to disrupt the existing relationship between check receipt and Medicaid benefits.
* An advance dated check is received – it is considered income to the beneficiary in the month of normal receipt.
* An individual's money goes to a bank by direct deposit, the funds may be posted to the account before or after the month they are payable. Whenever this occurs, the electronically transferred funds are treated as income in the month of normal receipt.

301.04.06 Income Determinations Involving Agents

(Eff. 10/01/05)

[POMS SI 00810.120](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500810120)

Monies received by an individual in his role as an agent (such as being a representative payee) are not income to him. Regular income rules apply for charging income that a Medicaid beneficiary receives which is not paid on behalf of another.

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| **Example**  Mr. Jones is receiving a Social Security check as the payee for his disabled child. This check is counted as income for the child, not Mr. Jones. |

[Table of Contents](#_top)

301.04.07 Income Derived from Joint Bank Accounts

(Eff. 10/01/05)

[POMS SI 00810.130](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500810130)

When an applicant/beneficiary has a joint bank account with another individual, deposits made to the account by other account holders are income to the applicant/beneficiary.

When an applicant/beneficiary and an ineligible individual who is not a deemor hold a joint bank account, income to the applicant/beneficiary includes the full amount of any deposit made by a third party or by the ineligible bank account holder unless the Medicaid beneficiary is acting as an agent.

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| **Example 1**  Mr. Jones has a bank account with his daughter. His daughter is not eligible for Medicaid, and she makes regular deposits into the account. These deposits are counted as income for Mr. Jones. |

If an applicant/beneficiary successfully rebuts ownership of a portion of funds in a joint account, deposits made by the other account holder are not income to the Medicaid beneficiary.

If an applicant/beneficiary successfully rebuts ownership of all the funds held in a joint bank account, deposits by the other account holders are not income to the applicant/beneficiary. (Refer to MPPM 302.26.03A for steps required to rebut ownership.)

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| **Example 2**  Mr. Jones has a bank account with his daughter. His daughter makes regular deposits into the account, but the daughter is not eligible for Medicaid. She successfully rebuts Mr. Jones ownership to any of the funds by demonstrating the account was opened solely with her funds, and that the only deposits into the account are from her weekly paycheck. None of the deposits into the account is countable as income to Mr. Jones. |

When two or more applicants and/or beneficiaries are joint account holders, deposits made by one individual are not income to the other.

[Table of Contents](#_top)

301.04.08 Computing Countable Income

(Rev. 10/01/23)

[POMS SI 00810.300](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500810300)

An individual's monthly income is one of the factors used to determine eligibility for benefits. Countable Income (CI) is the amount of income that remains after eliminating all amounts that are not income and applying all appropriate exclusions. Countable income includes both earned and unearned income. Section SC MPPM 301.06.05 regarding how to verify income.

The income receipt date, not the pay period ending date, is used to determine the countable income. If a DHHS 1233 ME, Medicaid Eligibility Checklist, is used to request income verification, request the income received four (4) weeks prior to the application/review receipt date. In instances where check stubs and/or the DHHS Form 1245 are not available, a declaratory statement of income can be used. The statement must clearly identify the employee and be signed by the employer. For decisions made on or after August 1, 2013, the following procedures for verifying income must be used.

| **Earned Income Verification Procedure-Reported Income** |
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| If an applicant/beneficiary reports earned income on an application or review form, the reported income must be accepted. If the electronic data source matches the reported income, take the following steps:   1. If the reported income is below the income eligibility standard:    1. If the reported income AND the electronic verification are below the income eligibility standard for the Non-MAGI category, use the reported income received as verified income. Do not request additional documentation.       1. If the income is reasonably compatible, or when both the reported and verified income are found to be below the eligibility standard, the reported income is used as verified income. Additional verification is not requested.       2. If the reported income is not reasonably compatible with the income eligibility standard and the EDS displays an income above the income eligibility standard, request an explanation from the applicant/beneficiary. If a reasonable explanation cannot be provided, paper documentation will be requested    2. If a reported income type does not have an EDS in Cúram, verificationmust be requested.    3. If reported income is zero and there is no EDS record in Cúram, check electronic data sources in Person Composite Service (PCS).       1. If there is a current EDS record, request an explanation.       2. If there is no current EDS record, budget zero income.    4. See the Self-employment in the Sources of Electronic Verification below for further explanation regard self-employed individuals 2. If the reported income is below the income eligibility standard and the electronic data source displays an income above the income eligibility standard, request additional documentation. 3. If the reported income is above the income eligibility standard and cannot be verified by electronic means, request additional documentation. 4. If both the reported income and the electronic verification are above the income eligibility standard, deny the application.   **Note**  Income cannot be verified via collateral call to the applicant/beneficiary or authorized representative.  **Note**  Long-Term Care programs (including OSS, Nursing Home, and Waiver) require verification of the exact income amount for budgeting. Also, Nursing Home and Waiver beneficiaries who have income over the eligibility standard can establish eligibility through a Miller Trust (Income Trust). Therefore, reasonable compatibility cannot be used to approve or deny Long-Term Care coverage. However, SCDHHS does not question income that is not reported or found in the EDS for Long-Term Care applicants/beneficiaries. For example, if no unemployment benefits were reported and none were found in the EDS and the eligibility specialist questions the beneficiary and the response is “I do not receive any unemployment and do not qualify to receive any unemployment.” No additional evidence is required.  **Sources of Electronic Verification:**   1. South Carolina Department of Revenue (SCDOR) 2. Person Composite Service (PCS) Wage Verification 3. Employment Security Commission (ESC)Wage Match 4. CHIP Data (SNAP/TANF)   **Acceptable Sources of Documentation:**   1. DHHS Form 1245, Wage Verification 2. Pay Stubs 3. Employer’s Records 4. Collateral Call to the employer 5. Federal Income Tax Records (Self-employment only)   When multiple forms of income verifications are available, the Eligibility Specialist must accept the verifications in the following order:  Wages   1. Paystubs 2. DHHS Form 1245, Wage Verification 3. Employer’s records/signed statement from the employer 4. South Carolina Department of Revenue (SCDOR) 5. Person Composite Service (PCS)/Equifax Verification 6. Employment Security Commission (ESC) Wage Match   Self-Employment   1. Federal Income Tax Records (Self-Employment only) 2. Bookkeeping Records 3. Self–Attestation (as a last resort)   Any electronic data source where the history is not kept in Cúram should be uploaded to OnBase. The Eligibility Specialist must also document in the System of Record (SOR) and in OnBase on the Documentation Template which means of verification was used for the determination. |

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| **Procedure – Determine Countable Monthly Income** (Use Budget Workbook)   1. Establish a 35-day window for reported income prior to and including the:    * application signature date;    * review signature date;    * date the application/review is received/ stamped in the Medicaid office;    * application effective date; or    * date a review is completed in MEDS (the Act on Decision date). 2. Evaluate the available reported earned income documentation dated within the 35 day window. Determine monthly countable income using the most recent consecutive pay periods provided (four weeks for income reported (weekly; two pay periods for, bi-weekly and, semi-monthly; one pay period for or monthly), unless one or more of those paychecks is determined not to be representative, for example, one paycheck is significantly higher or lower than usual.    * Convert income paid at a frequency other than monthly to a monthly amount. Enter the income into the SOR as a monthly amount. For example, if income is received quarterly, average the income over the three-month period and budget the income as monthly. 3. Disregard certain kinds of payments, property, or services that are not income for Medicaid purposes. If deeming applies, refer to [Appendix A](http://medsweb.scdhhs.gov/mppm/HTML/Section300/Chapter%20301%20SSI%20Liberalized%20Income.htm#Appendix_A) at the end of this chapter for items that are excluded from deeming. 4. Deduct income excluded under other Federal statutes.   **Note:**  In evaluating whether an item meets the definition of income, determine if it is something the individual can use to obtain food or shelter. If the item is not, do not count as income. |

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| **Procedure to Determine Monthly Average Income:**  **(Do not round the answer and drop any numbers after the penny.)**   * For **weekly** amounts, average the last four pay stubs, multiply by 52, and divide by 12.   **Example**  Mr. Jones received the following pay stubs:  $250.70 + $300.60 + $275.50 + $265.90 = $1,092.70 ¸ 4 = $273.17~~5~~ = $273.17  $273.17 x 52 = $14,204.84 ¸ 12 = $1,183.73~~7~~ = $1,183.73 (monthly countable income)   * For **bi-weekly** amounts, average the last two pay stubs, multiply by 26, and divide by 12.   **Example**  Mr. Jones received the following pay stubs:  $650.26 + $725.25 = $1,375.51 ¸ 2 = $687.75~~5~~ = $687.75  $687.75 x 26 = $17,881.50 ¸ 12 = $1,490.12~~5~~ = $1,490.12 (monthly countable income)   * For **semi-monthly** amounts, add the two pay stubs together and use the total. |
| **Entering Earned Income into Cúram-CGIS**  Use the calculator on the Non-MAGI workbook to add earned income into Cúram-CGIS.   * **Weekly:** Obtain the last 4 weeks of paystubs or other payment verifications. Enter each week into Non-MAGI workbook calculator. Enter the “Average Pay Period” amount into Cúram-CGIS, and select “Weekly” as frequency * **Bi-Weekly**: Obtain the last 2 paystubs or other payment verifications. Enter each check into Non-MAGI workbook calculator. Enter the “Average Pay Period” amount into Cúram-CGIS, and select “Bi-Weekly” as Frequency * **Semi-Monthly:** Obtain the last 2 paystubs or other payment verifications. Enter each check into Non-MAGI workbook calculator. Enter the “Average Pay Period” amount into Cúram-CGIS, and select “Semi-Monthly” as frequency * **Monthly:** Obtain the payment verification. Enter the value into Cúram-CGIS, and select “Monthly” as the Frequency   **NOTE**  If the income is not calculated correctly in CGIS when the frequency is entered as an option other than “Monthly”, submit a Helpdesk ticket. This issue is known, and the frequency of the issue must be assessed.  **SPECIAL NOTE**  Check for Spousal Impoverishment Income Allocations for Long Term Care programs. Use the total and enter the value into the wages box under income for Non-MAGI Manual Eligibility workbook. |

[Table of Contents](#_top)

301.04.09 Infrequent or Irregular Income Exclusion

(Rev. 12/01/23)

[POMS SI 00810.410](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500810410)

For this exclusion to apply, income must be received either infrequently or irregularly.

* Infrequent – An individual receives income on an infrequent basis, if it is received no more than once in a calendar quarter from a single source. Effective September 8, 2006, income cannot be considered infrequent if a payment is received from the same source either the month before or the month after, even if the payments occur in different calendar quarters.
* Irregular – An individual receives income on an irregular basis, if it is not a reasonable expectation to receive it.

This exclusion is applied as follows:

* The first $30 per calendar quarter of earned income, and
* The first $60 per calendar quarter of unearned income.

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| **Note**   * + A single source of earned income is an employer, a trade or a business.   + A single source of unearned income is an individual, a household, an organization, or an investment.   + Effective September 8, 2006, if an individual begins receiving a recurring payment (such as a social security check) in the third month of a quarter, the payment does not meet the definition of infrequent because it will be received in the following month, even though the following month is in another quarter. The same would be true if the recurring payment ended in the first month of a quarter, but had been received in the prior month in another quarter. |

| If someone receives unearned income... | And… | Then its receipt is... |
| --- | --- | --- |
| No more than once in a calendar quarter from a single source | ——— | Infrequent |
| No more than once in a calendar quarter from each of several sources | It is the same type of income in each instance | Infrequent |
| No more than once in a calendar quarter from each of several sources | It is a different type of income in each instance | Infrequent |
| More than once in a calendar quarter from the same source | It is a different type of income in each instance | Infrequent |
| More than once in a calendar quarter from the same source | It is the same type of income in each instance | **Not** infrequent |
| Any number of times in a calendar quarter | The individual could not reasonably have expected or budgeted for it | Irregular |
| Any number of times in a calendar quarter | The individual could reasonably have expected or budgeted for it (even if the individual did not know the exact amount) | **Not** irregular |

[Table of Contents](#_top)

|  |  |
| --- | --- |
| When someone receives infrequent or irregular… | Then this exclusion… |
| Unearned income | Applies to the first $60 of infrequent or irregular unearned income received in a calendar quarter |
| Earned income | Applies to the first $30 of infrequent or irregular earned income received in a calendar quarter |
| Unearned and earned income | Applies to the first $60 of infrequent or irregular unearned income and the first $30 of infrequent or irregular earned income |

The dollar amount of the exclusion does not increase even if both an eligible individual and spouse (eligible or ineligible) have infrequent or irregular income.

The exclusion is applicable to income received infrequently or irregularly by an eligible individual, eligible or ineligible spouse, ineligible parent, and ineligible child.

**Budgeting Examples for Income received other than monthly:**

* If the ES has been specifically instructed to budget the income as received, (i.e.: quarterly, semi-annually, or annually), remember that **ALL** exclusions must be calculated before entering the countable income into Cúram-CGIS. (See Example 1)
* For CGIS cases with income received other than monthly, follow the instructions found in MPPM 301.09.54 **Computing Unearned Income** for instruction on calculation and entry into Cúram. (See Example 2)

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| **Example 1**  **(Traditional Calculation)**  **(Unearned Income/Traditional Calculation)**  Mr. Jones receives $800 in SSA Monthly. In addition, he receives $1500 in rent every October for land he leases to a local farmer. This is infrequent unearned income. The calculations would be $1500 - 60= $1440 + $ 800= 2240.00 - $50 (general disregard) = $2190.00 in countable income in the month received. Mr. Jones would not be eligible for Medicaid in the month the rental income was received, but eligible for the remaining months of the year.  **(Earned Income/Traditional Calculation)**  Mr. Jones receives $450 in SSA monthly. He also provides lawn maintenance for an apartment complex. He Is paid $1830 annually for these services. The money is infrequent earned income. $1830-$30=$1800 would be counted as earned income in the month received. $1800- $65 earned income disregard = $1735.00 divided by ½= $842.50 counted in the month received. His total income in that month would be $1267.50. Using the traditional method, Mr. Jones would be ineligible in the month the income was received, but eligible for the remaining months of the year.  **Example 2**  **(For CGIS/ Cúram; Using monthly calculation)**  **(Unearned Income/ Converted to Monthly)**  Mr. Jones receives $800 SSA Monthly. In addition, he receives $1500 in rent every October for land he leases to a local farmer. Converting the unearned income to monthly equals $125.00. $800+$125= $925 less $50 (general disregard) =$875 countable income monthly. Mr. Jones would be Medicaid eligible.  **(Earned Income, received infrequently/Converted to Monthly)**  Mr. Jones receives $450 SSA monthly. He also provides lawn maintenance for an apartment complex. He Is paid $1830 annually for these services. The money is infrequent earned income. $1830 divided by 12 months= $152.50. Mr. Jones’ earned income calculated monthly plus his SSA income, less all earned income disregards total $443.75. Mr. Jones would be eligible for ABD. |

[Table of Contents](#_top)

301.04.10 Income of Members of Religious Orders

(Eff. 10/01/05)

[POMS SI 00810.700](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500810700)

The existence of a vow of poverty is a factor in determining whether cash is considered wages or net earnings from self-employment. The existence of a vow of poverty is also a factor in determining if payments made by a member to the order can be considered contributions for food, clothing, or shelter.

The treatment of income to members of religious orders who take a vow of poverty is determined by the source and nature of such income.

1. Cash for members of religious orders who take a vow of poverty is considered wages if:

* An individual receives compensation from the order as an active, working member of that order, whether or not the religious order has elected Title II coverage.
* An active, working member of a religious order receives compensation for performing services from an agency of the church supervising the order or from an affiliated institution, whether or not the religious order has elected Title II coverage.
* A member of a religious order receives compensation from a third party for services performed as an employee.

1. Remuneration for members of religious orders who take a vow of poverty is considered earnings from self-employment only when a member engages in self-employment activity unrelated to his membership in the order.
2. Any income provided by the order to a member who has taken a vow of poverty, which does not fall under #1 or #2 above is unearned income to the member even if turned over to the order.
3. Any income or resources turned over by the member to the order are considered to be in fulfillment of the vow of poverty and are not considered contributions for food, clothing, or shelter received from the order.
4. Unearned income received by a member from any source other than the order (such as Title II or VA benefits) is income to the member even if the member turns it over to the order.

301.04.11 Non-Representative Income

(Rev. 10/01/23)

Eligibility workers must determine if the income presented and collected during the application or review process is representative of the income received during the last four weeks. Representative means that there are no anticipated changes, and the documented income represents the applicant’s/beneficiary’s average income.

If a pay period in the last four weeks is unusually higher or lower, the eligibility worker must:

* Conduct a collateral call to the applicant/beneficiary to discuss any discrepancies regarding the non-representative pay,
* Conduct a collateral call to the employer if necessary,
* Determine how often such occurrences can be expected and,
* Document the decision in the case record as to whether or not to count the unusual amount in the budgeting process.
* Enter the value of the income after the non-representative income has been excluded into Cúram-CGIS with the appropriate frequency

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| **Example 1**  Applicant/beneficiary receives bi-weekly income. 1st check is for $1000.00. The 2nd check is for $1500.00. Applicant/beneficiary states that the last check was higher because of overtime received in the last three weeks. Applicant/beneficiary states that no additional overtime is expected to be received.  Eligibility worker would verify that $500.00 is the overtime amount and count the base pay of $1000.00 as the gross income in the budgeting process.  **Example 2**  Applicant/beneficiary receives weekly income. 1st check is $400.00. The 2nd check is $450.00. The third check is $520.00 and the 4th check is $580.00. Applicant/beneficiary states that each check is higher because they will be working overtime for the next three months.  Eligibility worker would accept applicant/beneficiary’s statement and count all weeks of income in the budgeting process.  **Example 3**  Applicant/beneficiary receives weekly income. 1st check is $350.00. The 2nd check is $195.00. The third check is $325.00 and the 4th check is $335.00. Applicant/beneficiary states that the 2nd check is unusually lower because of missing a couple of days of work, due to illness.  Eligibility worker would disregard the 2nd check and document the reason. The remaining three paychecks would be counted in the budgeting process. The eligibility worker will then divide the gross income by 3 to get the weekly average. |

301.04.12 Terminated/Reduced Income

(Eff. 10/01/23)

When an individual applies for Medicaid coverage, earned and unearned income must be verified beginning the month of application as per instruction provided for each income type. Income that terminates during the month of application is counted based on the actual amount received during the month. Therefore, verification of the actual amount received for the month is required. However, when income terminates or is reduced in the months following the application date, the eligibility specialist must not deny the case. If verification is provided either through an electronic data source (EDS) or returned by the applicant/authorized representative or employer, the eligibility specialist will assess eligibility beginning the month the applicant will meet income criteria.

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| **Examples: Earned Income**  **Example 1 (Non-MAGI)**  Mr. Richard Johnston is a 36-year-old man who was working prior to becoming disabled. Mr. Johnston is awaiting a disability determination. His income during the month of application is $3500.00. In the following month, he has no income. The MOA99 is returned six months after the application date with an adopted decision. He also began receiving SSA income of $1000 per month in the sixth month. Mr. Johnston is income eligible for ABD effective the month following the application date. The eligibility specialists budgeted $3500.00 for the month of application, $0.00 for the month following the application, and $1000.00 for the month the disability determination returned.  **Example 2 (Non-MAGI/LTC)**  Mr. Tippy Downs received $480.00 per week in wages during the month of application and the three months prior. Mr. Downs provided verification that he will only receive two checks in the application month because he only worked one week during that month. The application month will be authorized because only the two checks will be budgeted.  **Example 3 (LTC)**  Mrs. Emmy Golden is a 54-year-old woman who was working prior to becoming disabled. Mrs. Golden has received a disability determination. Her income during the month of application is $4500.00. In the following month, she has no income. She also began receiving SSA income of $2000 per month in the sixth month. Mrs. Golden has an approved Income Trust on file. Her income fell within the income limit for the current year for LTC effective the month following the application date. The eligibility specialists budgeted $4500.00 for the month of application and has the Income trust dissolved. The amount budgeted for the month following the application date is $0.00, and the amount budgeted for the month the disability determination is returned is $2000.00. |
| **Examples: Unearned Income**  **Example 1 (Non-MAGI)**  Mr. Ron Kim received unemployment benefits of $365.00 per week during the month of application and the three months prior. Mr. Kim provided verification that he will only receive two unemployment checks in the following month because his unemployment benefits will expire. The application month will not be authorized. Mr. Kim will be approved for ABD in the following month because only the two checks will be budgeted.  **Example 2 (LTC)**  John Chew received SSA benefits of $1000.00 and a settlement check of $12,000.00 from a car accident in the month of application. The settlement was a lump sum with no additional payments. An Income Trust is required for the month of application. The income trust can be dissolved in the month following the month of application.  **Note:**  If Mr. Chew did not enter the Nursing Home or Waiver program in the month of application, no Income Trust is required. Budget the case using the month of entry into the facility or program.) |

301.05 What is Not Income?

(Rev. 04/01/11)

[POMS SI 00815.001](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500815001)

Some items that an individual receives are not income because they do not meet the definition of income. Other items are income but are excluded by statute. Only those items specifically listed in the law and regulations can be excluded from income. If needed, POMS references have been included for detailed information concerning the items listed below.

| Item | Note | POMS Reference |
| --- | --- | --- |
| Medical and Social Services |  | [POMS SI 00815.050](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500815050) |
| Conversion or Sale of a Resource | Not counted as income, but evaluated under Resource rules. | [POMS SI 00815.200](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500815200) |
| Rebates and Refunds | Not counted as income, if it is a return of money already paid. | [POMS SI 00815.250](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500815250) |
| Income Tax Refunds | Not counted as income.  Refunds and advance payments related to the Earned Income Tax Credits and other credits contained in the Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010 are excluded from resources for 12 months | [POMS SI 00815.270](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500815270) |
| Credit Life or Disability Insurance Payments |  | [POMS SI 00815.300](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500815300) |
| Proceeds of a Loan | * Money received from a loan is not counted as long as the loan is bona fide. It is counted as unearned income in the month received, if there is no written agreement to repay. * Money received as repayment of the principal of a loan is not income, however, interest received is counted as unearned income | [POMS SI 00815.350](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500815350) |
| Bills Paid by a Third Party | Not counted as income, if directly paid by the third party. | [POMS SI 00815.400](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500815400) |
| Replacement of Income Already Received |  | [POMS SI 00815.450](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500815450) |
| Return of Erroneous Payments | Not counted as income, if returned immediately. | [POMS SI 00815.460](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500815460) |
| Weatherization Assistance |  | [POMS SI 00815.500](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500815500) |
| Wage-Related Payments | Includes items such as employer’s share of FICA, health insurance, and retirement. | [POMS SI 00815.600](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500815600) |

[Table of Contents](#_top)

301.06 Earned Income

**(Eff. 10/01/05)**

[POMS SI 00820.001 ff](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500820001)

Earned income is received in cash and consists of:

* Wages
* Net Earnings from Self-Employment (NESE)
* Payments for services performed in a sheltered workshop or work activities center
* Royalties earned by an individual in connection with any publication of his work and any honoraria received for services rendered

301.06.01 Sick Pay

(Eff. 10/01/05)

[POMS SI 00820.005](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500820005)

Sick pay is a payment made to or on behalf of an employee by an employer or a private third party for sickness or accident disability**.** Sick pay is either wages or unearned income. (**Note:** Payments to an employee under a Workers' Compensation law are neither wages nor sick pay.)

The following chart shows how to treat sick pay.

|  |  |  |
| --- | --- | --- |
| When Sick Pay Received | Attributable to Employee’s Own Contribution (Yes/No) | Type of Income |
| More than 6 months  after stopping work | N/A | Unearned |
| Within 6 months  after stopping work | No  Yes | Wages  Unearned Income |

To determine the 6‑month period after stopping work:

· Begin with the first day of non-work.

· Include the remainder of the calendar month in which work stops.

· Include the next six (6) full calendar months

[Table of Contents](#_top)

301.06.02 Wages

**(Eff. 10/01/05)**

[POMS SI 00820.100](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500820100)

Wages are what an individual receives (before deductions) for working as someone else's employee. Under certain conditions, services performed as an employee are deemed self-employment rather than wages (for example, ministers, real estate agents, share farmers).

Wages are counted at the earliest date of the following:

* When they are received, or
* When they are credited to the individual's account, or
* When they are set aside for the individual's use.

Wages may take the form of:

| TYPE | DEFINITION |
| --- | --- |
| Salaries | Payments (fixed or hourly rate) received for work performed for an employer. |
| Commissions | Fees paid to an employee for performing a service  (such as a percentage of sales). |
| Bonuses | Amounts paid by employers as extra pay for past employment (for example, outstanding work, length of service, holidays) |
| Severance Pay | Payment made by an employer to an employee whose employment is terminated independently of his wishes. |
| Military Basic Pay | Service member's wage, which is based solely on the member's pay grade and length of service |
| Special Payments received because of employment | These are items such as vacation pay or advanced/ deferred wages. |
| Payments to an Inmate  of a public institution | Payments made when an employer/ employee relationship exists. |
| AmeriCorps and National Civilian Community Corps Payments | Payments made for performing public service work. |

301.06.03 Cafeteria Plans

**(Rev. 02/01/15)**

[POMS SI 00820.102](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500820102)

A cafeteria plan is a written benefit plan offered by an employer in which:

* All participants are employees; and
* Participants can choose cafeteria-style from a menu of two or more cash or qualified benefits.

A qualified benefit is not considered part of an employee's gross income. Qualified benefits include, but are not limited to:

* Accident and health plans (including medical plans, vision plans, dental plans, accident and disability insurance)
* Group term life insurance plans (up to $50,000)
* Dependent care assistance plans
* Certain stock bonus plans under section 401(k)(2) of the IRC (but not 401(k)(1) plans)

A salary reduction agreement is an agreement between employer and employee whereby the employee, in exchange for the right to participate in a cafeteria plan, accepts a lower salary or foregoes a salary increase.

Amounts used to purchase cafeteria-plan benefits under a salary-reduction agreement are not the employee's wages and are not income for Medicaid purposes.

Payroll deductions used to purchase cafeteria-plan benefits in addition to or instead of as provided under a salary-reduction agreement are the employee's wages and are earned income.

Cash received under a cafeteria plan in lieu of benefits is considered wages. However, cash received as reimbursement for qualified-benefit expenses, such as childcare, is not income.

At the time of application or review:

* If an applicant’s reported income is below the threshold and reasonably compatible with electronic sources (whether by straight through processing or with a worker verifying), the worker does not need to pursue information regarding a cafeteria plan.
* If the applicant provides information (e.g. current check stub) whether as reported income or as verified income and the check stub indicates the presence of a cafeteria plan, the worker must act on that information and count income based on cafeteria plan policies.

[Table of Contents](#_top)

301.06.04 Wage Advances and Deferred Wages

**(Eff. 10/01/05)**

[POMS SI 00820.115](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500820115)

Wage advances are payments by an employer to an individual for work to be done in the future. An advance is wages in the month received.

Wages are considered "deferred" if they are received later than their normal payment date. Types of wage payments that may be deferred include vacation pay, dismissal and severance pay, back pay, and bonuses.

* Wages that are deferred due to circumstances beyond the control of the employee are considered earned income when actually received.
* Wages that are deferred at the employee's request or by mutual agreement with the employer are considered earned income when they would have been received had they not been deferred.

301.06.05 Verification of Wages

**(Rev. 11/01/18)**

[POMS SI 00820.133ff](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500820133)

Verification of wage amounts and frequency of receipt is required whenever an individual alleges he received wages, sick pay, or temporary disability payments.

The burden of proof is on the applicant/beneficiary. However, the eligibility worker should provide assistance if the applicant/beneficiary is unable to secure evidence of wages. The most common methods of verifying wages include pay stubs, written or oral statements from the employer and W2s, if no other verification is available.

If a DHHS 1233 ME, Medicaid Eligibility Checklist, is used to request income verification, request the income received four (4) weeks prior to the application/review receipt date. All income paid other than monthly must be converted to a monthly amount. Once determined, monthly income is projected over the next 12 months.

In instances where check stubs and/or the DHHS Form 1245 are not available, a declaratory statement of income can be used. The statement must clearly identify the employee and be signed by the employer. For decisions made on or after August 1, 2013, the following procedures for verifying income must be used.

| **Procedure – Earned Income Verification of Reported Income** |
| --- |
| If an applicant/beneficiary reports earned income on an application or review form, the reported income must be accepted. If the electronic data source matches the reported income, take the following steps:   1. If the reported income is below the income eligibility standard    1. Evaluate the reported income and the electronic verification to determine if it is below the income eligibility standard for the family size    2. Use the reported income received as verified income. Do not request additional paper documentation. 2. If the reported income is below the income eligibility standard and the electronic data source displays an income above the income eligibility standard, request additional documentation. 3. If the reported income is above the income eligibility standard and cannot be verified by electronic means, request additional documentation. 4. If both the reported income and the electronic verification are above the income eligibility standard, deny the application.   Sources of Electronic Verification:   1. Person Composite Service (PCS) Wage Verification 2. Employment Security Commission (ESC) Wage Match 3. Verify Direct 4. CHIP Data (SNAP/TANF)   Acceptable Sources of Paper Documentation: (To be requested only if an electronic verification source and/or income does not match the reported source and/or income.)   1. DHHS Form 1245, Wage Verification 2. Pay Stubs 3. Employer’s Records 4. Federal Income Tax records (Self-employment only)   All electronic verifications must be virtually printed in OnBase or if you are unable to access OnBase, you must print the electronic verification and place it in the case file. You must also document in the MEDS Notes screen or in OnBase which means of verification was used for the determination. |

[Table of Contents](#_top)

301.06.06 Different Forms of Business

**(Rev. 05/01/17)**

Income received by an individual from a business may be considered as self-employment income, wages as an employee, or unearned income depending upon the form of business and the individual's relationship to the business. The following policy explains the different forms of business.

1. **Sole Proprietorship**

A sole proprietorship is an unincorporated business owned by one individual. The owner has sole control and responsibility of the business, receives all the profits, and is legally liable for all the debts of the business. The owner of a sole proprietorship is self-employed. (Refer to MPPM [301.06.07](#NESE)for information on how to determine countable income.)

1. **Partnerships**

A partnership is an association of two or more people to carry on as co-owners a business for profit. A partnership can be created by a verbal or written contract between the individuals. There are three types of partnerships, a General Partnership, a Limited Partnership, and a Limited Liability Partnership. The income received from a partnership is either self-employment or unearned income depending on whether the individual is a general partner or a limited partner. The income tax form, Schedule K-1, Partner's Share of Income, Credits, Deductions, etc., that the partner receives from the partnership will show whether the individual is a general partner or a limited partner.

1. **General Partnership**: Each partner jointly owns the business, shares in the profits and losses, and is personally liable for all the debts of the business. There may or may not be a written Partnership Agreement. The income a general partner receives from the partnership is self-employment income. (Refer to MPPM [301.06.07](#NESE)for information on how to determine countable income.)
2. **Limited Partnership**: A business that is owned by at least one or more general partners who manage the business and one or more limited partners. Filing an application for Limited Partnership with the South Carolina Office of the Secretary of State forms an LP. The general partner or partners are responsible for the management of the company and are personally liable for all the debts of the business. The income a general partner receives from the partnership is self-employment income. (Refer to MPPM [301.06.07](#NESE)for information on how to determine countable income.)

The limited partner or partners have no personal liability for the debts of the business. The income a limited partner receives from a partnership is unearned income and must be reported on his or her individual income tax return. To determine the countable unearned income, request a copy of the Schedule K-1, Partner's Share of Income, Credits, Deductions, etc., from the partnership and the individual's Schedule E, Supplemental Income and Loss, which is filed with his or her personal income tax return.

1. **Limited Liability Partnership (LLP)**: A business that is set up like a general partnership except that the partners are granted limited liability. Usually, individuals who are in professions such as law, medicine, and accounting set up a Limited Liability Partnership. The partners are not personally liable for the malpractice or debts of the other partners or for the debts of the LLP. Filing an application for Limited Liability Partnership with the South Carolina Office of the Secretary of State forms an LLP. The income a general partner in an LLP receives from the partnership is self-employment income. The income a limited partner receives from a partnership is unearned income and must be reported on his or her individual income tax return. Refer to MPPM [301.06.07](#NESE) for information on how to determine countable income.)

[Table of Contents](#_top)

1. **Limited Liability Company (LLC)**

Filing Articles of Organization with the South Carolina Office of the Secretary of State forms a Limited Liability Company. The individual members of a Limited Liability Company are not personally liable for the debts of the company.

An LLC may be taxed as a sole proprietorship, partnership, or corporation. The Articles of Organization, the Operating Agreement, or their income tax forms will provide this information. An LLC with at least two members is classified as a partnership for federal income tax purposes unless it files Form 8832 and affirmatively elects to be treated as a corporation. An LLC with only one member is treated as a sole proprietorship for income tax purposes, unless it files Form 8832 and affirmatively elects to be treated as a corporation.

If the LLC is being taxed as a sole proprietorship, the policy for sole proprietorship income should be followed. If the LLC is being taxed as a partnership, the policy for partnership income should be followed. If the company is being taxed as a corporation, the policy for C corporation income should be followed.

1. **Corporations**

A corporation is formed by a transfer of money, property, or both by prospective shareholders in exchange for capital stock in the corporation. If money is exchanged for stock, the shareholder or corporation realizes no gain or loss. The stock received by the shareholder has a basis equal to the money transferred to the corporation by the shareholder. All corporations are divided into two groups based on how they are taxed: S Corporations which have elected Subchapter S treatment, and C Corporations which encompass all other corporations.

1. **S Corporation:** A small business corporation formed and operated under a State's general corporation law. It is like any other corporation, except that it is treated like a sole proprietorship or a partnership for Federal Income Tax purposes. The S Corporation files an "information" tax return to report its income and expenses, but it is not separately taxed. Instead the income and expenses of the corporation are divided among its shareholders, based upon the percentage of stock of the corporation that they own, who then report them on their own income tax returns (Schedule E, Supplemental Income and Loss.) An individual may also receive a salary from the business, and this should be counted as wages.

If the individual is actively engaged in the business, the income is self-employment income. (Refer to MPPM [301.06.07](#NESE) for information on how to determine countable income.)

|  |
| --- |
| **Note**  The information reported on their Schedule E, Supplemental Income and Loss, should be checked to determine whether the individual is actively engaged in the business. If the income is listed as Non-passive Income, the individual is actively engaged in the business. If it is listed as Passive Income, he or she is not actively engaged in the business. |

If the individual is not actively engaged in the business, the income received is countable unearned income. The individual will receive a Schedule K-1 from the S Corporation he may then use to complete Schedule E to file with his personal income tax return.

1. **C Corporation:** C corporations are treated by law as a separate legal entity. The owners of a corporation are the stockholders or shareholders. Owners of a C corporation are not considered self-employed. The C Corporation reports its income and expenses on a corporation income tax return and is taxed on its profits at corporation income tax rates. Dividends when paid are taxed to stockholders who report them as income. Dividends paid to a stockholder are countable unearned income when they are received.

A stockholder of a corporation may also be an employee of the corporation. If the stockholder is an employee, the wages are counted as earned income when they are received.

[Table of Contents](#_top)

301.06.07 Self-Employment Income

**(Rev. 05/01/17)**

Self-employment income is the gross income from a continuing trade or business activity minus the allowable operational expenses for that activity. This includes, but is not limited to running a business, performing a service, selling items you make or re-selling items to make a profit. A self-employed individual may be the sole owner of a business; a general partner in a partnership; a partner in a Limited Liability Partnership; a member of a Limited Liability Company being taxed as a partnership or sole proprietor; or a shareholder in an S Corporation who is actively engaged in the operation of the business.

An individual is not self-employed if the business is taxed as a C corporation, even if the person is the sole investor in the business. If the individual is a limited partner in a Limited Partnership or in a Limited Liability Partnership; or if the individual is a member (owner) of a Limited Liability Company that files federal income taxes as a corporation, any earned income actually received by the individual as an employee of the business is countable wages. Dividends or the share of income reported by the individual on his/her individual income tax is countable unearned income.

A self-employed farmer actively earns income from operating a farm for profit as either the owner or tenant. A farm includes stock, dairy, poultry, fish, bee, fruit, or truck farms. It also includes plantations, ranches, nurseries, or orchards.

To determine if an individual is self-employed, evaluate the individual’s work situation. If an employer is withholding Social Security and income taxes, the individual is not self-employed. A self-employed individual generally exercises control over how the business will be conducted, not just the end product. Also, a self-employed individual usually incurs operational expenses related to conducting his business or work activity.

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| **Example #1**  An electrician who works for a construction company, has materials provided and receives a regular paycheck with taxes withheld is not self- employed. An electrician who is self-employed solicits his own work, works on various jobs, provides his own tools, and is paid when the job is finished with no taxes withheld. |

[Table of Contents](#_top)

**Countable Self-Employment Income**

An individual's countable self-employment income from a business depends on the type of business and the individual’s relationship to the business.

1. Sole Proprietor – If the individual is the sole owner of the business, the individual’s countable self-employment income is the net profit from a business or farm. Net profit is the total gross earnings minus allowable business expenses. Any salary or disbursements made to the individual from his business are included as part of the countable self-employment income.

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| **Example #2**  An electrician’s gross receipts for the 12-month base period are $65,000 and his operational (business) expenses are $30,200. He has withdrawn from his account $400.00 per week in the same period for a total of $20,800. His gross income from the business is $34,800, the difference between receipts and expenses, rather than the amount he withdrew. |

1. General Partner – If the individual is a general partner, the individual’s countable self-employment income is calculated by subtracting the operational expenses from the gross receipts of the business in the base period and dividing that amount by each partner’s share. The earnings are divided according to the agreement. If no Partnership Agreement exists, the earnings must be divided equally among all general partners. Any salary or disbursements made to the individual from his business are included as part of the countable self-employment income.

Partnerships are required by the IRS to file a Form 1065, Partnership Return of Income, which shows the income and expenses of the partnership as well as the assets and liabilities of the partnership. The Form K-1 (Form 1065) is then completed using the Form 1065 and distributed to the partners to indicate their share of the earnings. If the partners do not file the required tax forms, they are still treated as partners for the purposes of determining countable income. The earnings are then reported on the individual’s tax return on a Schedule E as income.

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| **Example #3**  Two individuals work together as equal partners in a Carpet Cleaning business. Their gross receipts in the base period were $57,000 and their operating (business) expenses were $9,500. The gross income from the business is $47,500 and each partner’s gross income is $23,750. |

1. Member of a Limited Liability Company (LLC) Filing Federal Taxes as a Partnership – If the individual is a member of a Limited Liability Company which files federal income taxes as a partnership, and the individual is a general partner, the company is treated the same as a general partnership and the individual’s self-employment income is his/her share of the earnings.

If the individual is a limited partner, he/she is not self-employed. Limited partners treat as self-employment earnings only guaranteed payments for services they actually rendered to, or on behalf of, the partnership to the extent that those payments are payment for those services. Any dividends paid to him/her from the LLC are countable unearned income.

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| **Example #4**  Ms. Mitchell is one of three members of Styles & Files, a LLC with monthly profits of $900. The company’s Operating Agreement says the income of the LLC is taxed as a partnership with each member receiving an equal share of the profits. Ms. Mitchell’s countable self-employment income is $300.  **Example #5**  Mr. John Deere and his son have formed a LLC and are the only two members of John’s Tractor Service. The company’s Articles of Organization state that the income of the LLC will be taxed as a corporation. Mr. Deere and his son are not self-employed. |

1. Shareholder in an S Corporation – If the individual is a shareholder in an S Corporation and is actively working in the business, the individual’s earned income is his/her share of the profits. The S Corporation operates the same as a partnership in that the income is taxed at the individual level and there are no corporate taxes. An individual who is a shareholder in an S Corporation but is not actively working in the business is not self-employed. His share of the profits is countable unearned income.

S Corporations are required by the IRS to file a Form 1120S, U .S. Income Tax Return for an S Corporation, which shows the income and expenses of the corporation. The Form K-1 (Form 1120S) is then completed using the Form 1120S and distributed to the shareholders to indicate their share of the earnings. The earnings are then reported on the individual’s tax return on a Schedule E as income.

[Table of Contents](#_top)

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| **Example #6**  Mr. Smith is one of 12 shareholders in John’s Cleaning Service, an S Corporation with a monthly profit of $12,000. Mr. Smith formed the corporation, is responsible for its management, and cleans several of the businesses that have contracted with the corporation for services. Mr. Smith’s countable self-employment income is $1,000. ($12,000 divided by 12 = $1,000)  **Example #7**  Mr. Manning is one of 10 shareholders in Mike’s Investigations, an S Corporation with a monthly profit of $11,000. Mr. Manning does not perform any services for the corporation. His share of the monthly profits is $1,100 and is countable unearned income. ($11,000 divided by 10 = $1,100) |

**Calculating Multiple Self-Employment Businesses**

Each self-employment business is separate. Calculate the net self-employment income for each self-employment business separately.

* The losses on one business can offset the profit of another business.
* Do not use the losses of one period to offset the profits of another period.

Determine the expenses and gross income for each business separately and add the totals to determine gross income.

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| **Note**  Do not allow the same operational expenses more than once. For example, if the applicant/ beneficiary rents a space and uses it for two businesses, the rent deduction can only be allowed once. |

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| **Example #8**  Drew Blank operates Kids-R-Us Day Care and Blank Heating & Cooling. These are two separate business activities. Kids-R-Us Day Care received $35,000 in gross income and had $12,250 in expenses for a net profit of $22,750. Blank Heating & Cooling business had $28,000 in gross receipts and $4,500 in expenses for a net profit of $23,500. His income from self-employment is $46,250 ($22,750 + $23,500.)  **Example #9**  Alice Carroll has two separate businesses, White Rabbit House Cleaning and The Mad Hatter Tea Shop. White Rabbit House Cleaning received $12,000 in gross income and had $3,000 in expenses for a net profit of $9,000. The Mad Hatter Tea Shop had $20,000 in gross receipts and $23,250 in expenses for a net loss of $3,250. Her income from self-employment is $5,750 ($9,000 - $3,250 = $5,750.) |

**Verifying Countable Self-Employment Income**

The individual’s most recent tax return is used to verify the countable profits from self-employment or farming, if the income information on the tax return is representative of the current self-employment income and circumstances.

If a tax return is not available, or if the income reported on the most recent tax return is not representative of current income, business accounting records, ledger books, or bookkeeping records from the beginning of the current tax year up to the month of application, including those maintained by the individual, by either paper or in software programs such as QuickBooks, may be used to verify self-employment income. If there are no business records available at application, the applicant’s statement declaring the gross income received from the beginning of the current tax year up to the month of application should be accepted only as a last resort. Money earned and not received is not included.

**Note:** A declaratory statement cannot be accepted for operational expenses, since there is no business or current tax records available to verify the expenses.

[Table of Contents](#_top)

**Business Expense Deductions**

Business or operating expenses are the identifiable costs of producing goods or services and without which the goods or services could not be produced. Verified costs of certain items necessary for the operation of a self-employment business/farm are appropriately deducted from the total business income to determine earnings.

Some examples of allowable business deductions are:

* Cost of renting land, buildings, machinery, and equipment necessary for the operation of the business or farm;
* Cost of utilities for business or farm buildings;
* Cost of office supplies;
* Amount of real property taxes on business or farmland owned or being purchased by the individual;
* Cost of employees' wages and benefits and the employer's share of the employees' social security taxes;
* Costs of repairs and maintenance of business or farm property (including buildings, machinery, equipment, trucks) owned or being purchased by the individual, if such expenditures do not appreciably add to the value of the property;
* Interest portion of business and farm loans or mortgages;
* Insurance on business and farm property (including buildings, machinery, livestock, cars, trucks);
* Business licenses;
* Cost of gas and oil for business or farm vehicles;
* Cost of feed, fertilizer, seeds, plants, and farm supplies;
* Cost of breeding fees, veterinary fees, and livestock medicines;
* Cost of advertising;
* Postage;
* Cost of tools purchased for the business;
* Attorney fees related to the business;
* Cost of tax return preparation;
* Cost of goods sold;
* Business-related travel expenses;
* Cost of business transportation (including parking expenses). Travel expenses while at work (such as going to pick-up materials required for the business) are considered a business expense. Travel expenses to and from the individual's home to place of employment is **not** deductible. Personal use of a motor vehicle is **not** an allowable expense. If a vehicle is used both for business and personal purposes, the expenses must be divided between business and personal use. The expenses must be divided based on the number of miles driven for each purpose.

Some expenses the client may claim as business expenses are not allowed as deductions for eligibility purposes. They include:

* Depreciation; (loss of value, as because of wear)
* Entertainment expenses;
* The cost of purchasing income-producing real estate and capital assets such as equipment, machinery and other durable goods, including payments on the principal of a loan to purchase capital goods;
* Expenses and net losses from previous periods;
* Federal, state and local income taxes;
* Any expenses covered by the earned income deduction;
* Money set aside for the individual’s retirement and other work-related personal expenses such as transportation to and from work or personal entertainment expenses;
* Repayment on the principal of a bank loan;
* Debts from a previous business, including bankruptcy payments;
* Personal debts;
* Family expenses (Personal Use)

If the applicant/beneficiary alleges that cash or in-kind items (i.e., food, fuel) are withdrawn from a business for personal use, or if the eligibility worker has reason to believe that cash or in-kind items have been withdrawn from the business for personal use (reported income does not appear to be able to meet the applicant/ beneficiary’s living expenses):

* Ask if the withdrawals were properly accounted for. Were they deducted on tax returns or on business records in determining cost of goods sold?
* Unless the worker has specific reasons to doubt the applicant/beneficiary, accept the applicant/beneficiary’s allegation that the cost of goods sold were deducted on his business records. If they were deducted, then they were properly accounted for.
* If they were not deducted, ask the applicant/beneficiary to document the value of the withdrawals. Deduct this amount from operational expenses.

**Establishing annual gross earned income from self-employment**

Generally, it will be necessary for the self-employed individual to provide copies of their tax return from the previous year or the individual's current business records in order for a projection of annual gross income to be determined. Additionally, the self-employed individual's estimate of expected income and expenses must be secured.

The amount of annual gross earned income from self-employment shall be determined by subtracting the allowable annual operating expenses from the annual gross receipts.

| Situation | Treatment |
| --- | --- |
| Tax Return – No change expected for current year | The individual has been carrying on the same trade or business for some time, net earnings from self-employment have been fairly constant from year-to-year and he/she anticipates no change or gives no satisfactory explanation of why the net earnings for current and future months will be substantially different from what it has been in the past. The estimate of earnings for the current taxable year should be the same as the net profit last year. Net Profit would be the Gross Income minus the Allowable Operational Expenses. |
| Tax Return – Change expected for current year | The individual is engaged in the same business that he/she had the preceding taxable year and anticipates a change and can give a reason why there would be a substantial difference from what it has been in the past. Determine the ratio between his net profit and gross receipts for the last year and apply it to the gross income received for the current taxable year.  **Procedure**   * Using the applicant/beneficiary’s tax return from the previous year, divide the Gross Income by the Net Profit (Gross Income minus Allowable Operational Expenses) to calculate the ratio between Net Profits and Gross Income   Gross Income – Allowable Expenses = Net Profit  Net Profit ÷ Gross Income = Net-Gross Ratio   * Using the applicant/beneficiary’s business records from the beginning of the current year up to the month of application, determine the business’ Gross Income * Calculate a monthly average for the Gross Income received to date * Multiply the monthly average by the Net-Gross Ratio to calculate the Monthly Net Profit * Annualize the Monthly Net Profit   **Example:** John Crawling applies for Medicaid in July. Last year he had a net profit of $1,200 with $6,000 in gross income in his business. He reports that his business is doing better this year, and last year’s income tax return would not accurately reflect his income for this year. In the first six months of this year he has $3,900 in gross receipts.  $6,000 last year’s Gross Income  $1,200 last year’s Net Profit  $1,200 ÷ $6,000 = 20% Net-Gross Ratio  $3,900 Current year’s Gross Income for the first six months  $3,900 ÷ 6 = $650 monthly average  $650 x 20% = $130 Estimated Monthly Net Profit  $130 x 12 = $1,560 Estimated Annual Net Profit |
| No Tax Return – Established or New Business | The eligibility worker shall project an estimate of the individual's countable annual income based on the individual's current business records. The eligibility worker shall base the decision on the individual's business records for the current year unless the individual disputes this determination and provides a reasonable explanation as to why the current business records do not reflect the income (and expenses) that he expects to receive in the future. If the individual disputes the determination by providing a reasonable explanation as to why the eligibility worker projection is not satisfactory and provides a written estimate of his projected annual income and expenses, the eligibility worker shall use the individual's written estimate on which to base the eligibility determination. |

**Budgeting Profits from Self-Employment**

In general, self-employment income must be annualized. This means the total profits expected in receipt for a full year must be averaged to determine the monthly countable self-employment income.

1. If a 12-month period of self-employment income history is available, and it is representative of the current circumstances, this information may be used to determine the monthly countable self-employment income.
2. If a 12-month period of self-employment income history is not available, or if the self-employment history is not representative of the current circumstances, whatever current information is available to establish a best estimate of the countable self-employment income may be used. A shorter review period may need to be set until enough information has been gathered to establish an accurate best estimate for longer periods.
3. If the self-employment income is not intended to be the household's annual support, and the household anticipates income from another source to be its support for the other part of the year, the self-employment income over the number of months it is intended to cover must be pro-rated and that amount must be used as the monthly countable income from self-employment in those months.
4. If the self-employment income is intended to be part of the household’s annual support, and other income is received that is part of the annual support, the self-employment income must be annualized, even if the business is only conducted during part of the year.

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| **Example #10**  Mr. Lean is a teacher who operates a small business to support himself during the summer months. He relies upon this small business for support only for the summer and relies upon his income from teaching for the rest of the year.He receives income from his 9-month contract-teaching job only during the school year. Last year, Mr. Lean's business made $6,000 during the 3-month school vacation. He expects his earnings to be about the same this year. Count $2,000 self-employment income for the three months the income is intended to cover (June, July and August). Count the teaching income in the months it is received. During June, July and August, Mr. Lean's countable income will be only the self-employment income and, in the other months, his countable income will be only the income from teaching.  **Example #11**  Ms. Cross is a teacher who operates a small business during the summer. She relies upon this business to supplement her income from teaching; she considers both incomes part of her annual support. This is the first year of business for Ms. Cross. She expects to have $6,000 in the three summer months. This money, added to the money from her teaching contract, must be divided by 12. ($6,000 self-employment + $30,000 teaching = $36,000. $36,000 ¸ 12 = $3,000. Count $3,000 for each month.)  **Example #12**  Mr. Hire is a self-employed plumber who has only been in business for two months. He has not received any money from the business yet, but has paid $500 in business expenses. He expects to average about 20 jobs with approximate earnings of $50 from each job. Using his anticipated income of $1,000 per month (20 jobs x $50 per job) and deducting his actual business expenses of $500, you can determine that his countable monthly income is $500. Review the case within a few months to see if your best estimate is still valid.  **Example #13**  Ms. Small is a Certified Public Accountant. She works only for three months of the year–the three months preceding the income tax deadline. This is the only income she earns all year. She uses the earnings to supplement her annual unearned income. Ms. Small earned $10,000 last year and had $1,000 business expenses. Her annual earnings from self-employment were $9,000. Ms. Small has "a hunch" her earnings for this year will be less. She cannot give us a logical reason why this would be so. ($9,000 ¸12 = $750. Count $750 as her earned income each month.) |

301.06.08 Net Earnings from Self-Employment (NESE)

(Eff. 10/01/05)

[POMS SI 00820.200ff](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500820200)

[POMS SI 00820.210](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500820210)

[POMS SI 00820.220](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500820220)

NESE is the gross income from any trade or business, less allowable deductions for that trade or business. NESE also includes any profit or loss in a partnership. NESE is determined on an annual basis. The chart below indicates the steps and procedures to determine NESE:

| STEPS | PROCEDURE |
| --- | --- |
| Determine monthly NESE | Divide the entire taxable year's NESE equally among the number of months in the taxable year, even if the business:   * Is seasonal; * Starts during the year; * Ceases operation before the end of the taxable year; or * Ceases operation prior to initial application. |
| Verify net losses | Any verified net losses from self-employment are divided in the same way as net earnings. Then each month's net loss is deducted from earned income of the individual or spouse in that month. |
| Apply the 7.65% deduction | A 7.65% deduction is applied to net profit in determining NESE. Therefore, multiply net profit by .9235 to determine NESE. This deduction recognizes, as a business expense, part of the Social Security taxes paid. If Social Security tax is not paid (that is, in situations involving less than $400 per year in NESE, net losses, and when no tax return is filed), the deduction does not apply. |
| Include distributive shares | Any distributive share (whether or not distributed) of income or loss from a trade or business carried on by a partnership is included in NESE. |
| Allow work expenses | If an individual is self-employed (whether or not he is also a wage earner), reduce his earned income by any allowable work expenses that have not already been used to compute NESE. |
| Withdrawals for personal use | When an individual alleges that cash is withdrawn from a business for personal use:  A. Ask the individual whether the withdrawals were deducted on the individual's Federal Income Tax return in determining the cost of goods sold or the cost of expenses incurred, or deducted on his business records.  B. Accept the individual's allegation of whether the withdrawals were properly accounted for.  If the withdrawals were properly accounted for, do not count against income.  If the withdrawals were not properly accounted for, and:   * The individual cannot or will not provide the profit and loss statement, but alleges an amount of NESE, add the value of the withdrawals to the individual's allegation of NESE. * The individual alleges withdrawals for personal use but cannot or will not estimate the value of the withdrawals, develop for unstated income.   Assume that any deductions taken on business records are allowable, provided there is no evidence to the contrary. |

301.06.09 Payments for Services Performed in a Sheltered Workshop or Work Activities Center

(Eff. 10/01/05)

[POMS SI 00820.300](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500820300)

Payments for services performed in a sheltered workshop or work activities center are what an individual receives for participating in a program designed to help him become self-supporting, Payments for such services are a type of earned income and are counted when received or when set aside for an individual's use.

A sheltered workshop is a nonprofit organization or institution whose purpose is:

* To carry out a recognized program of rehabilitation for handicapped workers; and/or
* To provide such individuals with remunerative employment or other occupational rehabilitating activity of an educational or therapeutic nature.

A work activities center is:

* A sheltered workshop, or
* A physically separated department of a sheltered workshop having an identifiable program and separate supervision and records.

A work activities center is planned and designed exclusively to provide therapeutic activities for handicapped workers whose physical or mental impairment is so severe as to make their productive capacity inconsequential.

Therapeutic activities are custodial activities such as activities where the focus is on teaching the basic skills of living, and any purposeful activity so long as work or production is not the main purpose.

[Table of Contents](#_top)

301.06.10 Royalties and Honoraria

(Eff. 10/01/05)

[POMS SI 00820.450](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500820450)

Royalties include compensation paid to the owner for the use of property, usually copyrighted material, (such as books, music or art) or natural resources (for example, minerals, oil, gravel, or timber). Royalty compensation may be expressed as a percentage of receipts from using the property or as an amount per unit produced.

To be considered royalties, payments for the use of natural resources also must be received:

* Under a formal or informal agreement whereby the owner authorizes another individual to manage and extract a product (such as timber or oil); and
* In an amount that is dependent on the amount of the product actually extracted.

An outright sale of natural resources by the owner of the land or by the owner of rights to use the land constitutes conversion of a resource. Proceeds from the conversion of a resource are not income.

Royalties are earned income when they are:

* Received as part of a trade or business; or
* Received by an individual in connection with any publication of his work (such as publication of a manuscript, magazine article or artwork).

An honorarium is an honorary or free gift, reward, or donation usually provided gratuitously for services rendered (such as guest speaker), for which no compensation can be collected by law. An honorarium may include a gift of lodging or payment of an individual's expenses.

For income purposes, payment received for a service as described above is earned income. Any other payment received in cash connected with the service is unearned income to the extent it exceeds the individual's expenses.

Absent evidence to the contrary, assume that the amount of any honorarium received is in consideration of the actual services provided by the individual.

301.06.11 Minister’s Gross Income

(Rev. 12/01/21)

A minister’s gross income includes:

* Salary;
* Pensions received from retirement pay;
* Fees and honoraria for officiating at weddings, christenings, funerals and other services in the exercise of the ministry;
* Value of meals when furnished as part of his compensation; and
* Travel and automobile allowances, although these same items will be deducted as business expenses if incurred in the performance of his duties.

A minister’s gross income does not include:

* Rental allowance for a parsonage or value of a parsonage furnished to him;
* Housing allowance to pay expenses in providing a home. Generally, those expenses include rent, mortgage interest, utilities, and other expenses directly relating to providing a home;
* Payments made by the Church into his/her retirement and/or pension;
* Parsonage or housing allowances when included in retirement pay after the minister retires, or any other retirement benefit received after retirement, and
* Any monetary gifts.

301.07 Earned Income Exclusions

(Eff. 10/01/05)

[POMS SI 00820.500](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500820500)

The source and amount of all earned income must be determined, but not all earned income counts when determining eligibility. First, income is excluded as authorized by other Federal laws. Then, exclusions are allowed in the following order:

* Earned income tax credit payments
* Up to $30 of earned income in a quarter, if it is infrequent or irregular
* Up to $400 per month, but not more than $1,620 in a calendar year, of the earned income of a blind or disabled child under 22 years of age who is attending school
* Earned income of disabled individuals used to pay impairment-related work expenses
* Earned income of blind individuals used to meet work expenses
* Any earned income used to fulfill an approved plan to achieve self-support

Earned income is never reduced below zero. Any unused earned income exclusion is never applied to unearned income. Any unused portion of a monthly exclusion cannot be carried over for use in subsequent months.

The $20 ($50 for ABD) general and $65 earned income exclusions are applied only once to a couple, even when both members (whether eligible or ineligible) have income, since the couple's earned income is combined in determining eligibility.

301.07.01 Blind Work Expenses (BWE)

**(Eff. 10/01/05)**

[POMS SI 00820.535](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500820535)

BWE represent any earned income of a blind person that is used to meet any expenses reasonably attributable to earning the income.

BWE are deducted from earned income if the blind person:

* Is under age 65; or
* Is age 65 or older; and
* Received SSI payments due to blindness (or received payments under a former State plan for aid to the blind) for the month before attaining age 65.

The BWE exclusion applies only to earned income. BWE in excess of the earned income an individual receives during the month are never deducted from unearned income.

The BWE exclusion is applied to earned income immediately after applying:

* Any portion of the general income exclusion which has not been deducted from unearned income; and
* All other earned income exclusion except the exclusion of income used to fulfill an approved Plan for Achieving Self-Support (PASS).

A blind individual can claim the amount withheld for Federal, State, and local income taxes even though other factors may affect his or her tax liability (for example, number of dependents or business loss).

Except for items listed in the table in 401.07.02, the cost of any work-related item paid by a blind person may be deducted as BWE, regardless of:

* Any non-work benefit that may be derived from the item; or
* The item's relationship to the person's blindness.

For Examples of items that may be deductible as BWE, refer to [POMS SI 00820.555](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500820555). For further discussion regarding this issue, refer to [POMS SI 00820.545B.1](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500820545).

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| **Example**  Ms. Denise Peters, a blind individual, works as a typist. A community organization bought her a special typewriter that she needed to perform satisfactorily on the job. The value of the typewriter is not income to Ms. Peters, nor is it deducted as a BWE since she did not pay for it. |

[Table of Contents](#_top)

301.07.02 Impairment-Related Work Expenses (IRWE)

**(Eff. 10/01/05)**

[POMS SI 00820.540](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500820540)

IRWE are expenses for items or services which are directly related to enabling a person with a disability to work and which are necessarily incurred by that individual because of a physical or mental impairment.

To determine countable earned income in both initial claims and post-eligibility situations, IRWE may be deducted regardless of whether an individual’s eligibility was previously established without considering IRWE.

A payment for a service or item is excludable as IRWE for SSI payment/eligibility purposes when:

* The individual:
  + Is disabled (but not blind); and
  + Is under age 65; or
  + Received SSI as a disabled individual (or received disability payments under a former State plan) for the month before attaining age 65; and
* The severity of the impairment requires the individual to purchase or rent items and services in order to work; and
* The expense is reasonable; and
* The cost is paid in cash (including checks or other forms of money such as money orders, credit and/or charge cards) by the individual and is not reimbursable from another source (such as Medicare or private insurance); and
* The payment is made in a month the individual receives earned income for a month in which he both worked and received the services or used the item; or
* The individual is working but makes a payment before the earned income is received.

(Refer to [POMS SI 00820.560B](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500820560) for instructions on deducting expenses paid while working. See [POMS SI 00820.560C](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500820560) for instructions on deducting expenses paid prior to work. For instructions on deducting expenses paid after work has stopped, see [POMS SI 00820.560D.](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500820560))

An expense may meet the criteria for an IRWE even if it also is used for daily activities other than work.

[Table of Contents](#_top)

1. **Application of Exclusion**

* The IRWE exclusion only applies to earned income. IRWE in excess of the earned income an individual receives during the month are never deducted from unearned income. (Refer to [POMS SI 00820.560](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500820560)  for allocating expenses.)
* The IRWE exclusion is applied to earned income in the sequence below:
  + Immediately after deducting:

– Any portion of the general income exclusion which has not been deducted from unearned income; and

– The $65 earned income exclusion; and

* + Immediately before deducting one-half of the remaining earned income.

1. **SGA Determinations**

* IRWE may be deducted from earned income when determining Substantial Gainful Activity (SGA) for initial Title II and Title XVI situations and in Title II, continuing eligibility situations. (Refer to [POMS DI 10520.001 ff.](https://secure.ssa.gov/apps10/poms.nsf/lnx/0410520001)  for SGA.)
* For concurrently eligible individuals, the amount deducted for SGA purposes must be the same for both Title II and Title XVI.
* The amount excluded in the SSI payment/eligibility computations may differ from the amount used to determine SGA due to the use of other exclusions. (Refer to [POMS SI 00820.545](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500820545)  for information on the interaction of IRWE and other provisions.)
* The same rules are applied for SGA purposes and SSI payment/eligibility purposes when determining:
  + Whether an item or service meets IRWE criteria; and
  + The value of the item or service.

| **DEDUCTIBLE WORK EXPENSES** | | | |
| --- | --- | --- | --- |
| **TYPE OF EXPENSE** | **DEDUCTIBLE AS** | | **DEDUCTIBLE AMOUNT** |
| **BWE** | **IRWE** |
| Attendant care services which are rendered in the:   * Home (w/certain limitations); * Process of assisting a person in making the trip to and from work; or * Work setting. | X | X | (Refer to [Appendix B](#Appendix_B) of this chapter.) |
| Drugs and medical services which are essential to enable the person to work (such as medication to control seizures) | X | X | The amount paid |
| Expendable medical supplies  (such as bandages, catheters, face masks) | X | X | The amount paid |
| Federal, State and local income taxes and Social Security taxes | X |  | The amount withheld--assume the amount withheld reflects the person’s tax liability. |
| Dog Guide | X | X | The costs of purchasing the dog ad all associated expenses (such as food, licenses, vet services) |
| Fees (for example, licenses, professional association dues, union dues) | X |  | The amount paid |
| Mandatory contributions (such as pensions and disability) | X |  | The actual amount of the mandatory contribution.  (For Example, mandatory pension contributions are considered reasonably attributable to earning income and therefore, deductible.)  Pension contributions are considered savings plans and are therefore, not deductible. |
| Meals consumed during work hours | X |  | The actual value of the meal whether bought during work hours or brought from home |
| Medical devices  (Such as, braces, inhalers, pacemakers, respirators, wheelchairs) | X | X | The cost of the item plus maintenance and repair of such items whether the person works at home or the employer’s place of business |
| Non-medical equipment/ services (for example, air cleaners, air conditioners, child care costs, humidifiers, portable room heaters, safety shoes, uniforms, tools) | X | \* | The cost of the item plus maintenance and repair of such item whether the person works at home or at the employer’s place of business.  \*To be deductible as an IRWE, the item or service must be impairment related. |
| Other work-related equipment (for example, job coaching fees, one handed typewriters, special tools designed to accommodate a person’s impairment, telecommunication devices for the deaf, typing aids) | X | X | The cost of the item plus maintenance and repair of such item whether the person works at home or at the employer’s place of business. |
| Physical therapy | X | X | The amount paid |
| Prosthesis | X | X | The cost of the item plus maintenance and repair of such item |
| Structural modifications to the person’s home to create a workspace or to allow the person to get to and from work | X | X | The cost of the modifications |
| Training to use impairment-related expense item or an item that is reasonably attributable to work (such as Braille, cane travel, computer program courses, grammar, use of one-handed typewriters, use of special equipment)  (Note: Training does not include general education courses. Such courses may be excluded under PASS.) | X | X | The cost of training plus travel expenses to and from training |
| Transportation to and from work | \*\* | X | \*\* To be deductible as a BWE:   1. In own vehicle: the applicable allowance or, if more advantageous, the standard mileage rate permitted by IRS for non-governmental business use 2. For other than in own vehicle:   the actual cost of the bus, car pool, cab fare |
| Vehicle modification | X | X |  |

|  |
| --- |
| **ITEMS NOT DEDUCTIBLE AS BWE OR IRWE** |
| * In-kind payments * Expenses deducted under other provisions (such as PASS) * Expenses which will be reimbursed * Life maintenance expenses, to include the following (Note: list is not all-inclusive):   + Meals consumed outside of work hours   + Self-care items, including items of cosmetic rather than work-related nature   + General educational development   + Savings plans (like Individual Retirement Accounts or voluntary pensions)   + Life and health insurance premiums * Items furnished by others that are needed in order to work (Note: The value of such items is not considered income.) * Expenses claimed on a self-employment tax return |

301.07.03 Earned Income Tax Credit (EITC) and Child Tax Credit (CTC) Payments Exclusions

(Eff. 10/01/05)

[POMS SI 00830.060](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830060)

The Earned Income Tax Credit (EITC) is a special tax credit that reduces the Federal tax liability of certain low-income working taxpayers. This tax credit may or may not result in a payment to the taxpayer. EITC payments can be received as an advance from an employer or as a refund from IRS.

Exclude from income any EITC payments either as an advance or as a refund.

The Child Tax Credit (CTC) is a special refundable Federal tax credit that is available to certain low-income taxpayers with earned income. They must be parents, stepparents, grandparents, or foster parents with a dependent child. This child tax credit may provide a refund to individuals even if they do not owe any tax.

301.07.04 Census Bureau Income

(Eff. 11/01/08)

All wages paid by the Census Bureau for temporary employment must be totally disregarded for individuals applying for or receiving Medicaid benefits. This disregard does not apply to individuals receiving Nursing Home or HCBS whose eligibility is determined using the 300% FBR income limit. Regardless of the category or income limit used to determine Medicaid eligibility, this income must be counted to calculate the recurring income for Nursing Home and HCBS.

301.08 Unearned Income

**(Eff. 10/01/05)**

[POMS SI 00830.001](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830001) and [POMS SI 00830.010](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830010)

Unearned income is all income that is not earned income. Unearned income is counted as income in the earliest month it is:

* Received by the individual;
* Credited to the individual's account; or
* Set aside for the individual's use.

Retroactive Social Security benefits, whether paid in one lump sum or by installment, are counted as unearned income in the month payment is received, except in the following instances:

* Retroactive Retirement, Survivors, and Disability Insurance (RSDI) benefits must be paid in installments when paid to representative payees of individuals who are eligible because of drug addiction or alcoholism (DAA). The total of retroactive RSDI benefits paid in installments is treated as if paid in a lump sum in the usual manner. The total of such benefits paid in installments is considered unearned income in the month in which the first installment is made.
* RSDI benefits paid for a month for which an individual received an SSI payment (such as an offset month) are considered income in the month regularly due, not when received.
* In certain situations, SSA will agree at the beneficiary's request to pay by installment retroactive RSDI benefits that would otherwise be paid in one lump sum. In such cases, the total of retroactive RSDI benefits (except for amounts considered paid in a windfall offset) is counted as unearned income in the month such benefits were set aside for the individual's use.

301.08.01 Unearned Income Exclusions

(Eff. 10/01/05)

[POMS SI 00830.050](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830050)

An exclusion is an amount of income that does not count in determining eligibility and payment amount.

301.08.02 Expenses of Obtaining Income

(Eff. 10/01/05)

[POMS SI 00830.100](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830100)

An expense is one that is an essential factor in obtaining a particular payment(s). Unearned income does not include that part of a payment that is for an essential expense incurred in getting the payment.

For Example:

* From a payment received for damages in connection with an accident, subtract legal, medical, and other expenses connected with the accident.
* From a retroactive check from a benefit program other than SSI, subtract legal fees connected with that claim.

The following fees are considered essential to obtaining income and are allowed as deductions:

* **Document Fees** - A fee to acquire documentation to establish that an individual has a right to certain income (such as a fee for a birth certificate or medical examination) is an essential expense.
* **Guardianship Fees** - A guardianship fee is an essential expense only if the presence of a guardian is a requirement for receiving the income.

301.08.03 Overpayment Involved - Income Counting

(Eff. 10/01/05)

[POMS SI 00830.110](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830110)

Unearned income includes that part of another benefit payment (such as RSDI) that has been withheld to recover a previous overpayment.

The amount withheld is not income when the payment is received if:

* The individual received both SSI and the other benefit at the time the overpayment of the other benefit occurred; and
* The overpaid amount was included in figuring the SSI payment at that time.

This policy applies to the following benefits:

* + - * Annuities and pensions
* Retirement or disability benefits (including veteran’s pensions and compensation)
* Workers' Compensation
* Social Security benefits
* Railroad retirement annuities
* Unemployment insurance benefits
* Black Lung benefits

Overpayment means “overpayment as defined by the entity paying the benefit” and includes overpayments made to someone other than the individual whose benefits are withheld.

301.08.04 Garnishment or Other Withholding

(Eff. 10/01/05)

[POMS SI 00830.115](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830115)

Unearned income includes amounts withheld from unearned income because of a garnishment or to make certain other payments (such as payment of Medicare premiums).

Unearned income includes amounts withheld from unearned income whether the withholding is:

* Purely voluntary
* To repay a debt; or
* To meet a legal obligation.

This policy does not apply to amounts withheld to pay the expenses of obtaining the income since such amounts are not income.

| Some items for which amounts may be withheld but considered received are: | |
| --- | --- |
| Federal, State, or Local Income Taxes | Health or Life Insurance Premiums |
| Supplementary Medical Insurance (SMI – Medicare Part B) | Union Dues |
| Loan Payments | Garnishments |
| Child Support | Bank Service Charges |
| Inheritance Taxes | Guardianship Fees, if presence of a guardian is not a requirement for receiving the income |

[Table of Contents](#_top)

301.08.05 Medicare Buy-In

(Eff. 02/01/06)

Medicaid pays the Medicare Part B Premium for every person who is both Medicare and Medicaid eligible. The Social Security Administration assumes responsibility for determining and establishing Buy-In Part B coverage for Supplemental Security Income (SSI) eligibles. Buy-In coverage for non-SSI eligibles is established through a combined automated and manual process.

301.08.06 Verification and Documentation of Unearned Income

(Eff. 11/01/22)

Any electronic data source which does not keep history in Cúram-CGIS must be uploaded into OnBase.

An eligibility specialist must use the Documentation Template to document any collateral calls used to verify unearned income. Eligibility specialists must confirm the amount received, any deductions (including taxes), if the payment is a lifetime benefit, or if the person will receive an annual Cost-of-Living Adjustment. The eligibility specialist must request written documentation of the information verified during the call. It is not necessary to wait for the written documentation to return. Continue processing the case using the information obtained during the collateral call.

301.09 Sources and Treatment of Unearned Income

(Eff. 02/01/06)

The following sections list different sources of unearned income and how they are treated in the eligibility process.

301.09.01 Annuities, Pensions, Retirement, or Disability Payments

(Eff. 02/01/06)

[POMS SI 00830.160](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830160)

An annuity is 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.

Pensions and retirement benefits are payments to a worker following his retirement from employment. These payments may be paid directly by a former employer, by a trust fund, an insurance company, or other entity.

Disability benefits are payments made because of injury or other disability.

Annuities, pensions, retirement benefits, and disability benefits are counted as unearned income.

301.09.02 Title II/Retirement, Survivors and Disability Insurance (RSDI) Benefits

(Rev. 11/01/22)

[POMS SI 00830.210](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830210)

Retirement, Survivors, and Disability Insurance (RSDI) monthly benefits are counted as unearned income.

The amount of Title II is based on the following factors:

* Reductions, deductions, and dollar rounding, but before the collection of any obligations of the beneficiary (such as Supplementary Medical Insurance-SMI premium or prior overpayment) is counted as unearned income.
* If a monthly benefit payment has been reduced because of a Workers' Compensation offset, the net amount of the benefit received (plus any SMI premium withheld) is counted as unearned income.
* If all or part of a Title II benefit is being withheld to recover an overpayment, the amount of Title II before deduction for the overpayment is counted as unearned income.
* If the overpayment occurred when the individual was receiving SSI and the overpaid amount was included in unearned income at that time, the amount deducted for an overpayment is not counted in calculating chargeable Title II income.
* Money received because of a waiver approval when the money was previously withheld to recover a Title II overpayment and was included as Title XVI income when originally withheld is not counted as income.
* The amount of premiums deducted from RSDI benefits for SMI under Medicare is unearned income. Refunded SMI premiums are not counted as income.
* If a monthly Title II benefit payment has been reduced because of a garnishment, the gross amount of the benefit received (plus any SMI premium withheld) is counted as unearned income.

|  |
| --- |
| **Procedure**  Social Security Title II benefits can be verified by the following:   * BENDEX   + Use the “net monthly benefits payable” (MBC) amount as the gross amount.   + Drop or round down any cents shown in the net amount.   + Do not use the Gross Amount Payable (MBA) field * Person Composite Service (PCS)   + Use the “net” amount as the gross countable benefit.   + Drop or round down any cents listed in the net amount.   + Typically, the “net” amount and “gross” amount in PCS are consistent.     - If the “gross” amount is not consistent with the “net” amount, the user must determine if this lump sum is a one-time retroactive SSA payment or a reimbursement of Medicare premiums.       * Retroactive SSA lump sums appear as an increase in the “gross” amount in Person Composite Service (PCS).       * SSA lump sums are generally countable income in the month received         + Reimbursements for Medicare premiums are not countable income.       * If the “gross” amount in Person Composite Service (PCS) is less than the “net” amount, there may be an overpayment or garnishment being deducted from the benefit.         + These deductions from the income are not allowed deductions from the countable gross income budgeted, therefore, the “net” amount in Person Composite Service (PCS) is used. * SVES   + Use the “net monthly benefits payable” (MBC) amount as the gross amount.   + Drop or round down any cents shown in the net amount.   + Do not use the Gross Amount Payable (MBA) field. * Award letter from the Social Security Administration (if on file, current, or electronic data sources are not available) * Written verification from Social Security (Third Party Query – TPQY) (if on file, current, or electronic data sources are not available)   **Note**  Any electronic data source where the history is not kept in Cúram-CGIS must be uploaded to OnBase. (For example, PCS) |

[Table of Contents](#_top)

301.09.02A Suspended SSA Income

(Eff. 09/01/23)

When SSA benefits are suspended, the income is countable unless a valid reason for the suspension can be determined. The applicant/beneficiary must contact the Social Security Administration (SSA) to have the benefits continued for SSA and SSI income. For example, if the reason is “whereabouts unknown”, the income is countable beginning the month of application. Since the income is being counted monthly, **do not** count the lump sum in the month the beneficiary receives it. Continue to count the initial income unless there is a change in the actual monthly income amount.

A valid reason for suspended income is something outside of the applicant’s/ beneficiary’s control that cannot be cured. For example, the Social Security Administration has provided a letter indicating that SSA or SSI benefits will not be re-instated or will not be reinstated until a specific date. The suspended payments are countable in the month they are reinstated. If the beneficiary will receive a lump sum payment for the missing payments once the benefits are reinstated, see MPPM 301.08 Unearned Income.

301.09.03 Black Lung Benefits

(Eff. 02/01/06)

[POMS SI 00830.215](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830215)

Black Lung (BL) benefits are paid to miners and their survivors under the provisions of the Federal Mine Safety and Health Act (FMSHA). BL benefit payments are counted as unearned income.

The Social Security Administration (SSA) pays benefits under Part B of the FMSHA and the Department of Labor (DOL) pays benefits under Part C of the FMSHA.

In general, Part B benefits are paid on the third of the month while Part C benefits are paid on the fifteenth of the month. Both Part B and Part C BL benefits are subject to offsets (like Workers' Compensation) and can be reduced due to the recovery of an overpayment. In addition, Part C benefits may be reduced because of liens imposed by other Federal agencies such as the Internal Revenue Service (IRS). The amount deducted from a Part C BL benefit because of garnishment (such as liens imposed by other Federal agencies) is counted as unearned income.

|  |
| --- |
| **Procedure:**  Black Lung benefits can be verified by the applicant/beneficiary’s award letter or by contacting the US Department of Labor.  US Department of Labor Employment Standards Administration  Division of Coal Mine Workers' Compensation 500 Springdale Plaza; Spring Street Mount Sterling, Kentucky 40353  Telephone: 606-498-9776 Toll-Free: 1-800-366-4628 |

301.09.04 Civil Service and Federal Employee Retirement System Payments

(Eff. 02/01/06)

[POMS SI 00830.220](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830220)

The Office of Personnel Management (OPM) makes US Civil Service and Federal Employee Retirement System (FERS) payments because of disability, retirement, or death.

US Civil Service and FERS payments are counted as unearned income to the entitled retiree or individual survivor. Certain disability benefits paid within the first six (6) months after an employee last worked are earned income.

Retired Health Benefit (RHB) payments to annuitants are not counted as income. OPM provides annuitants under the Retired Health Benefits (RHB) program free coverage under Part B of Medicare. At the employee's option, the Part B premium may instead be paid to another health insurance plan or paid directly to the annuitant for use in purchasing health insurance coverage privately. All annuitants covered by the RHB program retired before 07/01/60.

If the individual has no acceptable documents, the eligibility worker should write or telephone OPM. Provide the individual's name and civil service annuity claim identification number (a seven‑digit number with a "CSA" or "CSF" prefix). If the claim number is not available, provide the individual's date of birth and Social Security Number.

The OPM telephone number is (724) 794-2005 or, toll-free, (888) 767-6738. Direct written inquiries to:

Office of Personnel Management

Retirement Operations Center  
Post Office Box 45  
Boyers, PA 16017

[Table of Contents](#_top)

301.09.05 Railroad Retirement Payments

(Rev. 12/01/22)

[POMS SI 00830.225](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830225)

Listed below are the three basic categories of payments made by the Railroad Retirement Board (RRB)

1. **Life and Survivor Annuities**
   * Life annuities for retirement and disability are paid under the Railroad Retirement (RR) Act to the railroad employee and his spouse. Children of a living annuitant are not entitled to benefits.
   * Survivor annuities are payable to widows, widowers, children, and dependent parents of railroad employees. A small number of widows receive two annuities, a regular widow's check and a check payable to them as designated survivors of retired railroad employees who elected to receive reduced benefits during their lifetimes.
   * RR annuity payments are similar to Title II benefits in that a check for one month is paid the next month. Also, Cost of Living Adjustments (COLA) for RR annuities are effective the same month as Title II COLAs.

**Social Security Benefits Certified by RRB**

* + SSA may authorize the payment of Social Security benefits for RR employees to RRB instead of directly to Treasury. Although RRB in these situations has responsibility for certifying Title II benefits to Treasury, they remain Title II benefits.
  + RR annuity payments and Social Security benefits certified by RRB may be paid as a single check.

**Unemployment, Sickness, and Strike Benefits**

* Unemployment, sickness, and strike benefits are computed on a daily basis with each check covering a period of up to 2 weeks. These claims are usually filed through the railroad employer or directly with RRB in Chicago.

Payments made by the RRB are counted as unearned income. Include the amount deducted from a RR benefit for Supplemental Medical Insurance (SMI) premiums. The amount of the RR annuity to charge as income is the amount before the collection of any obligations of the annuitant.

Verification of Life and Survivor Annuities and Social Security Benefits Certified by RRB may be verified by writing to the local Railroad Retirement Board at:

US Railroad Retirement Board

Quorum Business Park

7508 E. Independence Blvd.; Suite 120

Charlotte, NC 28227-9409

Phone: 877-772-5772

Fax: 704-344-6429

Obtain evidence of unemployment, sickness, and strike benefits from the individual's own records, such as an award letter or actual check. If this evidence is unavailable, contact RRB Headquarters in Chicago at:

Railroad Retirement Board

844 Rush Street

Chicago, IL 60611

|  |
| --- |
| **Note:** Local RRB offices do not maintain this information. |

301.09.06 Unemployment Insurance Benefits

(Eff. 02/01/06)

[POMS SI 00830.230](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830230)

Unemployment insurance benefits, also known as Unemployment Compensation, means payments received under a State or Federal unemployment law and additional amounts paid by unions or employers as unemployment benefits.

Unemployment insurance benefits are counted as unearned income.

301.09.07 Workers' Compensation

(Eff. 02/01/06)

[POMS SI 00830.235](http://policy.ssa.gov/poms.nsf/lnx/0500830235!opendocument)

Workers' Compensation (WC) payments are awarded to an injured employee or his survivor(s) under Federal and State WC laws, such as the Longshoremen and Harbor Workers' Compensation Act. A Federal or State agency, an insurance company, or an employer may make the payments.

* The WC payment less any expenses incurred in getting the payment is counted as unearned income.
* Any portion of a WC payment or award that the authorizing or paying agency designates for medical expenses or a legal or other expense attributable to obtaining the WC award is not income. The expenses may be past, current, or future. The WC payments designated for such expenses may be received in a lump sum or as a continuing payment.
* If an individual alleges having incurred expenses that exceed amounts designated for expenses, or for which no amount was designated, the normal rules pertaining to the expenses of obtaining income apply.

[Table of Contents](#_top)

301.09.08 Military Pensions

(Eff. 02/01/06)

[POMS SI 00830.240](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830240)

The Air Force, Army, Marine Corps, and Navy pay military pensions to military retirees and survivors normally on the first day of the month.

There are three categories of beneficiaries who may be entitled to military payments:

* RETIREE ‑ A person with 20 years of service who meets the requirements for entitlement
* ANNUITANT ‑ A survivor who is designated by the retiree to receive benefits upon the death of the retiree under the Retired Serviceman's Family Protection Plan (RSFPP), Survivor's Benefit Plan (SBP), or both
* ALLOTTEE ‑ Anyone other than an annuitant of the RSFPP or SBP who is designated to receive money out of the service member's or retiree's check. Entitlement as an allottee terminates upon the death of the retiree. However, an allottee can become an annuitant when the retiree dies.

The RSFPP and SBP annuitant programs pay money to surviving spouse(s) and children.

The SBP program also pays:

* "Insurable interest" persons (that is, someone other than a surviving spouse or child that a service member designated to receive survivor benefits based on monies withheld from his or her retirement payment under the provisions of the SBP program); and,
* Minimum Income level Widows (MIW) who are certified by the VA as having low income and are referred by the Department of Defense (DOD).

Military pensions are counted as unearned income. However, payments to MIWs are counted as income based on need not subject to the $20 general income exclusion.

If the individual does not have sufficient evidence, the appropriate Military Finance Center should be contacted. The following is a listing of the mailing address for each Military Finance Center.

| **Military Service Branch** | **Military Finance Center Mailing Addresses** |
| --- | --- |
| ARMY | Director, Retired Operations  Indianapolis, IN 46249  ATTN: Management Support Office  Parallel FO: 455 |
| NAVY | Defense Finance Accounting Service  Code 305  Finance Center; Anthony J. Celebrezze Building  Cleveland, OH 44199  Parallel FO: 388 |
| AIR FORCE | DFAF/DE/CIDM  Denver, CO 80279 ‑ 5000  Parallel FO: D24 |
| MARINE CORPS | Marine Corps Finance Center  1500 E. Bannister Street  Kansas City, MO 64197  Parallel FO: 736 |

[Table of Contents](#_top)

301.09.09 Department of Veterans Affairs Payments

(Rev. 11/01/12)

[POMS SI 00830.300ff](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830300)

The Department of Veterans Affairs (VA) has numerous programs that make payments to beneficiaries and their families. Treatment of those VA payments depends on the nature of the payments. The most common types of VA payments are:

* Pension
* Compensation
* Educational Assistance
* Aid and Attendance Allowance
* Housebound Allowance
* Clothing Allowance
* Payment Adjustment for Unusual Medical Expenses
* Payments to Vietnam Veterans' Children with Spina Bifida
* Insurance Payments
* Dependency and Indemnity Compensation (DIC)

Verification of various payment and benefits may be requested by contacting the regional benefits office at:

Department of Veterans Affairs

Columbia Regional Office

6437 Garners Ferry Road   
Columbia SC 29209  
Phone: 1-800-827-1000

301.09.09-A Pension Payments

(Eff. 02/01/06)

[POMS SI 00830.302](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830302)

Pension payments are based on a combination of service and a non service-connected disability or death. With a few rare exceptions noted below, VA pension payments are also based on need.

1. **Payments for Dependents**

VA may consider dependents’ needs in determining a pension. However, normally VA will not make a pension payment directly to a dependent during the lifetime of the veteran. Instead, the amount of the veteran's basic pension is increased if the veteran has dependents.

A VA pension payment that has been increased for dependents is an augmented VA payment. A VA pension payment made directly to the dependent of a living veteran is an apportioned payment.

1. **Frequency**

Pension payments are usually paid monthly; however, when the monthly payment due is less than $19, VA will pay quarterly, bi-annually or annually. VA may also make an extra payment if an underpayment is due.

1. **Unusual Medical Expenses**

When computing some needs-based pension payments, VA deducts unusual medical expenses from any countable income. This computation may result in an increase in a pension payment or in an extra payment. An increase or extra payment resulting from this computation is not income.

All VA pension payments except those listed below are Federally funded income based on need. As such, these payments are counted as unearned income to which the $20 general income exclusion does not apply.

**Exceptions:**

* VA Aid and Attendance and Housebound Allowances are not income. All or part of a VA pension may be subject to this rule.
* VA payments resulting from unusual medical expenses are not income. All or part of a VA pension payment may be subject to this rule.
* Certain pensions paid to veterans or their dependents are not needs based. These pensions are unearned income and the $20 general income exclusion applies. This exception applies to pensions paid on the basis of:
* A Medal of Honor, or
* A special act of Congress.

Assume that a VA pension is partly or entirely needs based unless there is evidence to the contrary.

[[Table of Contents](#_top)](#_top)

301.09.09-B Compensation Payments

(Eff. 02/01/06)

[POMS SI 00830.304](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830304)

Compensation payments are based on service‑connected disability or death and may be based on need. The following chart describes types of compensation payments and their treatment.

| **TYPE** | **TREATMENT** |
| --- | --- |
| Compensation payments to a surviving parent of a veteran | Counted as unearned income to which the $20 general income exclusion does not apply |
| Compensation payments resulting from unusual medical expenses, aid and attendance allowances, and housebound allowances | Not counted as income |
| Compensation payments to a veteran, spouse, child, or widow(er) | Counted as unearned income subject to the $20 general income exclusion |

VA may consider dependents’ needs in determining a compensation payment. Compensation payments may be paid directly to dependent parents on the basis of a service-connected death. A VA compensation payment that has been increased for dependents is an augmented VA payment. A VA compensation payment made directly to the dependent of a living veteran is an apportioned payment.

Apportionment is direct payment of VA benefits to a dependent. VA decides whether and how much to pay by apportionment on a case-by-case basis. Apportionment reduces the amount of the augmented benefit payable to the veteran or surviving spouse.

An augmented benefit is a benefit that is increased, or which has higher income eligibility limits, because of a dependent. An augmented VA benefit, which includes a designated beneficiary's portion and a dependent's portion, usually is issued as a single payment to the veteran or the veteran's surviving spouse.

301.09.09-C VA Educational Benefits

(Rev. 04/01/10)

[POMS SI 00830.306](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830306)

VA provides educational assistance under a number of different programs including vocational rehabilitation. The SSI income and resource policies that apply depend on the nature of the VA program.

The following are not considered in determining income:

* Vocational Rehabilitation – Payments made as part of a VA program of vocational rehabilitation are not income. This includes any augmentation for dependents.
* Withdrawal of Contributions – Any portion of a VA educational benefit that is a withdrawal of the veteran’s own contribution is conversion of a resource and is not income.

VA educational benefits other than those above, such as a stipend for housing, are unearned income. However, any portion of a grant, scholarship, or fellowship used for paying tuition, fees, or other necessary educational expenses is not counted as income.

301.09.09-D VA Aid and Attendance and Housebound Allowances

(Eff. 01/01/07)

[POMS SI 00830.308](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830308)

VA pays an allowance to veterans, spouses of disabled veterans, and surviving spouses who are in regular need of the aid and attendance of another person or who are housebound. This allowance is combined with the individual's pension or compensation payment.

VA Aid and Attendance and housebound allowances are not counted as income.

If a veteran without a spouse or child or a surviving spouse without a child is covered by a Medicaid plan for services furnished him by a nursing facility, the maximum pension that can be paid to or for the veteran or surviving spouse for any month after the month of admission to such nursing facility is $90. This reduced pension is an Aid and Attendance Allowance in all cases, and not income.For institutionalized individuals, this income is not counted in the eligibility or post eligibility steps, and he/she receives the $30 personal needs allowance.

[Table of Contents](#_top)

301.09.09-E VA Clothing Allowance

(Eff. 02/01/06)

[POMS SI 00830.310](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830310)

A lump sum clothing allowance is payable in August of each year to a veteran with a service-connected disability for which a prosthetic or orthopedic appliance (including a wheelchair) is used. The allowance is intended to help defray the increased cost of clothing due to wear and tear caused by the use of such appliances.

A VA clothing allowance is not counted as income.

301.09.09-F VA Payment Adjustment for Unusual Medical Expenses

(Eff. 02/01/06)

[POMS SI 00830.312](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830312)

VA considers unusual medical expenses when determining some needs-based pension and compensation payments. Expenses that exceed five percent (5%) of the maximum annual VA payment rate are considered unusual. The amount of the unusual medical expenses is deducted from countable income when computing the VA payment. As a result, the veteran, survivor, or dependent may receive a higher monthly VA payment, an extra payment, or an increase in an extra payment.

VA payments resulting from unusual medical expenses are not counted as income.

Any unspent VA payments resulting from unusual medical expenses are resources if retained into the calendar month following the month of receipt.

301.09.09-G Payments to Vietnam Veterans' Children with Spina Bifida

(Eff. 02/01/06)

[POMS SI 00830.318](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830318)

Beginning October 1, 1997, VA makes monthly payments to eligible children with spina bifida at one of three payment levels ($200, $700, or $1,200 in 1997 and $205, $715, or $1,226 in 1998), based on the degree of disability suffered by the child, as determined by VA. The payment levels will be subject to future adjustment by VA for cost-of-living increases.

VA payments made to or on behalf of certain Vietnam veterans' natural children regardless of their age or marital status, for any disability resulting from spina bifida suffered by such children, are not counted as income or resources. Interest earned on unspent payments is counted.

|  |
| --- |
| **Note**  While individuals receiving these payments are children of veterans, many would not meet the definition of "child" for SSI. They may be SSI applicants/beneficiaries and/or have spouses or children who are SSI applicants/beneficiaries. |

301.09.09-H Dependency and Indemnity Compensation (DIC)

(Eff. 11/01/12)

[POMS SI 00830.304](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830304)

Dependency & Indemnity Compensation (DIC) is a month benefit paid to eligible survivors of a:

* Military Service member who died while on active duty, active duty for training, or inactive duty for training OR
* Veteran whose death resulted from a service-related injury or disease, OR
* Veteran whose death resulted from a non-service-related injury or disease, and was receiving, or was entitled to received VA Compensation for service-connected disability that was rated as totally disabling
  + For at least 10 years immediately before death OR
  + Since the veteran’s release from active duty and for at least five years immediately preceding death, OR
  + For at least one year before death if the veteran was a former prisoner of ward who died after September 30, 1999

If the Military service member or veteran were living and receiving benefits, he/she would have been eligible for Aid and Attendance.

An eligible surviving spouse may receive an increased benefit if housebound or in need of Aid and Attendance.

DIC payments are not counted as income.

301.09.10 Temporary Assistance For Needy Families (TANF)

(Eff. 02/01/06)

[POMS SI 00830.403](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830403)

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 replaced Title IV-A of the Social Security Act (SSACT), which provided for Aid to Families with Dependent Children (AFDC) with cash block grants to States for Temporary Assistance for Needy Families (TANF). This legislation ended the Federal entitlement of individuals to cash assistance under Title IV-A, giving states flexibility to determine eligibility criteria and set benefit amounts.

TANF is provided under a program which:

* Uses income as a factor of eligibility, and
* Is funded by both the State and the Federal Government.

TANF payments are made to a family unit and are not counted as income.

[Table of Contents](#_top)

301.09.11 Support Payments - Spousal Support, Alimony

(Eff. 02/01/06)

[POMS SI 00830.418](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830418)

Alimony and support payments are cash contributions to meet some or all of a person's needs for food, clothing, or shelter. Support payments may be made voluntarily or because of a court order. Alimony (sometimes called "maintenance") is an allowance made by a court from the funds of one spouse to the other spouse in connection with a suit for separation or divorce.

Alimony, spousal, and other adult support payments are counted as unearned income.

301.09.12 Support Payments - Child Support

(Eff. 02/01/06)

[POMS SI 00830.420](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830420)

Child support payments are unearned income; exclude one-third of the amount (not the $50 child support disregard) of a payment made to or for an eligible child by an absent parent. This exclusion does not apply when determining the income of ineligible children in a deeming computation.

Child support payments (including arrearages) received by a parent after a child becomes an adult are income to the child regardless of whether or not the child lives with the parent or receives the money from the parent.

[Table of Contents](#_top)

301.09.13 Dividends and Interest

(Eff. 12/01/05)

[POMS SI 00830.500](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830500)

Dividends and interest are returns on capital investments such as stocks, bonds, or savings accounts.

Dividends and interest are unearned income in the earliest month they are:

* Credited to an individual's account and are available for use;
* Set aside for the individual's use; or
* Received by the individual.

Account service fees or penalties for early withdrawal do not reduce the amount of interest or dividend income.

The following chart indicates when dividends or interest are considered income or excluded income.

| When the source of the dividend or interest is... | Under | Then... |
| --- | --- | --- |
| A countable resource | MPPM 302.26 | The dividends or interest are excluded income. |
| An excluded resource | A Federal statute other than §1613(a) of the Social Security Act ([SI 01130.050](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130050)) | The dividends or interest are excluded income. |
| An excluded resource | §1613(a) of the Social Security Act ([SI 01130.050](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130050)) | Refer to the MPPM section related to the resource exclusion for treatment of interest or dividends. Refer to the table below |

| **Excluded resources under §1613(a) of the Social Security Act** | **MPPM SECTION** |
| --- | --- |
| Advance Earned Income Tax Credit Payments | 302.23.09D |
| Automobile | 302.16 |
| Burial Funds/Burial Spaces | 302.19 |
| Child Tax Credits | 302.23.09D |
| Commingled Funds | 302.25 |
| Dedicated Financial Institution Accounts | 302.23.02 |
| Disaster Assistance | 302.23.04 |
| Earned Income Tax Credits | 302.23.09D |
| Grants, Scholarships, Fellowships, and Gifts | 301.09.40 |
| Home | 302.14.01 |
| Home Replacement Funds | 302.14.02 |
| Life Insurance | 302.17 |
| Prepaid Burial Contracts | 302.20 |
| Property Essential to Self-Support | 302.21 |
| Real Property, Undue Hardship | 302.14.04 |
| Relocation Assistance | 302.23.09C |
| Repair/Replacement of Lost, Damaged or Stolen Resources | 302.23.03 |
| Replacement of Excluded Resources | 302.23.03 |
| Retroactive Payments (Title II and Title XVI) | 302.23.01 |
| Victims' Compensation | 302.23.09B |

[Table of Contents](#_top)

301.09.14 Interest and Appreciation in Value of Excluded Burial Funds and Burial Space Purchase Agreements

**(Eff. 02/01/06)**

[POMS SI 00830.501](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830501)

Interest earned on agreements representing the purchase of an excluded burial space as well as any appreciation in value is not counted as income (and resources), if left to accumulate.

301.09.15 Rental Income

**(Eff. 02/01/06)**

[POMS SI 00830.505](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830505)

Rent is a payment that an individual receives for the use of real or personal property, such as land, housing, or machinery. Rent is income for the holder of a Life Estate, not for the Remainderman.

Net rental income is gross rent less the ordinary and necessary expenses paid in the same taxable year.

Ordinary and necessary expenses are those necessary for the production or collection of rental income. In general, these expenses include:

* Interest on debts
* State and local taxes on real and personal property and on motor fuel
* General sales taxes
* Expenses of managing or maintaining property

However, the following expenses are not allowed as deductible:

* Principal portion of a mortgage payment
* Capital expenditures – an expense for an addition or increase in the value of property which is subject to depreciation for income tax purposes (such as new roof, replace central heating and air unit)
* Depreciation or depletion of property

Expenses are deducted when paid, not when incurred.

Net rental income is counted as unearned income unless it is earned income from self-employment (that is, someone who is in the business of renting properties).

Rental deposits are not counted as income to the landlord while subject to return to the tenant. Rental deposits used to pay rental expenses become income to the landlord at the point of use.

If the property is jointly owned, apportion the income equally among the owners.

301.09.16 Awards

**(Eff. 02/01/06)**

[POMS SI 00830.515](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830515)

An award is something received as the result of a decision by a court, board of arbitration, or the like. It is counted as unearned income subject to the general rules pertaining to income and income exclusions.

301.09.17 Gifts

**(Eff. 02/01/06)**

[POMS SI 00830.520](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830520)

A gift is something a person receives that is not repayment for goods or a service provided, and is not given because of a legal obligation on the givers' part. To be a gift, something must be given irrevocably (that is, the donor relinquishes all control.) “Donations" and “contributions" may meet the definition of a gift, if they are given irrevocably.

A gift is counted as unearned income subject to the general rules pertaining to income and income exclusions.

[Table of Contents](#_top)

301.09.18 Gifts of Domestic Travel Tickets

**(Eff. 02/01/06)**

[POMS SI 00830.521](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830521)

Domestic travel is travel in or between the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

The value of a ticket for domestic travel received by an individual, or his or her spouse, or parent whose income is subject to deeming is not counted as income if:

* The ticket is received as a gift; and
* The ticket is not converted to cash (that is, cashed in or sold)

A ticket received as a gift is treated as unearned income in the month the ticket was converted to cash.

301.09.19 Prizes

(Eff. 02/01/06)

[POMS SI 00830.525](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830525)

A prize is generally something won in a contest, lottery, or game of chance. A prize is counted as unearned income subject to the general rules pertaining to income and income exclusions.

Do not subtract gambling losses from gambling winnings in determining an individual's countable income.

If an individual is offered a choice between an in-kind prize and cash, the cash offered is counted as unearned income. This is true even if the individual chooses the in-kind item and regardless of the value, if any, of the in-kind item.

301.09.20 Work-Related Unearned Income

(Eff. 02/01/06)

[POMS SI 00830.530](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830530)

The following work-related payments are counted as unearned income:

* Certain in-kind items provided as remuneration for employment
* Money paid to a resident of a public institution when no employer/employee relationship exists
* Tips under $20 per month
* Jury fees (that is, fees paid for services, not expense money)
* Food, clothing, and shelter provided to members of the Uniformed Services and their families, cash allowances for these items, and most types of special and incentive pay

301.09.21 Uniformed Services - Pay and Allowances

(Eff. 02/01/06)

[POMS SI 00830.540ff](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830540)

Compensation to most members of the Uniformed Services takes the form of both earned and unearned income, and often of both cash and in-kind income.

The Uniformed Services are defined by law and include the:

* Army
* Navy
* Air Force
* Marine Corps
* Coast Guard
* Reserve and National Guard components of the above
* Public Health Service Commissioned Officer Corps
* National Oceanic and Atmospheric Administration Commissioned Officer Corps

Entitlements are pay, allowances, and other cash benefits due a service member. Entitlements can include basic pay, special and incentive pay, allowances, advance pay, and reimbursements for certain work-related expenses. In-kind benefits are not considered entitlements.

Basic (or base) pay is the service member's wage. It is based solely on the member's pay grade and length of service. Basic pay is subject to FICA tax as well as income tax.

Allowances are cash benefits that compensate the service member, at least in part, for the expenses of housing, food, clothing, and special situations during periods of active duty service. Allowances are not paid for weekend drills of Reserve and National Guard components.

Only basic pay constitutes wages (earned income). All special pay and allowances, except hostile fire pay, are chargeable unearned income to the service member.

Hostile fire pay is not counted as income. Any unspent hostile fire pay becomes a resource if retained into the following month and not otherwise excluded.

A quarters (housing) allowance is not income if:

* The service member lives in free on-base housing, and
* The allowance is paid and deducted in the same pay period.

The following chart is a list of National Pay and Finance Centers.

| **SERVICE**  **BRANCH** | **FACILITY ADDRESS** | **PARALLEL**  **FIELD OFFICE** |
| --- | --- | --- |
| Air Force | Documentation Branch  Directorate of Resource Management  Building 444  HQ Air Force Accounting and Finance  Denver, CO 80279 | Aurora, CO B.O.  (D24) |
| Army | USAFAC, CMDR  Social Security Sections  Centralized Pay Operations  Fort Benjamin Harrison  Indianapolis, IN 46249‑0865 | Indianapolis, IN  D.O. (455) |
| Coast Guard | Commandant  US Coast Guard  Washington, DC 20593 | Washington  (M Street), DC  D.O. (270) |
| Marine Corps | Centralized Pay Division  Marine Corps Finance Center  1500 East Bannister Road  Kansas City, MO 64197 | Kansas City  (South), MO D.O.  (736) |
| National Guard for South Carolina. (If needed for another state, refer to POMS [RS 01404.315](http://policy.ssa.gov/poms.nsf/lnx/0301404315!opendocument).) | The Rembert C. Dennis Bldg. 1000 Assembly St. Columbia, SC 29201 | Strom Thurmond Federal Bldg. 1835 Assembly St. Columbia, SC 29202 |
| National Oceanic and Atmospheric Administration | Commissioned Personnel Division - NCI  Rockwall Building, Room 115  Department of Commerce, NOAA  Rockville, MD 20852 | Rockville, MD B.O. (A33) |
| Navy | Navy Finance Center  Anthony J. Celebrezze Building  Cleveland, OH 44199 | Cleveland  (Downtown), OH  D.O. (388) |
| Public Health Service | US Public Health Service  Employment Operations Ranch  Commissioned Personnel Div.  Park Lawn Bldg., Room 4‑35  5600 Fishers Lane  Rockville, MD 20852 | Rockville, MD B.O. - (A33) |

[Table of Contents](#_top)

301.09.22 Sick Pay as Unearned Income

(Eff. 02/01/06)

[POMS SI 00830.543](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830543)

Any payments because of sickness and accident disability paid more than six (6) months after work stopped because of that sickness or disability are unearned income.

301.09.23 Death Benefits

(Eff. 02/01/06)

[POMS SI 00830.545](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830545)

A death benefit is something received as the result of another's death. Examples of death benefits include:

* Proceeds of life insurance policies received due to the death of the insured
* Lump sum death benefits from SSA
* RR burial benefits
* VA burial benefits
* Inheritances in cash or in-kind
* Cash or in-kind gifts given by relatives, friends, or a community group to "help out" with expenses related to the death

|  |
| --- |
| **Note:** Recurring survivor benefits such as those received under Title II, private pension programs are not death benefits. |

Death benefits provided to an individual are counted as income to such individual to the extent that the total amount exceeds the expenses of the deceased person's last illness and burial paid by the individual.

Last illness and burial expenses include: related hospital and medical expenses; funeral, burial plot, and interment expenses; and other related expenses.

301.09.24 Inheritances

(Eff. 02/01/06)

[POMS SI 00830.550](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830550KC)

An inheritance is cash, right, or non-cash item(s) received as the result of someone's death. An inheritance is a death benefit.

|  |
| --- |
| **Note**  Until an item or right has a value (that is, can be used to meet the heir's need for food or shelter), it is neither income nor a resource. The inheritance is income in the first month it has a value and can be used. |

If an individual transfers an inheritance, the individual is subject to penalty under the Medicaid transfer of assets provisions, even if the transfer occurs in the month that the inheritance is received. (Refer to MPPM 304.08 for information about Transfer of Assets-Nursing Home.)

An inheritance is not income to an individual if the inheritance is something that was considered that individual's resource (either as a member of an eligible couple or through deeming of resources) immediately before the death. The proceeds of a life insurance policy were not a resource before the death.

[Table of Contents](#_top)

301.09.25 Disaster Assistance – (Presidentially-Declared Disaster)

(Eff. 02/01/06)

[POMS SI 00830.620](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830620)

[CFR §416.1124](http://www.ecfr.gov/cgi-bin/text-idx?SID=eeff858ebb5f2cb3b68f08744a936245&mc=true&node=se20.2.416_11124&rgn=div8)

[CFR §416.1150](http://www.ecfr.gov/cgi-bin/text-idx?SID=eeff858ebb5f2cb3b68f08744a936245&mc=true&node=se20.2.416_11150&rgn=div8)

[26 U.S. Code § 139](http://www.gpo.gov/fdsys/pkg/USCODE-2010-title26/html/USCODE-2010-title26-subtitleA-chap1-subchapB-partIII-sec139.htm)

This section addresses Presidentially declared disasters. There are no specific instructions or exclusions addressing other disasters.

At the request of a State governor, the President may declare a major disaster when the disaster is of such severity and magnitude that effective response is beyond the capabilities of the State and local governments, and Federal assistance is needed. Disasters include such things as hurricanes, tornadoes, floods, earthquakes, volcano eruptions, landslides, snowstorms, drought.

Assistance provided to victims of a Presidentially declared disaster includes assistance from:

* Federal programs and agencies
* Joint Federal and State programs
* State or local government programs
* Private organizations (for example, the Red Cross)

The value of support and maintenance in cash or in-kind is not counted as countable income if:

* The individual lived in a household which he or she (or he and another person) maintained as his or their home at the time a catastrophe occurred in the area; and
* The President declared the catastrophe a major disaster for purposes of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (formerly the Disaster Relief Act of 1974); and
* The individual stopped living in his home because of the catastrophe and began to receive support and maintenance within 30 days after the catastrophe; and
* The individual receives support and maintenance while living in a residential facility maintained by another person. A residential facility is to be interpreted broadly, including a private household, a shelter, or any other temporary housing arrangement resorted to because of the disaster.

Assistance (other than support and maintenance) received under the Robert T. Stafford Disaster Relief and Emergency Assistance Act or any other Federal statute because of a catastrophe which the President declares to be a major disaster, is excluded from countable income. This includes assistance to repair or replace the individual's own home or other property, and disaster unemployment assistance.

301.09.25A COVID-19 Economic Impact Payments (EIPs)

[POMS SI 00830.620](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830620)

[POMS SI 01130.620](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130620)

(Rev. 4/01/23)

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

First Round: Payment levels were up to:

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

Second Round: Payment levels were up to:

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

Third Round: Payment levels were up to:

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

**Non-MAGI Determinations**

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

[Table of Contents](#_top)

301.09.26 Federal Emergency Management Agency (FEMA) Emergency Food Distribution and Shelter Programs

(Eff. 02/01/06)

[POMS SI 00830.625](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830625)

Through a national board chaired by the Federal Emergency Management Agency (FEMA) and local boards, funds are provided to private nonprofit organizations and State and local governmental entities for providing emergency food and shelter to needy individuals. The entity receiving these funds decides how they will be best used (such as to buy beds and blankets, to stock a soup kitchen or to pay an individual's rent.) The Federal funds are not provided to meet ongoing basic needs.

Assistance involving FEMA funds is subject to the general rules pertaining to income and income exclusions. It is neither IBON nor ABON.

Assistance involving FEMA funds is most often provided in-kind by private nonprofit organizations and with State certification will qualify for exclusion as Home Energy Assistance and Support and Maintenance Assistance (HEA/SMA.)

[Table of Contents](#_top)

301.09.27 Federal Housing Assistance

(Eff. 02/01/06)

[POMS SI 00830.630](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830630)

The Federal Government through the Office of Housing and Urban Development (HUD) and the Farmers Home Administration (FMHA) provides many forms of housing assistance including:

* Subsidized housing (such as, public housing, reduced rent, cash toward utilities)
* Loans for renovations
* Loans for construction, improvement, or replacement of farm homes and other buildings
* Mortgage or investment insurance
* Guaranteed loans and mortgages

This assistance may be provided directly by the Federal Government or through other entities such as local housing authorities or nonprofit organizations.

The value of any assistance paid with respect to a dwelling unit is not counted as income or resources if paid under:

* The United States Housing Act of 1937 (Section 1437 et seq. of 42 U.S.C.)
* The National Housing Act (Section 1701 et seq. of 12 U.S.C.)
* Section 101 of the Housing and Urban Development Act of 1965 (Section 1701s of 12 U.S.C., Section 1451 of 42 U.S.C.)
* Title V of the Housing Act of 1949 (Section 1471 et seq. of 42 U.S.C.)
* Section 202(h) of the Housing Act of 1959

301.09.28 Food Programs with Federal Involvement

(Eff. 02/01/06)

[POMS SI 00830.635](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830635)

The value of the following is not counted as income and/or resources.

| **Program** | **Exclude as** |
| --- | --- |
| Food Stamp Program | Income and Resources |
| School Lunch Programs | Income and Resources |
| Child Nutrition Programs | Income and Resources |
| Nutrition Programs for Older Americans | Income and Resources |

[Table of Contents](#_top)

301.09.29 Programs for Older Americans

(Eff. 02/01/06)

[POMS SI 00830.640](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830640)

The Federal Government through the Administration on Aging is involved in a variety of programs for older Americans. State or local governments or community organizations may operate the programs. Some types of programs are:

* Health services
* Nutrition services
* Legal assistance
* Community service employment

A wage or salary paid under Programs for Older Americans is counted as earned income subject to the general policies regarding earned income.

Anything provided under the Programs for Older Americans other than a wage or salary is not counted as income.

301.09.30 Refugee Cash Assistance, Cuban and Haitian Entrant Cash Assistance and Federally-Reimbursed General Assistance Payments to Refugees

(Eff. 02/01/06)

[POMS SI 00830.645](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830645)

Refugee Cash Assistance, and Cuban and Haitian Entrant Cash Assistance are federally funded programs that make ongoing needs-based payments to refugees during their first 8 months in the United States. The State or local government according to AFDC standards and rules makes the payments, although there need not be a child involved. The Federal Government will also reimburse States and localities for any general assistance payments made to refugees during their second 19-31 months in the United States.

Refugee Cash Assistance, Cuban and Haitian Entrant Cash Assistance, and Federally reimbursed general assistance payments to refugees are Federally funded income based on need and, unless excluded under a PASS, are counted dollar for dollar as income. The $20 general income exclusion does not apply to this income.

A payment under one of these programs is always considered a cash payment. The Presumed Maximum Value (PMV) cannot be applied to this income.

[Table of Contents](#_top)

301.09.31 Refugee Reception and Placement Grants and Refugee Matching Grants

(Eff. 02/01/06)

[POMS SI 00830.650](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830650)

Federal funds are provided to national voluntary refugee resettlement agencies such as Catholic Charities or the Hebrew Immigrant Aid Society, which provide services (including food, clothing and shelter) related to initial resettlement of new refugees. Assistance involving these funds will usually be received during the first 30 days after the refugee arrives in this country.

Refugee reception and placement grants are provided by the Department of State. Refugee matching grants are provided by the Department of Health and Human Services.

Assistance involving a refugee reception and placement grant or a refugee-matching grant is subject to the general rules pertaining to income and income exclusions.

301.09.32 Victims' Compensation Payments

(Eff. 02/01/06)

[POMS SI 00830.660](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830660)

Effective 05/01/91, any payment received from a fund established by a State to aid victims of crime is not counted as income.

301.09.33 Payments in Foreign Currency

(Eff. 02/01/06)

[POMS SI 00830.105](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830105)

Occasionally, an individual receives income in a monetary unit other than **US** dollars. This usually will be in the form of a check or a direct deposit to a bank.

The US dollar value of a payment made in foreign currency, less expense, is income. Count foreign currency payments when received unless the individual alleges and can establish that the payment was received too late in the month for conversion prior to the following month.

Use a check or documents in the individual's possession to verify receipt of a foreign payment and the amount in foreign currency. If the payment is made directly to a bank, the bank may provide a statement of the amount received.

The exchange rate for conversion of the foreign currency into US dollars can be verified by:

* A receipt for the individual's last exchange, or
* A telephone call to a local bank or currency exchange.

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| **Note**  Assume that the value of the exchange rate remains the same as last verification unless there is reason to believe otherwise. |

[Table of Contents](#_top)

301.09.34 Income Based on Need (IBON)

(Eff. 02/01/06)

[POMS SI 00830.170](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830170)

Income Based on Need (IBON) is assistance:

* Provided under a program that uses income as a factor of eligibility; and
* Funded wholly or partially by the Federal Government or a non-governmental agency (such as Catholic Charities or the Salvation Army) for meeting basic needs (that is, the funds are provided specifically for a formalized program whose general purpose is similar to that of the SSI program).

Income based on need is counted as income dollar for dollar, unless it is totally excluded by statute (such as food stamps) or excluded under a PASS. The $20 general income exclusion does not apply to IBON.

301.09.35 State Assistance Based on Need (SABON)

(Eff. 02/01/06)

[POMS SI 00830.175](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830175)

SABON is assistance:

* Provided under a program that uses income as a factor of eligibility; and
* Funded wholly by a State (including the District of Columbia, Indian tribes and the Northern Mariana Islands), a political subdivision of a State, or a combination of such jurisdictions.

If a program uses income to determine payment amount but not eligibility, it is not SABON (such as some crime victims compensation programs).

State Assistance Based on Need is not counted as income.

301.09.36 Work Relief (Workfare) Programs

(Eff. 02/01/06)

[POMS SI 00830.185](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830185)

Many governmental assistance programs require that certain beneficiaries work in exchange for the assistance provided. Most often, the amount of the assistance payment is divided by the minimum wage and the beneficiary performing some required service for the resulting number of hours. Usually a participant in such a work program is given money to cover any expenses incurred (such as, carfare, special clothing, miscellaneous)

The fact that an individual is required to work in exchange for an income based on need or assistance based on need payment does not change the nature of the payment. The payment in such situations is an assistance payment and is not counted as unearned income.

[Table of Contents](#_top)

301.09.37 Foster Care and Adoption Assistance

(Eff. 02/01/06)

[POMS SI 00830.410](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830410) and [POMS SI 00830.415](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830415)

An individual is considered to be in foster care when:

* A public or private nonprofit agency places the individual under a specific placement program; and
* The placement is in a home or facility which is licensed or otherwise approved by the State to provide care; and
* The placing agency retains responsibility for continuing supervision of the need for such placement and the care provided.

A foster care payment is a payment made to the foster care provider for meeting the needs of the individual in care.

An agency may make an additional payment to the foster care provider for his own use (such as an incentive or service payment not intended to support the child). While these two payments may be combined and termed the "foster care payment" by the issuing agency, only the part that is provided to meet the needs of the individual in care is the foster care payment. Treatment of foster care payments depends on the funding source of the payments, the purpose of the payments, and whether the SSI beneficiary is the provider or beneficiary of the care.

The following is a listing of different types of foster care and adoption assistance situations and their funding source:

1. **Title IV-E Foster Care Payments**

* For the individual in care, foster care payments made under Title IV-E are considered Federally funded income based on need to the individual in care. This income is not subject to the $20 general income exclusion and is not ISM.
* Payments made under Section 477 of Title IV-E (Independent Living Initiatives) are cash assistance from a governmental social services program and, therefore, are not counted as income.
* For the foster care provider, foster care payments are not income to the provider. Amounts paid to a provider of foster care in excess of the foster care payment are counted as income to the provider.

1. **Title IV-B or Title XX Foster Care Payments**

* Foster care payments involving funds provided under Title IV-BB or Title XX of the Social Security Act are social services and are not income.

1. **Other Foster Care Payments**

* Foster care payments not included above are subject to the general rules pertaining to income and income exclusions.

1. **Adoption Assistance Under Title IV-E**

* Adoption assistance cash payments made to adoptive parents under Title IV-E are federally funded income based on need to the adopted child. This income is not subject to the $20 general inclusion exclusion and the Presumed Maximum Value (PMV) cannot be applied. Therefore, the total payment is considered cash income to the individual and is counted dollar for dollar.

In addition to a cash payment to the adoptive parents, social services may be provided under Title IV-E. Social services are not counted as income.

1. **Adoption Assistance Under Title IV-B or Title XX**

* Adoption assistance payments involving funds provided under Title IV-B or Title XX of the Social Security Act are social services and are not counted as income.

1. **Other Adoption Assistance**

* Adoption assistance payments not included above are subject to the general rules pertaining to income and income exclusions.

Although payments made under Title IV-E are always income to the child, other adoption assistance payments may result in income to the parent or the child depending on the nature of the assistance. It is important when dealing with needs-based payments to remember that the income test must apply to the person to whom we attribute the income in order to exclude the payment as assistance based on need or not to apply the $20 general income exclusion.

301.09.38 Child Care Payments

(Eff. 02/01/06)

[POMS SI 00830.417](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830417)

Childcare assistance programs may provide payments to low-income families or to children with special needs. Such payments may be made for certain childcare activities such as early childhood development, before and after-school services, and services designed to permit a parent to continue working.

The Child Care and Development Block Grant Act (CCDBGA) provide Federal funds for a variety of childcare payments and assistance. Payments made under CCDBGA are not counted as income. There is no specific resource exclusion for payments made under CCDBGA.

Other childcare payments above are subject to the general rules pertaining to income and income exclusions.

[Table of Contents](#_top)

301.09.39 Educational Assistance

(Eff. 02/01/06)

[POMS SI 00830.450](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830450)

Educational assistance is provided in many forms. Treatment will vary depending on the nature and sometimes the use of the assistance. Educational assistance may be earned or unearned income and may be counted or excluded.

Grants, scholarships, and fellowships are amounts paid by private nonprofit agencies, the US Government, instrumentalities or agencies of the US, State and local governments, foreign governments, and private concerns to enable qualified individuals to further their education and training by scholastic or research work.

Any amount provided by an individual to aid a relative, friend, or other individual in pursuing his studies where the grantor is motivated by family or philanthropic considerations is a gift and is not a grant, scholarship, or fellowship.

Any amount which is earned income is not a grant, scholarship, or fellowship.

Any portion of a grant, scholarship, or fellowship used for paying tuition, fees, or other necessary educational expenses is not counted as income. This exclusion does not apply to any portion set aside or actually used for food, clothing, or shelter.

Allowable expenses include carfare, stationery supplies, and impairment-related expenses necessary to attend school or perform schoolwork (for example, special transportation to and from classes, special prosthetic devices necessary to operate school machines or equipment)

Allowable fees include laboratory fees and student activity fees.

301.09.40 Grants, Scholarships, and Fellowships

(Eff. 02/01/06)

[POMS SI 00830.455](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830455)

Federal funds or insurance are provided for a number of educational programs at middle school, secondary school, undergraduate and graduate levels under Title IV of the Higher Education Act of 1965 and student assistance programs of the Bureau of Indian Affairs (BIA). Included are work-study programs, upward bound and talent search programs, as well as grants-in-aid and loans for college study.

Any grant, scholarship, or loan to an undergraduate student for educational purposes made or insured under any program administered by the Commissioner of Education is not counted as income and resources.

Any portion of student financial assistance for attendance costs received from a program funded in whole or in part under Title IV of the Higher Education Act of 1965 or under BIA Student Assistance Programs is excluded from income and resources. Attendance costs are:

* Tuition and fees normally assessed a student carrying the same academic workload (as determined by the institution), including costs for rental or purchase of any equipment, materials, or supplies required of all students in the same course of study; or
* Allowances for books, supplies, transportation, and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution.

This exclusion applies to the common programs of Federal financial aid for college students such as Supplemental Education Opportunity Grants (SEOG), National Defense Student Loans (NDSL), Pell Grants, and State Student Incentive Grants (SSIG).

[Table of Contents](#_top)

301.09.41 Royalties

(Eff. 02/01/06)

[POMS SI 00830.510](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830510)

Royalties include compensation paid to the owner for the use of property, usually copyrighted material, (such as books, music, or art) or natural resources (for example, minerals, oil, gravel or timber). Royalty compensation may be in the form of a percentage of receipts from using the property or as an amount per unit produced.

To be considered royalties, payments for the use of natural resources also must be received:

* Under a formal or informal agreement whereby the owner authorizes another individual to manage and extract a product (such as timber or oil), and
* In an amount that is dependent on the amount of the product actually extracted.

An outright sale of natural resources by the owner of the land or by the owner of rights to use of the land constitutes the conversion of a resource. Proceeds from the conversion of a resource are not income.

Royalties are counted as unearned income unless they are:

* Received as part of a trade or business, or
* Received by an individual in connection with any publication of his work. Royalties earned by an individual in connection with any publication of his work are earned income (such as publication of a manuscript, magazine article, or artwork).

Some documents concerning royalty payments will provide both a gross and a net payment amount. When the difference between the gross and the net figures is due to income taxes withheld or windfall profit tax deductions, use the gross figure when determining income.

When the difference between the gross and net figures represents a production or severance tax (most oil royalties will be reduced by this tax), use the net figure when determining income. The production or severance tax is a cost of producing the income and, therefore, is deducted from the gross income.

301.09.42 Job Training Partnership Act (JTPA)

(Eff. 02/01/06)

[POMS SI 00830.535](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830535)

The purpose of the Job Training Partnership Act (JTPA) is to prepare individuals for entry into the labor force. JTPA funding is much like a block grant and programs will vary among states and among areas within states. JTPA payments may be called "needs-based" for JTPA purposes but are not "income based on need" or "assistance based on need" for Medicaid purposes. JTPA payments may be in cash or in-kind, and participants in JTPA may receive supportive services in cash or in-kind. Usually, adult participants receive only supportive services.

JTPA payments are subject to the general rules pertaining to income and income exclusions.

[Table of Contents](#_top)

301.09.43 Workforce Investment Act (WIA)

(Eff. 07/01/07)

[POMS SI 00830.535](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830535)

The Workforce Investment Act replaced the Job Training Partnership Act (JTPA.) The Workforce Investment Act of 1998 (WIA), which became effective July 1, 2000, establishes a national workforce preparation and employment system (America's Workforce Network) to meet the needs of businesses, job seekers and those who want to further their careers. Individuals have easy access to information and services through the One-Stop Career Center system.

Payments from WIA programs are subject to the general rules pertaining to income and income exclusions.

[Table of Contents](#_top)

301.09.44 Job Corps

(Renumbered 07/01/07, Eff. 02/01/06)

[POMS SI 00830.536](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830536)

The Job Corps is a Job Training Partnership Act (JTPA) program. The living allowance (also called student pay) is the regular, recurring payment to Job Corps participants. It is paid bi-weekly and may include bonuses and/or incentive payments. FICA is withheld from the entire amount. The living allowance is wages.

The readjustment allowance is paid at the completion or termination of the program based on length of participation. It may include bonuses and/or incentive payments. FICA is withheld from the entire amount. The readjustment allowance, including any amount deducted to pay the participant's share of a dependent's allowance, is wages.

A bi-weekly dependent's allowance may be paid directly to a participant's dependent. The Federal Government pays for half. The other half is subsequently deducted from the participant's readjustment allowance. This allowance is counted as unearned income to the dependent.

The clothing allowance is furnished only as a voucher redeemable at a designated clothing store. The clothing allowance (voucher) is not income.

The transportation allowance is furnished only as tickets (usually bus tickets) that cannot be converted to cash. This allowance is not income.

Supportive services are services such as childcare, transportation, medical care, meals, and other reasonable expenses provided in-kind. Those supportive services (such as medical services, transportation to and from medical treatment, counseling, job placement services) provided in-kind which are medical or social services are not income.

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| **Note:** The Job Corps program itself is not a governmental social or medical services program. |

Bonuses and incentive payments are wages.

A Job Corps participant who is a student child qualifies for the student child earned income exclusion.

301.09.45 AmeriCorps and National Civilian Community Corps (NCCC) Payments

(Renumbered 07/01/07, Eff. 02/01/06)

[POMS SI 00830.537](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830537)

AmeriCorps is a national service program authorized by the National and Community Service Trust Act and administered by CNCS. AmeriCorps provides grants to state and local groups and to nonprofit organizations for community service projects such as educational programs, environmental activities, and disaster relief.

Participants of AmeriCorps and NCCC receive a stipend or living allowance generally based on minimum wage requirements. Participants also are eligible to receive an educational award made after the completion of a specified term of service. The educational award is for educational assistance only and must be applied to college tuition, vocational training, or outstanding college loans. AmeriCorps or NCCC must pay the educational award directly to an educational institution or to a loan‑holder for repayment of a student educational loan.

Instead of an educational award, AmeriCorps and NCCC participants may receive, with the approval of the director of CNCS, an alternative benefit. The alternative payment for NCCC members is equal to one-half the amount of any educational award and is paid directly to the participant.

The type of payment determines the treatment of payments made under AmeriCorps and NCCC.

* **Living Allowance Payments**

Stipends or living allowance payments are wages and are subject to the general rules regarding wages and earned income exclusions.

* **Food and Housing/Shelter**

Any food or shelter received by participants is not wages, but is unearned income in the form of In-kind Support and Maintenance (ISM) and is not counted.

* **Clothing/Clothing Allowance Payments**

Any clothing allowance payments are unearned income and subject to the general rules regarding unearned income and exclusions.

Educational awards are wages when credited to the educational institution or loan-holder for repayment of a student educational loan, and subject to the general rules regarding wages and earned income exclusions.

Any payments made as an alternative to educational awards are wages and are subject to the general rules regarding wages and earned income exclusions.

[Table of Contents](#_top)

301.09.46 Low Income Energy Assistance

(Renumbered 07/01/07, Eff. 02/01/06)

[POMS SI 00830.600](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830600)

Through a block grant, the Federal Government provides funds to states for energy assistance (including weatherization) to low income households. This assistance may be provided by a variety of agencies (such as State or local welfare offices, community action agencies, special energy offices) and known by a variety of names (for example, HEAP, Project Safe) It is most often provided in a medium other than cash (such as, voucher, two-party check, direct payment to vendor) but may be in cash.

Home energy assistance payments or allowances are not counted as income or resources.

301.09.47 Home Energy Assistance and Support and Maintenance Assistance (HEA/SMA)

(Renumbered 07/01/07, Eff. 02/01/06)

[POMS SI 00830.605](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830605)

Home energy or support and maintenance assistance is not counted as income if it is certified in writing by the appropriate State agency to be both based on need and:

* Provided in-kind by a private nonprofit agency; or
* Provided in cash or in-kind by a supplier of home heating oil or gas, a rate-of-return entity providing home energy, or a municipal utility providing home energy.

301.09.48 ACTION Programs/Corporation for National and Community Services (CNCS) (*Formerly Domestic Volunteer Services*)

(Renumbered 07/01/07, Eff. 02/01/06)

[POMS SI 00830.610](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830610)

The Federal Government through ACTION, the Federal domestic volunteer agency, is involved in a number of volunteer service programs including:

* Volunteers in Service to America (VISTA)
* University Year for ACTION (UYA)
* Special and Demonstration Volunteer Programs
* Retired Senior Volunteer Program (RSVP)
* Foster Grandparent Program
* Senior Companion Program

Payments to volunteers under ACTION programs are not counted as income or resources. Payments are counted if the Director of the ACTION agency determines that their value, adjusted to reflect the hours served, is equivalent to or greater than the minimum wage in effect.

[Table of Contents](#_top)

301.09.49 Community Service Block Grants

(Renumbered 07/01/07, Eff. 02/01/06)

[POMS SI 00830.615](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830615)

The US Department of Health and Human Services makes community service block grants to States to provide a broad range of services and activities to assist low-income individuals and alleviate the causes of poverty in a community. States may subsequently make grants or enter into contracts with private nonprofit organizations or political subdivisions.

Assistance involving community service block grants is subject to the general rules pertaining to income. It is neither Income Based On Need (IBON) nor Assistance Based On Need (ABON).

301.09.50 Relocation Assistance

(Renumbered 07/01/07, Eff. 02/01/06)

[POMS SI 00830.655](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830655)

Relocation assistance is provided to persons displaced by projects that acquire real property. The following types of reimbursement, allowances, and help are provided:

* Moving expenses
* Reimbursement for losses of tangible property
* Expenses of looking for a business or farm
* Displacement allowances
* Amounts required to replace a dwelling which exceed the agency's acquisition cost for the prior dwelling
* Compensation for increased interest costs and other debt service costs of replacement dwelling (if it is encumbered by a mortgage)
* Expenses for closing costs (but not prepaid expenses) on replacement dwelling (if it is encumbered by a mortgage)
* Rental expenses for displaced tenants
* Amounts for down payments on replacement housing for tenants who decide to buy
* Mortgage insurance through Federal programs with waiver of requirements of age, physical condition, personal characteristics, etc., which borrowers must usually meet
* Direct provision of replacement housing (as a last resort)

Relocation assistance provided under the Uniform Relocation Assistance and Real Property Acquisitions Policies Act is not counted as income.

This exclusion applies to relocation assistance provided to persons displaced by any Federal or Federally assisted project. Any Federal assistance is sufficient to bring into play the Federal statutes controlling acquisition of real property, requiring that relocation assistance be available and not counted as income.

However, if the only Federal assistance is revenue sharing, this exclusion does not apply, since such funds are considered to belong to the governmental unit that received them from the Federal Government.

Relocation assistance provided by a State or local government or through a State-assisted or locally assisted project is not counted as income.

301.09.51 Long-Term Care Insurance

(Renumbered 07/01/07, Eff. 02/01/06)

Long-term care insurance policies may pay benefits directly to the individual or to the nursing facility.

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| **Procedure**  If the insurance company makes payments directly to the individual, consider them countable unearned income.  If the insurance company makes payments directly to the nursing facility, it is considered a third party payment. The eligibility worker must complete a [DHHS Form 3230 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%203230%20ME.pdf), Medicaid Third Party Liability (TPL) Collection form. (Refer to MPPM 102.07.06.)  Acceptable forms of verification:   * Statement from the insurance company * Copies of checks |

[Table of Contents](#_top)

301.09.52 South Carolina Vocational Rehabilitation Job Readiness Vocational Training Center Services

**(Renumbered 07/01/07, Eff. 02/01/06)**

Training stipends paid by the South Carolina Vocational Rehabilitation Department Job Readiness Vocational Training Center (JRVTC) services program do not count as income for SSI related programs unless they are high enough to show an individual is engaged in substantial gainful activity (SGA.)

301.09.53 Other Unearned Income Exclusions

**(Renumbered 05/01/09, Eff. 02/01/06)**

[POMS SI 00830.700—POMS SI 00830.880](https://secure.ssa.gov/apps10/poms.nsf/subchapterlist!openview&restricttocategory=05008)

The following chart describes other unearned income exclusions and their treatment.

| **SOURCE OF INCOME** | **TREATMENT** |
| --- | --- |
| Agent Orange Settlement Payments | Excluded (from income and resources).  *(Refer to* [*POMS SI 00830.730*](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830730)*.)* |
| Austrian Social Insurance Payments | Excluded payments based on wage credits;  Counted payments not based on wage credits.  *(Refer to* [*POMS SI 00830.715*](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830715)*.)* |
| Bureau of Indian Affairs Adult Custodial Care and Child Welfare Assistance Payments  (BIA ACC and CWA) | BIA ACC and CWA payments (other than foster care assistance) made to non-institutionalized individuals are Federally funded income based on need and, therefore, count as income dollar for dollar.  The presumed maximum value rule applies to income resulting from BIA ACC and CWA payments made on behalf of institutionalized individuals.  BIA foster care assistance is considered a social service and, therefore, is not income.  *(Refer to* [*POMS SI 00830.810*](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830810)*.)* |
| Bureau of Indian Affairs General Assistance (BIA GA) | BIA GA payments are Federally-funded income based on need and, therefore, count as income on a dollar-for-dollar basis regardless of whether they are paid in cash or in-kind. The $20 per month general income exclusion does not apply.  *(Refer to* [*POMS SI 00830.800*](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830800)*.)* |
| Department of Defense (DOD) Payments to Certain Persons Captured and Interned by North Vietnam | *(Refer to* [*POMS SI 00830.745*](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830745)*.)* |
| Energy Employees Occupational Illness Compensation Program Act (EEOICPA) | Excluded from both resource and income. Any retained funds and interest earned on these funds are excluded. |
| Exclusion of Income from Individual Interests in Indian Trust or Restricted Lands | Effective 01/01/94, up to $2,000 per year in payments derived from individual interests in Indian Trust or restricted lands is excluded from income. Such payments include any interest that accrues on funds while held by Bureau of Indian Affairs (BIA).  *(Refer to* [*POMS SI 00830.850*](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830850)*.)* |
| Gifts to Children with Life Threatening Conditions | *(Refer to* [*POMS SI 00830.750*](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830750)*.)* |
| Home Produce for Personal Consumption | Excluded if consumed by individual or his household; Counted if:   * Not a trade or business (unearned) * A trade or business, and individual is not an Indian (earnings from self-employment). * Individual is an Indian and exempt from income tax (unearned income). * Individual is not exempt from income tax (self-employment earnings).   *(Refer to* [*POMS SI 00830.700*](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830700)*.)* |
| Indian Fishing Rights Income | *(Refer to* [*POMS SI 00830.880*](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830880)*.)* |
| Indian-Related Exclusions | *(Refer to* [*POMS SI 00830.830*](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830830) *for policy on the treatment of various claims and Federal laws.)* |
| Individual Indian Money Accounts | Regular income and resources rules concerning restricted and unrestricted accounts apply.  *(Refer to* [*POMS SI 00830.820*](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830820)*.)* |
| Japanese American and Aleutian Restitution Payments | Excluded (both income and resources)  *(Refer to* [*POMS SI 0830.720*](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830720)*.)* |
| Netherlands WUV Payments to Victims of Persecution | Excluded  \*Interest earned on unspent payments is counted.  *(Refer to* [*POMS SI 00830.725*](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830725)*.)* |
| Payment to Victims of Nazi Persecution | Excluded  \*Interest earned on unspent payments is counted.  *(Refer to* [*POMS SI 00830.710*](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830710)*.)* |
| Processing Inquiries from Potential Barney Class Members | *(Refer to* [*POMS SI 00830.855*](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830855)*.)* |
| Radiation Exposure Compensation Trust Fund (RECTF) Payments | Excluded  \*Interest earned on unspent payment is counted.  *(Refer to* [*POMS SI 00830.740*](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830740)*.)* |
| Refund of Taxes Paid on Real Property or Food | Excluded  *(Refer to* [*POMS SI 00830.705*](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830705)*.)* |

301.09.54 Computing Unearned Income

(Rev. 10/01/23)

The burden of providing updates to SCDHHS regarding unearned income received at a frequency other than monthly lies with the applicant/beneficiary. CGIS does not allow for future payments to be processed. This specifically impacts recurring income and possible payments in Long Term Care programs. Eligibility specialists must evaluate the case for possible income received at a frequency other than monthly during the Annual COLA and during the Annual Case Review.

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| **Entering Unearned Income in Cúram-CGIS**  Monthly, Quarterly, Semi-Annual, and Annual income must be entered with a frequency of “Monthly”. For amounts received other than monthly, manually calculate the monthly amount and document on the Documentation Template. Enter the new value of the payment and select “monthly” as the frequency.  EXAMPLE: For quarterly amounts, divide the income received by 3.  Ms. Waters receives a retirement pension once a quarter  $450 ÷ 3 = $150 (monthly countable income)  See CGSI Manual 3.01 Benefit Evidence for additional details. |

[Table of Contents](#_top)

301.10 Plan for Achieving Self-Support (PASS) as an Income Exclusion

(Eff. 02/01/06)

[POMS SI 00870.001ff](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500870001)

Income, whether earned or unearned, of a blind or disabled beneficiary may be excluded if such income is needed to fulfill a Plan for Achieving Self-Support (PASS).

This exclusion does not apply to a blind or disabled individual age 65 or older, unless he was receiving SSI or State disability or blind payments for the month before he became age 65.

Requests for the establishment of a PASS must be forwarded to the State Department of Health and Human Service, Bureau of Eligibility, Policy and Oversight, for review and approval.

(Refer to POMS SI 00870.001ff for further information regarding the establishment of a PASS.)

301.11 Deeming of Income

(Rev. 09/01/20)

[POMS SI 01320.000ff](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501320000)

The term deeming identifies the process of considering another person’s income and resources to be available for meeting a Medicaid applicant/beneficiary’s basic needs. Deemed income and resources are attributed to an eligible individual whether or not they are actually available to him with the following restrictions:

* Deeming only applies in household situations; and
* In South Carolina, income is deemed from an ineligible parent to an eligible child.

Deeming is based on the concept that a parent(s) and children who live together have a responsibility for each other and share income and resources. Both SSI and Medicaid regulations require deeming in household situations. **Refer to** [**Appendix A**](#Appendix_A) **for income deeming procedures and important policy considerations.**

A portion of an ineligible parent’s income is used to provide for the living expenses of the ineligible parent and his spouse and those of any ineligible children living in the same household. Based on this consideration, allocations are given to:

* Ineligible parent(s); and
* Ineligible children in the household.

Application of the allocations reduces the amount of income available for deeming.

(Refer to Appendix A for income deeming procedures.)

301.12 Income Computation Methods Used to Determine Medicaid Eligibility

(Rev. 01/01/14)

The Electronic Budget Workbook must be used to determine Medicaid eligibility for all categories. Use the version that applies the income and resource limits that are/were in effect in the month for which eligibility is being determined. For example, if Medicaid eligibility is being determined for the month of March, use the Budget Workbook that uses the income and resource limits effective for March. If Medicaid eligibility is being determined for the month of September, use the Budget Workbook that uses the income and resource limits effective for September.

When calculating a transfer of resources penalty for an institutional case, use the current version of the Budget Workbook effective for the month in which the case decision is being completed.

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| **Example #1**  Jane applies for ABD on January 8, 2014. She is requesting retroactive coverage for the months of November and December 2013. Two different budget workbooks must be used to determine her eligibility. The January 2014 Workbook is used to determine eligibility for January, the application month; and the October 2013 Workbook must be used to determine eligibility for November and December, the retroactive months.  **Example #2**  June applies for ABD on March 8, 2014. She does not request retroactive coverage. The January 2014 workbook is used to determine eligibility for March, the application month.  **Example #3**  Mr. Jackson entered Green Nursing Facility on November 2 and applied for vendor payment on November 30. The eligibility worker discovers Mr. Jackson transferred property to his daughter last year. Mr. Jackson is otherwise Medicaid eligible. The eligibility worker processes Mr. Jackson’s application on January 10. When the worker calculates the transfer penalty for Mr. Jackson, she will use the January Budget Workbook to calculate the transfer penalty. |

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| **Exceptions**  The Electronic Budget Workbook will not complete eligibility determinations for the following categories and/or situations and must be budgeted manually: Minor Children applying for ABD |

301 Appendix A Income Deeming Procedures

(Eff. 10/01/05)

[POMS SI 01320.000ff](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501320000)

For deeming purposes, the following definitions apply:

* A child is someone who is neither married nor the head of a household and is under age 18.
  + An eligible child for deeming purposes, is a natural or adopted child under age 18 who lives in a household with one or both and is eligible for or applying for Medicaid. A child is eligible if he receives Medicaid from any source.

Deeming no longer applies beginning the month following the month the child attains age 18. An individual attains a particular age on the day preceding the anniversary of his birth. Deeming applies in the month of attainment of age 18 regardless of whether an application filed that month is filed before or after the day of attainment.

* + An ineligible child is a natural or adopted child of an eligible individual or the natural or adopted child of a parent or the parent’s spouse who lives in the same household with the eligible individual and is under age 18, or under age 22 and a student regularly attending school or college or training that is designed to prepare him/her for a paying job.
* A parent whose income and resources are subject to deeming is one who lives in the same household with an eligible child and is:
  + A natural or adoptive parent of the child; or
  + The spouse of the natural or adoptive parent (including common law marriages).
* A parent’s income and resources are deemed to an eligible child beginning the month:
  + After the month the child comes home to live with the parent(s) (such as the month following the month the child comes home from the hospital); or
  + Of birth when a child is born in the parent’s home; or
  + After the month the adoption becomes final; or
  + After the month of marriage (that is when a natural or adoptive parent marries).
    - Deeming applies from a parent to a child when they live together in the same household. However, if a natural or adoptive parent is deceased or is divorced from the stepparent, and the child is living with the stepparent, the stepparent is not considered a parent or spouse of a parent of the eligible child for deeming purposes. In addition, a relative or other adult who has legal custody of a child but is not also the natural or adoptive parent is not a parent for deeming purposes. Also, a relative or other adult who has legal custody of a child but is not also the natural or adoptive parent of the child is not a parent for deeming purposes.

**Income Excluded from Deeming**

Income that is not income to an eligible individual is also not income to an ineligible parent. In addition, the following types of income are excluded:

* Exclude income used by an ineligible parent (or ineligible child) to make court ordered support payments.

*Exception: If an ineligible child receives child support payments, do not disregard one-third of the payment as is done for an eligible child.*

* In-Home Supportive Services (IHSS) payments provided under Title XX or other Federal, State or local governmental programs to an eligible individual and paid by the individual to his parent or child living in the same household in return for in-home supportive services (such as, chore, attendant, homemaker) are excluded from income for deeming purposes. Such payments made directly to the eligible individual are also excluded for deeming purposes.

Retroactive IHSS payments are not a resource for one calendar month following the month of receipt. Any unspent portion becomes if retained into the second calendar month following receipt.

**Public Income Maintenance Payments (PIM) Received by a Deemor**

Any PIM payment received by an eligible parent and any income counted in determining the payment is excluded from income in the deeming computation. Resources continue to be deemed or combined from the parent receiving the income based on need.

If a parent who receives the PIM payments wishes to apply for Medicaid, the PIM payment is counted according to the rules regarding the specific payment. PIM payments are made under:

* TANF/FI
* SSI
* The Refugee Act of 1980
* The Disaster Relief Act of 1974
* General Assistance Programs of the Bureau of Indian Affairs
* State or local government assistance programs based on need
* VA benefits based on need

No allocation is given for a parent who receives a PIM payment.

**Events Affecting Deeming (Parents/Children)**

Several events can change deeming status:

* If the ineligible parent becomes eligible, deeming from the parent stops beginning the month the parent becomes eligible.
* If the eligible parent becomes ineligible, deeming of the parent’s income begins with the first month of the parent’s ineligibility to determine if the child is eligible.
* If the ineligible parent dies, deeming stops the month after the month of death.
* If the ineligible parent and eligible child no longer live in the same household, deeming of the parent’s income stops effective the month after the month the parent (or child) leaves the household.
* If the ineligible parent and eligible child begin living in the same household, the parent’s income is deemed to the child beginning the month after the month they begin living together.

*For Example : Newborn child comes home. No income of the parent(s) is deemed until the month following the month after the child is home.*

* If an eligible child becomes institutionalized, deeming stops the month of entry into the facility.
* If an eligible child reaches age 18, deeming stops the following month.

[Table of Contents](#_top)

301 Appendix B Definitions of Provisions

(Rev. 09/01/15, Eff. 11/01/14)

An IRWE means an expense for an item or service that is directly related to enabling an impaired individual to work and which is necessarily incurred by that individual because of a physical or mental impairment. Such an expense may involve payment for the purchase, installation, maintenance and repair of an impairment-related item or payment for an impairment-related service. (Exception: There can be no separate amount deducted for maintenance and repair of automobiles or vans used for transportation to and from work, since these costs are included in the mileage rates indicated below.)

**A. Attendant Care Services**

1. General

For purposes of this provision "attendant care services" are those forms of physical assistance which help an impaired individual meet his or her essential personal needs at home or at work, such as bathing, toileting, dressing, cooking, eating, communicating, traveling to and from work, and similar personal needs. However, this definition is applicable only to those services that can be shown to be needed to enable the individual to work.

1. Attendant Care at Work or to and from Work

Payments made for attendant care services are deductible as IRWE if the services are needed in the work setting or in assisting the impaired individual in traveling to and from work.

1. Attendant Care at Home

Payments made for attendant care services rendered in the home are deductible only if the services relate to preparations for going to work, or to assistance required by the impaired individual immediately upon his or her arrival home from work. Some Examples of allowable in‑home attendant care services would be those relating to bathing, dressing, cooking, eating, administering medications, or arranging medical devices in the period of time immediately preceding the impaired individual's departure for work, or immediately following his or her return home from work. Such services should generally require no more than one or two hours in the morning or evening. Examples of attendant care services, the costs of which would not be allowable as deductions, would be those performed on non-workdays, or those performed at any time which involve shopping or general homemaking (such as cleaning or laundry).

1. Attendant Care Which Incidentally Benefits Family

Payments made for attendant care of the impaired individual are deductible even if, while attending to that individual, the attendant performs services that incidentally also benefit the individual's family. An example would be a situation in which the attendant, in addition to helping the impaired individual bathe and dress, also cooks for him or her and other members of the individual's family may incidentally share the meal.

1. Attendant Care to Others Not Applicable

Payments made by the impaired person for services rendered to someone else are not deductible. Payments are deductible only when the services are provided for, or the items are used by, the impaired individual. For Example , any payment by an impaired individual to care for his or her child is not deductible.

2. Attendant Care by a Family Member

1. Family Member

For the purpose of this provision, a "family member" is anyone who is related to the impaired individual by blood, marriage, or adoption, whether or not that person lives with the impaired individual.

1. Payment

If an impaired individual pays a member of his or her family to perform attendant care services, such payment will generally not be deductible as an IRWE unless:

* It is established that the family member (who has been otherwise employed) suffers economic loss by reducing (the number of hours of) or terminating his or her own employment in order to perform such service; and
* The payment is made to the family member in cash (including checks or other forms of money); payment "in-kind" (such as room and board) is not deductible.

1. Documentation and Pro-ration

See below concerning documentation of attendant care services by a family member concerning pro-ration of such expenses.

**B. Medical Devices**

Medical devices are defined as durable medical equipment that can withstand repeated use, are primarily used to serve a medical purpose, and are generally not useful to a person in the absence of an illness or injury. Example s in this category are wheelchairs, hemodialysis equipment, respirators, intermittent positive pressure breathing machines, pacemakers, inhalators, nebulizers, suction machines, traction equipment, braces (leg, arm, back and neck), and similar items.

**C. Prostheses**

Prostheses include devices that replace internal body organs or external body parts. Examples of prosthetic devices are artificial hips and artificial replacements of arms, legs, or other parts of the body. Payment made for a prosthetic device that is used primarily for cosmetic rather than functional purposes usually is not deductible.

**D. Other Equipment**

Other equipment means items, other than durable medical equipment and prostheses, which an impaired individual may need to perform the tasks required in his or her job, or to move from home to mode of transportation, or to control the disabling condition at home or in the work setting so as to be able to function in a work activity.

1. Work-Related Equipment

Payments for equipment that is impairment-related and necessary for the impaired individual to do his or her job are deductible when the equipment is paid for by the impaired individual and not provided by an employer. Costs paid by the individual for training in the use of such equipment are also deductible. Example s of such equipment are one-handed typewriters, typing aids (for example, page-turning devices), measuring instruments, vision and sensory aids for the blind, telecommunications devices for the deaf and special tools that have been specifically designed to accommodate the individual's impairment. (Where a self-employed individual deducts the costs of such equipment as a business expense, the cost is not deductible as an IRWE in determining SGA or SSI countable earned income.)

1. Residential Modifications

Residential modifications are defined as changes that are made to the impaired individual's home in order to accommodate his or her functional limitations. Whether or not the cost of residential modifications will be deductible as IRWE, however, depends upon the location of the impaired person's place of work.

1. Individual Employed Outside the Home

An impaired person who is employed away from home may require changes outside his or her residence which permit the individual to get to his or her means of transportation (such as the installation of an exterior ramp for a wheelchair-confined person or special exterior railings or pathways for someone who requires crutches). Getting to one's mode of transportation can be regarded as part of the total process of getting to and from work. Payment for modifications that make possible the individual’s movement from his or her residence to transportation would be deductible, therefore, as an IRWE. However, changes which modify the interior architecture or operation of the impaired individual's residence are primarily intended to facilitate his or her functioning in the home environment; therefore, payment for these changes are not deductible as IRWE. Example s of such modifications are the enlargement of doorframes and the lowering or rearrangement of kitchen appliances and bathroom facilities for a person who is wheelchair‑confined, or the installation of a stairway chairlift for someone with leg braces.

1. Individual Works at Home

Payments for modifying the interior of the home in order to create a working space to accommodate an individual's impairment are deductible to the extent that the modifications pertain specifically to the workspace. Example s of such modifications are the enlargement of a doorway leading into an office or any other type of work area or the modification of the workspace to accommodate problems in dexterity. However, when the determination involves payments made by a self-employed individual who works at home, the costs of such modifications generally are deductible from gross income as business expenses. Any such costs deducted as business expenses are not deductible as IRWE.

1. Non-Medical Appliances and Equipment
2. Items Essential to Individual's Functioning

Payments for devices which are used by an individual who works at home or elsewhere and which are not ordinarily used for medical purposes, such as portable room heaters, air conditioners, humidifiers, dehumidifiers, electric air cleaners and posture chairs, are not generally deductible as IRWE. However, in some unusual situations, the impaired individual may be able to establish an impairment‑related and medically verified need for such an item because it is essential for the control of the disabling condition both at home and in the work setting. To be considered essential, the item must be of such a nature that if it were not available to the impaired individual there would be an immediate adverse impact on his or her ability to function in his or her work activity. If the situation is as described above, payment for the item is regarded as an IRWE regardless of whether the item is used at home or in the work place. An Example is the need for an air cleaner by an individual with severe respiratory disease who cannot function in a non-air cleaned environment.

1. Items Used for Physical Fitness

Expenses for items that are used for physical fitness purposes, such as an Exercycle, are not deductible unless the items are prescribed by the treating physician as necessary for treatment of an individual's impairment and necessary to enable the individual to work.

**E. Routine Drugs and Routine Medical Services**

1. Routine Drugs and Services

Payments for routine drugs and routine medical services are deductible if such drugs and services are necessary for control of the disabling condition, thereby enabling the individual to work, and if the individual pays for them.

"Routine" refers to the regularly prescribed type of medical treatment or therapy followed for the particular impairment. "Control" refers to reducing or eliminating symptoms or slowing down progression of the disease.

Even if the drugs or medical services do not control the impairment, payments for such items are deductible if the drugs or medical services were provided with the medical objective of controlling the condition.

Examples of items in this category are anticonvulsant drugs needed to control epilepsy or anticonvulsant blood level monitoring; radiation treatment or chemotherapy for cancer patients; corrective surgery for spinal disorders; and antidepressant medications for mentally ill persons.

1. Diagnostic Procedures

Payments for diagnostic procedures are deductible only if the objective of the procedures is related to the control of the disabling condition to enable the individual to work, and the impaired person pays for such procedures. For Example , payment for a diagnostic procedure is deductible if it is performed to ascertain how the impairment is progressing or to determine what type of treatment to provide for the impairment.

Example s of items in this category, the costs of which would be deductible, are electroencephalograms and brain scans undertaken with respect to a disabling epileptic condition and tests to determine the extent to which appropriate medications are controlling a diabetic condition.

1. Drugs And Services For Minor Physical Or Mental Conditions

Payments for drugs or medical services that are used by the impaired individual only for minor physical or mental problems not resulting in any significant loss of function are not deductible. Example s of such items and services are: yearly routine physical examinations, allergy treatment (when such condition does not constitute a disabling condition), dental examinations, optician services, and eyeglasses (when unrelated to a disabling visual impairment).

**F. Similar Items and Services**

This category includes items and services, other than those defined in subsections A. through E. above, which are related to an individual's impairment and are needed in order for the individual to work and for which he or she pays. The following are Examples.

1. Medical Supplies And Services

Included here for Example are: physical therapy; medical supplies of an expendable nature, such as incontinence pads, catheters, bandages, elastic stockings, face masks, irrigating kits, disposable sheets, and bags.

1. Dog Guide

Expenses paid by a person disabled by blindness in owning a dog guide are deductible as an IRWE since the dog enables the individual to overcome functional limitations related to basic mobility and travel. Deductible expenses include the costs of purchasing a dog, food, licenses, and veterinary services.

1. Transportation Costs

Transportation costs paid by an impaired individual are deductible if certain conditions discussed below are met. Such costs, including operating costs, are deductible.

* 1. Modified Vehicles

An impaired person may have deductible transportation costs if he or she requires structural or operational modifications to a vehicle in order to drive, or be driven, to work. If the impaired individual requires a specially modified vehicle in order to work, the cost of the modification (but not the cost of the vehicle) is treated as an IRWE. Modifications to the vehicle must be critical to its operation by, or its accommodation of, the impaired person and must be directly related to the impairment; that is, without the modification the individual would either be unable to drive, or would be unable to ride in, the vehicle. To be deductible, the cost of the modification must be paid by the impaired individual. Vocational rehabilitation (VR) agencies will often agree to pay for modifications to vehicles purchased by handicapped persons; the costs of such modifications paid by the VR (or any other source) may not be deducted from the individual's earnings. Most cases involving modifications to a vehicle will be clear-cut, but the necessity for the modification should be verified through the treating physician or VR agency.

* 1. Special Transportation Situations

An impaired person may also have deductible transportation costs if, solely because of the impairment, he or she requires a special means of transportation in order to get to and from work. Such situations must be verified by a physician (or VR counselor, when appropriate) and include such things as the inability to use available public transportation, the need for driver assistance, or the use of taxicabs.

1. Services Received In Or Through A Community Residence Program

Community residence living, whether for physically, mentally or emotionally handicapped persons, will generally require attendant care or support services which, to some extent, will entail IRWE. Community residence programs may include group homes, foster care arrangements and supervised individual, or group apartments.

Expenses for services received in or through a community residence program may be deductible as IRWE provided the usual criteria applicable to other allowable services are met: the service must be impairment-related; the individual must need the service in order to sustain work activity (that is, the service must be directly related to enabling an individual to hold and function in a job); it must be verified that a service available to the individual was actually used by the individual; the individual must pay for the service (that is, cannot be funded, subsidized or reimbursed for the amount paid); and the amount of the expense must be within "reasonable limits."

Verification of the nature of the service, its relationship to work, and the individual's need for, use of, and payment for the service should be accomplished through the professional staff who provide the service and the physician (if any) who attends the individual.

Each case must be developed individually to determine the extent to which the resident actually uses a service that is potentially deductible as an IRWE.

Monthly fees required for supportive living arrangements may cover a variety of charges including room, board, support services, attendant care, and transportation. Furthermore, fees may be paid from a combination of sources including State and/or Federal funding, Title II and/or Title XVI benefits, and the individual's earnings. Since both deductible and nondeductible services are provided in community residence programs and the individual may, in effect, pay only a portion of the total expense of deductible services, the monthly program fees and the individual's payment to the program must be prorated to determine how much the individual actually pays for deductible services.

1. Individual Pays Entire Monthly Program Fee

When the individual pays the entire program fee, the District Office should first try to learn whether there is a stated agreement or contract between the residence program and the individual as to how the monthly fee is apportioned for the various things provided by the program.

1. Agreement or Contract Exists

If an agreement or contract has been made, the terms of the agreement should be followed. For Example, if the agreement specifies that 20 percent of the individual's total payment is attributable to attendant care or support services, and half of those services are identified as work-related, then 10 percent of the individual's monthly payment could be deducted as IRWE for such services.

1. No Agreement or Contract Exists

If no agreement or contract has been made, the monthly amount paid by the individual for deductible services may be determined in one of two ways:

a) Apportion Total Budget of Residence Program

The amount of IRWE for work-related attendant care or support services may be determined by ascertaining how the total budget of the residence program is divided into its various elements, such as, room, board, and support services. The proportion spent for each element would be applicable, at the same rate, to the amount paid by the individual. For example, if the residence program spends 20 percent of its budget on attendant care or support services, and half of those services are identified as work-related, then 10 % of the monthly fee paid by the individual for such services could be deducted as IRWE.

* 1. Estimate Portion Paid by Individual

If the kind of information needed for the above procedure is not available, it will be necessary to estimate that portion of the total amount paid by the individual to the residence program which can be attributed to work-related attendant care or support services. Such an estimate may be reached by inquiring about the various things the individual actually receives (such as room, transportation, attendant care), and by assigning a value to each of those things in terms of the total amount paid for them by the individual. The help of professional staff in the residence program, as well, perhaps, as that of the individual will be needed to identify those attendant care or support services which are work-related, and to establish a reasonable apportionment of monthly fees to such services.

1. Individual Pays Part of Monthly Program Fee

When the individual pays only a portion of the total monthly residence program fee, and the balance is paid from State or Federal funds or some other source, the District Office should try to learn whether the supplemental funds are prescribed by law (or some other form of agreement) for only certain things (such as only for housing, only for counseling).

**NOTE:** Where the SSI individual's payment to the facility is not payment in full and the payment can be attributed either towards IRWE or towards food and shelter, the adjudicator (with input from the individual where appropriate) should attribute the payment in the manner more advantageous to the individual.

1. Supplemental Funds Are Prescribed

If supplemental funds are prescribed for only certain things, the amounts attributable to such things cannot be deducted because, under such circumstances, payment for them would not be made by the individual.

1. Supplemental Funds Are Not Prescribed

If supplemental funds (or any portion of them) are not prescribed, the District Office may follow the procedure outlined above in subsection F.4.a. That is, the District Office should first try to learn whether there is a stated agreement or contract between the residence program administrators and the individual as to how the monthly fee is apportioned for the various things provided.

1. Agreement or Contract Exists

When there is an agreement, its terms should be followed; that is, only that portion of the expense for attendant care or support services that is paid by the individual would be deductible. For Example, if the agreement specifies that $200 of the total monthly fee is attributable to attendant care or support services and half of these services are work‑related, then $100 is potentially deductible as an IRWE. If the total cost of maintaining the individual in the residence is paid equally by the individual and some other source, then one‑half of this amount, or $50, could be deducted as an IRWE for the work‑related services.

b) No Agreement or Contract Exists

If the individual pays only a portion of the total monthly residence fee, and there is no agreement as to how the fee is to be apportioned, the District Office may follow one or the other of the two procedures outlined above (such as, by pro-ration of the residence budget or by estimation of the costs of attendant care or support services) to determine:

* What portion of the total monthly cost of maintaining the individual in the residence is attributable to attendant care or support services;
* What percentage of those services can be identified as work-related; and
* What portion of the total monthly cost is attributable to the individual.

For Example, if the total monthly fee for community residence were $1,000, and the resident paid $700 ($350 from earnings, $350 from Title II benefits), and the balance or $300 were paid with unassigned State funds, then the individual would be paying from his or her own funds seven‑tenths of any particular expense. If attendant care or support services constituted 20 percent of the total monthly fee, and half of those services were identified as work-related services, then 10 percent of the total monthly fee ($100) would be attributable to deductible services. Since the individual could be said to pay seven-tenths of any particular expense, then $70 could be deducted as an IRWE for the service.

**G. "Reasonable Limits"**

The law provides that an amount equal to the cost to the individual of attendant care services, medical devices, equipment, prostheses, and similar items and services will be deductible from earnings in determining SGA and SSI countable earned income. The deductible amount, however, is subject to reasonable limits. Generally, the amount paid for medical services, medical devices ("durable medical equipment"), prostheses, and similar medically‑related items and services will be considered reasonable if it is no more than the Medicare prevailing charge established for the same item or service in the individual's community under Part B of Title XVIII of the Social Security Act (Health Insurance for the Aged and Disabled).

Prevailing charge information is available from individual Medicare carriers. If the amount paid for an item or service exceeds the Medicare prevailing charge in the individual's community, an amount equal to the prevailing charge will be deducted from earnings. If the impaired individual wishes to establish the reasonableness of the amount paid, he or she may rebut the prevailing charge guidelines by demonstrating that the amount paid is consistent with the standard or normal charge for the same or similar item or service in his or her community. If the reported item or service is not listed in the Medicare guidelines, the amount paid will be considered reasonable if it does not exceed the standard or normal charge for the same or similar item or service in the impaired individual's community

[Table of Contents](#_top)

# **CHAPTER 302—Non-MAGI/Supplemental Security Income (SSI) Related Resource Policy—Liberalized**

[302.01 Introduction 105](#_Toc152298920)

[302.02 Resource Limit 105](#_Toc152298921)

[302.02A Resource Reduction Period 105](#_Toc152298922)

[302.03 Resource Definitions 107](#_Toc152298923)

[302.04 Resources vs. Income 109](#_Toc152298924)

[302.05 Liberalized Resource Policy 109](#_Toc152298925)

[302.06 Whose Resources to Count 110](#_Toc152298926)

[302.07 Unknown Assets 110](#_Toc152298927)

[302.08 Ownership Interest 111](#_Toc152298928)

[302.08.01 Sole Ownership 111](#_Toc152298929)

[302.08.02 Shared Ownership 111](#_Toc152298930)

[302.08.03 Equitable Ownership 112](#_Toc152298931)

[302.08.04 Property Rights with No Ownership 114](#_Toc152298932)

[302.09 Factors That Make Property a Resource 114](#_Toc152298933)

[302.10 Access to Resources 115](#_Toc152298934)

[302.10.01 Individual Declared Legally Incompetent 115](#_Toc152298935)

[302.10.02 Types of Access 116](#_Toc152298936)

[302.11 Retirement Funds 117](#_Toc152298937)

[302.12 Loans, Promissory Notes and Property Agreements 118](#_Toc152298938)

[302.13 Inheritances and Un-Probated Estates 119](#_Toc152298939)

[302.14 Resource Exclusions 120](#_Toc152298940)

[302.14.01 Home Property 120](#_Toc152298941)

[302.14.02 Home Replacement Funds 121](#_Toc152298942)

[302.14.03 Installment Sales Contract 122](#_Toc152298943)

[302.14.04 Jointly Owned Property 123](#_Toc152298944)

[302.14.05 Bona fide Effort to Sell 123](#_Toc152298945)

[302.15 Resource Exclusions for Tribal Members 125](#_Toc152298946)

[302.16 Automobiles 125](#_Toc152298947)

[302.16.01 Rebuttals 128](#_Toc152298948)

[302.17 Life Insurance 128](#_Toc152298949)

[302.17.01 Development of Countable Life Insurance 131](#_Toc152298950)

[302.17.02 Estimated Cash Surrender Value Table 134](#_Toc152298951)

[302.17.03 Accelerated Life Insurance Payments 135](#_Toc152298952)

[302.18 Death Benefits for Last Illness and Burial Expenses 136](#_Toc152298953)

[302.19 Burial-Related Resources 137](#_Toc152298954)

[302.19.01 Burial Spaces 137](#_Toc152298955)

[302.19.02 Burial Space Exclusion 138](#_Toc152298956)

[302.19.03 Burial Funds 139](#_Toc152298957)

[302.19.04 Burial Fund Exclusion 139](#_Toc152298958)

[302.19.05 Burial Fund Penalty 140](#_Toc152298959)

[302.19.06 Burial Fund Exclusion and Re-Determination 141](#_Toc152298960)

[302.20 Pre-Need Burial Contracts 141](#_Toc152298961)

[302.20.01 Pre-Need Burial Contracts Including Burial Spaces and Burial Funds 141](#_Toc152298962)

[302.20.02 Revocable Pre-Need Burial Contracts 142](#_Toc152298963)

[302.20.03 Irrevocable Pre-Need Burial Contracts 143](#_Toc152298964)

[302.20.04 Life Insurance Funded Burial Contracts 144](#_Toc152298965)

[302.20.04A Effect of the Assignment of Ownership on Burial Exclusion 144](#_Toc152298966)

[302.20.04B Effect of the Assignment of Proceeds on Burial Exclusion 145](#_Toc152298967)

[302.21 Property Essential to Self Support 145](#_Toc152298968)

[302.21.01 Essential Property Excluded – Regardless of Value or Rate of Return 145](#_Toc152298969)

[302.21.02 Essential Property Excluded – Up to $6,000 Equity – Regardless of Rate of Return 146](#_Toc152298970)

[302.21.03 Essential Property Excluded – Up to $6,000 Equity – If It Produces a 6% Rate of Return 147](#_Toc152298971)

[302.22 Resources Set Aside as Part of Plan for Achieving Self-Support 148](#_Toc152298972)

[302.23 Retained Cash Payments 148](#_Toc152298973)

[302.23.01 Retroactive Supplemental Security Income (SSI) and Retirement, Survivors, and Disability Insurance (RSDI) 148](#_Toc152298974)

[302.23.02 Dedicated Accounts for Past-Due Benefits Due to Individuals Under Age 18 Who Have a Representative Payee 149](#_Toc152298975)

[302.23.03 Cash Received for the Repair or Replacement of Lost, Damaged, or Stolen Excluded Resources 150](#_Toc152298976)

[302.23.04 Disaster Assistance 150](#_Toc152298977)

[302.23.04A COVID-19 Economic Impact Payments (EIPs) 150](#_Toc152298978)

[302.23.05 Presidentially Declared Major Disasters 151](#_Toc152298979)

[302.23.06 Netherlands WUV Payments to Victims of Persecution 151](#_Toc152298980)

[302.23.07 German Reparations Payments 152](#_Toc152298981)

[302.23.08 Austrian Social Insurance Payments 152](#_Toc152298982)

[302.23.09 Benefits Excluded from Both Income and Resources by a Federal Statute Other Than Title XVI 152](#_Toc152298983)

[302.23.09A Agent Orange Settlement Payments 152](#_Toc152298984)

[302.23.09B Victims Compensation 153](#_Toc152298985)

[302.23.09C Relocation Assistance Payments 153](#_Toc152298986)

[302.23.09D Tax Advances and Refunds Related to Earned Income Tax Credits 153](#_Toc152298987)

[302.23.09E Radiation Exposure Compensation Trust Fund Payments 154](#_Toc152298988)

[302.24 Gifts of Domestic Travel Tickets 154](#_Toc152298989)

[302.25 Identifying Excluded Funds That Have Been Co-mingled with Non-Excluded Funds 154](#_Toc152298990)

[302.26 Countable Resources 154](#_Toc152298991)

[302.26.01 Cash 155](#_Toc152298992)

[302.26.02 Checking/Savings Accounts 155](#_Toc152298993)

[302.26.03 Joint Checking/Savings Accounts 157](#_Toc152298994)

[302.26.03A Rebuttal of Joint Checking/Savings Accounts 157](#_Toc152298995)

[302.26.04 Time Deposits 158](#_Toc152298996)

[302.26.05 Conservator Account 158](#_Toc152298997)

[302.26.06 Stocks 159](#_Toc152298998)

[302.26.07 Mutual Fund Shares 159](#_Toc152298999)

[302.26.08 US Savings Bonds 160](#_Toc152299000)

[302.26.09 Municipal, Government, or Corporate Bonds 160](#_Toc152299001)

[302.26.10 Other US Government Securities 160](#_Toc152299002)

[302.26.11 Contents of a Safety Deposit Box 160](#_Toc152299003)

[302.26.12 Non-Home Real Property 161](#_Toc152299004)

[302.26.13 529 Plan 161](#_Toc152299005)

[302.26.14 Direct Express Account 162](#_Toc152299006)

[302.27 Cash to Purchase Medical or Social Services 162](#_Toc152299007)

[302.28 Retroactive In-Home Supportive Services 163](#_Toc152299008)

[302.29 Encumbrance 163](#_Toc152299009)

[302.30 Trust Property 166](#_Toc152299010)

[302.30.01 Trust Terms and Definitions 166](#_Toc152299011)

[302.30.02 Instruments Similar to Trusts 167](#_Toc152299012)

[302.30.03 Use of Trust Funds 169](#_Toc152299013)

[302.30.04 Trust Revocability and Its Effect on the Status as a Resource 170](#_Toc152299014)

[302.30.05 Disbursements from Trusts 170](#_Toc152299015)

[302.30.06 Special Needs Trusts 171](#_Toc152299016)

[302.30.07 Pooled Trusts 173](#_Toc152299017)

[302.30.08 Achieving a Better Life Experience (ABLE) Accounts 174](#_Toc152299018)

[302.30.08A Designated Beneficiary of ABLE Account 174](#_Toc152299019)

[302.30.08B Excluded ABLE account contributions, balances, earnings, and distributions 175](#_Toc152299020)

[302.30.08C Countable ABLE account balances and distributions 177](#_Toc152299021)

[302.31 Uniform Gifts to Minors Act 177](#_Toc152299022)

[302.31.01 UGMA and Sources 178](#_Toc152299023)

[302.31.02 While Donee Remains a Minor 178](#_Toc152299024)

[302.31.02 When the Donee Reaches Age 18 179](#_Toc152299025)

[302 Appendix A Excluded Resources 180](#_Toc152299026)

[302 Appendix B Verification Procedures 183](#_Toc152299027)

[302 Appendix C Knowledgeable Source Statements 184](#_Toc152299028)

[302 Appendix D Rebuttal Of Ownership of Assets Other Than Joint Bank Accounts 185](#_Toc152299029)

[302 Appendix E Stocks, Bonds, Mutual Funds 186](#_Toc152299030)

[302 Appendix F Life Estate and Remainder Interest Tables 189](#_Toc152299031)

[302 Appendix G Asset Verification System (AVS) 192](#_Toc152299032)

302.01 Introduction

**(Eff. 10/01/05)**

Medicaid uses the value of a person’s resources as a factor in determining eligibility for Supplemental Security Income (SSI)-related programs. It is generally expected that individuals or couples whose resources exceed the limit will use the excess to meet their needs before becoming eligible for Medicaid.

This chapter will describe the treatment of resources when determining eligibility for the SSI-related Medicaid programs using modified SSI resource policy (such as ABD, SLMB, QWDI, and Institutional). Each program has an established resource limit. If countable resources exceed the limit, eligibility cannot be established. The applicable limits will be discussed in the program specific chapters of this manual.

SSI policy is used as the basis of determining financial eligibility for Medicaid for the adult categories of assistance. SSI policy is explained in the Program Operations Manual System (POMS). This manual provides references to sections in the POMS for more detailed explanations of policy and procedures. Sometimes, Medicaid policy is different from SSI, especially if an individual is institutionalized. The differences will be discussed in the institutional chapter.

|  |
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| **Note**   * Not everything a person owns is a resource. * Not all resources count against the limit.   + The Social Security Act and other Federal laws require certain types and amounts of resources to be excluded. If a resource is not specifically excluded, it is considered countable. * In certain situations, Federal law requires other people to share financial responsibility. In those situations, their resource(s) are considered along with those of the applicant/beneficiary. * If countable resources exceed the limit, an individual or couple is not eligible. |

[Table of Contents](#_top)

302.02 Resource Limit

(Eff. 10/01/05)

[(POMS SI 01110.003)](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501110003)

Federal law establishes a limit on the value of resources an individual or couple may own and still be eligible for Medicaid. The resource limit for adults follows the Supplemental Security Income (SSI) rules except in certain situations. The limits for each program will be explored in the program specific chapters.

302.02A Resource Reduction Period

(Eff. 12/01/23)

A resource reduction period is defined as the process of reducing excess resources below the maximum allowable resource limits. A resource reduction differs from an encumbrance because excess resources are not used to accommodate prior medical bills. If an applicant/ beneficiary’s combined resources exceed the resource limit, the Eligibility Specialist must allow up to 45 days from the **application received date** for the applicant to spend down the resources for Non-MAGI programs. Encumbrance (MPPM 302.29) must be explored for all liberalized Non-MAGI and Long-Term Care categories before a resource reduction is requested.

**For individuals applying for Long Term Care, refer to 304.05.02A.**

A resource reduction may occur when:

* An applicant purchases a preneed burial contract during the month of application or in a month after applying for Medicaid
* An applicant purchases personal items during the month of application or in a month after applying for coverage
* An applicant no longer has the funds during the month of application or in the month after applying. (Non-MAGI does not request verification of how the money was used. Long-Term Care does request verification of how the money was spent.)

If an applicant applying for Non-MAGI coverage is over the resource limit after the Eligibility Specialist determines the individual is otherwise eligible, it must be determined if the resources can be reduced below the limit within 45 days of the application date. The Eligibility Specialist must contact the applicant or authorized representative via collateral call, explain the available options to reduce the excess resources, and follow-up in writing with a DHHS Form 1233.

* The Eligibility Specialist must contact the applicant or AR via collateral call to inform the applicant they are over the resource limit, explain what options are available for reducing the excess resources within 45 days from the application date and follow-up in writing with a DHHS Form 1233.
  + If the applicant indicates that the resources cannot be reduced within 45 days of the application date, deny the application.
  + If the applicant indicates that the resources can be reduced within 45 days of the application date:
    - The applicant will be required to contact the agency within 45 days to report if they are under the limit
      * If the applicant reports that they are over the limit, deny the application for excess resources
      * If the applicant reports they are under the limit, the Eligibility Specialist must verify the current value of the resources
        + If countable value is under the limit, determine eligibility
        + If countable value is over the limit, deny for excess resources
      * If the applicant fails to contact the agency, the application is denied for excess resources.

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| **Resource Reduction Procedure** |
| If the applicant has alleged that the resource is no longer available to them, the Eligibility Specialist must request updated records indicating that the applicant no longer has the resource(s). Examples of verifications include any combination of the following:   * Bank Statements, Teller Receipts, Receipts showing dates funds were spent, and/or AVS Results (only as a last resort) * Letter from a life insurance company showing a loan against the cash surrender value, life insurance policy showing a change in ownership, etc. * Account closure letters for annuities * Document showing that an individual no longer owns real or personal property or showing there is a bona fide effort to sell   This verification must be obtained before allowing a reduced equity value for resources. Once the verification is received, the equity value of the resources can be established for the month the resources were spent down.  IMPORTANT: While a resource reduction is beneficial for both Non-MAGI and Long-Term Care, a Non-MAGI applicant must keep in mind the following:   * If Long-Term Care services are needed within the next 5 years, any resources gifted to someone other than a spouse during a resource reduction could result in a transfer of assets for less than Fair Market Value. * Verification that the applicant is no longer the owner of a resource is required for Non-MAGI. For Long-Term Care, verification of how a resource was spent is also required. |

302.03 Resource Definitions

(Eff. 10/01/05)

|  |  |  |  |
| --- | --- | --- | --- |
| Type | **Definitions** | **Examples** | **POMS** |
| General Definition | All assets, including real and personal property, which an individual or couple:   * Owns * Can apply toward basic needs of food, clothing, and shelter – either directly or by conversion * Is not legally restricted from use for support and maintenance | * Home * Land * Bank Accounts * Burial Assets * Life Insurance * Automobiles * Investments | [SI 01110.100](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501110100) |
| Liquid Resources | Cash or items that are readily converted to cash (within 20 days) | * Stocks, bonds and mutual fund shares * Checking and savings accounts, time deposits, CDs * US Savings Bonds, treasury bills, notes * Mortgages and promissory notes | [SI 01110.305](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501110305) |
| Non-Liquid Resources | Are not cash and are not readily convertible to cash | * Building, land, and other real property rights * Vehicles * Farm machinery and livestock * Household goods and personal effects * Non-cash business property | [SI 01110.310](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501110310) |
| Exclusion | A resource, or part of a resource’s value, that is not considered in the eligibility determination | (Refer to list in MPPM [302.14](#S_302_14).) |  |
| Countable Resources | Resources remaining after all exclusions are applied.  \*\*The current or fair market value of resources must be verified and the equity value considered. |  |  |
| Current or Fair Market Value (CMV or FMV) | The amount a resource can be expected to sell for on the open market or the sales price, if sold for a higher amount. |  |  |
| Equity Value | The current market value minus any legal debt (payoff amount) | House has a market value of $150,000. The mortgage payoff is $80,000. The equity value is $70,000. |  |
| Conserved Funds | Funds or property being held for an individual by another person | Daughter has $30,000 in a bank account in her name, but it is actually her parents’ money. She uses it exclusively for their needs. |  |

[Table of Contents](#_top)

302.04 Resources vs. Income

(Eff. 10/01/05)

It is important to distinguish between resources and income to know which rules to use for any given month. An item is not subject to both income and resource rules in the same month.

**Income**

Items received in cash or in-kind during a month are evaluated under the income rules.

**Resources**

Items evaluated under the resource rules include any income retained for use in the month after it is received and all other items not defined as income.

**Converted Resources**

If an individual sells, exchanges, or replaces a resource, what he receives in return is a resource that has been converted from one type of resource to another.

Examples of converted resources:

* A lot with equity value of $5,000 is sold, and the money is deposited into a money market account.
* A life insurance policy is cashed in, and the proceeds are used to purchase a pre-need burial contract.
* An individual sells a piece of property for $25,000. The $25,000 is a resource.

**Note:** When a resource changes form, it may change: (1) from an excluded resource to a countable one, (2) from a countable resource to an excluded one, or (3) to something that is not considered a resource for Medicaid purposes.

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| **Example #1**  An excluded vehicle is sold, and the proceeds are deposited into a checking account. The money received then becomes countable.  **Example #2**  A life insurance policy with a face value of $15,000 and a cash value of $9,500 is cashed in, and the proceeds are used to purchase a paid-in-full cemetery plot for the applicant/beneficiary (excluded) and an irrevocable pre-need burial contract (not a resource after 30 days). |

[Table of Contents](#_top)

302.05 Liberalized Resource Policy

(Rev. 10/01/07)

The Social Security Act allows states the option of using more liberal resource criteria than SSI in certain instances. South Carolina has received approval to use the following liberalized policies for the ABD, QMB, SLMB, Working Disabled, QDWI, Institutional, and Home and Community-Based Services programs.

Liberalized policies include the following:

* Eligibility may be established effective the first day of the month, if the countable resources fall below the limit at any time during the month.
* The value of one vehicle is automatically excluded.
* The value of life estate interest in real property is excluded. (Refer to MPPM [302.08.03](#S_302_08_03).)
  + Real property may be located in another state.
  + The individual may have more than one life estate – all are excluded.
* The value of household goods and personal effects is excluded.
* The value of undivided interest in real property is excluded.
* The value of an un-probated estate is excluded. (Refer to MPPM [302.13](#S_302_13))
* The cash value of life insurance is excluded, if the combined face value of all policies is $10,000 or less.
* The burial fund exclusion is not offset by the face values of life insurance.

302.06 Whose Resources to Count

(Rev. 10/01/10)

[POMS SI 01110.530](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501110530)

When eligibility is determined or re-determined, the resources of the following must be considered:

* Applicant/beneficiary
* Spouse (legal or common law) of the applicant/beneficiary
  + If they live in the same household
  + Even if they are not applying or are ineligible (**Exception:** Institutionalized individuals discussed in MPPM Chapter 304).
* Parent(s) of an applicant/beneficiary who is a child under age 18 if living in the same household.

Funds or property being held or conserved for an individual by another person are considered as a resource for the individual, even if the individual’s name does not appear on the title of the resource. The policy in effect for the type of resource must be used to make the eligibility determination for the individual. For example, a daughter has a bank account only in her name, but the money is being held for her father and his Social Security checks are being deposited into the account; the account is considered a resource for the father.

302.07 Unknown Assets

(Eff. 10/01/05)

[POMS SI 01110.117](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501110117)

An individual may be unaware of his ownership of an asset. The asset is not a resource for the period during which the individual is unaware of his ownership.

Once discovered, the value, including any monies accumulated on it through the month of discovery, must be treated as follows:

* Month of discovery – treated as income
* Month after the month of discovery – any remaining value is a resource

302.08 Ownership Interest

(Eff. 10/01/05)

[POMS SI 01110.510](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501110510)

The type and form of ownership may affect the value of property and its status as a resource.

302.08.01 Sole Ownership

(Eff. 10/01/05)

|  |  |
| --- | --- |
| **Type of Ownership** | **What it Means** |
| Sole Ownership | Only one person owns the property and may sell, transfer or dispose of the property. |

302.08.02 Shared Ownership

(Eff. 10/01/05)

| **Type of Ownership** | **What it Means** |
| --- | --- |
| Shared Ownership | Two or more people own it together |
| Tenancy-in-common | * Two or more people have an undivided fractional interest in the whole property. * Interest may not be equal. * One may dispose of his share without permission of the other owner(s). * When one owner dies, his interest passes to his heirs or estate. * No automatic right to survivorship |
| Joint Tenancy | * Each person has an undivided interest in the whole property. In effect, each owns all of the property. * Right to survivorship applies to the other owner(s). |
| Tenancy by the entirety | * Exists only with married couples * While married, property can only be disposed if both give consent. * Right to survivorship applies. * If divorced, they become tenants-in-common and each can sell without the other’s consent. |
| **Procedure:**   * Assume each owner owns only his fractional interest unless there is evidence otherwise. * Divide the total value among the owners to match their percentage of ownership.   + If each of two owners owns ½ interest, divide by two.     - FMV $50,000 – each has a resource worth $25,000.   + If there are two owners, one owns 1/3 and the other 2/3.     - FMV $90,000     - FMV ($90,000) ¸ 3 = $30,000, the value for the first owner.     - $30,000 x 2 = $60,000, the value for the second owner. | |
| **Exception #1**  Joint bank accounts or time deposits (Jim Smith or Eve Thomas). All of the funds belong to the individual in equal shares if there is more than one applicant/beneficiary. If only one account holder is an applicant/beneficiary, the entire account is counted as his. | |
| **Exception #2**  For an institutionalized individual with a joint bank account or time deposit (Jim Smith or Eve Thomas), assume all of the funds belong to him. | |

[Table of Contents](#_top)

302.08.03 Equitable Ownership

(Eff. 02/01/06)

An equitable ownership interest exists without legal title to property. It can exist despite another party’s having legal title or no one having it. A court of equity determines the existence of an equitable ownership interest. However, under certain circumstances, the eligibility worker can conclude that an equitable ownership exists and make a resource determination accordingly.

|  |  |
| --- | --- |
| **Type of Ownership** | **What it Means** |
|  | * Exists without legal title to property. * Legal title may belong to another or to no one.   **Examples:**   * Person allows someone, such as a child, to purchase a car in his or her name due to insurance or credit problems. The child makes the payments on the vehicle, but it is in the parent’s name. * A person may gain equitable ownership in a home by making mortgage payments or paying for improvements. |

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| **Procedure:**  If equitable ownership is alleged, obtain corroborating evidence to support the allegation such as:   * Property – Cancelled checks showing the other person is making/made the payments * Bank Accounts – Verification such as whose money was used to establish the account, or verification of who makes the deposits and withdrawals. * Statements from both parties as to why the resource is showing in the applicant/beneficiary’s or their spouse’s name.   If equitable ownership is verified, do not count as a resource for the applicant/beneficiary. |

| **Type of Ownership** | **What it Means** |
| --- | --- |
| Life Estate Interest | * Individual has certain property rights during his life or someone else’s life. * May be conditional (**Example:** surviving spouse has the right to live in the home until remarriage). * Legal document is required (such as a will or deed). * Unless the legal document restricts rights, the life estate owner has the right to possess, use, and obtain profits from the property (such as rents). * Life estate interest can be sold. |
| **Procedure:** A life estate is excluded. This exclusion is not limited to property located in South Carolina. In addition, if an individual has a life estate interest in more than one piece of property, all are excluded. If a life estate is transferred or sold, eligibility for vendor payment or HCBS may be affected, refer to MPPM 304.08. | |

| **Type of Ownership** | **What it Means** |
| --- | --- |
| Remainder Interest | * Remainderman inherits property upon the death of the life estate holder. * No right to possess or use the property until the life estate terminates * Remainder interest may be sold before the termination of the life estate unless the document establishing it restricts this right. |
| **Procedure:** A remainder interest is excluded. If a remainder interest is transferred or sold, eligibility for vendor payment or HCBS may be affected, refer to MPPM 304.08.  When the life estate holder dies, the remainderman attains ownership of the resource, which must then be evaluated under the appropriate resource policy. | |

[Table of Contents](#_top)

| **Type of Ownership** | **What it Means** |
| --- | --- |
| Un-probated estate | An individual may have an equitable ownership in an un-probated estate if he:   * Is an heir or relative of the deceased * Receives income from the property * Acquires rights through intestacy laws |
| **Note:** An un-probated estate is excluded. | |

| **Type of Ownership** | **What it Means** |
| --- | --- |
| Trusts | Trustee holds legal title.  Beneficiary has equitable ownership. |
| **Procedure:** All trust documents must be sent to Policy and Process Management for review and for clearance on how the trust affects eligibility. | |

| **Type of Ownership** | **What it Means** |
| --- | --- |
| Fee simple | * Absolute, unconditional ownership of real property * At owner’s death, property passes to his heirs. * Can apply to solely- or jointly owned property. |

[Table of Contents](#_top)

302.08.04 Property Rights with No Ownership

(Eff. 10/01/05)

| **Type of Ownership** | **What it Means** |
| --- | --- |
| Leasehold | Individual has use and possession of property for a specific time period and usually for a specified rent. |
| **Procedure:** A “lease for life” must be sent to Policy and Process Management. | |

| **Type of Ownership** | **What it Means** |
| --- | --- |
| Incorporeal Interests | No ownership of the physical property  Applies to: Mineral Rights, Timber Rights and Easements |
| Mineral Rights | Ownership in natural resources such as coal or oil, coming from the property. |
| Timber Rights | Permits one party to cut and remove trees from property owned by another. |
| Water Rights | Gives owner of river or shore front property the right to access and use the adjacent water. |
| **Procedure to Determine the Value of Incorporeal Rights:**  The value of Incorporeal Rights must be verified by a knowledgeable source. The knowledgeable source must be familiar with values of such incorporeal rights in the area. The knowledgeable source must not be related to the applicant/beneficiary or to a member of his or her immediate family.  **Examples of Knowledgeable Sources:**   * Local office of the Farmer's Home Administration or Agricultural Stabilization and Conservation Service for rural land * County Agricultural Extension Service   **The knowledgeable source statements must contain the following information:**   * A description of the property to which the individual has the incorporeal right; * The estimated value; * The period of time to which the estimate applies; and * The name and business address of the person providing the estimate.   If the validity of the estimate is doubtful, obtain a second knowledgeable source statement. | |

302.09 Factors That Make Property a Resource

(Eff. 10/01/05)

[POMS SI 01120.010](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501120010)

Property of any kind, including cash, is a resource only if it meets all criteria listed below.

| **Resource** |
| --- |
| **Ownership Interest**  An individual must have some form of ownership interest in property in order for the property to be considered a resource. The fact that an individual has access to property, or has a legal right to use it, does not make it a resource if there is no ownership interest. |
| **Legal right to access (spend or convert) property**  An individual must have a legal right to access property. Even with ownership interest, property cannot be a resource if the owner lacks the legal ability to access funds for spending or convert non-cash property into cash.  The fact that an owner does not have physical possession of property does not mean it is not his resource. It is a resource if the owner still has legal ability to spend it or convert it into cash.  An individual has free access to, and unrestricted use of, property even when he can take actions only through an agent (such as a representative payee or conservator) |
| Legal ability to use for personal support and maintenance Even with ownership interest and legal ability to access property, a legal restriction against the property’s use for the owner’s own support and maintenance means the property is not a resource. |

302.10 Access to Resources

(Rev. 04/01/24)

S.C. Code Ann. § 62-5-100

Unless there is a court order signed by a judge stating an individual has been declared incapacitated, he is capable of managing his own affairs under state law and his resources are countable for Medicaid eligibility purposes. (Note: Competency does not affect consideration of resources.)

302.10.01 Individual Declared Legally Incompetent

(Eff. 10/01/05)

|  |  |
| --- | --- |
| **Court has appointed Guardian or Conservator** | **Court has not appointed Guardian**  **or Conservator** |
| Resources owned by the individual are considered available resources.  Individual may not dispose of property but the conservator can with court approval (in South Carolina).  Seeking Court approval   * Is NOT a legal restriction to the sale or disposal of property * Does NOT change the property’s status as a countable resource to the individual | Resources owned by the individual are NOT considered available. Individual does NOT have access to the resource until a guardian or conservator is appointed. |

[Table of Contents](#_top)

302.10.02 Types of Access

(Eff. 10/01/05)

Resources are accessible through an agent, litigation, or a petition-conservatorship account. Listed below is more information on these three types of access to resources.

* Access Via an Agent [POMS SI 01120.020](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501120020)

An individual is considered to have free access to, and unrestricted use of, property even when he can take those actions only through an agent (such as a representative payee or guardian)

|  |
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| **Example**  Jean Simmons receives Social Security benefits. Her mother, Laura Simmons, is her representative payee and has Power of Attorney. The check goes to a bank account named “Laura Simmons for Jean Simmons.” The bank account is a countable resource because Jean has unlimited use through her mother. |

* **Access Only Via Litigation**

If there is a legal restriction, or a bar, to the sale or use of property (such as a co-owner legally blocks the sale of jointly-owned property), an individual is not required to undertake litigation in order to accomplish the sale or access. The property is not a resource under such circumstances in a month if a legal bar exists as of the first moment of that month.

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| **Example #1**  Cindy Lorrick and her sister, Sallie Comer, co-own a piece of property inherited from their parents. Last year, Sallie took legal action to prevent Cindy from selling. Cindy is not required to enter into litigation to gain the ability to sell, so the property is not a resource.  **Example #2**  Stella Black applied for ABD in March. She co-owns a piece of property with her sister valued at $25,000. She wanted to sell it, but a legal restriction placed on it on April 5 prevents this. Since the restriction was not in place until April, the property is countable in March and excluded in April. |

* **Access Via Petition - Conservatorship Account** [POMS SI 01140.215](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501140215)

Petitioning a court is different from undergoing litigation. Seeking court approval is not a legal restriction against use. Although the individual does not have access to the asset, the conservator does. Therefore, it is available for the individual's support and maintenance and is, therefore, that individual's resource. This is true despite the fact that the individual or his agent is required to petition the court to withdraw funds for the individual's support and maintenance.

[Table of Contents](#_top)

302.11 Retirement Funds

(Eff. 10/01/05)

[POMS SI 01120.210](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501120210)

Retirement funds are annuities or work-related plans that are designed to provide income when work ends. Listed below are some examples:

* Pensions, disability, or retirement plans administered by an employer or union
* 401K
* IRA
* Keogh or Roth plans
* Some profit sharing plans

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| Procedure – Retirement Fund  Value of the Fund:  The resource value of the fund is the amount that can currently be withdrawn after deducting certain expenses   * The amount of a penalty is deducted when determining a value. * The amount of any taxes due is NOT deducted.  When is a Retirement Fund a Resource? When the individual has the option of withdrawing a lump sum even if he is not eligible for periodic payments   * If the individual applies for period payments and is denied, the value becomes a countable resource the month after the month periodic payments are denied. * A delay in payment beyond the individual’s control makes it a non-liquid resource.   **When is it Not a Resource?**   * When a person must terminate employment to obtain payment. * When a person is eligible for and is receiving periodic payments.   Note:   * Periodic Payments   + An individual must apply for them if eligible.   + If he has a choice of a lump sum or periodic payments, he must take the payments.   + The periodic payments are counted as income. * Ineligible spouses   + Any retirement funds owned by an ineligible spouse are excluded as a resource.   + Periodic payments are counted as the spouse’s income. * Previously unavailable funds are a countable resource the month after the month it becomes available.  Types of Verification:  * Pension or annuity statements * Letter from plan manager * Check stubs |

[Table of Contents](#_top)

302.12 Loans, Promissory Notes and Property Agreements

(Eff. 10/01/05)

[POMS SI 01120.220](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501120220)

[POMS SI 01140.300](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501140300)

This section involves the principal amounts of these items. The interest paid is ALWAYS considered unearned income. All promissory notes must be sent to the Bureau of Eligibility Administration for evaluation and approval.

**Bona Fide Agreement —** legally valid and made in good faith

* May be written or oral
* Oral agreement is bona fide if it is legally binding and includes:
  + Borrower’s acknowledgement of his obligation to repay
  + A schedule and plan for repayment
  + Borrower’s intent to repay from income or property

**Negotiable Agreement—**legal title to the agreement or the amount of the agreement can be transferred to another party

**Loan—**One party gives money to another party who promises to repay it in full.

* It may or may not include paying interest.
* It must be written (promissory note) and enforceable under State law.

**Promissory Note—**Written agreement where one person promises to pay another party a specific amount at a specific time.It can be repayment of money or a payment for services or goods.

**Property Agreement—**a piece of property is used to secure payment of a debt or performance of services. Other names for property agreements include:

* Mortgage
* Land contract
* Contract for deed

A person holding a contract for the sale of real estate owns two things until the agreement is settled: (1) the real estate and (2) the value of the agreement. (**Note:** The real estate is not a resource because it cannot be sold.)

A contract must be evaluated to determine if it is a resource and, if so, how it should be treated.

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| **Procedure – Individual is the Seller or Creditor**  **Bona Fide, Negotiable Agreement:**   * The agreement is a resource. * The goods or money represented in the agreement are not a resource because they are not accessible – the agreement replaces them as a resource. * Debtor’s payments against the principal are a conversion of a resource, not income.   **Example**  Debtor pays $500 per month–$350 toward principal and $150 in interest. The $350 is a converted resource and the $150 is unearned income.) **Non-Bona Fide, Non-Negotiable Agreement:**  * The agreement is not a resource. * Payments are income, not a converted resource. * The goods or money represented in the agreement may be a resource if the seller/creditor has access for his own use.   **Types of Verification:**   * Copy of Agreement * Courthouse checks: online or via [DHHS Form 1255 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201255%20ME.pdf), Verification of Real and Personal Property |

302.13 Inheritances and Un-Probated Estates

(Eff. 10/01/05)

[POMS SI 01120.215](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501120215)

Unprobated estates are excluded from resources until probate is completed. The eligibility worker must evaluate the status of the unprobated estate at annual review.

An inheritance is a not a resource until the month following the month in which it meets the definition of income. Thereafter, if retained, the property is evaluated as a resource. (Refer to MPPM 304.09 for information about transfer of assets in Nursing Home and other institutional categories.)

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| Procedure  Obtain copies of the will and/or probate records either from the beneficiary/authorized representative or through the probate court (via [DHHS Form 1255 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201255%20ME.pdf), Verification of Real and Personal Property). If the probate is complete, there should be a discharge order in the court records but the status can be verified through the court staff.  An individual’s relationship to a deceased person may be verified by:   * Court records * Birth certificates * Marriage license |

[Table of Contents](#_top)

302.14 Resource Exclusions

(Eff. 10/01/05)

The value of the resources in this section may be excluded, in part or in whole, when determining eligibility.

302.14.01 Home Property

(Rev. 04/01/24)

[POMS SI 01130.100](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130100)

An individual’s home is property he has ownership interest in and is his principal place of residence. It may include:

* The shelter he lives in.
* The land on which the shelter is located.
* All buildings on the land.

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| Procedure – Home Property:   * A principal place of residence is the dwelling that an individual considers his principal home and to which he intends to return. It may be:   + Real or personal property   + Fixed or mobile   + Located on land or on water (**Example:** If a person who owns and resides in a houseboat on the lake, the boat may qualify as home property.) * Even though it will be excluded, ownership of homestead property must be verified. * If a person owns land and intends to reside on it, it may be considered home property if there is no other principal place of residence. * If a person owns the land but not the shelter, the land is considered the residence. (**Example:** A person owns the land he lives on but lives in a mobile home owned by his parents.) * If a person owns the shelter but not the land, the shelter is the residence. (**Example:** A person owns the mobile home but rents the lot on which the home is located.)   **Treatment**  An individual’s home, regardless of value, is an excluded resource for Medicaid eligibility if the individual:   * Resides in the home; or * Intends to return to the home. (**Example:** An individual is residing with his children due to illness but intends to go home when health permits. The intent is based entirely on the person’s **desire** to return home.)   The intent to return must be documented in the case record by one of the following:   * Answering “Yes” to the intent to return question on the [DHHS Form 3401](https://www.scdhhs.gov/sites/default/files/3401_HealthyConnections_Inst_OSS.pdf), Healthy Connections Application for Institutional/Waiver/OSS or [DHHS Form 3400-B](https://www.scdhhs.gov/sites/default/files/FM3400-B-HealthyConnectionsAddendumForInstitutionalWaiver.pdf), Healthy Connections Additional Information for Institutional/Waiver Services. * Completing and signing a [DHHS Form 1277](http://medsweb.scdhhs.gov/EligibilityForms/FM%201277%20ME.pdf), Statement of Intent to Return Home   **Note**  If the individual has returned home during the process of making an eligibility determination, the intent to return is assumed and a DHHS Form 1277 is not needed.  **The home exclusion applies to:**   * The shelter in which he lives. * All buildings on the excluded property. * The land on which the shelter is located AND any land adjoining it as long as it is not separated by land that neither the individual nor his spouse has ownership interest in.   **Example:** Property would be considered adjoining if the road were not there. Things such as easements, roads, and utility lines do not separate land. |

[Table of Contents](#_top)

If an individual leaves the home and does not intend to return to it, it is no longer considered the principal place of residence. The home exclusion no longer applies as of the date the individual leaves with the intent not to return or the date he no longer intends to return. The month after there is no intent to return, the property will then be considered a countable resource unless another exclusion develops.

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| **Procedure:**  **A home can be excluded without an intent to return, if:**   * A spouse or dependent relative of an institutionalized individual resides in the home.   + Dependency may be financial or medical.     - Verification includes: tax returns, cancelled checks   + Relatives may include:     - Child, step-child, grandchild     - Parent, step-parent, grandparent     - Sibling, step-sibling, half sibling     - Aunt, uncle, cousin, niece, nephew     - In-law     - Verification includes birth certificates, marriage license, family records, court orders * Sale of the home would cause an undue hardship to a co-owner due to loss of housing. (**Note:** Co-ownership would need to be verified with a copy of the deed or title and [DHHS Form 1255](http://medsweb.scdhhs.gov/EligibilityForms/FM%201255%20ME.pdf), Verification of Real and Personal Property.) * If the individual has returned home during the process of making an eligibility determination, the intent to return is assumed and a DHHS Form 1277 is not needed. |

[Table of Contents](#_top)

302.14.02 Home Replacement Funds

(Eff. 10/01/05)

[POMS SI 01130.110](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130110)

If an individual sells an excluded home, the proceeds may be excluded if he:

* Plans to buy another excluded home.
* Buys the home within 3 full calendar months of receiving the proceeds.

302.14.03 Installment Sales Contract

(Eff. 10/01/05)

[POMS SI 01130.110](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130110)

If the proceeds from the sale of an excluded home are received under an installment sales contract, the contract is excluded if the individual:

* Plans to use the entire down payment and the entire principal portion of the payment to buy another excludable home.
* Purchases the new home within 3 calendar months of receiving the down payment or installment.

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| Procedure  The case record must contain a signed statement from the individual/authorized representative that he intends to purchase a new home.  **What is considered a proceed from the sale?**   * Lump Sum – The net amount the seller receives at closing/settlement * Installments – Down payment and/or principal portion of any installment payment   **Verification:**   * Copy of closing/settlement papers * Copy of installment contract and amortization schedule   **Proceeds may be used for the following expenses when buying another excludable home:**   * Down payment * Closing/settlement costs * Loan processing fees and points * Moving expenses   + Necessary repairs or replacement of the new home’s structures or fixtures IF identified and documented before the new home is occupied. This may include: Roof; heating and air conditioning; plumbing; built in appliances. * Mortgage payments   **Types of Verifications:**   * Copy of closing statement * Copy of loan application * Copy of home inspection reports * Receipts for moving expenses and/or repairs   **What happens if the proceeds are not re-invested in a timely manner?**   * Lump Sum – the exclusion is revoked retroactively to the date of receipt. * Installment Contract – the exclusion of the contract itself and the unused portion of any installments received are revoked retroactively to the date the unused proceeds were received.   + The exclusion may be reinstated if a new intent is signed within three (3) full calendar months of receiving an installment. Reinstatement is effective with the date the new intent is signed**.** |

[Table of Contents](#_top)

302.14.04 Jointly Owned Property

(Eff. 10/01/05)

[POMS SI 01130.130](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130130)

If an individual owns property jointly with another person(s), the value of his interest may be countable unless the sale would cause an undue hardship to a co-owner due to loss of housing.

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| **Procedure – Jointly Owned Property**  **Undue hardship would result if the co-owner:**   * Uses the property as his principal place of residence. * Would have to move if the property was sold. * Has no other readily available housing.   **Example:**  Mr. Allen and his son jointly own a piece of land. The son and his family live on the property and have no other place to live. Mr. Allen applies for Medicaid. The property is excluded because the sale would cause an undue hardship to his son.  However, if the son owned another house nearby which was vacant and inhabitable, there would be other available housing. In this case, undue hardship would not exist. The value of Mr. Allen’s interest would be countable. |

[Table of Contents](#_top)

302.14.05 Bona fide Effort to Sell

(Rev. 10/01/23)

[POMS SI 01150.201](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501150201)

Real property may be excluded if an individual is making a reasonable, bona fide effort to sell it. Such efforts include listing it for sale with a real estate agent, media advertisements, and conducting regular open houses. The individual must maintain their effort to sell unless good cause exists. Good cause exists when circumstances beyond an individual's control prevent his taking the required actions to accomplish reasonable efforts to sell. In addition, he must accept a reasonable offer for the property. An offer to buy or sell property is reasonable or legitimate if the offer is at least two-thirds of the estimated Current Market Value (CMV) unless the owner proves otherwise.

In the liberalized resource categories, the resource may be excluded beginning the month it is put up for sale.

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| **Procedure – Bona Fide Effort to Sell**  **Types of Verification:**   * Copy of listing with a realtor * Advertisement in newspaper or other media * “For Sale” sign on property   Step for Eligibility Worker:  Verification of the continued effort to sell must be documented in the case record.  **Examples of Good Cause:** No offer to buy received.A legitimate offer does not result in a sale.Escrow begins but closing does not take place within the disposal period.Incapacitating illness or injury, such as the individual becomes homebound or hospitalized for a prolonged period due to illness or injury and cannot take the steps necessary to sell the resource or to arrange for someone to sell it on his behalf.  * Part owner of a resource dies, and administration or probate of the estate delays efforts to sell the resource (assuming that the property continues to be a resource).   **Example #1**  Dale Livingston is a patient at Caring Hearts Nursing Home. He applied for Nursing Home Assistance on July 25 after he listed some non-home property for sale with a realtor on July 14. The eligibility worker obtains a copy of the sales listing which verifies the date the property was listed for sale. The property is an excludable resource beginning July.  **Example #2**  Samantha Ryan has a piece of property up for sale by owner. The case record contains copies of the following: newspaper advertisement, the receipt paying for 8 weeks of advertisement, and a photograph of the For Sale By Owner sign.  **Example #3**  Gladys Lorick is a Medicaid beneficiary whose property has been excluded due to a bona fide effort to sell. Her daughter (and Power of Attorney) accepted an offer on the property. However, the buyer backed out of the deal at closing. Ms. Lorick immediately started sales efforts again. Good cause exists. |

[Table of Contents](#_top)

302.15 Resource Exclusions for Tribal Members

(Eff. 07/01/11)

[POMS SI 01130.150](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130150)

The American Recovery and Reinvestment Act of 2009 (Recovery Act), requires States to exclude certain types of Indian-specific property from being considered as “resources” when determining Medicaid or CHIP eligibility for an individual who is an Indian.

Resources are excluded in two categories:

* Property connected to the political relationship between Indian Tribes and the Federal government; and
* Property with unique Indian significance

The following resources must be excluded:

* Property, including real property and improvements, that is held in trust, subject to Federal restrictions, or otherwise under the supervision of the Secretary of the Interior; located on a reservation, including any federally-recognized Indian Tribe’s reservation, pueblo, or colony, including former reservations in Oklahoma, Alaska Native regions established by the Alaska Native Claims Settlement Act and Indian allotments on or near a reservation as designated and approved by the Bureau of Indian Affairs of the Department of the Interior.
* For any federally-recognized Tribe not described in paragraph (1), property located within the most recent boundaries of a prior Federal reservation.
* Ownership interests in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish) resulting from the exercise of federally-protected rights.
* Ownership interests in or usage rights to items not covered by paragraphs (1) through (3) that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable Tribal law or custom.

302.16 Automobiles

(Rev. 02/01/23)

[POMS SI 01130.200](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130200)

An automobile is any vehicle used for transportation. It can be motorized or animal drawn. All vehicles must be considered in the eligibility process – even those that are unregistered or inoperable.

**Examples of Automobiles**

* Car or truck
* Boat
* All-terrain vehicle
* Horse-drawn wagon
* Horse

Medicaid automatically excludes the first vehicle regardless of value. It may be possible to exclude a second vehicle using SSI policy. If an exclusion cannot be developed, verify the current market value and/or equity value of the vehicle.

A second automobile per household is excluded regardless of the value if it is used for transportation of the applicant/beneficiary or a member of the individual’s household.

**ASSUMPTION:** Assume the automobile is used for transportation, absent evidence to the contrary.

The equity value of any automobile, other than those excluded, is a resource when it:

* Is owned by the applicant/ beneficiary; and
* Cannot be excluded under another provision (for example, property essential to self-support, plan for achieving self-support, or conditional benefits).

The following vehicles do not meet the definition of an automobile:

* A vehicle that has been junked;
* A vehicle that is used only as a recreational vehicle (such as a boat used on weekends for pleasure).

The equity value of such a vehicle is a resource.

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| **Procedure – Excluded/Non-Excluded Vehicle(s):**   * Medicaid automatically excludes one vehicle regardless of value. * A second vehicle for the individual or a household member may be excluded regardless of value if it is used for transportation. * The ownership of all vehicles must be verified.   + For liberalized categories, attestation can be used to verify ownership for up to two vehicles. Additional verification is not required.   + If there are three or more vehicles, verification of ownership and value must be completed according to the Vehicle Ownership and Value procedures shown below. * The exclusion(s) may be applied in a way that is most advantageous to the applicant/ beneficiary. Apply the exclusion to the automobiles with the greater equity value, * If the value of an automobile cannot be excluded, the equity value is countable toward the resource limit. |

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| **Procedure – Vehicle Ownership and Value**  **Verification:**  To Determine Ownership of Vehicle   * Accept self-attestation if one or two vehicles are alleged * [DHHS Form 1255 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201255%20ME.pdf), Verification of Real or Personal Property * Vehicle registration or title * Tax receipt * Court House records * Statement from a knowledgeable source * DMV Web Tool – Can be used to view vehicles, boats, and mobile homes that are titled in an individual’s name. This information can be considered as lead information and the eligibility worker must follow-up with the applicant/beneficiary if there is a discrepancy between what was reported on an application or review and the information shown on the DMV Web Tool.   + To access the DMV Web Tool:     - Go to <https://www.scdmvonline.com/DMVmember/logon.aspx>. This is a secure log-in requiring authorization with an agency assigned User ID     - Select the button next to “Title History” in the “Type of Report” box. Click on the “Name Search” button.     - Enter first name, last name, and birth date; or Business name and city. Click the “Submit” button. A list of vehicles titled to that individual or business will appear.   To Determine Current Market Value of Vehicle   * Kelley Blue Book (<http://www.kelleybluebook.com/>) * NADA (<http://www.nadaguides.com/>)   **Note**  When using Kelley Blue Book, use the “trade-in” value for Medicaid purposes. These figures are available through the hard copy book or online. If using the book, it must be the current month’s issue. Also, assume the vehicle is in average condition, absent evidence to the contrary.  To Determine Attributes of Vehicle   * + - Knowledgeable source statement to include the following:   + Detailed description of the automobile including the year, make, model, equipment, mileage, number of doors   + Estimated value   + Business address and telephone number of the source providing the information.   **Note**  The source must be a disinterested, unrelated party (such as a used car dealer, automobile insurance company, bank loan officer.)  To Determine the Pay-Off Amount of Vehicle   * Statement of pay off amount from the lender * Monthly loan statement/payment voucher, if payoff is indicated   **Note**  When money is owed on a vehicle, the equity value of the vehicle must be determined. The equity value of the vehicle is the FMV minus the pay-off amount. |

[Table of Contents](#_top)

302.16.01 Rebuttals

(Eff. 10/01/05)

An individual may indicate that a vehicle does not belong to him even though it is registered in his name. He must provide evidence to rebut ownership.

An individual may disagree with a value of an automobile. He must provide verification of the lesser value.

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| **Procedure – Rebuttal of Ownership:**  The individual/authorized representative must provide a written statement to include:   * Description of the automobile * Name, address, and telephone number of the alleged owner * Explanation of the inconsistencies in ownership records * Statement and corroborative evidence from the alleged owner   + Copy of the bill of sale if records do not show the change of ownership   + If equitable ownership is claimed, receipts or cancelled checks verifying alleged owner made or is making:     - Loan payments     - Tax payments     - Repairs/expenses   **Example**  Son’s vehicle is purchased in the father’s name because of the son’s credit but the son makes the loan and insurance payments. Obtain verification that the son is making the payments. |
| **Procedure – Rebuttal of Current Market Value:**  If the individual disagrees with the value established by the eligibility worker, he must obtain a written appraisal of the value from a knowledgeable source. He is responsible for any cost involved in obtaining the statement. |

302.17 Life Insurance

(Rev. 10/01/23)

[POMS SI 01130.300](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130300)

A life insurance policy is a contract. The purchaser (owner) pays premiums to the company (insurer). In return, the insurer agrees to pay a specified sum to a designated person(s), known as beneficiaries, upon the death of the insured person. The owner and the insured may or may not be the same person. The policy should state the owner’s name, if different from the insured.

Below are common terms associated with life insurance. (Refer to MPPM Chapter 104 – Appendix I for definitions of these and other terms.)

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| --- | --- |
| Cash Surrender Value | Dividend Accumulations |
| Face Value | Dividend Additions |
| Proceeds | Dividends |

Generally, the types of life insurance policies are:

* Term Life Insurance
  + Usually in effect for a specific length of time such as 20 years, or length of employment.
  + Does not accrue cash value.
* Whole Life Insurance
  + Accrues cash value.
  + Remains in effect unless the premiums are not paid or the policy matures.
* Burial Insurance – The terms of the contract prevent the proceeds from being used on anything other than burial expenses of the insured.

A life insurance policy is a resource if it generates a Cash Surrender Value (CSV). The value of the insurance policy is the cash surrender value.

Unless otherwise indicated, assume that a:

* Term policy without a table of CSVs, if it appears otherwise complete, does **not** generate a CSV;
* Life insurance policy that does not generate a CSV also does **not** pay dividends;
* Life insurance policy issued by a nonparticipating or stock company does **not** pay dividends;
* Life insurance policy issued by a participating or mutual company pays dividends.

**NOTE:** The kind of company issuing the life insurance policy is usually identified by a designation following its name on the face page of the policy (“participating” or “non-participating”).

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| **If bank statements were scanned into OnBase:**  Eligibility Specialist should review all bank statements turned in for potential information regarding life insurance companies; check for life insurance policy numbers, and any auto drafts from a life insurance company.   * If life insurance companies are found, the Eligibility Specialist should contact the applicant and/or authorized representative to determine the face value of the policy and make collateral calls to the insurance company if necessary.   + If the Eligibility Specialist is unable to make contact with the applicant and/or Authorized Representative, a DHHS Form 1233 Request for information along with DHHS Form 1280 (if a signed copy is not already in OnBase) needs to be sent to the applicant/beneficiary to request the needed information.   If a DHHS Form 1280 is signed and scanned in OnBase already, then the Eligibility Specialist should send the DHHS Form 1280 to the designated life insurance companies listed on the bank statement. |

If the attested total Face Value of policies owned by an individual insuring someone equals $10,000 or less, the life insurance can be excluded without additional verification. If there is a copy of the policy(ies) or other applicant/beneficiary provided verification in the case record, the eligibility specialist will use that information to verify the details of the policy in CGIS. If no copy of the policy or other verification is available, the Eligibility Specialist will indicate that the information is “unknown” and still consider the attested face value of the policies. Reminder: Whether countable or excluded, life insurance policy information, including the Face Values of policies attested to, must be documented on the documentation template and entered into CGIS even if other information is unknown.

If an applicant/beneficiary or his spouse owns life insurance, the policies may require to be verified. The individual/authorized representative should provide a copy of all the life insurance policies and the most recent dividend statement for each one. For all policies that cannot be excluded, verify the following:

* Owner
* Insured
* Face Value
* Date the life insurance policy was purchased
* Maturity date, if specified
* Policy number
* Address, phone number, or any contact information for the insurance company
* Information regarding whether the life insurance policy pays dividends and, if it does, what option the policy owner selected for their disposition (i.e., accumulations, additions, applied to premiums, paid by check)
* Current amount of dividend accumulations, if any.

If a policy is countable, in addition to what is listed above, verify the current CSV. This may be verified either by a statement from the company or by mailing a [DHHS Form 1280](http://medsweb.scdhhs.gov/EligibilityForms/FM%201280%20ME.pdf), Verification of Life Insurance Values, to the company. Make sure to include:

* any dividend additions that may increase the value of the policy, and
* any loans that may decrease the value.

If the total Face Value of policies owned by an individual insuring someone is greater than $10,000, the life insurance must be verified. If there is a copy of the policy(ies) or other applicant/beneficiary provided verification in the case record, the Medicaid eligibility worker does not have to verify the policy(ies) with the insurance company.

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| **Example:**  Bill and Jane Baggins are both applying and both own life insurance policies.  Bill Baggins owns:  Policy One: Bill’s son, Jimmy is the insured and the policy’s FV is $10,000.  Policy Two: Bill’s daughter, Jannie is the insured and the policy’s FV is $10,000.  Policy Three: Bill’s wife, Jane is the insured and the policy’s FV is $10,000.  Policy Four: Bill is the insured and the policy’s FV is $10,000.  Jane Baggins owns:  Policy One: Jane’s husband, Bill is the insured and the policy’s FV is $10,000.  Policy Two: Jane’s daughter, Jannie is the insured and the policy’s FV is $10,000.  Policy Three: Jane’s son, Jimmy is the insured and the policy’s FV is $10,000.  Policy Four: Jane is the insured and the policy’s FV is $10,000.  All policies are excluded except for any dividend accumulations that have occurred. |

After exclusions are developed, any remaining cash value must be considered in the eligibility determination. The cash surrender value of any policy that cannot be excluded is countable toward the resource limit.

[Table of Contents](#_top)

302.17.01 Development of Countable Life Insurance

(Rev. 09/01/14)

Consider the resource value of a life insurance policy to be its cash surrender value (CSV), not its face value (FV).

* Term life insurance policies do not have cash value and are not included.
* Burial insurance policies are not included.

There is a difference between being the insured, the owner, and the beneficiary of the policy.

**Insured**

The insured is the person on whose life the insurance company issues the policy.

**Owner**

The owner of a policy is the one who has control of the policy. He may take such actions as:

* Cash in a policy
* Take a loan against the cash value
* Change ownership to another person
* Change the beneficiary

An individual may own life insurance on himself or on another person. A life insurance policy can be a resource only to the owner of the policy.

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| **Note**  The value of any life insurance policies owned by an individual must be considered in the eligibility determination process. |

**Beneficiary**

The beneficiary is the individual(s) who receives the proceeds of the policy at the insured individual’s death.

A person may be both the owner and the beneficiary. (**Example:** Jim Wright purchases a $10,000 life insurance policy on his mother, Janis Wright, and is the beneficiary upon her death.)

For all policies owned by an individual, separate the policies based on who is insured. Total the FV for each insured person separately. If the total FV for the insured person is less than or equal to $10,000, do not count the policies as a resource for the owner.

The $10,000 FV life insurance exclusion applies for each insured person.

**Dividend additions**

The insurance companies use surplus company earnings, called dividend additions, to buy more insurance protection for the life insurance policy owner. Dividend additions increase the FV and CSV.

* Do **not** include the **FV** of dividend additions when determining whether a life insurance policy is a countable or excluded resource:
* If the life insurance policy is a **countable** resource, do include the **CSV** of dividend additions when determining the resource value of the policy.
* If the life insurance policy is an **excluded** resource, do **not** include the CSV of dividend additions when determining the individual's countable resources.

**Dividend accumulations**

Dividend accumulations are surplus company earnings, which accrue in an account that the insurance company controls for the policy owner. The policy owner can access these funds without penalty at any time without affecting the FV or CSV. Therefore dividend accumulations may be countable resources unless they are excluded under a different resource exclusion (e.g., set aside for burial).

* Do not exclude dividend accumulations under the life insurance provision, even if you exclude the life insurance policy that pays the accumulations.
* Unless the accumulations are excludable under another provision (for example, because they have been set aside for burial), count the accumulations as a resource, even if you exclude the life insurance policy itself because the policy's FV is $10,000 or less.

**Note**

If the verification cannot be obtained from the insurance company, the cash value tables contained in the policy may be used or the Estimated Cash Surrender Value according to instructions contained in MPPM 302.17.02.

The countable cash surrender values of the policies and accumulations are countable toward the resource limit unless it can be excluded as a burial asset. (Refer to MPPM [302.19](#S_302_19).)

Even if a policy is excluded, any accumulated dividends are countable toward the resource limit unless they are excluded under another provision such as the burial exclusion. (Refer to MPPM 302.19 for information on Burial Exclusion.)

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| **Example #1**  **Owner has two policies on himself**  Mr. Parr, an aged individual, owns two life insurance policies on himself with the following values:   * $4000 FV with $5000 CSV, * $5000 FV with $1000 CSV   $5000 FV + $4000 FV = $9000 total FV which is less than $10,000 total FV.  The total FV of his policies is less than $10,000, therefore the CSV of the policies are excluded.  **Example #2**  **Owner has policies for herself and others**  Mrs. Hogenson, an aged individual, owns the following polices on herself, her husband and their daughter Edna:   * Mrs. Hogenson   + $4000 FV with $5000 CSV,   + $5000 FV with $1000 CSV   Total FV = $9000 which is less than $10,000, therefore the polices are excluded   * Mr. Hogenson   + $15,000 FV with $2000 CSV   Total FV = $15,000 which is greater than $10,000, therefore the CSV is a countable resource for Mrs. Hogenson   * Edna   + $7500 FV with $2000 CSV   Total FV = $7500 which is less than $10,000, therefore the polices are excluded  Do not combine the FV of all the policies owned by Mrs. Hogenson because the policies do not all insure the same person.  **Example #3**  Joan Howard has four life insurance policies insuring herself. Two are with Life of Georgia and have Face Values of $1,500 each. She also has two $750 FV policies with Liberty Life. The total Face Value of all the policies is $4,500, so the policies are excluded.  **Example #4**  Tanner Shull applied for ABD. He has three life insurance policies insuring himself with Face Values of $750; $2,500; and $12,000. The total Face Value is $15,250. Since this exceeds $10,000, the eligibility worker must verify the cash values and count them toward the resource limit unless a burial exclusion is developed.  **Example #5**  Amanda Weaver has two life insurance policies insuring herself. One is a whole life policy with a Face Value of $2,500. The other is a term life policy with a Face Value of $10,000. The term life policy has no cash value and is excluded. The whole life policy is excluded because the FV is less than $10,000. |

302.17.02 Estimated Cash Surrender Value Table

(Eff. 10/01/05)

| # Years Policy has been in Effect | Estimated CSV equals this percentage of FV |
| --- | --- |
| 20 or more | 60% |
| 15-19 | 50% |
| 11-14 | 45% |
| 6-10 | 30% |
| 4-5 | 20% |
| 3 | 10% |
| 2 | 5% |
| 1 | 0% |

**Using the Estimated CSV**

The eligibility worker is permitted to use the estimated cash surrender value until verification is received. The following guidelines should be followed.

1. **The eligibility determination is otherwise complete, and the resource limit is met using the estimated CSV.**

The eligibility worker must:

* Approve the application OR complete the annual review; AND
* Continue attempts to verify the CSV.

1. **The eligibility determination is complete except for verifying the CSV.**

* If the resources exceed the limit using the estimated CSV but the other countable resources are below the limit, the eligibility worker must not take action until the CSV is verified.
* If the resources would exceed the limit without using the estimated CSV, the eligibility worker is to use the estimated CSV in the resource budget and deny the application or begin closure procedures.

1. **The resource limit is met but other information is needed to complete the eligibility determination.**

The eligibility worker must request verification of the CSV.

302.17.03 Accelerated Life Insurance Payments

(Eff. 10/01/05)

Accelerated life insurance payments are proceeds paid to a policyholder before death. Plans vary from company to company; however, all involve early payout of some or all of the proceeds of the policy. Most of the plans fall into three basic types depending on the circumstances that cause the payments to be accelerated.

**Basic Plans**

* Long Term Care Model – allows payments if the policyholder requires an extended stay in a care facility or, in some instances, healthcare services at home.
* Dread Disease or Catastrophic Illness Model – allows payments if the policyholder suffers from a specified covered disease or illness (such as cancer or AIDS).
* Terminal Illness Model – allows payments following the diagnosis of a terminal illness where death is likely to occur within a specified time frame.

Some companies refer to these payments as “living needs” or “accelerated death” payments. Depending on the plan, the receipt of payments may reduce the FV of the policy by the amount of the payments and may reduce the CSV in a proportionate manner. In other cases, a lien may be attached to the policy in the amount of the payments that results in a proportionate reduction in the CSV.

[Table of Contents](#_top)

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| Procedure – Accelerated Life Insurance Payments:  These payments can be used to meet basic needs of food, clothing, and shelter. This is NOT a conversion of a resource because payments are made from the proceeds of the policy rather than from the cash value. The payments should be treated as follows:   * Month of receipt – consider as income * Any money remaining the following month is considered a resource. |

302.18 Death Benefits for Last Illness and Burial Expenses

(Eff. 10/01/05)

[POMS SI 01120.115](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501120115)

Death benefits are received because of another person’s death.

Examples include:

* Life insurance proceeds
* Social Security death benefits
* Burial benefits from the Railroad or Veterans Administration
* Inheritances
* Gifts from relatives, friends, or the community to help with expenses

**Note:** Recurring survivor benefits from a pension or retirement plan or the Social Security Administration are NOT death benefits.

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| **Procedure –Death Benefits**  **If Death Benefits Are Not Considered Income, then:**   * Month of receipt – Excluded * Month after receipt – Excluded * 2nd month following receipt – Countable resource, if retained   **Exception:** If the death benefits are repayment for expenses already paid, they are considered resources the month after receipt, if retained.  **Verification** of paid expenses must be obtained. Paid expenses and examples of verification are listed below.   * Life Insurance   + Copy of check   + Contact with or statement from the company * Gifts – statements from the party making the gift * Inheritance   + Will   + Probate records * Other types of money (such as SSA)   + Copy of check   + Other written verification * Expenses   + Payment receipts   + Cancelled checks   **Example #1**  **Death Benefits Not Considered a Resource**  When her uncle passed away, Beth Smith received $4,000 as beneficiary of his life insurance policy. She received it in July and intends to spend the entire amount on his last illness and burial expenses. She has already received bills totaling $900 that she paid. On August 1, she received a funeral bill for $2,900 and a few days later received a cash gift of $500 to be used for last illness and burial expenses. She pays the $2,900 funeral bill in August and intends to use the remainder to pay some hospital expenses. Treatment Neither the $4,000 Ms. Smith received in July nor the $500 she received in August is unearned income. Since she used $900 of the $4,000 life insurance check in July, as of August 1, she had a $3,100 balance that is not a resource for August. During August she paid the $2,900 bill and then had $200 left. However, the $500 she receives in August gives her $700 to use for hospital expenses. She must spend $200 in August for burial or last illness expenses; otherwise, the $200 will count as a resource September 1. Any portion of the $500 remaining as of October 1 will be counted as a resource.  **Example#2**  **Death Benefits as a Resource**  Jane Smith has total countable resources of $1,980 consisting of a $1,000 savings account and $980 checking account. Her brother died in late October. In November, she receives $3,000 as beneficiary of her brother's life insurance policy. She has last illness and burial expenses of $2,750 to pay. There will be no more bills after these. Treatment Of the $3,000 Ms. Smith received, $250 is unearned income in November because last illness and burial expenses are only $2,750. The $2,750 is not considered unearned income and will not be a resource until January 1, if she still has it then. The $250 amount will be a resource on December 1 when added to the money she has in her checking and savings accounts. |

[Table of Contents](#_top)

302.19 Burial-Related Resources

(Eff. 10/01/05)

There are two different types of burial related resources: Burial space and burial funds. This section will explain the difference in the two.

302.19.01 Burial Spaces

(Rev. 09/01/14)

[POMS SI 01130.400](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130400)

Burial spaces are used to contain and mark the remains of a deceased person. A burial space is a(n):

* Burial plot;
* Gravesite;
* Crypt;
* Mausoleum;
* Casket;
* Urn;
* Niche; or
* Other repository customarily and traditionally used for the deceased's bodily remains.

The term also includes necessary and reasonable improvements or additions to such spaces, including but not limited to:

* Vaults;
* Headstones, markers, or plaques;
* Burial containers (e.g., for caskets); and
* Arrangements for the opening and closing of the gravesite.
* A contract for care and maintenance of the gravesite, sometimes referred to as endowment or perpetual care, can be excluded as a burial space.

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| **Burial Space Verification Procedure** |
| **Procedure – Burial Spaces**  **To verify the Applicant/Beneficiary’s burial spaces:**   * Obtain copies of the deed, purchase contract or agreement. However, if the applicant alleges a burial plot that would be otherwise excluded, the plot does not have to be verified. * Contact the cemetery office to verify current market value of burial space items. * Determine that the items have been paid for in full. If not paid for, the amount paid is considered a **burial fund** rather than a burial space. * For more information about burial funds, refer to MPPM 302.19.03. * For more information about verification procedures, refer to MPPM 302, [Appendix B](#Appendix_B). |

302.19.02 Burial Space Exclusion

(Rev. 09/01/14)

A burial space or agreement, which represents the purchase of a burial space held for the burial of the individual, his or her spouse, or any other member of his or her immediate family, is an excluded resource, regardless of value. No limit exists on the value of the burial space that may be excluded. Taxes paid on burial spaces are also excluded.

A burial space may be excluded if intended for the use of the:

* Applicant/Beneficiary,
* Applicant/Beneficiary’s spouse, and
* Applicant/Beneficiary’s immediate family, including parents, children, siblings, and spouses of these relations.

If an Applicant/Beneficiary attests to owning one burial plot, the plot is excluded. If an Applicant/Beneficiary and his/her spouse attest to owning two burial plots, the plots are excluded. To exclude additional burial spaces the Development of Burial Exclusion, [DHHS Form 1766-A ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201766-A%20ME.pdf), must be completed. The form must include the individual’s name and relationship to the Applicant/Beneficiary.

Only one burial item, serving the same purpose, may be excluded for each person. For example, a cemetery plot and a casket may be excluded for the same person, but a casket and an urn may not be excluded.

The burial space exclusion is in addition to, and has no effect on, the burial funds exclusion.

302.19.03 Burial Funds

(Rev. 09/01/14)

[POMS SI 01130.410](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130410)

Burial funds are funds clearly designated for an individual’s burial. Burial funds include:

* Revocable burial contracts,
* Revocable burial trusts,
* Installment sales contracts for burial spaces,
* Cash,
* Financial accounts such as checking or savings accounts,
* Stocks, bonds, certificates of deposits (CDs), and
* Life insurance cash value.

These funds must be clearly designated for the individual’s or spouse’s burial, cremation, or other burial-related expenses. Property other than that listed in this definition will not be considered burial funds, and may not be excluded under the burial funds provision. For example, a car, real property, etc. are not burial funds.

Expenses included for burial funds exclusion purposes are generally those related to preparing a body for burial and any services prior to burial. They include transportation of the body, embalming, cremation, flowers, clothing, etc.

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| **Burial Fund Verification Procedure** |
| To verify the Applicant/Beneficiary’s burial fund:   * Obtain copies of a bank statement, brokerage statement, or statement from a funeral home. * Obtain verification of the amount already paid, remaining principal balance on cemetery items, and accrued interest on a pre-need burial contract. * For more information about verification procedures, refer to MPPM 302, [Appendix B](#Appendix_B). |

302.19.04 Burial Fund Exclusion

(Rev. 09/01/14)

An Eligibility Worker may exclude up to $1,500 each in funds set aside for:

* The burial expenses of the Applicant/Beneficiary, and
* The burial expenses of the individual’s spouse.

Burial fund items are considered resources unless a burial fund exclusion is developed. To develop a burial fund exclusion the Applicant/Beneficiary must complete and sign the Development of Burial Exclusion, [DHHS Form 1766-A ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201766-A%20ME.pdf). The form should include the name of the individual for whom the fund is designated and the value designated for burial fund.

The $1,500 maximum exclusion amount must be reduced by any amount held in an irrevocable trust or burial contract that represents burial fund exclusion. Interest accrued on an excluded, designated amount is excluded.

Burial funds may be commingled with burial-related assets, but must be kept separate from nonburial-related assets to be excluded. A burial fund may be excluded retroactively to the date the individual originally designated the funds for burial.

This exclusion is separate from and in addition to the burial space exclusion.

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| **Burial Fund Examples** |
| * Mr. Brown creates a checking account with a $1,500 balance for burial expenses. The entire amount may be excluded. * Mr. Brown creates a checking account with a $2,000 balance for burial expenses. Since $1,500 is the maximum that can be excluded for a burial fund, the remaining $500 is counted toward the resource limit. * Mr. Brown applies on May 1, 2014 and signs [DHHS Form 1766-A ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201766-A%20ME.pdf), designating a checking account for burial expenses. He created the account two years ago. He is seeking retroactive coverage for February, March, and April 2014. The exclusion may be given for those months. * Mr. Brown has a checking account with a balance of $2,000. He plans to use $1,500 for burial expenses and the remaining $500 for non-burial expenses. The burial fund exclusion may not be applied to this bank account because the burial funds are co-mingled with non-burial funds. As a solution, Mr. Brown may want to consider opening another checking account to separate the non-burial expenses. If he does so, he must provide verification of the accounts, and complete Form 1766-A ME. |

302.19.05 Burial Fund Penalty

(Rev. 09/01/14)

If a burial fund is used for a purpose other than the burial arrangements of the Applicant/Beneficiary or the Applicant/Beneficiary’s spouse for whom the funds were set aside, a penalty is imposed on the Applicant/Beneficiary. The amount misused is counted as a resource for the month following the discovery of the misused fund.

If the misused fund includes non-excluded burial funds, assume the funds were used in this order:

* Non-excluded interest
* Non-excluded designated amount
* Excluded interest
* Excluded designated amounts

The penalty only applies to excluded interest and designated amounts.

If an Applicant/Beneficiary loses eligibility, a new burial fund exclusion must be developed if the individual re-applies at a later date.

302.19.06 Burial Fund Exclusion and Re-Determination

(Rev. 09/01/14)

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| **Burial Fund Exclusion Re-Determination Procedure** |
| To continue the Applicant/Beneficiary’s burial fund exclusion at re-determination:   * Verify the current value of the fund. * Verify the exclusion’s requirements are still being met. * If the burial fund’s amount has increased, determine the source of the increased amount, i.e. interest. * If the burial fund contains excluded and non-excluded amounts, use the formula below to determine the current excludable portion:  |  |  | | --- | --- | | Amount of Original Exclusion | x Present Fund Amount = Current Excluded Portion | | Total Amount of Original Fund |   The Burial Fund Excluded Interest Worksheet, [DHHS Form 933](http://medsweb.scdhhs.gov/EligibilityForms/FM%20933.pdf) is used to calculate excluded and non-excluded interest for burial funds. |

302.20 Pre-Need Burial Contracts

(Eff. 10/01/05)

[POMS SI 01130.420](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130420)

A pre-need burial contract is an agreement between an individual and a funeral home where the buyer pays in advance for his, or another person’s, burial arrangements.

302.20.01 Pre-Need Burial Contracts Including Burial Spaces and Burial Funds

(Rev. 07/01/09)

Many pre-need contracts include both burial space and burial fund items. Expenses related to the burial space include: casket, vault, opening/closing costs at the cemetery. Expenses related to the burial fund include: embalming, clothing, visitation room, transportation, flowers.

There are two types of pre-need contracts: revocable and irrevocable. Each is described below, as well as, how they are treated in the eligibility determination.

A pre-need contract must be examined to determine if:

* It is revocable or irrevocable.
* It is paid for in full.
* The value of each item is provided.

Payment for a contract has taken place when an applicant/beneficiary transfers a liquid resource to the funeral provider or when specific life insurance policies have been designated on the pre-need burial contract. A liquid resource designated but not transferred to the funeral provider as payment for a contract is counted as an available resource. A resource cannot be designated for future payment of a pre-need contract and that resource be excluded as a resource.

If an applicant’s resources exceed the allowable limit, he is allowed to establish a pre-need contract to reduce his resource below the limit.

[Table of Contents](#_top)

302.20.02 Revocable Pre-Need Burial Contracts

(Rev. 10/01/13)

Revocable contracts may be sold or the money may be refunded. They are considered resources. However, a full or partial exclusion may be developed.

Contracts that **are paid** in full:

* If the value of all the items IS provided, both the burial space and burial fund exclusion may be developed.
* If the value of the burial space items IS NOT provided, only the burial fund exclusion may be developed.

Contracts that **are not** paid in full:

* Only the burial fund exclusion may be developed UNLESS the contract verifies the burial space items are paid for and the burial funds items are being paid on.

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| **Procedure – Revocable Pre-Need Burial Contracts**  **Verification Needed:**   * Copy of the contract * Statement from the provider of service   **Treatment:**   * Revocable pre-needs are considered a resource. A burial exclusion may be developed. A [DHHS Form 1766-A ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201766-A%20ME.pdf) must be completed and signed. * If the contract is paid in full:   + Any portion of the contract clearly representing burial spaces may be excluded entirely, regardless of value.   + Up to $1,500 of the remaining portion of the contract may be excluded as a burial fund. * If the contract is not paid in full, it should be treated as a burial fund unless it is verified that the burial spaces themselves are paid in full and considered “held for” the individual. * All calculations must be shown on the workbook.   **Example:** Mrs. Olsen applies for Medicaid. She just purchased a revocable contract at Landon’s Funeral Home. The contract verifies it is paid in full and includes the following:  $1,500 Casket  $1,000 Vault  $1,000 Headstone  $500 Opening/closing costs  $200 Embalming  $300 Visitation room  $1,000 Funeral service  $5,500 Total value  Because the contract is paid in full, the burial space items may be excluded. The first four items are burial space items and may be excluded under the burial space exclusion. The remaining $1,500 may be excluded under the burial fund exclusion. A [DHHS Form 1766-A ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201766-A%20ME.pdf) must be completed to designate the contract and apply the exclusion. |

[Table of Contents](#_top)

302.20.03 Irrevocable Pre-Need Burial Contracts

(Rev. 10/01/10)

Some contracts are irrevocable. The money cannot be refunded or the contract sold without significant hardship. South Carolina law requires that all contracts be revocable for the first 30 days. At the end of the 30 days, the contract becomes irrevocable unless the owner specifies otherwise. Only the amount of funds paid or specific life insurance policies designated for a pre-need burial contract may be considered for exclusion.

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| Procedure – Irrevocable Pre-Need Burial Contracts  Verification Needed:   * Copy of the contract * Contact with the service provider   Treatment:   * If the contract remains revocable after the 30 days, it is treated as described in the Revocable Contract section above. * If the contract becomes **irrevocable:**   + It is not a resource to the individual.   + It is not considered a resource retroactive to the date it was purchased.   + The portion that represents burial funds offsets the $1500 burial fund exclusion.   + If the contract is not paid in full, the portion paid represents burial funds and is excluded.   **Example**  Mr. Allen applies for Medicaid under the ABD program on March 10. He has a savings account worth $6,000. He also has a life insurance policy with a Face Value of $15,000 and a CSV of $800 that he designates for his burial. Since his resources exceed the $6,600 limit, he uses $4,500 of his savings to purchase an irrevocable pre-need contract on March 15. A copy of the contract verifies he paid $1,500 for the casket, $1,000 for the vault, $500 for the opening and closing costs at the cemetery, and $1,500 for other services.   1. On the 30th day, Mr. Allen decides to have the contract remain revocable. It is considered a resource. He signs a [DHHS Form 1766-A ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201766-A%20ME.pdf) designating the contract for his burial. The $3,000 paid for the casket, vault, and opening and closing costs are excluded as burial space items. The remaining $1,500 is excluded as a burial fund. 2. If Mr. Allen decides to allow the contract to become irrevocable, it becomes so on April 14. It is not a resource and not countable effective March. That portion of the irrevocable burial contract that represents burial fund items, which is $1500, offsets the $1500 Burial Fund Exclusion. The $800 Cash Value of the life insurance that was previously designated for burial then becomes a countable resource. His countable resources would be: savings 2,100 ($8,600 - $4,500) + $800 CSV = $2,900 which is below the ABD resource limit. Assuming all other criteria are met, Medicaid can begin effective March 1. |

302.20.04 Life Insurance Funded Burial Contracts

(Eff. 10/01/05)

[POMS SI 01130.425](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130425)

This is not considered burial insurance. A person purchases life insurance and assigns either the proceeds or ownership of the policy to the funeral service provider. This assignment may be revocable or irrevocable.

302.20.04A Effect of the Assignment of Ownership on Burial Exclusion

(Eff. 10/01/05)

* **Revocable Assignment**
* The burial space exclusion does not apply because the items are not paid for until the death of the individual.
* The burial fund exclusion may apply. The cash surrender value of the life insurance policy is the resource value.
* **Irrevocable Assignment**
* The burial space exclusion may apply IF the values of the items are provided.
* The life insurance policy is not a resource because the individual no longer owns it.
* The contract is not a resource.
* The value of the burial fund items offsets the value of any other burial fund items.

[Table of Contents](#_top)

302.20.04B Effect of the Assignment of Proceeds on Burial Exclusion

(Eff. 10/01/06)

The burial space exclusion does not apply because:

* The provider will not be paid until the death of the individual.
* Spaces are not being “held for” the individual.

The resource value of the contract is the cash surrender value of the life insurance policy.

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| **Procedure – Cash Surrender Value:**   * If the Face Value of all life insurance policies for the individual total $10,000 or less, exclude the Cash Surrender Value under the life insurance exclusion. * If the Face Values total more than $10,000, verify and count the Cash Surrender Value toward the limit. The $1,500 burial fund exclusion may apply. |

302.21 Property Essential to Self Support

(Eff. 10/01/05)

[POMS SI 01130.500](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130500)

The exclusion may apply to real or personal property. All property described below must be in current use or, if not in use for reasons beyond the individual's control, there must be a reasonable expectation that the required use will resume.

Resources excluded under this provision generally fall into three categories:

1. Essential Property Excluded – Regardless of Value or Rate of Return
2. Essential Property Excluded – Up to $6,000 Equity – Regardless of Rate of Return
3. Essential Property Excluded – Up to $6,000 Equity – If It Produces a 6% Rate of Return

302.21.01 Essential Property Excluded – Regardless of Value or Rate of Return

(Eff. 10/01/05)

[POMS SI 01130.501](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130501)

* Property essential to self-support used in a trade or business

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| Procedure – Property Essential to Self Support Used in a Trade or Business  Verification Needed:  Obtain a statement regarding:   * Description of the trade or business * Description of the assets of the trade or business * The number of years the business has been operated * Names of any co-owners * Estimated gross and net earnings of the trade or business for the current tax year.   Obtain a copy of the latest tax return available. |

* Government permits granting authority to engage in income producing activity

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| Procedure  **Examples of Income Producing Activities Needing Government Authorization:**   * Commercial fishing * Tobacco crops   **Verification Needed:**   * Individual’s signed statement as to:   + Type of license, permit or other property   + Name of issuing agency   + If license is required for engaging in this activity   + How the license, permit or property is being used   + If not being used, why not * Copy of the license, permit and/or other documents |

[Table of Contents](#_top)

* Personal property used by an employee for work

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| **Examples of Personal Property Used at Work:**   * Tools * Uniforms * Safety Equipment |

302.21.02 Essential Property Excluded – Up to $6,000 Equity – Regardless of Rate of Return

(Eff. 10/01/05)

[POM SI 01130.502](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130502)

* Applies to non-business property – may be real or personal property.
* No specified rate of return is required.
* Property must be in use or, if not in use for reason beyond the individual’s control, there must be a reasonable expectation that the required use will resume.
* If the equity value exceeds $6,000, the excess is not excluded; it is countable toward the resource limit. (**Example:** If the resource is valued at $7,000, then $6,000 is excluded and $1,000 is counted.)

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| **Procedure**  **Example of Non-Business Property – Real or Personal:**   * Property used to grow produce or livestock raised solely for the individual’s household, like land * Property used in activities essential to the above – such as tractor used for plowing, boat for fishing. (**Note:** This does not include any vehicle that qualifies as an automobile.)   **Verification Needed:**   * Individual’s statement giving:   + Description of property   + Description of how it is used   + Estimate of the Current Market Value (CMV) and any legal encumbrances   + Verification of the CMV |

[Table of Contents](#_top)

302.21.03 Essential Property Excluded – Up to $6,000 Equity – If It Produces a 6% Rate of Return

(Eff. 10/01/05)

[POMS SI 01130.503](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130503)

* Applies to non-home income producing property
* Equity value = current market value – legal debts
* Up to $6,000 can be excluded if the net annual return is equal to or greater than 6% of the equity value.

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| Procedure  Example of Non-Home Income Producing Property:   * Property rented to someone for use in farming   **Verification Needed:**   * Individual’s statement giving:   + Description of property   + Description of how it is used   + Estimate of the Current Market Value (CMV) and any legal encumbrances   + Verification of the CMV   **Treatment:**   * Any equity value exceeding $6,000 counts toward the resource limit.   (**Example:** Property meets the 6% rule but has an equity value of $7,500. The amount of $6,000 is excluded under this provision and the remaining $1,500 is countable.)   * If the net annual return is less than 6%, the entire equity value is counted.   **Exceptions:**   * + Lower return that is beyond the individual’s control     - Crop failure     - Fire     - Illness   + There is a reasonable expectation that the property will again produce a 6% return.   + Up to 24 months is allowed for the resumption of a 6% return. This begins with the first day of the tax year following the one in which the rate dropped below 6%   **Note:** If the individual owns more than one piece of non-home property:   * The 6% return rule applies individually to each piece. * The $6000 equity value limit applies to the combined equity values of properties meeting the 6% return rule.   **Example:**  Mr. Green has a piece of land on which he grows corn for sale at the market. The equity value of the land is $7,000.   1. He nets a minimum of $500 per year in sales. $500 ¸ $7,000 = 7.14%. Therefore, $6,000 of the equity value is excluded, and $1,000 is counted. 2. Last year, his crop caught fire and he made no money. He expects to plant/sell again next year at the regular rate. The $6,000 may still be excluded because the he had no control over the fire. His 24-month period began Jan 1.   3. Mr. Green owns three non-connected acres of pastureland. He rents them to different horse and cattle owners for $500 per year each. They have equity values of $2,000; $3,500 and $1,200 for a total of $6,700.  · 6% rule: $500 ¸ $2,000 = 25%  · $500 ¸ $3,500 = 14% and $500 ¸ $1,200 = 42%  · Since the 6% rule is met, $6,000 is excluded, and $700 is countable. |

[Table of Contents](#_top)

302.22 Resources Set Aside as Part of Plan for Achieving Self-Support

(Eff. 10/01/05)

[POMS SI 01130.510](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130510)

A Plan for Achieving Self-Support (PASS) allows blind and disabled (but not aged) individuals to set aside income and/or resources necessary for the achievement of its goals. Resources set aside as part of an approved PASS are excluded.

302.23 Retained Cash Payments

(Eff. 10/01/05)

The treatments of retained cash payments are discussed in the following sections.

302.23.01 Retroactive Supplemental Security Income (SSI) and Retirement, Survivors, and Disability Insurance (RSDI)

(Eff. 10/01/05)

[POMS SI 01130.600](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130600)

The unspent portion of retroactive SSI and RSDI benefits is excluded from resources for **nine calendar months** following the month in which the individual receives the benefits.

* **Retroactive SSI**

Retroactive SSI benefits are SSI benefits issued in any month after the calendar month for which they are paid. Thus, benefits for January that are issued in February are retroactive.

* **Retroactive Social Security Benefits (RSDI)** Retroactive RSDI benefits are those issued in any month that is at least two calendar months after the calendar month for which they are paid. Thus, RSDI benefits for January that are issued in February are not retroactive, but RSDI benefits for January that are issued in March are retroactive.

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| **Procedure for Verification:** Obtain verification of the amount of the retroactive payment and the month of receipt. The best source is a copy of the Award Letter from Social Security. |

[Table of Contents](#_top)

302.23.02 Dedicated Accounts for Past-Due Benefits Due to Individuals Under Age 18 Who Have a Representative Payee

(Eff. 10/01/05)

[POMS SI 01130.601](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130601)

Past-due benefits and other underpayments deposited into a dedicated financial institution account and any accrued interest or other earnings on such an account are excluded from resources. This exclusion does not apply if funds are co-mingled.

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| **Exception**  If the financial institution requires other funds be used to open the dedicated account, these funds may be co-mingled in the account until the end of the month following the month that the past-due benefits are paid.  **Note**  If the benefits are not deposited into a dedicated account, there is a time limitation on the exclusion. |

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| **Procedure**  **Verification:**  The eligibility worker must obtain verification of:   * The amount of past due benefits, such as a copy of the award letter. * The dedicated bank account.   If the bank requires other funds be used to open the account, then verify:   * The fact that the bank requires other funds to be used to open the account. * The amount used to open the account. * The date the other funds were withdrawn.   **Treatment:**   * Exclusion applies to:   + The past due benefit   + Any interest or earnings, such as dividends, earned on and left to accrue in the excluded account. * The exclusion does not apply to:   + Any funds, other than the past-due benefits the bank requires be used to open the account.     - If these funds are not withdrawn by the end of the month following the month the past-due benefits are paid, the exclusion will not apply at all.   + The entire account for any month in which the past-due benefits is co-mingled with other funds. * The exclusion is time limited if:   + The past-due benefits are not deposited into a dedicated account.   + Limited to the lesser of:     - 6 months     - Until the funds are deposited into the dedicated account – obtain verification. |

[Table of Contents](#_top)

302.23.03 Cash Received for the Repair or Replacement of Lost, Damaged, or Stolen Excluded Resources

(Eff. 10/01/05)

[POMS SI 01130.630](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130630)

Cash receipts for the replacement or repair of lost, damaged, or stolen excluded resources are not treated as resources for a certain amount of time.

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| **Procedure**  Such receipts are not considered resources for 9 months from the date of receipt. This may be extended up to 9 more months if the individual verifies good cause for the repair or replacement not being done.  Good cause exists if circumstances beyond the individual’s control:   * Prevent the repair or replacement of the property * Keep the individual from contracting for such repair or replacement   If good cause is alleged, obtain a statement from the individual describing the circumstances and any corroborating evidence that may be available. |

302.23.04 Disaster Assistance

(Eff. 10/01/05)

[POMS SI 01130.620](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130620)

Disaster Assistance includes assistance received from the following sources:

* The Disaster Relief and Emergency Assistance Act (P.L. 100‑707)
* Another Federal statute because of a presidentially-declared major disaster
* A State or local government’s comparable assistance
* A disaster assistance organization

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| **Note:** If the funds are excluded from income, the unspent amount is excluded from resources. |

302.23.04A COVID-19 Economic Impact Payments (EIPs)

[POMS SI 00830.620](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830620)

[POMS SI 01130.620](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130620)

(Rev. 4/01/23)

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

First Round: Payment levels were up to:

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

Second Round: Payment levels were up to:

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

Third Round: Payment levels were up to:

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

**Non-MAGI Determinations**

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

302.23.05 Presidentially Declared Major Disasters

(Eff. 10/01/05)

[POMS SI 01130.620](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130620)

Some catastrophes (such as hurricane damage) cause such wide spread destruction that the President of the United States declares them Major Disasters. Any unspent funds are excluded from resources.

[Table of Contents](#_top)

302.23.06 Netherlands WUV Payments to Victims of Persecution

(Eff. 10/01/05)

[POMS SI 01130.605](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130605)

The Netherlands' Act on Benefits for Victims of Persecution 1940-1945, WUV (Wet Uitkering Vervlgingsslachtoffers) provides payments to individuals who were victims of persecution during World War II during the German and Japanese occupation of the Netherlands and the Netherlands East Indies (now the Republic of Indonesia).

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| **Note:**   * Excluded: Unspent WUV payments made by the Dutch Government. * Counted: Interest earned on unspent WUV payments. |

302.23.07 German Reparations Payments

(Eff. 10/01/05)

[POMS SI 01130.610](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130610)

German reparations payments are made to:

* Certain survivors of the Holocaust under the Federal Republic of Germany's Law for Compensation of National Socialist Persecution, or German Restitution Act.
* These payments may be made periodically or in a lump sum.

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| **Note:** Unspent German reparations payments are excluded from resources. |

302.23.08 Austrian Social Insurance Payments

(Eff. 10/01/05)

[POMS SI 01130.615](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130615)

The nationwide class action lawsuit, Bondy v. Sullivan, involved Austrian social insurance payments that were based on wage credits granted under Paragraphs 500‑506 of the Austrian General Social Insurance Act. These paragraphs grant credits to individuals who suffered a loss (that is, were imprisoned, unemployed, or forced to flee Austria) during the period of March 1933 to May 1945 for political, religious, or ethnic reasons.

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| **Procedure – Austrian Social Insurance Payments** **Excluded:** Austrian social insurance payments not based on wage credits are excluded.  **Not Excluded:** Unspent Austrian social insurance payments based on wage credits granted under Paragraphs 500‑506 of the Austrian General Social Insurance Act granted under Paragraphs 500‑506 are not excluded from resources under this provision.  **Note:** Interest earned on unspent Austrian social insurance payments is counted as income unless it can be excluded under another provision, such as infrequent or irregular income. |

302.23.09 Benefits Excluded from Both Income and Resources by a Federal Statute Other Than Title XVI

(Eff. 10/01/05)

Federal statutes other than Title XVI specify many SSI income and resources exclusions. Examples of these are listed below.

302.23.09A Agent Orange Settlement Payments

(Eff. 10/01/05)

[POMS SI 01130.660](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130660)

* No limit on the length of time unspent funds are excluded.
* Interest earned on conserved payments is counted as income.

302.23.09B Victims Compensation

(Eff. 10/01/05)

[POMS SI 01130.665](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130665)

Some states establish funds to assist victims of crimes. Unspent payments received from such a fund are excluded for 9 months IF received for expenses incurred or losses suffered because of the crime.

Interest earned on unspent victims' compensation payments is not excluded from income or resources.

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| **Examples of Victims’ Compensation Payments:**   * Medical expenses resulting from injuries * Lost wages |

[Table of Contents](#_top)

302.23.09C Relocation Assistance Payments

(Eff. 10/01/05)

[POMS SI 01130.670](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130670)

Sometimes projects acquire real property and individuals are displaced from their home or business. Relocation assistance may be provided to them under local, State, or Federal programs. Such payments may be excluded for certain lengths of time. The length of the exclusion depends on the source.

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| **Procedure – Relocation Assistance Payments**  **State and Local Program Assistance**  Unspent payments are excluded from resources for 9 months.  **Federal Assistance**  There is no time limit on the exclusion for assistance provided under the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970.  **Note:** Interest earned on unspent payments IS NOT excluded from income or resources. |

302.23.09D Tax Advances and Refunds Related to Earned Income Tax Credits

(Rev. 04/01/11)

[POMS SI 01130.676](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130676)

An unspent Federal tax refund or payment made by an employer related to Earned Income Tax Credits (EITC) is excluded from resources for 12 months following the month the refund or payment is received.

Interest earned on unspent tax refunds related to EITC's is not excluded from income or resources.

302.23.09E Radiation Exposure Compensation Trust Fund Payments

(Eff. 10/01/05)

[POMS SI 01130.680](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130680)

The Radiation Exposure Compensation Trust Fund (RECTF) authorizes the Department of Justice (DOJ) to make compensation payments to individuals (or their survivors) that were found to have contracted certain diseases after exposure. The payments will be made as a one-time lump sum.

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| **Procedure – Radiation Exposure Compensation Trust Fund Payments**  Unspent payments are excluded from resources. Interest earned on unspent payments is counted as income unless it is excludable under another provision. |

302.24 Gifts of Domestic Travel Tickets

(Eff. 10/01/05)

[POMS SI 01120.150](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501120150)

The value of a ticket for domestic travel received by an individual (or spouse) is not a resource if the ticket is:

* Received as a gift;
* Not converted to cash; and
* Excluded from income.

302.25 Identifying Excluded Funds That Have Been Co-mingled with Non-Excluded Funds

(Eff. 10/01/05)

[POMS SI 01130.700](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130700)

To qualify for exclusion, excludable funds must be identifiable. This does not require them to be separate from other funds (such as in a separate bank account.)

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| **Procedure:**  When withdrawals are made from co-mingled funds, assume non-excluded funds are withdrawn first. If excluded funds are withdrawn, the excluded funds left in the account can only be added to by:   * Deposits of subsequent funds excluded under the same provision * Excluded interest |

302.26 Countable Resources

(Eff. 10/01/05)

The value of countable resources is considered in determining eligibility. The following are considered countable resources.

302.26.01 Cash

(Eff. 10/01/05)

[POMS SI 01140.010](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501140010)

Money on hand that is in the form of coin or currency.

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| **Treatment** | **Verification** |
| Countable | Accept allegation of cash on hand. If rare coin collection, obtain knowledgeable source statement.  (Refer to [Appendix C](#Appendix_C) for definition of knowledgeable sources.) |

[Table of Contents](#_top)

302.26.02 Checking/Savings Accounts

(Rev. 11/01/23)

[POMS SI 01140.200](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501140200)

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| **Treatment** | **Verification** |
| Unrestricted access: all funds are considered a resource.  Restricted access: only the portion the individual can withdraw is considered a resource. | * Bank statements * Bank book * Written Statement from bank * Collateral Call with bank * Asset Verification System (AVS) * DHHS Form 1253 ME, Request for Financial Investigation (Only if unable to verify with AVS) |
| **Policy**  A resource shall not be considered as an asset and as income in the same month. When income received in a month is deposited into a checking or savings account, the value of such account for that month will be determined by subtracting the total amount of income deposited from the lowest balance of the account. We will assume that all income received by an applicant, beneficiary, or their family is deposited into an account. An exception will be if:   * It has been reported by the individual that there is income not deposited into an account; or * We know for sure that there is income not deposited into an account. * If the applicant or beneficiary is eligible without subtracting the income, it is not necessary to make the adjustment to the balance.   **Example**  A beneficiary in a nursing home has an Income Trust. The Schedule A lists specific income that is deposited into the trust. The identified income would not be subtracted from other bank accounts owned by the beneficiary.  **Example**  An applicant reports that he receives Social Security Retirement that is deposited into his checking account. He also receives a private pension check in the mail. He tells the case worker that he normally takes the check to the bank to cash it and keeps the cash on hand. The amount of the private pension will not be subtracted from the total. Do not count the cash he keeps as resource in that month. | |
| **Procedure**  If more than one bank account is listed on the application or if more than one bank account is found when AVS returns, the Eligibility Specialist must verify the applicant’s/beneficiary’s ownership interest in each account. Bank Statements may be scanned into OnBase in no specific order. If bank statements are provided, Eligibility Specialists **must review the name of the institution and account numbers** to ensure that each account is verified individually. Verification must be documented in the case record and on the Documentation Template for each account.  AVS reports the balance for all accounts as of the first day of the month. To determine the countable balance, the Eligibility Specialist should total the balances of all accounts and then subtract the income received by the household from the lowest total balance of all the verified checking or savings accounts as one balance.   * You do not have to identify the specific account used by the applicant or beneficiary, but you do have to record on the documentation template how you determined the countable amount. * If an applicant or beneficiary has earned income, subtract the net income to reflect what the individual received. Additional information may need to be obtained from the applicant or beneficiary.   When reviewing the AVS results, balances from the 1st day of the following month can be used as verification of the lowest monthly balance of a previous month due to “neighboring” balances. “Neighboring” refers to the AVS or bank statement balance for the subsequent month being the same as the last day of the application month or retroactive request month. Eligibility Specialists must document the use of neighboring balances on the Documentation Template.  **Neighboring Balances Example (AVS)**  An ABD applicant applied for coverage on 7/23/2023 requesting retroactive coverage. The AVS results have returned with a value of $10,000.00 for 6/1/2023 after income is deducted. However, the 7/1/2023 AVS balance is $7000.00. The applicant meets resource eligibility for ABD in the retroactive month and in the application month because the beginning balance of July can also be used as the ending balance for June.  **Neighboring Balances Example (Bank Statement)**  An ABD applicant applied for coverage on 7/23/2023. The AVS results have returned with a value of $10,000.00 for 7/1/2023 after income is deducted. However, there is a bank statement on file for 8/1/2023 indicating that balance on 8/1/2023 was $7000.00. The applicant meets resource eligibility for ABD in the application month because the beginning balance of August can also be used as the ending balance for July.  **Note**  The concept of “neighboring” balances applies to all programs using liberalized resources.  **Note**  If there is a bank statement on file showing the lowest balance for the month, use the bank statement. If there is no bank statement on file and the “neighboring” balance on the AVS shows a lower balance’ use the AVS results without requesting additional information. If the AVS “neighboring” balance, does not help the individual become eligible, request a bank statement for the month(s) being assessed to determine the lowest monthly balance.  If the countable resources of the individual or family are over the appropriate resource limit, obtain the lowest balance for each account if this may make a difference in the eligibility determination. Total the lowest balances and then subtract the total income received, following the same procedure shown above.  **Example**  An applicant has non-homestead property valued at $100,000 that does not meet any exclusions and makes her ineligible for Medicaid. It is not necessary to obtain bank balances before denying the application. | |

302.26.03 Joint Checking/Savings Accounts

(Rev. 10/01/23)

[POMS SI 01140.205](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501140205)

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| **Treatment** | **Verification** |
| If one owner is an applicant/beneficiary and has unrestricted use, all funds are counted.  If more than one owner is an applicant/ beneficiary, divide the balance evenly between the owners, and count the individual’s share toward his countable resources. | * Bank statements * Bank book * Written Statement from bank * Collateral Call with bank * Asset Verification System (AVS) * DHHS Form 1253 ME, Request for Financial Investigation. (Only if unable to verify with AVS) |
| **Procedure**  Refer to MPPM 302.26.02 | |

302.26.03A Rebuttal of Joint Checking/Savings Accounts

(Eff. 10/01/05)

An applicant/beneficiary may rebut ownership of part or all of the funds in a jointly held account. He is responsible for providing verification to support this claim. If the rebuttal is successful, the applicant/beneficiary must be advised of responsibilities for record keeping and future treatment of the account.

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| **Procedure for Rebuttal**  If an applicant/beneficiary rebuts applicable ownership assumption, each of the joint account holders must complete and sign the [DHHS Form 904 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%20904.pdf), attaching necessary verifications, to document the following:   * Bank Name, account number, and the names of the account holders * Ownership of the funds, including amounts if partial ownership is claimed * Reasons for establishing a joint account; * Who has made deposits to and withdrawals from the account. Verification of the deposits and withdrawals must be attached (for example; pay stub; award letter; cancelled checks. * How withdrawals have been spent.   **If a rebuttal is successful, the applicant/beneficiary must be advised of the following:**   * If partial ownership is established, the applicant/beneficiary must keep records of all future deposits and withdrawals to provide at review to allow for proper determination of countable resources. * If the applicant/beneficiary owns none of the funds (that is, the individual’s name is on another person’s account for emergency purposes only), they must not add any of their own funds to the account in the future. * If full ownership is attributed to the applicant/beneficiary, any future deposits by the other account holder(s) will be considered income and/or a resource to the applicant/ beneficiary. |

302.26.04 Time Deposits

(Eff. 09/01/16)

[POMS SI 01140.210](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501140210)

Examples: Certificates of Deposit (CD), savings certificates

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| **Treatment** | **Verification** |
| The resource value is the amount the owner would receive upon withdrawing it at that time, excluding interest paid that month. Generally, that is:   * Amount originally deposited; * Plus accrued interest for all but the current month; and * Minus any penalty for early withdrawal. | * Asset Verification System (AVS) response * Bank statements * Redemption receipts |

[Table of Contents](#_top)

302.26.05 Conservator Account

(Eff. 10/01/05)

[POMS SI 01140.215](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501140215)

A person or institution has been court appointed to manage and preserve an individual’s assets.

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| **Treatment** | **Verification** |
| Absent evidence to the contrary, the funds are available for the individual's support and maintenance and are countable as that individual's resource. | See court order establishing account. |

302.26.06 Stocks

(Eff. 10/01/05)

[POMS SI 01140.220](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501140220)

Types of stocks: common; over the counter (penny stock), preferred (refer to MPPM Chapter 104 – Appendix I for definitions of various kinds of stocks.)

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| **Treatment** | **Verification** |
| Shares of stock represent ownership in a business corporation.  Their value shifts with demand and may fluctuate widely.  Absent evidence to the contrary, assume each owner owns an equal share of the stock and can sell the stock at will, at current value.  Broker fees do not reduce the value that stocks have as a resource. | Stock Certificate  Brokerage Account statement  (Refer to [Appendix E](#Appendix_E) on how to read stock tables.) |

302.26.07 Mutual Fund Shares

(Eff. 10/01/05)

[POMS SI 01140.230](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501140230)

Types of mutual funds: growth funds, income funds, balanced funds, municipal bonds, money market funds, load funds, no load funds (refer to MPPM Chapter 104 – Appendix I for definitions of various types of mutual funds.)

| **Treatment** | **Verification** |
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| Shares in a mutual fund represent ownership in the investments held by the fund. The investments may be pooled assets (such as stocks or bonds, managed by an investment company. A mutual fund share represents ownership interest in this pool as opposed to a particular stock or bond. | (Refer to [Appendix E](#Appendix_E) for table on Mutual Funds and Stocks.) |

[Table of Contents](#_top)

302.26.08 US Savings Bonds

(Rev. 11/01/07)

[POMS SI 01140.240](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501140240)

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| **Treatment** | **Verification** |
| US Savings Bonds issued on or after 02/01/03 cannot be redeemed for twelve months after the issue date on the face of the bond.  The individual in whose name a US Savings Bond is registered owns it. The Social Security Number shown on a bond is not proof of ownership.  The co-owners of a US Savings Bond own equal shares of the redemption value of the bond.  If one of the co-owners refuses to relinquish possession of the bond, it is not a resource for the other owner. | Table of redemption value for US Savings Bonds  Statement from a bank  On-line at: [www.TreasuryDirect.gov](http://www.TreasuryDirect.gov) |

302.26.09 Municipal, Government, or Corporate Bonds

(Eff. 10/01/05)

[POMS SI 01140.250](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501140250)

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| **Treatment** | **Verification** |
| These are negotiable and transferable.    Value as a resource is their CMV. Their redemption value, available only at maturity, is immaterial. | Copy of the bond and contact the bond’s issuer to verify the value. |

302.26.10 Other US Government Securities

(Eff. 10/01/05)

[POMS SI 01140.990](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501140990)

Examples of other US Government Securities: Treasury Bills, Treasury Notes and Bonds, Tiger and Cats, Federal Agency Securities

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| **Treatment** | **Verification** |
| Countable | Receipt of purchase and contact with the issuer to verify the value. |

[Table of Contents](#_top)

302.26.11 Contents of a Safety Deposit Box

(Eff. 10/01/05)

An applicant/beneficiary or his spouse may have a safe deposit box. Some of the contents may be countable as resources.

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| **Treatment** | **Verification** |
| Treatment is dependent upon the type of resources, if any, that are contained in the safety deposit box (that is, stock certificate; coins; jewelry; life insurance policies).  (Refer to appropriate MPPM sections for specific resources.) | Obtain a signed, written statement from the applicant/beneficiary, the spouse, or the authorized representative listing the contents of the safety deposit box.  For any resource contained in the box, obtain appropriate verification of the value (such as, financial statements, knowledgeable source statements.) |

302.26.12 Non-Home Real Property

(Eff. 10/01/05)

This is land and any permanent buildings/immovable objects attached to it that are not considered a principal place of residence.

| **Treatment** | **Verification** |
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| Generally, a countable resource if it can be sold at its CMV.   * Resource value is the CMV minus any legal debt. * If jointly owned, count the individual’s share.   Exclusion can be developed if there is a bona fide effort to sell. (Refer to MPPM [302.14.05](#S_302_14_05).) | Ownership and/or value may be verified by:   * Tax assessment notice or bill * Current mortgage statement * Deed * Report of title search * Wills, court records, or other documentation of inheritance * Appraisal   Bona-Fide effort to sell can be verified by:   * Copy of realtor listing (must set up a tickler file to update when listing expires) * Copy of newspaper advertisement   Rebuttal of Fair Market Value   * Knowledgeable source statements * Example of when a rebuttal may be done: Condemned property |

[Table of Contents](#_top)

302.26.13 529 Plan

(Eff. 10/01/05)

This is a State-sponsored investment program. Parents may fund these to pay for their child’s college education.

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| **Treatment** | **Verification** |
| Parents are the owners and the account is considered a resource.  Withdrawal for reason other than to pay for qualified college education is taxed at their rate plus a 10% penalty. | Account Statements |

302.26.14 Direct Express Account

(Eff. 08/01/23)

Federal benefits can be obtained through Direct Express debit cards. As of January 2020, Comerica Bank serves as the fiscal agent for the Direct Express prepaid debit card program, which is run by the U.S. Department of the Treasury's Bureau of the Fiscal Service.

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| **Treatment** | **Verification** |
| The Direct Express attested balance is considered a resource.  If the applicant or beneficiary is eligible without subtracting the income, it is not necessary to make an adjustment to the balance.  SSI, SSA, and other government benefits are examples of unearned income that is deposited into a Direct Express account. | Accept client’s statement of account balance.  Accept client’s attestation on any current Medicaid application or review.  Accept client’s verbal statement.  Accept self-attestation for any persons who have Social Security checks directly deposited onto Direct Express cards. This refers to Direct Express cards only.  All other pre-paid cards such as Blue Bird, Green Dot, Netspend etc., are to be handled like regular bank accounts (refer to 302.26.02 Checking/Savings Accounts). |

302.27 Cash to Purchase Medical or Social Services

(Eff. 10/01/05)

[POMS SI 01120.110](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501120110)

A cash payment for medical or social services that is not income also is not a resource for the month following the month of receipt.

**Exception**

Cash received as a repayment for bills already paid is a resource and is counted the month after receipt.

**Note:** If the cash was neither income nor repayment, it is not a resource for the month following the month of receipt.

302.28 Retroactive In-Home Supportive Services

(Eff. 10/01/05)

[POMS SI 01120.112](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501120112)

In-Home Supportive Services (IHSS) are payments from governmental programs to a spouse or parent of a disabled individual who provide certain IHSS such as:

* Attendant
* Homemaker
* Chores

This type of payment is made under limited circumstances.

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| **Procedure – In-Home Supportive Services**  **Treatment:**   * Ineligible Spouse or Parent   + Income when received   + Not included as income for deeming purposes * Retroactive Payments   + A payment is considered retroactive if the payment is made after the month it was due.     - Excluded the month of receipt and the calendar month after receipt.     - Beginning the second calendar month after receipt, it is a resource and is subject to deeming.     - Any interest included is also counted.   + A payment is NOT considered retroactive if it is made in the month due, but after the month the service(s) was provided. |

[Table of Contents](#_top)

302.29 Encumbrance

(Rev. 12/01/23)

An encumbrance is defined as a legal obligation to pay a debt. If an applicant/ beneficiary’s combined resources exceed the resource limit, the eligibility worker must deduct the amount of any encumbrances from the Current Market Value (CMV) to determine the equity value of a resource. The equity value is countable toward the resource limit. Encumbrances **must** be explored for all liberalized Non-MAGI and Long-Term Care categories as an option in reducing resources.

An encumbrance may occur when:

* The applicant has funds in a bank account or the cash value of a life insurance policy, and has a legal obligation to pay medical expenses that were incurred prior to the month of requested eligibility;
* The applicant/beneficiary has signed an irrevocable preneed burial contract with a funeral home and assigned an existing life insurance policy(ies) to the funeral home, but the insurance company records do not indicate an irrevocable assignment or change in ownership (reference MPPM 302.20.02); or
* The applicant/beneficiary has alleged a check has been written from a bank account, and it has not cleared the bank.

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| Encumbrance Procedure When a Legal Obligation Exists to Pay Medical Expenses |
| If the applicant incurred medical expenses before the month of requested eligibility, and he has a legal obligation to pay his medical expenses, give a deduction for the actual amount paid for the cost of medical care. Allowable costs include:   * Nursing home bills, * Doctor bills, * Hospital charges, * Durable medical equipment costs, and * Prescription drug expenses.   **Verifications Needed:**   * Copy of the medical expense, * Paid receipt or cancelled check, and * Updated bank statement or verification the life insurance policy(ies) was cashed in and used to pay for the expenses   Once the verifications have been obtained, the countable resources can be established as of the requested month. Eligibility cannot be established in the month the debt was incurred. |

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| **Encumbrance Procedure When a Check Has Not Cleared the Bank** |
| If the beneficiary has alleged a check has been written from a bank account, and the check has not cleared the bank, the eligibility worker must examine evidence indicating that the check was written, therefore legally obligating the funds from the bank account.  **Verifications Needed:**   * Paid receipt, or * Copy of Cancelled check.   This verification must be obtained before allowing a reduced equity value of the bank account. Once the verification is received, the equity value of the bank account can be established by deducting the amount of the written check. |

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| **Encumbrance Procedure for a Life Insurance Funded Pre-need Burial Contract** |
| The cash value of life insurance used to fund a pre-need burial contract can be considered for an exclusion back to the date the contract was signed once verification of the change in ownership of the life insurance policy to the funeral home is provided. Refer to MPPM 302.20 for detailed information on pre-need burial contracts.  **Verifications Needed**   * Copy of pre-need burial contract, and * Documentation from the insurance company showing the change in ownership to the funeral home |

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| **Encumbrance Examples** |
| **Example 1**  **Medical Expenses:** Ms. Jane Doe was in the nursing home as private pay and applied for MAO-Nursing Home Assistance on January 4, 2023. She incurred a nursing home bill for December 2022 for $2,800 and has $3,000 in her bank account. She has a legal obligation to pay the bill. On February 4, 2023 she paid the nursing home $2,800 for the December 2022 bill.  The equity value of the bank account can be established as of the application month when the applicant presents the bill and paid receipts, which verifies that the resource was used toward the payment of the incurred nursing home bill. The incurred nursing home bill of $2,800 is an encumbrance. In determining the equity value of the bank account, the encumbrance of $2,800 is deducted from the $3,000 bank account. Eligibility can be established for January 2023, if the applicant is otherwise eligible.  **Example 2**  **Medical Expenses:** Ms. Jess Brown entered the nursing home on June 1, 2022, and applied for MAO-Nursing Home assistance the same day. She has an outstanding hospital bill for May 2022 in the amount of $3,000. For June, she had $400 in the bank and life insurance with a cash value of $4,000. In July, she cashed in the life insurance, deposited the $4,000 into her bank account, and paid the hospital bill. She provides verification of all the transactions.  The $3,000 payment can be deducted from Ms. Brown’s June resources; therefore, the worker should deduct the hospital bill amount from the total amount of Ms. Brown’s bank account. ($4,400 - $3,000 = $1,400) Because $1,400 is below the allowable $2000 limit, eligibility can be established for June 2022.  **Example 3**  **Preneed Burial Contract:** Mr. James Fletcher applied for MAO Nursing Home Assistance on May 5, 2023. He has a bank account with a balance of $825. He also has a Carolina Life insurance policy with a face value of $12,000 and cash value of $5,000. His preneed burial contract dated April 4, 2023, with Jones Funeral Home is marked as irrevocable, and indicates the Carolina Life insurance policy is assigned to Jones Funeral Home. The life insurance company verifies that their records show Mr. Fletcher as owner. Mr. Fletcher initiates the paperwork with the insurance company to assign the policy. Once it is verified that the ownership of the policy has changed to the funeral home, the insurance cash value can be deducted from the countable assets, effective with the date of the preneed contract, April 2023.   |  |  | | --- | --- | | **Initial Calculations** | **Final Calculations** | | Bank Balance 825.00  Life Insurance CV 5000.00  Countable Resources 5825.00 | Bank Balance 825.00  Life Insurance CV – excluded 0.00  Countable Resources 825.00 |   **Example 4**  **Check:** Mr. John Doe applied for ABD on January 4, 2023. As of January 31, 2023, Mr. Doe’s bank statement shows a checking account balance of $1,350 that, combined with his other alleged countable resource, is over the resource limit. Mr. Doe alleges that the statement balance includes his rent check of $500 that he wrote and gave to his landlord on January 2, 2023, but that his landlord has not cashed the check. The Eligibility Specialist examines Mr. Doe’s check register and finds an annotation for a check in the amount of $500 written on January 2, 2023. Since there is evidence that Mr. Doe has written the check from his account, the Eligibility Specialist can deduct the amount of the un-cashed check. The un-cashed check of $500 is an encumbrance. In determining equity value of the bank account, the encumbrance of $500 is deducted from the $1,350 in the bank account. Eligibility can be established for January 2023, if otherwise eligible. |

302.30 Trust Property

(Eff. 10/01/05)

[POMS SI 01120.200](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501120200)

The policy in this section applies to the treatment of trusts as related to SSI determinations. For information on the treatment of trusts for Medicaid purposes, refer to Chapter 304, Nursing Home, Waivered Services, and General Hospital.

A trust is a legal arrangement involving property and ownership interests. Property held in a trust may or may not be considered a resource for SSI purposes. The general rules concerning resources apply to evaluating the resource status of property held in a trust.

Trusts are often complex legal arrangements involving State law and legal principles. All trusts **must be sent** to the Division of Medicaid Policy and Planning at the State Department of Health and Human Services for review and a determination of the appropriate treatment of the trust.

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| **Procedure – Trust Property**  **For ALL Trusts, the eligibility worker must:**   * Obtain a copy of the trust document * Forward a copy of the trust document to the DHHS Division of Medicaid Policy and Planning. The Division will:   + Review the document and may have agency attorneys review the document and determine the appropriate treatment.   + Forward the determination to the county eligibility worker for the instructions to be carried out. |

302.30.01 Trust Terms and Definitions

(Eff. 10/01/05)

The following are common terms associated with Trusts. (Refer to MPPM Chapter 104 – Appendix I for definitions of these and other terms.)

| **Term** | Definition |
| --- | --- |
| Discretionary Trust | Trustee has full discretion of the trust. He decides under what circumstances a distribution is appropriate, and the amount of any distributions. The beneficiary has NO CONTROL over the trust. |
| Grantor | The creator of a trust. (Also known as the settlor or trustor.) |
| Grantor Trust | The grantor is also the sole beneficiary. |
| Mandatory Trust | Trustee is required to pay trust earnings from the principal to the beneficiary or for his use. Trustee has no discretion.  **Example:** Specific dollar amounts are to be paid out at the beneficiary’s 25th, 30th, and 35th birthdays. |
| Residual Beneficiary | Not a current beneficiary but will receive benefits under specific circumstances.  **Example:** Children of the grantor receive the residual benefits of the trust at his spouse’s death or remarriage. |
| Trust | Property interest where property is held by a trustee with the duty to use the property for another’s benefit |
| Trust Beneficiary | Person for whose benefit the trust exists. Does not hold legal title but has equitable ownership. |
| Trust Earnings (Income) | **Examples:** interest, dividends, royalties, rents. Unearned income if able to use these trust earnings for support |
| Trustee | Holds legal title to property for another person’s use or benefit. Generally, may not revoke the trust or use it for personal gaint. |
| Trust Principal | Property placed in the trust plus any earnings paid in and left to accumulate |
| Totten Trust | This is a tentative trust. The grantor makes himself/herself the trustee of his own funds for the benefit of someone else. If he dies, ownership passes to the beneficiary. |

[Table of Contents](#_top)

302.30.02 Instruments Similar to Trusts

(Eff. 09/01/16)

The following accounts and instruments are similar to trusts and may be titled as trusts but may or may not be considered a resource.

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| **Instrument** | **Definition** | **Difference from a Trust** |
| Conservator Account | * Established by a court * Court appointed conservator uses the account for the individual. | Beneficiary is the owner even when the assets are not available. |
| **Procedure**  **Verification:**   * Copy of court order appointing conservator * Copy of bank statements for the conservator account   **Treatment:** Generally, counted as a resource. (Refer to MPPM [302.10.01](#S_302_10_01).) | | |

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| **Instrument** | **Definition** | **Difference from a Trust** |
| Patient Trust Account | * Held and maintained by institution * Used for things such as toiletries, cigarettes, candy. | Patient is the owner. |
| **Procedure**  Obtain verification from the nursing home or institution verifying the amount in the fund and any interest from the past 3 months. Acceptable verification includes:   * [DHHS Form 1272 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201272%20ME.pdf), Request for Financial Verification from Medical Facility * Written statement from the facility * Eligibility worker’s documentation of a telephone statement by a member of the nursing facility’s staff   **Treatment:** Count as resource. | | |

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| **Instrument** | **Definition** | **Difference from a Trust** |
| Representative Payee Account | * “In trust for” account * Improperly titled * Best titled in both the individual and the payee’s names. | Beneficiary is the owner. |
| **Procedure**  **Verification:**   * Bank statements * Asset Verification System (AVS) * Other verification from the bank * [DHHS Form 1253 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201253%20ME.pdf), Request for Financial Investigation (Only if unable to verify with AVS)   **Treatment:** Count as resource. | | |

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| **Instrument** | **Definition** | **Difference from a Trust** |
| Totten Trust | * Individual deposits his own funds into an account and holds the account as owner for the benefit of another individual. |  |
| **Procedure**  **Verification:**   * Bank statements * Asset Verification System (AVS) * Written statement from bank * [DHHS Form 1253 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201253%20ME.pdf), Request for Financial Investigation (Only if unable to verify with AVS)   **Treatment:**  Any funds “held for” an individual are considered that individual’s resource. | | |

[Table of Contents](#_top)

302.30.03 Use of Trust Funds

(Eff. 10/01/05)

If an individual (claimant, recipient or deemor) has legal authority to **revoke** the trust and then use the funds to meet his food, clothing or shelter needs, or if the individual can direct the use of the trust principal for his support and maintenance under the terms of the trust, the trust principal is a resource for SSI purposes.

The following individuals usually have the authority to revoke a trust and its assets.

* **Grantor**
  + Sometimes, the grantor has the authority to revoke a trust.
  + Even if the power to revoke is not specifically retained, the trust may be revocable in certain situations.
  + State law may contain presumptions as to revocability of trusts.
  + If the principal reverts to the grantor at revocation and can be used for support and maintenance, the principal is a resource.
* **Beneficiary**
  + Generally, does not have the power to revoke a trust.
  + Trust may be a resource if he has the authority to direct the use of the principal:
    - Under specific trust provisions
    - By order of the trustee
  + The trustee should not be considered an agent of the beneficiary unless the trust specifically states this. The opposite is true in the case of a Power of Attorney who acts as an agent.
* **Trustee**
  + Trustees occasionally have the right to revoke a trust.
  + Trust is not a resource to the trustee on these occasions **unless** the trustee:
    - Becomes the owner at revocation.
    - Can withdraw and use the principal for his own support.
  + The trustee is considered a third party.
* **Totten Trust**

The creator of a Totten trust has the authority to revoke the financial account trust at any time. Therefore, the funds in the account are his resource.

302.30.04 Trust Revocability and Its Effect on the Status as a Resource

(Eff. 10/1/05)

The following is used to determine when a trust is not a resource.

* Individual does not have:
  + Legal authority to revoke the trust
  + Legal authority to use the assets for his own support and maintenance
* The Trust is IRREVOCABLE:
  + By its terms and
  + Under State law
* Grantor Trust
  + If Grantor is sole beneficiary, it is generally considered revocable regardless of the Trust’s language.
  + If there is a residual beneficiary, it is generally considered irrevocable.

[Table of Contents](#_top)

302.30.05 Disbursements from Trusts

(Rev.04/01/07)

**Trust Principal is NOT a Resource**

If the trust principal is not a resource, disbursements from the trust **may be** income depending on the nature of the disbursements. Regular rules to determine when income is available apply. (Refer to MPPM Chapter 301 on Income.)

**Trust Principal IS a Resource**

If the trust principal is a resource to the individual, disbursements from the trust principal received by the individual are not income, but conversion of a resource. (However, trust earnings, such as interest, are income.)

* **Trust Earnings**

Trust earnings are NOT income to:

* The trustee unless designated under the terms of the trust (for example, fees)
* The beneficiary unless payment is made to the beneficiary
  + - Under the terms of the trust or
    - By the trustee

Trust earnings are income to the individual for whom trust principal is a resource, unless the terms of the trust make the earnings the property of another.

* **Additions to Principal**

Additions to trust principal made directly to the trust are not income to the grantor, trustee or beneficiary.

Additions to principal may be income or conversion of a resource, depending on the source of the funds. If funds from a third party are deposited into the trust, the funds are income to the beneficiary. If funds are transferred from an account owned by the individual to the trust, the funds are not income, but conversion of a resource from one account to another.

* **Assignment of Income**

A legally assignable payment that is assigned to a trust is income for SSI purposes **unless the assignment is irrevocable**. If the assignment is revocable, the payment is income to the individual legally entitled to receive it.

**Note:** Certain payments are non-assignable by law and, therefore, are income to the individual entitled to receive the payment under regular income rules. They may not be paid directly into a trust, but individuals may attempt to structure trusts so that it appears that they are so paid. **Exception:** Institutional Income Trusts and Special Needs Trusts allow for placing income in a trust after receipt without the right to the payment being irrevocably assigned. Refer to MPPM 304.19 for Income Trusts and MPPM 302.30.06 for Special Needs Trusts.

**Non-assignable payments include**:

* + Family Independence (FI or TANF) payment (formerly known as Aid to Families with Dependent Children-AFDC)
  + Railroad Retirement Board-administered pensions
  + Veterans Administration pensions and assistance
  + Federal employee retirement payments (CSRS, FERS) administered by the Office of Personnel Management
  + Social Security Title II and SSI payments
  + Private pensions under the Employee Retirement Income Security Act (ERISA) [29 U.S.C.A. section 1056(d)]

[Table of Contents](#_top)

302.30.06 Special Needs Trusts

(Rev. 02/01/17)

This type of trust is designed especially for individuals under the age of 65 who meet the SSI definition of disability. Special Needs Trusts established for a disabled individual age 64 or younger are exempt from the application of the transfer of assets penalty provision. Therefore, funds placed in a Special Needs Trust established for an individual age 65 or older will be subject to a penalty for a transfer of assets for less than fair market value. Further, once an individual reaches age 65, any funds or assets placed into the trust will be considered a transfer, even if the trust was properly established by a disabled individual age 64 or younger.

Criteria

* Established for the sole benefit of the disabled individual by:
  + Disabled Individual (Only for trusts established on or after December 13, 2016)
    - Individual’s spouse
    - A person with legal authority to act in place of or on behalf of the individual or the individual’s spouse,
    - A person acting at the direction or upon the request of the individual or the individual’s spouse.
  + Parent
  + Grandparent
  + Legal Guardian
  + Court
* Must be funded initially with the income and/or resources of the disabled individual

**Note**: Assets from any individual may be placed in the trust after the initial funding.

* Must contain a provision stating that at the individual’s death, the state will receive all amounts remaining in the trust up to the amount expended by Medicaid on the individual’s behalf.
* Some Special Needs Trusts have a provision allowing the trustee to make loans from the trust. On or after September 1, 2003, any loan provision must be accompanied by a requirement that the trustee furnish SCDHHS with documentation of the following:
  + Source of the payback funds
  + An amortization schedule (schedule of the monthly payments of principal and interest)
    - Must have a reasonable rate of interest
    - Must be actuarially sound (that is, expected to be paid back during the person’s life expectancy).
  + Documentation must be provided prior to funds being disbursed for the loan.
  + Loans made that do not meet the above requirements are counted as income in the month received.
* May be established with the individual’s income.
  + The income must belong to the individual and be placed in the trust after he or she has received it.
  + Income that is placed in the trust is not counted when determining the individual’s Medicaid eligibility. Any income, including Social Security Benefits, VA pensions, private pensions, can be placed directly in the trust by the applicant/beneficiary without it affecting the individual’s Medicaid eligibility. Also any income generated by the trust, which remains in the trust, is not counted as income.
  + Any payments paid by the trust directly to the individual are counted as income for eligibility purposes.
  + Any payments made by the trust to purchase food or shelter for the individual is considered as in-kind income for eligibility purposes.

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| **Procedure**  **When Trust is Established:** The eligibility worker must forward copies of the trust to the Division of Policy and Planning for review and approval using Service Manager. The relationship of the individual establishing the trust to the disabled individual must be documented.  **At Annual Review:** The eligibility worker must verify whether any money has been paid to the beneficiary to determine countable income. Request copies of bank statements or an accounting of any disbursements for the beneficiary.  **At the time of case closure, including death of a beneficiary**: The eligibility worker must forward a copy of the trust with identifying information to:  Department of Health and Human Services  Division of Third Party Liability  1801 Main Street  Columbia, SC 29202 |

[Table of Contents](#_top)

302.30.07 Pooled Trusts

(Rev. 08/01/08)

Pooled trusts contain the assets of individuals who meet the SSI definition of disability. Although a pooled trust may be established for beneficiaries of any age, only trusts established for a disabled individual age 64 or younger are exempt from the application of the transfer of assets penalty provision. Therefore, funds placed in a pooled trust established for an individual age 65 or older will be subject to a penalty for a transfer of assets for less than fair market value. Further, once an individual reaches age 65, any funds or assets placed into the trust will be considered a transfer, even if the trust was properly established by a disabled individual age 64 or younger.

Criteria

In order for such a trust to be exempt from the transfer of assets penalty, the trust must:

* Be established and managed by a non-profit association

**Example:** Babcock Center

* Have a separate account maintained for each beneficiary
* Contain an account in the trust solely for the benefit of the disabled individual which is funded by the disabled individual, parent, grandparent, legal guardian or court; and
* Contain a provision stating that at the individual’s death, the state will receive all amounts remaining in the individual’s account up to the amount expended by Medicaid on the individual’s behalf.

Although an account is established for each member of the pooled trust, funds in the trust are pooled for investment and management purposes.

302.30.08 Achieving a Better Life Experience (ABLE) Accounts

(Eff. 09/01/16)

[POMS SI 01130.740](https://secure.ssa.gov/poms.nsf/lnx/0501130740);

[26 U.S.C. 529A](http://uscode.house.gov/view.xhtml?req=(title:26%20section:529A%20edition:prelim));

[S.C. Code Ann. § 11-5-400-§ 11-5-460](http://www.scstatehouse.gov/sess121_2015-2016/bills/3768.htm)

An Achieving a Better Life Experience (ABLE) account is a type of tax-advantaged account that an eligible individual can use to save funds for the disability-related expenses of the account’s designated beneficiary, who must be blind or disabled by a condition that began before the individual’s 26th birthday.

An ABLE program can be established and maintained by a State or a State agency directly or by contracting with a private company (an instrumentality of the State). An eligible individual can open an ABLE account through the ABLE program in any State. State legislation established the South Carolina ABLE Savings Program effective April 29, 2016.

Upon the death of the designated beneficiary, funds remaining in the ABLE account, after payment of any outstanding, qualified disability expenses, reimburse the State(s) for Medicaid benefits that the designated beneficiary received.

302.30.08A Designated Beneficiary of ABLE Account

(Eff. 09/01/16)

An eligible individual can be the designated beneficiary of only one ABLE account, which must be administered by a qualified ABLE program.

* The designated beneficiary is the eligible individual who established and owns the ABLE account. To be an eligible individual, he or she must be:
  + 1. eligible for Supplemental Security Income (SSI) based on disability or blindness that began before age 26;
    2. entitled to disability insurance benefits (DIB), childhood disability benefits (CDB), or disabled widow’s or widower’s benefits (DWB) based on disability or blindness that began before age 26; or
    3. someone who has certified, or whose parent or guardian has certified, that he or she:
  + has a medically determinable impairment meeting certain statutorily specified criteria; or,
  + is blind; and,
  + the disability or blindness occurred before age 26.
* A person with signature authority can establish and control an ABLE account for a designated beneficiary who is a minor child or is otherwise incapable of managing the account. The person with signature authority must be the designated beneficiary's parent, legal guardian, or agent acting under power of attorney. The designated beneficiary is considered to be the owner of an ABLE account, regardless of whether someone else has signature authority over it.

302.30.08B Excluded ABLE account contributions, balances, earnings, and distributions

(Rev. 09/01/21)

Exclude contributions to an ABLE account as income to the applicant or beneficiary. A contribution is the deposit of funds into an ABLE account. Any person can contribute to an ABLE account. However, the Internal Revenue Service (IRS) limits the total annual contributions that any ABLE account can receive from all sources to the amount of the per-donee gift-tax exclusion in effect for a given calendar year. For 2021, that limit is $15,000.

A contribution made by an individual into his or her ABLE account is not income to the individual. However, income received by the individual and deposited into his or her ABLE account is income to the individual.

The fact that a person uses his or her income to contribute to an ABLE account does not mean that his or her income is not countable for Medicaid as it normally would be. Income received by an applicant or beneficiary and deposited into his or her ABLE account is income to the individual. For example, an individual can have contributions automatically deducted from his or her paycheck and deposited into an ABLE account. In this case, include the income used to make the ABLE account contribution in the individual’s gross wages.

An individual cannot use direct deposit to avoid income counting.

Examples of payments that might be deposited into an ABLE account, but still are counted as income as they otherwise would be, include:

* Wages;
* Benefit payments (Title II, Veterans Administration, pensions, etc.); and
* Mandatory Support payments (child support or alimony).

Excluded contributions include rollovers from a family member's (siblings, stepsiblings and half-siblings, by blood or by adoption) ABLE account to an individual’s ABLE account.

The funds in an ABLE account can accrue interest, earn dividends, and otherwise appreciate in value. Earnings increase the account's balance. Exclude any earnings an ABLE account receives from the income of the designated beneficiary.

Exclude the entire balance of funds in an ABLE account from resources for Medicaid determinations. SSI determinations completed by the Social Security Administration exclude up to and including $100,000 of the balance of funds in an ABLE account from the beneficiary’s resources.

Qualified disability expenses (QDE) are expenses related to the blindness or disability of the designated beneficiary and for the benefit of the designated beneficiary. In general, a QDE includes, but is not limited to, the following types of expenses:

* Education;
* Housing;
  + Housing expenses for purposes of an ABLE account are the same as they are for in-kind support and maintenance purposes, except for food. QDEs for housing are payments for:
    - Mortgage (including property insurance required by the mortgage holder);
    - Real property taxes;
    - Rent;
    - Heating fuel;
    - Gas;
    - Electricity;
    - Water;
    - Sewer; or
    - Garbage removal.
* Transportation;
* Employment training and support;
* Assistive technology and related services;
* Health;
* Prevention and wellness;
* Financial management and administrative services;
* Legal fees;
* Expenses for ABLE account oversight and monitoring;
* Funeral and burial; and,
* Basic living expenses.

A distribution is the withdrawal or issuance of funds from an ABLE account. The designated beneficiary or the person with signature authority determines when he or she makes distributions. Distributions are only to or for the benefit of the designated beneficiary. A distribution from an ABLE account is not income but is a conversion of a resource from one form to another. Do not count distributions from an ABLE account as income of the designated beneficiary, regardless of whether the distributions are for non-housing QDEs, housing QDEs, or non-qualified expenses.

Exclude from the designated beneficiary’s countable resources a distribution for a QDE other than housing if he or she retains it beyond the month received. This exclusion applies while the:

* Designated beneficiary maintains, makes contributions to, or receives distributions from the ABLE account;
* Distribution is unspent;
* Distribution is identifiable. (**NOTE:** Excludable funds commingled with non-excludable funds must be identifiable.); and
* Individual still intends to use the distribution for a non-housing related QDE.

302.30.08C Countable ABLE account balances and distributions

(Rev. 11/01/17)

The funds in an ABLE account are always excluded for Medicaid eligibility decisions.

A special rule applies when the balance of an SSI recipient's ABLE account exceeds $100,000 by an amount that causes the recipient to exceed the SSI resource limit--whether alone or with other resources. When this situation happens, the Social Security Administration (SSA) places the recipient into a special SSI suspension period where:

* SSA suspends the recipient's SSI benefits without time limit (as long as he or she remains otherwise eligible);
* The recipient retains continued eligibility for Medicaid; and
* The individual’s eligibility does not terminate after 12 continuous months of suspension.

The special suspension rule does not apply when:

* The balance of an individual’s ABLE account exceeds $100,000 by an amount that causes the recipient to exceed the SSI resource limit;
* But the resources other than the ABLE account alone would make the individual ineligible for SSI, due to excess resources

If an individual is ineligible for any reason other than excess resources in an ABLE account, the special suspension status does not apply.

If a designated beneficiary uses a distribution previously excluded, for a non-qualified purpose or a housing-related QDE, or the individual’s intent to use it for a qualified disability expense changes, count the amount of funds used for a non-qualified expense or housing-related QDE as a resource as of the first moment of the month in which the funds were spent. Presume that the individual’s intent to use the funds for a QDE changed as of the first of the month he or she spent the funds. If an individual’s intent to use the funds for a QDE changes at any other time, but he or she has not spent the funds, count the retained funds as a resource as of the first of the following month.

302.31 Uniform Gifts to Minors Act

(Eff. 10/01/05)

[POMS SI 01120.205](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501120205)

Most States have adopted the Uniform Gifts to Minors Act (UGMA) that permits making gifts that are tax free to minors. The UGMA is sometimes called the Uniform Transfers to Minors Act.

Under UGMA legislation:

* An individual (donor) makes an irrevocable gift of money or other property to a minor (the donee);
* The gift, plus any earnings it generates, is under the control of a custodian until the donee reaches the age of majority established by State law;
* The custodian has discretion to provide to the minor or spend for the minor’s support, maintenance, benefit, or education as much of the assets as he deems equitable; and
* The donee automatically receives control of the assets when he reaches the age of majority.

302.31.01 UGMA and Sources

(Eff. 10/01/05)

A custodian of UGMA assets cannot legally use any of the funds for his own personal benefit. Therefore,

* The assets are not his resources.
* Additions to or earnings on the principal are not income to the custodian who has no right to use them for his own support and maintenance.

Additions to the principal may be income to the donor before becoming part of the UGMA principal.

|  |
| --- |
| **Example**  If the donor is a deemor who receives rental income and adds it to a child's UGMA funds, consider the rental income as income for deeming purposes. |

302.31.02 While Donee Remains a Minor

(Eff. 10/01/05)

**What IS Income to the Minor?**

* Custodian’s disbursements to the minor
* Disbursements on behalf of the minor used to make certain third-party vendor payments

**What is NOT Income?**

* The UGMA property
* Any additions or earnings
  + 1. When the Donee Reaches Age 18

(Eff. 10/01/05)

* All UGMA property will become available to him.
* All funds in the UGMA will count as income the month the minor reaches age 18.

|  |
| --- |
| **Procedure – When the Donee Reaches Age 18**  **Verification Needed:**   * A copy of the document of ownership such as:   + Certificate of Deposit   + Written documentation from the donor   **Treatment:** Accept any document as valid unless there is evidence otherwise.  If there is no documentation, treat as though there is no UMGA. |

[Table of Contents](#_top)

302 Appendix A Excluded Resources

(Eff. 10/01/06)

Commonly Excluded Resources

The following chart identifies the most commonly excluded resources. It also identifies if there are limits on the value or length of time the resource may be excluded.

| Resource | Limit on Value of Exclusion | Limit on Length of Time of Exclusion | Further Reference  MPPM & POMS |
| --- | --- | --- | --- |
| **Home property** Principal place of residence, including the land it sits on and other buildings on it.  Vacant land if person intends to live on it and has no other residence to exclude.  Funds from the sale of a home if invested timely in a replacement home | No  No  No | No  No  Yes | [SI 01130.100](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130100) |
| **Automobile** One vehicle regardless of value. Second vehicle if used for transportation | No | No | [SI 01130.200](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130200) |
| Life Insurance with face values totaling $10,000 or less | Yes | No | [SI 01130.300](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130300) |
| Burial funds for applicant/beneficiary and their spouse | Yes | No | [SI 01130.410](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130410) [– SI 01130.412](https://secure.ssa.gov/apps10/poms.nsf/subchapterlist!openview&restricttocategory=05011) |
| Burial space items owned or held by applicant /beneficiary and/or their spouse or immediate family member | No | No | [SI 01130.400](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130400) –  [SI 01130.412](https://secure.ssa.gov/apps10/poms.nsf/subchapterlist!openview&restricttocategory=05011) |
| Certain pre-need burial contracts | Yes | No | [SI 01130.400](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130400) –  [SI 01130.412](https://secure.ssa.gov/apps10/poms.nsf/subchapterlist!openview&restricttocategory=05011) |
| Retained SSI and Social Security Lump Sum benefits | No | Yes | [SI 01130.600](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130600) |
| **Real property other than homestead**  Property that owner is making a bona fide effort to sell  Jointly owned that can not be sold without an undue hardship (loss of housing) to the other owner | No  No | No  No | [SI 01130.140](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130140)  [SI 01130.130](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130130) |
| Household goods and personal effects | No | No | [SI 01130.430](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130430) |
| Property essential to self-support | Yes | No | [SI 01130.500](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130500) –  [SI 01130.504](https://secure.ssa.gov/apps10/poms.nsf/subchapterlist!openview&restricttocategory=05011) |
| **Cash** (including accrued interest) received from any source at any time to replace or repair lost, damaged or stolen excluded resources | No | No | [SI 01130.630](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130630) |
| Resources of a blind or disabled person which are necessary to fulfill a Plan for Achieving Self-Support (PASS) | No | No | [SI 01130.510](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130510) |
| Federal disaster assistance received due to a Presidentially declared major disaster, including interest accumulated thereon | No | No | [SI 01130.620](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130620) |
| Tax refunds related to Earned Income Tax Credit (EITC) | No | Yes | [SI 01130.676](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130676) |

[Table of Contents](#_top)

Less Commonly Excluded Resources

The following chart identifies the most commonly excluded resources. It also identifies if there are limits on the value or length of time the resource may be excluded.

| Resource | Limit on Value of Exclusion | Limit on Length of Time of Exclusion | Further Reference  MPPM & POMS |
| --- | --- | --- | --- |
| Restricted, allotted Indian land if the Indian/owner cannot dispose of the land without permission of other individuals, his tribe or an agency of the Federal Government | No | No | [SI 01130.150](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130150) |
| Stock held by native Alaskans in Alaska regional or village 01/01/92 when the stock becomes a resource | No | No |  |
| Radiation exposure compensation trust fund payments | No | No | [SI 01130.680](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130680) |
| German Reparation payments made to World War II Holocaust survivors | No | No | [SI 01130.610](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130610) |
| Austrian social insurance payments | No | No | [SI 01130.615](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130615) |
| Japanese-American and Aleutian restitution payments | No | No | [SI 01130.683](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130683) |
| Certain items excluded from both income and resources by other Federal statutes | Varies | No |  |
| Agent Orange settlement payments to qualifying veterans and survivors | No | No | [SI 01130.660](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130660) |
| Victims compensation payments | No | Yes | [SI 01130.665](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130665) |
| State or local relocation assistance payments | No | Yes | [SI 01130.670](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130670) |

[Table of Contents](#_top)

302 Appendix B Verification Procedures

(Rev. 04/01/10)

The value of resources does not have to be verified if:

* The resource is totally excluded – regardless of its value, such as home property and one automobile.
  + Life insurance must be verified even if the individual alleges the total Face Value is below the excludable limit.
  + Ownership must be verified for excluded Homestead property and excluded automobiles for all SSI-related categories
  + The value and ownership of Homestead property must be verified for individuals applying for Nursing Home or HCBS.)
* The alleged value of total countable resources exceeds the applicable limit.
* The individual is ineligible for a reason other than excess resources

The equity value of a resource should be developed whenever:

* The current market value of all countable resources exceeds the applicable limit,
* The individual alleges a debt against the resource, and
* The alleged equity value could permit eligibility.

The individual's allegation of the property's value should be accepted if:

* Countable resources, including the real property, exceed the limit; and
* The individual does not allege any debts against the property that would reduce countable resources to within the limit.

[Table of Contents](#_top)

302 Appendix C Knowledgeable Source Statements

(Eff. 10/01/05)

VERIFICATION OF FAIR AND CURRENT MARKET VALUE

OF REAL PROPERTY

**Appraisal** - When an appraisal is readily available, use it to establish the value of real property.

**Tax Assessed Value** – If an appraisal or other method of valuation is not readily available, the County Tax Assessors Office assessed value may be used, for Medicaid purposes, to establish the value of real property for eligibility. If the property was sold, use the higher of the sale price or the tax assessed value as the fair market value.

**Knowledgeable Source Statement** - When an appraisal is not readily available, or if the applicant/beneficiary disagrees with the tax assessed value, use the statement of a knowledgeable source that is familiar with property values in the area to verify the value of real property. The knowledgeable source must not be related to the applicant/ beneficiary or to a member of his or her immediate family.

Examples of knowledgeable sources are:

* Real estate brokers
* Local office of the Farmer's Home Administration or Agricultural Stabilization and Conservation Service for rural land
* Banks, savings and loan associations, mortgage companies, and similar lending institutions
* Official of the local property tax jurisdiction (the individual's estimate, not the office's assessment)
* County Agricultural Extension Service

Knowledgeable source statements must contain the following information:

* A description of the property and its condition;
* The estimated value of the property;
* The period of time to which the estimate applies; and
* The name and business address of the person providing the estimate.

If the validity of the estimate is doubtful, obtain a second knowledgeable source statement. Always obtain a second estimate if the first estimate is less than the tax assessed value and the knowledgeable source cannot provide a reasonable explanation for the discrepancy.

[Table of Contents](#_top)

302 Appendix D Rebuttal Of Ownership of Assets Other Than Joint Bank Accounts

(Eff. 10/01/05)

If the applicant indicates that an asset does not belong to him, or did not belong to him at the time of transfer, he is required to provide documentary evidence of his claim. When the asset is not a checking or savings account, the individual must initially furnish a statement that includes:

* A description of the asset in question;
* The name, address, and telephone number of the alleged owner of the asset;
* A written explanation from the client, or the authorized representative, justifying and explaining the inconsistent record of ownership; and
* Statements and corroborative evidence from the alleged owner to include:
* Supporting equity ownership; or
* Indication that payments were made for the property, or indication of sustained payment of taxes and/or expenses; or
* Indications that improvements were made (and paid for) to the property beyond those that would normally be expected of a non-owner.

It is the applicant’s responsibility to provide adequate supporting evidence. The eligibility worker should forward all the evidence to the Bureau of Eligibility Administration at the State Department of Health and Human Services. State office concurrence is required before approval of such a rebuttal petition.

[Table of Contents](#_top)

302 Appendix E Stocks, Bonds, Mutual Funds

(Eff. 10/01/05)

**DESCRIPTION OF STOCKS**

**1. Common Stock**

Common stock usually is held in the form of a certificate registered in the owner's name. Dividends usually are paid quarterly and may vary with company earnings.

* “Listed” stocks are those listed on the NYSE, AMEX, or on one of the regional exchanges such as Boston, Philadelphia, or Chicago.
* Over-the-Counter (OTC) stocks, which include “penny” stocks, are not listed on the major exchanges. They usually are reported in the National Association of Security Dealers Automated Quotations (NASDAQ) system.

**2. Preferred Stock**

Preferred stock receives preference with respect to dividends and, in case of bankruptcy, the distribution of assets. Preferred stock dividends:

* Are paid at a fixed rate;
* Must be paid before common stock dividends can be paid; and
* Must be made up later, when not paid timely, whereas common stock dividends may be skipped.

Reading Stock Quotations

Stock tables vary little from publication to publication. The following quote is typical, showing from left to right:

* The standard abbreviation of the name of the company (Philadelphia Electric in this case), followed by “pf” for preferred stock on the second line;
* The dividend amount;
* The price-to-earnings ratio;
* Sales volume, in thousands;
* The day's high, low, and closing prices (22 3/4 = $22.75); and
* The change in price from the previous day.

| **NAME** | **DIV** | **PE** | **SALES** | **HIGH** | **LOW** | **LAST** | **CHG** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Phil El | 2.20 | 9 | 4323 | 22 7/8 | 22 5/8 | 22 3/4 | - 1/8 |
| Phil E pf | 4.30 | - | 50 | 42 3/4 | 42 3/4 | 42 3/4 | - |

[Table of Contents](#_top)

DESCRIPTION OF BONDS

Bonds usually are bought and sold through brokers, securities dealers, or other investors. They may sell for more or less than their face value or purchase price, depending on a variety of factors.

**Reading Bond Quotations**

The following is a typical bond quotation, showing from left to right:

* The name of the issuer (AT&T);
* The bond's nominal or coupon rate (3 7/8 percent);
* The last two digits of the year in which the bond matures (1990);
* The current yield (5.6 percent);
* The number of bonds traded during the year (54,000);
* The highest, lowest, and last price of the bond for the period covered by the quotation (bond prices are quoted on a par of 100, so the last price of 69 1/4 equals $692.50); and
* The net change in the bond price.

| **ISSUE** | **CURRENT YIELD** | **SALES 1000's** | **HIGH** | **LOW** | **CLOSE** | **CHANGE** |
| --- | --- | --- | --- | --- | --- | --- |
| AT&T 3 7/8, 90 | 5.6 | 54 | 69 3/4 | 69 1/4 | 69 1/4 | -3/8 |

[Table of Contents](#_top)

DESCRIPTION OF MUTUAL FUNDS

“Mutual fund” is a term that encompasses a wide range of investments. Basically, it is a pool of assets (such as stocks or bonds) managed by an investment company. A mutual fund share represents ownership interest in this pool as opposed to a particular stock or bond.

**Reading Mutual Fund Quotations**

The format of the following table is typical of those shown in newspapers and financial publications, showing from left to right:

* The names of the funds available for each management group (in this case, four funds managed by the Fund Founders Group);
* The high and low values for the preceding 52-week period;
* The most recent closing price;
* The change over the previous week; and
* The fund's income and capital gains totals for the previous 12 months.

| **Fund Founders** | **52 Weeks** | |  | **Week's** |  | **Capital** |
| --- | --- | --- | --- | --- | --- | --- |
| **Group** | **H** | **L** | **Close** | **Change** | **Income\*** | **Gains** |
| Growth n. | 8.77 | 6.28 | 6.37 | -0.08 | 0.157 | 2.505 |
| Income n. | 15.18 | 13.72 | 13.87 | +0.01 | 1.273 | 0.232 |
| Mutual | 11.56 | 9.74 | 9.98 | -0.07 | 0.426 | 0.706 |
| Special n. | 37.11 | 22.88 | 23.54 | -0.13 | 1.900 | 1.395 |
| n = no-load |  |  |  |  |  |  |
| \*= Last 12 months |  |  |  |  |  |  |

[Table of Contents](#_top)

302 Appendix F Life Estate and Remainder Interest Tables

(Eff. 10/01/05)

(UNISEX LIFE ESTATE OR REMAINDER TABLE)

To calculate the value of a Life Estate or Remainder Interest, find the person’s age, and multiply the Current Market Value by the decimal in the appropriate column.

| AGE | LIFE ESTATE | REMAINDER |
| --- | --- | --- |
| 0  1  2  3  4 | .97188  .98988  .99017  .99008  .98981 | .02812  .01012  .00983  .00992  .01019 |
| 5  6  7  8  9 | .98938  .98884  .98822  .98748  .98663 | .01062  .01116  .01178  .01252  .01337 |
| 10  11  12  13  14 | .98565  .98453  .98329  .98198  .98066 | .01435  .01547  .01671  .01802  .01934 |
| 15  16  17  18  19 | .97937  .97815  .97700  .97590  .97480 | .02063  .02185  .02300  .02410  .02520 |
| 20  21  22  23  24 | .97365  .97245  .97120  .96986  .96841 | .02635  .02755  .02880  .03014  .03159 |
| 25  26  27  28  29 | .96678  .96495  .96290  .96062  .95813 | .03322  .03505  .03710  .03938  .04187 |
| 30  33  32  33  34 | .95543  .95254  .94942  .94608  .94250 | .04457  .04746  .05058  .05392  .05750 |
| 35  36  37  38  39 | .93868  .93460  .93026  .92567  .92083 | .06132  .06540  .06974  .07433  .07917 |
| 40  41  42  43  44 | .91571  .91030  .90457  .89855  .89221 | .08429  .08970  .09543  .10145  .10779 |
| 45  46  47  48  49 | .88558  .87863  .87137  .86374  .85578 | .11442  .12137  .12863  .13626  .14422 |
| 50  51  52  53  54 | .84743  .83674  .82969  .82028  .81054 | .15257  .16126  .17031  .17972  .18946 |
| 55  56  57  58  59 | .80046  .79006  .77931  .76822  .75675 | .19954  .20994  .22069  .23178  .24325 |
| 60  61  62  63  64 | .74491  .73267  .72002  .70696  .69352 | .25509  .26733  .27998  .29304  .30648 |
| 65  66  67  68  69 | .67970  .66551  .65098  .63610  .62086 | .32030  .33449  .34902  .36390  .37914 |
| 70  71  72  73  74 | .60522  .58914  .57261  .55571  .53862 | .39478  .41086  .42739  .44429  .46138 |
| 75  76  77  78  79 | .52149  .50441  .48742  .47049  .45357 | .47851  .49559  .51258  .52951  .54643 |
| 80  81  82  83  84 | .43659  .41967  .40295  .38642  .36998 | .56341  .58033  .59705  .61358  .63002 |
| 85  86  87  88  89 | .35359  .33764  .32262  .30859  .29526 | .64641  .66236  .67738  .69141  .70474 |
| 90  91  92  93  94 | .28221  .26955  .25771  .24692  .23728 | .71779  .73045  .74229  .75308  .76272 |
| 95  96  97  98  99 | .22887  .22181  .21550  .21000  .20486 | .77113  .77819  .78450  .79000  .79514 |
| 100  101  102  103  104 | .19975  .19532  .19054  .18437  .17856 | .80025  .80468  .80946  .81563  .82144 |
| 105  106  107  108  109 | .16962  .15488  .13409  .10068  .04545 | .83038  .84512  .86591  .89932  .95455 |

[Table of Contents](#_top)

302 Appendix G Asset Verification System (AVS)

(Rev. 10/01/23)

**Verification of Financial Accounts**

Refer to MPPM 302.26.02 for policy and procedures related to determining the countable amount for bank accounts verified through AVS.

SCDHHS has implemented an Asset Verification System (AVS) to directly verify accounts located at banks and credit unions. The AVS search consists of a Financial Institution search, which is for accounts attested to by an applicant/beneficiary, and a Geographical Search (GEO Search), which identifies any additional accounts not attested to by the applicant/ beneficiary. This system will reduce or eliminate the need to request account statements from an applicant or beneficiary to either verify a current balance or to complete a look-back for a Long-Term Care application.

AVS replaces the use of a DHHS Form 1233 or DHHS Form 1253 to request bank account information.

* If account information is returned through AVS that results in a negative action, always contact the applicant/beneficiary to explore any possible exclusions, deductions or exemptions
* Balances from the 1st day of the following month can be used as verification of the lowest monthly balance of the previous month due to “neighboring” balances. “Neighboring” refers to the AVS or bank statement balance for the subsequent month being the same as the last day of the application month or retroactive request month. Eligibility Specialists must document the use of neighboring balances on the Documentation Template.
* Any responses that return account information must be uploaded into OnBase
* The Action section of the Documentation Template must include a note indicating when an AVS request is created
* Any accounts verified through AVS must be documented in the Resource section of the Documentation Template and in the System of Record based on the account number and type.

|  |
| --- |
| **Note**  If there is a bank statement on file showing the lowest balance for the month, use the bank statement. If there is no bank statement on file, but the “neighboring” balance on the AVS result shows a lower balance, use the AVS response without requesting additional information. If the AVS “neighboring” balance does not help the individual become eligible, request a bank statement for the month(s) being assessed to determine the lowest monthly balance.  **Note**  If current bank account information necessary to complete a decision is already in the record, a new AVS request is not required to process the application or review. This includes a DHHS Form 1253 that has already been completed by a Financial Institution or statements that have been provided by an applicant or beneficiary in response to a DHHS Form 1233. An AVS request is created and then checked at the time of next review. |

**Applications and Reviews**

When processing an application or review, check the application/review for indication of an account or accounts

* Applications
  + If a bank account is listed on the application, create both an AVS request for the specific Financial Institution (FI) and a Geosearch
    - If a Financial Institution is non-participating with AVS, if unable to verify an account with a collateral call, use DHHS Form 1253 to request the information
  + If no bank account is listed on the application, create a Geosearch only
  + For Non-MAGI, use the default date range
* Reviews
  + If a bank account is listed on the review or if there is a bank account in the record, create an AVS request for the specific Financial Institution (FI)
  + Edit the date range so that it includes the current month only
  + Create a Geosearch if one has never been completed either at application or a previous review. This means that a Geosearch is requested only once for an applicant or beneficiary during a period of eligibility
  + If a Geosearch was created at the previous application or review, check for any responses that may have been returned since the case was processed
    - If a response is discovered with an unreported account, verify the account before completing a decision
* Analyze the application/review to prepare for collateral calls and for any other information that may be required to complete processing
* Check AVS for any responses that may have been returned prior to beginning collateral calls, so that if necessary, the information can be discussed with the applicant/beneficiary
* When collateral calls have been completed, put the case into 15 day follow-up if:
  + A DHHS Form 1233 needs to be sent to the applicant/beneficiary to ask for any other information,
  + An AVS request was created for reported accounts at specific FI and it has not been returned when checking AVS and the account cannot be verified by a collateral call, or
  + Verification is required from a third party
* When the case comes back into workflow, check AVS for any new responses and finish processing the case. It is not necessary to wait the full 15 days for the AVS responses if all other information has been returned. EXCEPTION If a request was created for accounts at a specific FI and it has not been returned when checking AVS, place the case in 15-day follow-up if the account cannot be verified by a collateral call
* If no information is required, check AVS for any additional responses that may have been returned while completing the collateral calls and finish making a decision on the case

**Long Term Care Application for Nursing Home or In-Home Care (Waiver)**

* Do not ask for any bank statements from the applicant
* If an account is listed on the application or DHHS Form 3400-B, create an FI and Geosearch and modify the date range to allow for the look-back for transfers
  + If the application includes copies of bank statements for the current months and the three previous months, create an FI and Geosearch
    - If no transfers are indicated on the bank statements, the application can be processed as soon as all other information is returned without waiting the 15 days. At the next review, check for any responses that may have been returned
    - If a possible transfer is indicated on the bank statements, wait at least 15 days for the AVS responses to be returned
* If the applicant is currently receiving ABD or SLMB, use the information in the case record to complete a modified look-back and create a request adjusting the date range as appropriate
* Analyze application to prepare for collateral calls and for any other information that may be required to complete processing
* Prior to beginning collateral calls, check AVS for any responses that may have been returned
* If a DHHS Form 1233 is required or if a request for information is sent to a third party, put the case in 15 day follow-up
* When the case comes back into workflow, check AVS for any additional responses
* If no additional information is required once collateral calls have been completed, check AVS for any new responses and process the case as appropriate
* If a request was created for a specific FI and has not been returned by the end of the 15-day follow-up period and you are unable to obtain the information from the applicant/beneficiary or by a collateral call, send a DHHS Form 1253 to the bank requesting the account information.

|  |
| --- |
| **Asset Verification System Workflow**  Diagram  Description automatically generated |
| * **Non-MAGI Application**   + Use the default date range * **Review**   + Edit date range to current month * **Long Term Care**   + New Application:     - Edit the date range to complete the required look-back for transfers   + Current ABD Eligible:     - Edit Date Range to current month and any period when a transfer may have occurred   + Current SSI Eligible     - Do not complete a look-back   + No longer SSI Eligible     - Edit beginning Date Range to end of SSI coverage |

# **CHAPTER 303—Medicare Saving Programs (MSP), Aged, Blind and Disabled (ABD)**

[303.01 Introduction 198](#_Toc152299482)

[303.01.01 Eligibility Criteria 198](#_Toc152299483)

[303.01.02 Categorical Requirements 198](#_Toc152299484)

[303.01.03 Non-Financial Requirements 198](#_Toc152299485)

[303.02 Aged, Blind and Disabled (ABD) Introduction 199](#_Toc152299486)

[303.02.01 ABD Eligibility 199](#_Toc152299487)

[303.02.02 ABD Retroactive Period 199](#_Toc152299488)

[303.02.03 Early Application for ABD 199](#_Toc152299489)

[303.03 Qualified Medicare Beneficiaries (QMB) Introduction 200](#_Toc152299490)

[303.03.01 QMB Eligibility 200](#_Toc152299491)

[303.03.02 Dual Eligibility 200](#_Toc152299492)

[303.03.03 QMB Retroactive Period 201](#_Toc152299493)

[303.03.04 Early Application for QMB 201](#_Toc152299494)

[303.04 Specified Low Income Medicare Beneficiaries (SLMB) Introduction 201](#_Toc152299495)

[303.04.01 SLMB Eligibility 201](#_Toc152299496)

[303.04.01A SLMB Plus (Dual Eligibility) 201](#_Toc152299497)

[303.04.02 SLMB Retroactive Period 203](#_Toc152299498)

[303.04.03 Early Application for SLMB 203](#_Toc152299499)

[303.05 Qualifying Individuals (QI) Introduction 204](#_Toc152299500)

[303.05.01 QI Eligibility 204](#_Toc152299501)

[303.05.02 QI Retroactive Period 205](#_Toc152299502)

[303.05.03 Early Application for QI 205](#_Toc152299503)

[303.06 General Financial Criteria 205](#_Toc152299504)

[303.06.01 Individual vs. Couple Cases 206](#_Toc152299505)

[303.06.02 Financial Requirements 207](#_Toc152299506)

[303.06.03 Income 208](#_Toc152299507)

[303.06.03A Social Security, Railroad Retirement, and Federal Poverty Level (FPL) COLAS 208](#_Toc152299508)

[303.06.03B Income Considerations 210](#_Toc152299509)

[303.06.03C Income Budgeting 210](#_Toc152299510)

[303.06.04 Resources 214](#_Toc152299511)

[303.06.04A Verification and Documentation 214](#_Toc152299512)

[303.06.04B Resource Considerations 215](#_Toc152299513)

[303.07 Application Process 215](#_Toc152299514)

[303.07.01 Standard of Promptness 215](#_Toc152299515)

[303.07.02 Application Form and Intake of Applications 216](#_Toc152299516)

[303.08 Annual Review for ABD, QMB, SLMB and QI 218](#_Toc152299517)

[303.09 Case Examples 219](#_Toc152299518)

303.01 Introduction

(Eff. 09/01/17)

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

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

303.01.01 Eligibility Criteria

(Eff. 09/01/17)

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

303.01.02 Categorical Requirements

(Eff. 09/01/17)

An individual must be:

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

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

303.01.03 Non-Financial Requirements

(Eff. 09/01/17)

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

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

303.02 Aged, Blind and Disabled (ABD) Introduction

(Eff. 09/01/17)

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

303.02.01 ABD Eligibility

(Eff. 09/01/17)

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

303.02.02 ABD Retroactive Period

(Eff. 09/01/17)

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

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

303.02.03 Early Application for ABD

(Rev. 09/01/23)

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

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

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| **MEDS Procedure**   1. Update the information on the Household Member Detail screen, HMS06    1. Medicare Coverage should be entered as yes and have the Medicare number.    2. SS Claim number should be entered as yes and have the social security claim number.    3. TPL insurance should be entered as yes.    4. Unearned income should be entered as yes if they are receiving SSA or SSDI. 2. Verify the Medicare Coverage screen, HMS08 has the beginning date for Part A and Part B. 3. When approving the budget group after you make decision (Shift F3) go to the Medicaid Eligibility Decision screen, ELD02 and update the Medicaid Begin date to the month the recipient will be turning 65 and then modify the update. Complete the case by acting on decision (Shift F12).   **Early Application Procedure Cúram-CGIS**  Use the current processing date to determine if the case should be processed or denied based on the 90-day application rule. If the eligibility specialist performs Check Eligibility and the system shows eligibility within 60 days of the date the application is being processed, the application can be processed in Cúram. If the 60th day falls on or after the 1st of the month, Cúram will allow coverage to be authorized as if the 60 days were met on the last day of the month. Refer to the CGIS Manual section titled “Processing cases when Cúram is showing approval for future eligibility” for additional instructions. |

303.03 Qualified Medicare Beneficiaries (QMB) Introduction

(Rev. 11/01/20)

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

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

303.03.01 QMB Eligibility

(Eff. 09/01/17)

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

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

[[Table of Contents](#_top)](#_top)

303.03.02 Dual Eligibility

(Rev. 11/01/20)

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

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

303.03.03 QMB Retroactive Period

(Eff. 09/01/17)

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

303.03.04 Early Application for QMB

(Eff. 09/01/21)

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

303.04 Specified Low Income Medicare Beneficiaries (SLMB) Introduction

(Eff. 09/01/17)

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

303.04.01 SLMB Eligibility

(Rev. 04/22/22)

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

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

303.04.01A SLMB Plus (Dual Eligibility)

(Rev. 05/01/22)

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

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

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

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

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

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

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| **Procedure**  In CGIS, SLMB coverage will be authorized separately from the full coverage category. When the beneficiary is determined to be eligible for both SLMB coverage and a full coverage category, authorize the full coverage first in the authorization dialog box. The SLMB coverage will be authorized second in the hierarchy.  **NOTE:** SLMB Plus eligibility can only be determined when CGIS is the System of Record. SLMB Plus eligibility cannot be processed in MEDS.   1. Add the Medicare Benefit Evidence to the Income Support Application or the Income Support Case 2. Verify Medicare Parts A and B 3. Income Support Application-    1. Apply the Benefit Evidence to the Income Support Application    2. Check Eligibility    3. Select Ready for Determination    4. Select Authorize    5. Authorize the full coverage category first and then SLMB coverage   **NOTE:** All decisions in Cúram-CGIS must be made at the same time on the Income Support Application.   1. Income Support Case-    1. Check Eligibility    2. Apply the Benefit Evidence to the Income Support Case    3. Return to the previous Check Eligibility    4. Select the List Action Button    5. Authorize the SLMB coverage   **NOTE:** Extend the Certification Period as appropriate based on current procedures and “Reassess” all active Product Delivery Cases (PDCs) to make the full coverage and the SLMB Plus coverage align in the System of Record (SOR).   1. The SLMB+ Indicator will display as “Y” in the Individual Eligibility Tab on the Person Page. |

303.04.02 SLMB Retroactive Period

(Eff. 04/22/22)

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

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

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

303.04.03 Early Application for SLMB

(Rev. 09/01/23)

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

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

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| **Procedure**  **Early Application Procedure Cúram-CGIS**  Use the current processing date to determine if the case should be processed or denied based on the 90-day application rule. If the Eligibility Specialist performs Check Eligibility and the system shows eligibility within 60 days of the date the application is being processed, the application can be processed in Cúram. If the 60th day falls on or after the 1st of the month, Cúram will allow coverage to be authorized as if the 60 days were met on the last day of the month. Refer to the CGIS Manual section titled “Processing cases when Cúram is showing approval for future eligibility” for additional instructions.  **Procedure Cúram-CGIS**   1. When an applicant is only applying for SMLB coverage,    1. Mark yes for Benefits when submitting/entering the Income Support Application    2. Follow the collateral call process to try to obtain the information from the applicant/beneficiary or the Authorized Representative if the information was not provided on the application.    3. If unable to verify via collateral call, **DO NOT** deny SLMB coverage prior to receiving a response from Interfaces.    4. Place the Tracking Form in Follow-Up for 15-days to await the return of the BENDEX data. If there is no Tracking Form, the eligibility specialist must create one. 2. When a dual eligible applicant is applying and the full coverage category is ready for approval, but the Medicare has not been verified,    1. Delete the Medicare benefits from the Income Support Application and approve the full coverage category.    2. Add the Medicare Benefits back to the Income Support Case once the Full benefits are approved    3. Follow the collateral call process to try to obtain the information from the applicant/beneficiary or the Authorized Representative if the information was not provided on the application.    4. If unable to verify via collateral call, **DO NOT** deny SLMB prior to receiving a response from Interfaces.    5. Place the Tracking Form in Follow-Up for 15-days to await the return of the BENDEX data. If there is no Tracking Form, the eligibility specialist must create one. |

303.05 Qualifying Individuals (QI) Introduction

(Eff. 09/01/17)

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

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

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

303.05.01 QI Eligibility

(Eff. 09/01/17)

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

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

303.05.02 QI Retroactive Period

(Rev. 08/01/19)

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

303.05.03 Early Application for QI

(Rev. 09/01/23)

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

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| **Early Application Procedure Cúram-CGIS**  Use the current processing date to determine if the case should be processed or denied based on the 90-day application rule. If the eligibility specialist performs Check Eligibility and the system shows eligibility within 60 days of the date the application is being processed, the application can be processed in Cúram. If the 60th day falls on or after the 1st of the month, Cúram will allow coverage to be authorized as if the 60 days were met on the last day of the month. Refer to the CGIS Manual section titled “Processing cases when Cúram is showing approval for future eligibility” for additional instructions.  **Early Application Procedure MEDS**   1. Update the information on the Household Member Detail screen, HMS06    1. Medicare Coverage should be entered as yes and have the Medicare number.    2. SS Claim number should be entered as yes and have the social security claim number.    3. TPL insurance should be entered as yes.    4. Unearned income should be entered as yes if they are receiving SSA or SSDI. 2. Verify the Medicare Coverage screen, HMS08 has the beginning date for Part A and Part B. 3. When approving the budget group after you make decision (Shift F3) go to the Medicaid Eligibility Decision screen, ELD02 and update the Medicaid Begin date to the month the recipient will be turning 65 and then modify the update. Complete the case by acting on decision (Shift F12). |

* 1. General Financial Criteria

(Eff. 09/01/17)

ABD and MSPs use the following general financial eligibility criteria.

303.06.01 Individual vs. Couple Cases

(Eff. 01/01/23)

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

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| **Procedures for Determining “Individual” vs. “Couple” Cases:**  Treat the applicant/beneficiary as an “Individual”, if:   * The applicant/beneficiary has never married, is divorced, or is widowed. * The applicant/beneficiary is separated from his/her spouse. This would apply to either type of separation:   + Marriage breakup   + Separation due to illness:     - Spouse resides with a child who is providing care for him or both.     - Spouse resides in a Nursing Facility or Residential Care Facility. * The spouse is in the home but is an SSI recipient. * The applicant/beneficiary is a minor child who is not married.   **Note**  Treat the spouse applying for non-MAGI coverage and the spouse in the facility as a couple to determine eligibility in the month the spouse entered the facility. Treat the spouse applying for non-MAGI coverage as an individual for the following months.   * Month of Entry into Facility = Treat as a Couple * Month following Facility Entry Date = Treat the Community Spouse as an Individual   **Note**  A legally divorced couple who reside together are budgeted as “individuals” in the determination. **Following the month of separation, an applicant/beneficiary is treated as an individual. When budgeting, be mindful of any income and resource allocations given to the individual from the spouse residing in a facility.**  Treat the Applicant(s) as a “Couple” Case, if:   * The applicant(s) is a married couple (legal or common law before July 24, 2019) and are: * Residing together AND * Neither is an SSI recipient.   **Example 1**  John Bell applied for Medicaid on April 15, 2022. He reported that he and his wife, Sally Bell, have been separated since December 2021. John Bell is treated as an individual to determine his eligibility for Medicaid. Sally is not entered as a Household Member in CGIS.  **Example 2**  John Bell was approved for Medicaid effective April 1, 2022, as an individual. He reported that his wife, Sally Bell, returned home on June 10th, 2022. John and Sally Bell are treated as a couple effective June 1, 2022, to determine his continued eligibility for Medicaid. Salley must be added to John’s Household in CGIS using the Guided Change function.  **Example 3**  Erica Smith applied for Medicaid on August 20, 2022. She reported that she separated from her spouse, Harry Smith, on August 2, 2022. Erica and Harry are treated as a couple in August. In September, Erica is counted as an individual. In CGIS, use the effective date of change in Harry’s Household Member evidence to end date the evidence for August 31, 2022.  **Example 4**  Erica Smith was approved for Medicaid effective September 1, 2022, as an individual on August 30th. She reported that her separated spouse returned home on September 25, 2022. Erica and Harry are treated as a couple beginning September 1, 2022. In CGIS, edit Harry’s Household Member evidence to remove the end date (8/31/2022) because Harry left on August 2, 2022, and returned on September 25, 2022.  **Note**  When a previously separated spouse returns home, the returning spouse is counted, and the current beneficiary must be reassessed using the couple limits in the month that the spouse returns home. When the return of a spouse is reported, it is important that the eligibility specialist determine the date of the return. If an exact date cannot be determined, the month of the spouse's return must be established to evaluate the eligibility.   * The 15-day Adverse Action rule applies when coverage must be terminated due to ineligibility. (Refer to MPPM 101.09.03) * If the spouse is not in the System of Record as a Household Member, add the spouse into Cúram-CGIS or MEDS household. (Refer to the [Add a Household Member (Guided Change) Job Aid](https://www1.scdhhs.gov/ees/TrainingPortal_NonMAGI/) for CGIS Case; refer to Supervisor for MEDS cases)   **Note**  If one member of the couple is applying for MSP or ABD and the other member receives Home and Community Based Services, they are still considered a couple. |

303.06.02 Financial Requirements

(Eff. 01/01/24)

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

**Income**

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

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

**Resources**

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

* $9,430 for an Individual
* $14,130 for a Couple

303.06.03 Income

(Eff. 09/01/17)

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

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

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

(Eff. 03/01/24)

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

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

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

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

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

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

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

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| **Procedure for COLA Application/Redetermination Disregard**   1. Budget eligibility using current income 2. If applicant/beneficiary is eligible, approve case or continue eligibility. 3. If applicant/beneficiary is not eligible, print completed budget for the case record. 4. Complete second budget using the current Social Security and/or Railroad Retirement benefit and apply a disregard of the most current COLA increase received by the applicant/beneficiary if not given in a prior eligibility period. Enter that amount of the COLA to be being disregarded in the Budget Workbook. Print the second budget for the case record. 5. If the applicant/beneficiary is eligible, approve/continue eligibility in MEDS. 6. If the applicant/beneficiary is ineligible, deny/close case in MEDS. |

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| **Example #1**  **Applicant applies prior to Federal Poverty Level (FPL) increase**  Gloria Lane applied for ABD on January 15, 2024. Her only income is Social Security.  January 2024 - $1,300 (Received $40 COLA)  January 2023 - $1,260  The income limit in January 2024 is $1,215. All other eligibility criteria have been met.   * $1,300 – $50 (General Income Disregard) = $1,250 * $1,250 > $1,215   Since Ms. Lane is not eligible using her current income, use the Annual COLA Application/ Review Process. Determine her eligibility using the amount of Social Security she received prior to the last COLA.   * $1,260 (SSA received in 2023) – $50 (General Income Disregard) = $1,210 * $1,210 < $1,215   Ms. Lane is eligible for ABD.  Rebudget Ms. Lane’s case for March 2024 when the FPL limits are updated. The income limit for March 2024 is $1,255.   * $1,300 – $50 (General Income Disregard) = $1,250 * $1,250 < $1,255   Ms. Lane continues to be Medicaid eligible.  **Example #2**  **Applicant applies after the FPL increase**  Jamie Summers applies for ABD on March 29, 2024. Her only income is Social Security disability. Her 2024 gross benefit is $1,326. The most current COLA she received was in January 2024 in the amount of $41. All other eligibility criteria have been met.   * $1,326 – $50 (General Income Disregard) = $1,276 * $1,276 > $1,255   Ms. Summers is not eligible based on her 2024 Social Security.  Use her current SSA income and disregard the most current COLA to determine eligibility.   * $1,326 – $41 (Disregard 2024 COLA) = $ 1,285 * $1,285 – $50 (General Income Disregard) = $1,235 * $1,235 < $1,255   Ms. Summers is eligible for ABD by disregarding the 2024 Social Security COLA. |

[Table of Contents](#_top)

303.06.03B Income Considerations

(Eff. 09/01/17)

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

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

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

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

303.06.03C Income Budgeting

(Rev. 10/01/23)

* The source and gross amount of all earned and unearned income must be verified.
* Not all income is countable.
* Income that is excluded under Federal Law must be determined.
* Before entering some frequencies of income (i.e., weekly, bi-weekly, and semi-monthly) into Cúram-CGIS, the income must be calculated using the Non-MAGI Manual Eligibility Workbook.

**Allocation**

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

* A child is someone who is neither married nor the head of a household and is:
  + Under age 18; or
  + Under age 22 and regularly attends school, college, or training designed to prepare him for a paying job. School attendance must be verified. Refer to [POMS SI 00501.010](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500501010)
* The maximum allocation per child is determined as follows:

Couple SSI FBR – Individual SSI FBR = Maximum Allocation

* The child’s allocation is determined as follows:

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

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

**Note**

When a minor child has been hospitalized for 31 days and does not meet the income limit for Partners for Healthy Children (PHC) or ABD, the child must be processed for General Hospital (MAO-GH) coverage. The MAO-GH eligibility must be determined from the month the applicant applied for Medicaid coverage or any Retroactive months requested. Refer to MPPM 304.31 for additional information. The 31-day count begins the first day the child was admitted to the hospital.

Deeming

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

Do not use the deeming process for a minor child who does not meet the ABD financial criteria and must be processed for General Hospital coverage on the 31st consecutive day in the facility. The child is considered an individual after remaining in the hospital for over 30 days.

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| Procedures – Basic Income Considerations:  Adult Applicant – No Dependent Children   * Unearned Income: * Verify the source and gross amount of all unearned income for the applicant and the spouse, if applicable. * Total the gross income. * Exclude any unearned income as authorized by Federal Laws (Refer to MPPM Chapter 301) * Apply $50 general disregard (given only once in couple cases) * Earned Income: * See section 301.04.08 for earned income verification procedures on reported income. Verify the source and gross amount of all earned income for the applicant and the spouse, if applicable. * Total the gross earned income. * Exclude any income as authorized by Federal Laws. * Apply other exclusions in the following order: * Earned income tax credit payments * Up to $30 of earned income in a quarter, if it is infrequent or irregular (Refer to MPPM 301.04.09.) * Up to $2,290 per month, but not more than $9,230 in a calendar year, of the earned income of a blind or disabled child under 22 years of age who is attending school * Any portion of the $50 monthly general income exclusion which has not been excluded from unearned income in that some month * $65 of earned income in a month (given only once in couple cases) * Earned income of disabled individuals used to pay impairment-related work expenses * One-half of total remaining earned income in a month * Earned income of blind individuals used to meet work expenses * Any earned income used to fulfill an approved plan to achieve self-support   Total remaining unearned and earned income and compare to the applicable limit. |

[Table of Contents](#_top)

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| Adult Applicant – With Dependent Child  Adult   * Unearned Income: * Verify the source and gross amount of all unearned income for the applicant and the spouse, if applicable. * Total the gross income. * Exclude any unearned income as authorized by Federal Laws (Refer to MPPM Chapter 301.) * Apply $50 general disregard (given only once in couple cases) * Earned Income: * Verify the source and gross amount of all earned income for the applicant and the spouse, if applicable. * Total the gross earned income. * Exclude any income as authorized by Federal Laws. * Apply other exclusions in the following order: * Earned income tax credit payments * Up to $30 of earned income in a quarter if it is infrequent or irregular (Refer to MPPM 301.04.09.) * Up to $2,290 per month, but not more than $9,230 in a calendar year, of the earned income of a blind or disabled child under 22 years of age who is attending school * Any portion of the $50 monthly general income exclusion which has not been excluded from unearned income in that some month * $65 of earned income in a month (given only once in couple cases) * Earned income of disabled individuals used to pay impairment-related work expenses * One-half of total remaining earned income in a month * Earned income of blind individuals used to meet work expenses * Any earned income used to fulfill an approved plan to achieve self-support * Total remaining unearned and earned income. * Subtract allocation for any ineligible child/children (See steps below.) * Compare remainder to the appropriate income limit.   Child/Children’s Allocation   * Determine the child’s income. * Subtract from the allocation amount for a child. * The remainder is the total allocation for the child. * If there is more than one child, do the above for each child and total.   Subtract total allocation from the parent’s income as shown above. |

[Table of Contents](#_top)

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| Minor Child Applicant  Ineligible Parent(s)’ Allocation to Ineligible Children   * Determine parent(s)’ unearned income after exclusions. * Subtract an allocation for each ineligible child and total (Refer to steps under adult applicant with dependent child.) * Determine parent(s)’ earned income. * Subtract any unused allocation.   Deeming to Eligible Child   * Remaining unearned income from allocation step: * Subtract $50 general income exclusion (only given once, even if both parents are in the home and have income). * Remainder is countable unearned income. * Remaining earned income: * Subtract any remaining general income disregard. * Subtract $65 work expense exclusion. * Subtract one-half of remaining earned income. * Remainder is countable earned income. * Add countable unearned and countable earned income. * Subtract the parent(s), personal allocation (Individual SSI FBR for an Individual or a couple.) * The remainder is the amount of income available for deeming.   Income Determination for Eligible Child   * Unearned income calculation: * Begin with the amount of income available for deeming from previous step. * Add child’s unearned income. * Subtract $50 general income exclusion. * Obtain total countable unearned income. * Earned income calculation: * Begin with child’s gross earned income. * Subtract $65 work expense exclusion. * Subtract one-half of remaining income. * Obtain net earned income. * Subtract any Plan for Self-Support (PASS) amount. * Obtain countable earned income.   Total countable unearned and earned income and compare to the income limit for an individual.  Note:   * Earned income is never reduced below zero. * Any unused earned income exclusion is never applied to unearned income. * Any unused portion of a monthly exclusion cannot be carried over for use in a subsequent month. * The $50 general and $65 earned income exclusions are applied only once to a couple, even when both members have income (whether eligible or ineligible), since the couple’s earned income is combined in determining eligibility. |

303.06.04 Resources

(Eff. 09/01/17)

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

303.06.04A Verification and Documentation

(Rev. 09/01/23)

Resources must be verified and documented in the case record.

* Verification is substantiation or authentication of submitted information.
* Documentation is the written record and explanation of verified information and methods used to complete the verification. Eligibility Specialists must provide an explanation or justification of methods used for counting or excluding resources on the Documentation Template.

Example:

If “neighboring” balances are used for the lowest monthly balance for the application month, an explanation/justification is required on the Documentation Template under the comments for the specific resource.

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| **Procedure for Verification:**   * Refer to the resource chapter for acceptable forms of:   + Verification   + Rebuttal evidence * Verify and document any alleged resources.   **(Exception:** Verification of value is not required for resources that are totally excluded, regardless of value, but ownership must be verified for excluded Homestead property and excluded automobiles.)   * Verify and document any resources revealed through IEVS checks. * Property checks are not required if ownership is not alleged.   **Note:** If each member of a couple has life insurance, each is entitled to the exclusion if the total face values for each insured person are $10,000 or less.  **Example**  Mr. Brown has life insurance totaling $5,000. Mrs. Brown has $4,000 in life insurance. No cash value is counted for either.  **Example**  Mrs. Price has two policies one insures herself valued at 10,000. The other insures Mr. Price valued at 10,000. Mr. Price also has two policies valued at 10,000 each. One insures himself. The other ensures Mrs. Price. All four policies are excluded. (See MPPM 302.17 Life Insurance) |

303.06.04B Resource Considerations

(Eff. 09/01/17)

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

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

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

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

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

303.07 Application Process

(Eff. 09/01/17)

303.07.01 Standard of Promptness

(Eff. 09/01/17)

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

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

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

303.07.02 Application Form and Intake of Applications

(Rev. 12/01/19)

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

**Note**

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

* The application date is the date a signed application form is received at a DHHS office. **Note**

An application form received unsigned is NOT considered an application; it MUST be returned to the applicant/authorized representative for a signature. The date the returned application form is received by a DHHS office with the required signature is the application date.)

* If an interview is needed it may be conducted either in person or by telephone.
* Any necessary verification is requested using the [DHHS Form 1233 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201233%20ME.pdf), Medicaid Eligibility Checklist, giving reasonable time for it to be returned.

[[Table of Contents](#_top)](#_top)

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| **Procedures for Applications:**  **Mail-In Applications:**   * Review for completeness. * Contact the applicant/authorized representative if: * All questions are not answered * Clarification is needed * If needed, conduct either a face-to-face or telephone interview.   **All Applications:**   * Conduct an interview if needed. * Whether there is an interview or not, make sure the applicant/authorized representative is advised of: * Eligibility requirements * Standard of Promptness * Right to a Fair Hearing and how to request one * The applicant’s Civil Rights * The applicant’s responsibilities: * Give complete and accurate information, * Report changes in circumstances within 10 days of the change * The requirement to repay funds received ineligibly * Verification process * The computer matching process (IEVS) * The type and scope of Medicaid services, including the availability of retroactive coverage * All appropriate pamphlets and brochures * Evaluate the information provided by the applicant/authorized representative. * Verification: * Obtain verification of:   + - Any questionable non-financial information     - All alleged income: See MPPM 301.04.08 for procedures for earned income verification of reported income     - All alleged resources   + Verification can be requested from:     - The applicant/authorized representative using DHHS Form 1233 ME giving:       * A list of necessary verifications       * A reasonable length of time to provide needed information     - Third Parties, such as:       * Court House records ([DHHS Form 1255 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201255%20ME.pdf))       * Banks         + Asset Verification System (AVS),         + [DHHS Form 1253 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201253%20ME.pdf) if already in the record or if unable to verify with AVS)       * Insurance Companies ([DHHS Form 1280 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201280%20ME.pdf))   + All information/verification must be     - Documented in the case record, and     - Evaluated using the program requirements.   + Budget all income and resources and apply appropriate limits.   + Disposition:   + Approval     - Approve, if all eligibility criteria is met.     - MEDS will generate a notice giving the effective date of eligibility.     - Notify any other agencies or departments as needed, such as Third Party Liability regarding other insurance coverage.   + Denial     - Deny, if any one eligibility factor is not met.     - MEDS will generate a denial notice which includes:       * Reason for denial (make sure correct code is entered into MEDS).       * Supporting Medicaid MPPM Section reference. |

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| **LIS Application from SSA**   * Central Eligibility   + Evaluate Application     - Send Exception Letter if the applicant is currently eligible     - If the reported income is less than or equal to 100% FPL, pend the application for ABD (PCAT 32)     - If the reported income is greater than 100% FPL and less than or equal to 120% FPL, pend the application for SLMB (PCAT 52)     - If the reported income is greater than 120% FPL and less than or equal to 150% FPL, pend the application for QI (PCAT 48)     - If the reported income is greater than 150% FPL, deny the application   + The DHHS Form 3400-A, Additional Information for Select Medicaid Programs, will be sent to the applicant if the application is pended in Cúram-CGIS   + The application will be virtually printed into OnBase if the case is pended in Cúram-CGIS * Local Eligibility   + Applications will be placed in WLP and general workflow   + If the DHHS Form 3400-A is returned within 30 days, process the application   + If the DHHS Form 3400-A is not returned within 30 days, deny the application for failure to return information |

303.08 Annual Review for ABD, QMB, SLMB and QI

(Rev. 11/01/18)

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

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

[[Table of Contents](#_top)](#_top)

303.09 Case Examples

(Rev. 08/01/23)

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| **Example #1 – Aged Individual**  **Scenario:** Carl Wade, date of birth 06/24/44, applies for Medicaid. He mails a completed, signed application to the local office along with a copy of his driver’s license. It is received on July 5. He alleges his only income for the year has been $750 per month in Social Security. Alleged resources are a checking account, an irrevocable pre-need burial contract worth $6,500, and a 2010 Toyota. A $7,000 CD matured in May, was deposited into the checking account, and then used to purchase the pre-need. He has Medicare Part A and B. He was hospitalized in April and has requested retroactive coverage. The application is processed on August 10.  **Analysis:** Categorical Eligibility – Aged (verified by driver’s license)  Verification Needed:   * Verification of SSA - BENDEX; SVES query, SSA letter * Low Balance of Checking Account for April, May, June, and July (copies of statements, AVS or [DHHS Form 1253 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201253%20ME.pdf)) * CD – Verification of:   + April Balance   + Redemption date and amount   + Deposit into checking account (checking statement) * Copy of Pre-need Contract * Medicare Coverage (BENDEX; copy of card)   **Note:** It would be good to verify the Toyota (copy of registration). However, it is not required since one vehicle is totally excludable regardless of value.  Verified Information:   * BENDEX verifies:   + Gross SSA of $950   + DOB – aged so categorical criteria is met * DHHS 1253 from the bank verifying:   + CD Balance of $7000 in April and it’s redemption for that amount on May 2   + Checking:     - Low Balances of $200 for April; $800 in May, $150 in June, and July balance of $450.     - Deposit of $7000 on May 2 from CD     - Non interest bearing account   + Copy of Pre-need verifying it is irrevocable and was purchased on May 30.   **Budgeting:**  Income   * ABD: $950 – $50 = $900 * QMB: $950 – $20 = $930   Resources:   * April: $200 (checking) + $7,000 (CD) = $7,200 * May: $800 (checking) only. Pre-need is irrevocable after 30 days and is not a resource. CD was deposited into the checking account and used to purchase the pre-need. * June: $150 * July: $450 (checking)   **Disposition:** Mr. Wade is over age 65 and meets the Aged categorical requirement. For April, his income was below the limit. However, his countable resources exceeded the individual resource limit. He meets both the income and resource criteria for May, June, and July. He is denied for April for excess resources and approved for ABD effective May 1. His also meets the QMB income limit. His QMB eligibility is effective September 1 (the month after the determination is completed). |

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| **Example #2 – Applicant’s Spouse is on SSI**  **Scenario:** Eva Banks applied for ABD Medicaid on January 15, 2023, at her local office alleging disability. She worked until April 2022 when she was diagnosed with cancer. Her insurance lapsed effective January 1, and she will be unable to return to work. She did not request retroactive coverage. She receives a Long Term Disability check for $800 per month so she has not applied for Social Security yet. Her husband receives SSI and SSA. They have two children, ages 13 and 16. Each child receives $120 per month in SSA; the children are eligible for PHC. She has a checking account with $500, a Life Insurance policy with a face value of $5,000, savings of $800, and a 2010 Ford Taurus.  **Analysis:** Categorical Eligibility – She is under age 65 and disability must be established.  Verification Needed:   * Disability determination * Proof she applied for Social Security Disability * Gross Long Term Disability Benefit (check stub or letter) * January Bank statement for checking and savings * Children’s gross Social Security benefits * Verification husband is a SSI recipient   **Note:**  Verification of the automobile is not required since the one vehicle is totally excluded regardless of value.  Verification of the life insurance face value is not required since the attested value is less than $10,000  Verified Information:   * MAO 99 dated February 10, 2023, verifies disability onset date as October 1, 2022. * Copies of Long Term Disability check stubs for January 2023 verify gross of $800 per month. * Bank statement for January 2023 verifies:   + Checking account is non-interest bearing and had a low balance of $75 in January.   + Savings account accrues quarterly interest with the last payment in December for $2.25 and a January balance of $802.25. * Social Security letter of February 2023 verifies she applied for disability. * SDX of February 4, 2023, verifies husband receives SSI and SSA. * BENDEX of February 4, 2023, verifies the two children receive $120 each in SSA benefits for 2022 and 2023 based on the father’s Social Security benefit. * BENDEX of February 15, 2023, verifies no SSA benefits for her at this point.   **Budgeting:**  Initial eligibility determination based on 2022 Income and Income Limits:   * Unearned: $800 – $50 (general disregard) = $750   (**Note:** Mr. Banks’ income is excluded since he is a SSI recipient.)   * Earned: $0 – $0 = $0 * Total: $750 + $0 = $750 * Allocation: Maximum allocation for 2016 is $367 per child   + Child A: $367 – $120 = $247   + Child B: $367 – $120 = $247   + Total Allocation $247 + $247 = $494 * Countable Income: $750 – $464= $256 which is < $990 (2016 Income Limit)   2017 Income Limit rebudget in March   * Unearned: $800 – $50 (general disregard) = $750   (**Note:** Mr. Banks’ income is excluded since he is a SSI recipient.)   * Earned: $0 – $0 = $0 * Total: $750 + $0 = $750 * Allocation: Maximum allocation for 2017 is $368 per child   + Child A: $368– $120 = $248   + Child B: $368– $120 = $248   + Total Allocation $248 + $248 = $496 * Countable Income: $750 – $496= $254 which is < $1,005 (2017 Income Limit)   Resources:   * $75 + $802.25 = $877.25 which is < $7,560 (individual limit since spouse is on SSI)   **Disposition:** Ms Banks meets all of the eligibility criteria and may be approved effective January 1, 2023.  **Note:** Ms. Banks must be advised to report if she begins receiving SSA. However, the eligibility worker is responsible for follow up. This may be done by checking BENDEX data, sending an SVES query, or requesting verification from Ms. Banks. |

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| **Example #3 – Aged Couple**  **Scenario:** Fred and Ethel Jones, dates of birth 03/14/34 and 02/25/35, apply for Medicaid. Their application is received on March 2, 2017, and retroactive coverage is requested. According to the application, Mr. Jones receives a Social Security check for $735, and his wife receives $850. They have a checking account at People’s Bank. Both have Medicare Part A and B. They state they own a mobile home, a 2009 Ford Taurus and a 2008 Ford Ranger. Both have a $10,000 life insurance policy, but the company name and policy numbers are not listed.  **Analysis:** Categorical Eligibility – both are Aged  **Steps for Eligibility Worker:**   * Send the [DHHS Form 1233 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201233%20ME.pdf), Medicaid Eligibility Checklist, to Mr. and Mrs. Jones requesting:   + Copies of the Life Insurance policies (also send the [DHHS Form 1280 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201280%20ME.pdf), Verification of Life Insurance Values, for their signatures in case they are needed). * Check BENDEX for verification of the gross SSA amounts; send a SVES query if needed * Send a [DHHS Form 1255 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201255%20ME.pdf) Property check or perform an On-line property search * Create individual AVS requests for Mr. and Mrs. Jones   Mr. and Mrs. Jones return to the eligibility worker their March 10th bank statement and the first page of their life insurance policies with Liberty Life.  VerifiedInformation**:**   * Bank Balances:   + AVS verifies:     - December 2016: $1,800 balance     - January 2017: $1,347 balance     - February 2017: $2,680 balance     - March 2017: $1,098 balance * On-line property search verifies only the mobile home (homestead) and the two vehicles alleged on the application. (**Note:** It is not necessary to verify the values of the two vehicles since they are both excluded regardless of value.) * Copy of the Life Insurance policies indicates the face value is $10,000 each, excluded * BENDEX verify gross SSA amounts:   + - Mr. Jones: 2016: $733.00 2017: $735.00     - Mrs. Jones: 2016: $848.00 2017: $850.00   **Budgeting:**   * December 2016:   + Income:     - $733 + $848 = $1,581 – $50 (general disregard) = $1,531. (**Note:** This exceeds the ABD limit of $1,335.)     - SLMB Budget: $1,581 – $20 = $1,561 < SLMB limit: $1,602   + Resources:     - $1,800 (Bank) which is less than the $11,090 limit. * January 2017   + Income: $1,581 – $20 = $1,561 < SLMB limit: $1,602   + Resources: $1,347 (Bank) * February 2017   + Income: $1,561 < SLMB limit: $1,602   + Resources: $2,680 (Bank) * March 2017   + Income:     - $735 + $850 = $1,585 – $50 (General Disregard) = $1,535 > ABD limit: $1,354     - $1,585 – $4 (Total COLA received 2017) = $1,581 – $50 = $1,531 > ABD limit: $1,354 (**Note:** This exceeds the ABD limit)     - $1,585 – $20 = $1,565 < SLMB limit: $1,624   + Resources:     - Bank: $1,098   **Disposition:**  ABD/QMB ineligible due to excess income. SLMB may be approved effective December 1, 2016. |

[[Table of Contents](#_top)](#_top)

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

# **CHAPTER 304—Nursing Home, Home and Community-Based Services, and General Hospital**

[304.01 Introduction to Nursing Home, and Home and Community Based Services 230](#_Toc149697171)

[304.02 Application Form 231](#_Toc149697172)

[304.02.01 SSI or Other Medicaid Beneficiaries Applying for Nursing Home or Home and Community Based Services 231](#_Toc149697173)

[304.02.02 Requests for Additional Information 233](#_Toc149697174)

[304.03 Categorical Eligibility Criteria 233](#_Toc149697175)

[304.04 Non-Financial Eligibility Criteria 235](#_Toc149697176)

[304.05 Financial Eligibility Criteria 236](#_Toc149697177)

[304.05.01 Income 236](#_Toc149697178)

[304.05.01A Budgeting DDSN Work Therapy Wages 237](#_Toc149697179)

[304.05.02 Resources 238](#_Toc149697180)

[304.05.02A Reducing Excess Resources 239](#_Toc149697181)

[304.05.03 Homestead Property 240](#_Toc149697182)

[304.06 Level of Care 242](#_Toc149697183)

[304.06.01 Level of Care Certification 242](#_Toc149697184)

[304.06.02 When a Level of Care is Required 243](#_Toc149697185)

[304.06.03 Client Status Document 245](#_Toc149697186)

[304.06.04 Client Status Document From CLTC 246](#_Toc149697187)

[304.06.05 Client Status Document From DDSN 247](#_Toc149697188)

[304.06.06 Client Status Document for PACE 248](#_Toc149697189)

[304.06.07 Client Status Document for the Psychiatric Residential Treatment Facility (PRTF) Waiver 250](#_Toc149697190)

[304.07 Standard of Promptness 252](#_Toc149697191)

[304.07.01 Arranging for Alternate Placement 253](#_Toc149697192)

[304.08 Transfer of Assets Prior to February 8, 2006 253](#_Toc149697193)

[304.09 Transfer of Assets on or after February 8, 2006 253](#_Toc149697194)

[304.09.01 Definitions that Apply to Transfer of Assets and Trusts 253](#_Toc149697195)

[304.09.02 Transfer of Assets for Less than Fair Market Value 255](#_Toc149697196)

[304.09.02A Effective Date of Transfer of Assets Policy 256](#_Toc149697197)

[304.09.02B Individuals Affected by Transfer of Assets Provisions 256](#_Toc149697198)

[304.09.02C Look-Back Date/Period 257](#_Toc149697199)

[304.09.02D Penalty Period – Important Points 263](#_Toc149697200)

[304.09.02E Transfers by a Spouse 267](#_Toc149697201)

[304.09.02F Transfers of Jointly Held Assets 267](#_Toc149697202)

[304.09.02G Transfers and Lifetime Rights to Property 268](#_Toc149697203)

[304.09.02H Transfer of Assets in Month of Receipt 270](#_Toc149697204)

[304.09.02I Transfer of Income 270](#_Toc149697205)

[304.09.03 Exceptions to the Penalty 271](#_Toc149697206)

[304.09.04 Waiver of Transfer Penalty Procedure and 30-Day Hold 274](#_Toc149697207)

[304.09.05 Calculating the Penalty Period 275](#_Toc149697208)

[304.09.06 Notification of Penalty 278](#_Toc149697209)

[304.09.07 Medicaid Benefits during Penalty Period 278](#_Toc149697210)

[304.09.08 Annuities 278](#_Toc149697211)

[304.10 Obtaining Other Assets/Elective Share 279](#_Toc149697212)

[304.11 Promissory Notes 280](#_Toc149697213)

[304.11.01 Actuarially Sound Notes 281](#_Toc149697214)

[304.11.02 Transfer of Assets Related to Promissory Notes 281](#_Toc149697215)

[304.11.03 Default on Payments 283](#_Toc149697216)

[304.11.04 Forgiving Principal Portions of Promissory Notes 283](#_Toc149697217)

[304.12 Annuities 284](#_Toc149697218)

[304.12.01 Periodic Payments 284](#_Toc149697219)

[304.12.02 Purpose of Annuity 284](#_Toc149697220)

[304.12.03 Transfer penalty 286](#_Toc149697221)

[304.13 Spousal Impoverishment Provisions 287](#_Toc149697222)

[304.13.01 Definitions 287](#_Toc149697223)

[304.14 Spousal Impoverishment and Resources 287](#_Toc149697224)

[304.14.01 Separated Spouses 289](#_Toc149697225)

[304.14.02 Undue Hardship 291](#_Toc149697226)

[304.15 Budgeting Income and Resources Under Spousal Impoverishment Provisions 292](#_Toc149697227)

[304.15.01 Eligibility 292](#_Toc149697228)

[304.15.02 Post-Eligibility 292](#_Toc149697229)

[304.15.02A Income Allocation 293](#_Toc149697230)

[304.15.02B Resource Allocation 302](#_Toc149697231)

[304.15.02C Changes in Community Spouse’s Resources after Approval 303](#_Toc149697232)

[304.15.03 Prenuptial Agreement 304](#_Toc149697233)

[304.15.04 Resource Assessment 304](#_Toc149697234)

[304.16 30-Consecutive Day Requirement 304](#_Toc149697235)

[304.16.01 Effective Date of Eligibility 310](#_Toc149697236)

[304.16.02 Moving from a Medical Facility to Home and Community Based Services 311](#_Toc149697237)

[304.16.03 Moving from Home and Community Based Services to a Medical Facility 311](#_Toc149697238)

[304.17 Permit Days 312](#_Toc149697239)

[304.18 Vendor Payment 312](#_Toc149697240)

[304.18.01 Recurring Income Used to Determine Vendor Payment 312](#_Toc149697241)

[304.18.02 Protected Income 322](#_Toc149697242)

[304.18.03 Medicaid Eligibility and Vendor Payment 324](#_Toc149697243)

[304.19 Income Trust 324](#_Toc149697244)

[304.19.01 Who May Be Covered Under this Provision 325](#_Toc149697245)

[304.19.02 Income Trust Requirements 325](#_Toc149697246)

[304.19.03 Explanations and Forms to Give at Intake 325](#_Toc149697247)

[304.19.04 Establishing an Income Trust 326](#_Toc149697248)

[304.19.04A Who Can Sign the Trust Document? 326](#_Toc149697249)

[304.19.04B Review of the Income Trust 327](#_Toc149697250)

[304.19.04C Death of an Applicant 328](#_Toc149697251)

[304.19.05 Funding the Income Trust 328](#_Toc149697252)

[304.19.06 Income Eligibility 331](#_Toc149697253)

[304.19.07 Billing for Home and Community Based Services Waiver Program Participants 348](#_Toc149697254)

[304.19.08 Annual Accounting 348](#_Toc149697255)

[304.19.09 Trust Modification: Trustee or Bank Account Change 349](#_Toc149697256)

[304.19.10 Non-Compliance with Terms of the Income Trust 350](#_Toc149697257)

[304.19.11 Death of Income Trust Principal Beneficiary 350](#_Toc149697258)

[304.19.12 Income Trust Dissolution 351](#_Toc149697259)

[304.19.13 Income Trust and Transfer Penalties 351](#_Toc149697260)

[304.19.14 Income Trust Identification/Set up Flow 352](#_Toc149697261)

[304.20 Other Trusts 353](#_Toc149697262)

[304.20.01 Undue Hardships and Trusts 354](#_Toc149697263)

[304.21 Bed Hold Policy 355](#_Toc149697264)

[304.22 Medicare/Co-Insurance 356](#_Toc149697265)

[304.23 DHHS Form 181 (Notice of Admission, Authorization and Change of Status for Long-Term Care) 357](#_Toc149697266)

[304.23.01 Initiation of DHHS Form 181 357](#_Toc149697267)

[304.23.02 Signature Requirements 358](#_Toc149697268)

[304.24 Program for All-inclusive Care for the Elderly (PACE) 358](#_Toc149697269)

[304.24.01 PACE Participant Enters a Nursing Home 358](#_Toc149697270)

[304.24.02 PACE Participant Enters a Residential Care Facility 359](#_Toc149697271)

[304.24.03 PACE Participant Terminated from Program 359](#_Toc149697272)

[304.25 Denial of Payment for New Admissions (DPNA) 360](#_Toc149697273)

[304.26 Miscellaneous Facts about Nursing Facilities 361](#_Toc149697274)

[304.26.01 Private vs. Semi-Private Rooms 361](#_Toc149697275)

[304.26.02 Solicitation of Contributions from Medicaid Beneficiaries by Providers of Long-Term Care Services 361](#_Toc149697276)

[304.26.03 Sitters 361](#_Toc149697277)

[304.26.04 Condition of Admission 361](#_Toc149697278)

[304.26.05 Continuing Care Retirement Communities (CCRCs) 362](#_Toc149697279)

[304.27 Estate Recovery 362](#_Toc149697280)

[304.28 Basic Application Process for Nursing Home and Home and Community Based Service Cases 364](#_Toc149697281)

[304.29 Case Record Requirements 367](#_Toc149697282)

[304.30 Annual Review Procedures 368](#_Toc149697283)

[304.30.01 Nursing Home 368](#_Toc149697284)

[304.30.02 Home and Community Based Services 369](#_Toc149697285)

[304.31 Introduction to General Hospital 370](#_Toc149697286)

[304.31.01 General Hospital vs. Nursing Home Assistance 371](#_Toc149697287)

[304.31.02 Non-Financial Eligibility Criteria 371](#_Toc149697288)

[304.31.03 Categorical Eligibility Criteria 371](#_Toc149697289)

[304.31.04 Financial Criteria 374](#_Toc149697290)

[304.31.05 Continued Eligibility 374](#_Toc149697291)

[304.31.06 Basic Application Process 374](#_Toc149697292)

[304.31.06A Receipt of Application/Intake 374](#_Toc149697293)

[304.31.06B Processing of Application 375](#_Toc149697294)

[304.31.06C Determination of Eligibility/Ineligibility 376](#_Toc149697295)

[304.31.06D Continued Eligibility 376](#_Toc149697296)

[304.32 Palmetto Coordinated System of Care (PCSC) Waiver 376](#_Toc149697297)

[304 Appendix A Life Expectancy Table 378](#_Toc149697298)

[304 Appendix B Non-Covered Medical Expenses and Allowable Deductions 379](#_Toc149697299)

[304 Appendix C DHHS Form 181 380](#_Toc149697300)

[304 Appendix D Current Average Monthly Nursing Facility and Medicaid Payment Rates 382](#_Toc149697301)

[304 Appendix E Comparison of Applicable Required Elements for Institutional Programs (NH-HCBS-GH) 387](#_Toc149697302)

[304 Appendix F Recurring Income (Cost of Care) Allowable Deductions – NH/HCBS Cases 388](#_Toc149697303)

[304 Appendix G Home Equity Procedures Flowchart 389](#_Toc149697304)

[304 Appendix H Waiver Programs Comparison Chart 390](#_Toc149697305)

[304 Appendix I Look-back Procedures for ABD Applicants 393](#_Toc149697306)

[304 Appendix J Phoenix Procedures 394](#_Toc149697307)

[304 Appendix K Determining a Reasonable Rate of Interest for Promissory Notes 401](#_Toc149697308)

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

(Eff. 09/01/17)

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

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

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

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

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

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

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

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

[Table of Contents](#_top)

304.02 Application Form

(Eff. 10/01/13)

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

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

(Rev. 08/01/19)

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

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

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| **Supplemental Security Income Recipients**   * SSI recipients who enter a facility and have their SSI benefits terminated will be required to file a Medicaid application. * Dual eligibles (recipients of both Retirement, Survivors, and Disability Insurance (RSDI) and SSI benefits) who enter a facility permanently (more than 90 calendar days) and whose RSDI benefit is greater than $50 will usually have their SSI benefits terminated. Therefore, a Medicaid application will be required * Dual eligibles entering a facility temporarily (less than 90 calendar days) usually continue to qualify for SSI. A Medicaid application is not required * Dual eligibles (recipients of both Retirement, Survivors, and Disability Insurance (RSDI) and SSI benefits) who enter a facility permanently (more than 90 calendar days) and whose RSDI benefit is less than $50 will usually continue to receive SSI benefits. A Medicaid application is not required * The Payment category should be changed to 54 for the period during which the individual is both in a nursing facility and SSI eligible |

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| **SSI only** | | |
|  | **Expected Length of Stay** | |
| **Less than 90 days in the facility** | **90 days or more in the facility** |
| * No application required * Change PCAT 80 to PCAT 54 at approval * Sign and send 181 | * No application required * Change PCAT 80 to PCAT 54 at approval * Sign and send 181 |
| **SSI and another source of income** | | |
|  | **Expected Length of Stay** | |
| **Less than 90 days in the facility** | **90 days or more in the facility** |
| Other income less than or equal to $50 | * No application required * Change PCAT 80 to PCAT 54 at approval * Sign and send 181 | * No application required * Change PCAT 80 to PCAT 54 at approval * Sign and send 181 |
| Other income greater than $50 | * No application required * Change PCAT 80 to PCAT 54 at approval * Sign and send 181 | * Application required * No look-back while SSI eligible * After 90 days in facility, SSI should close   + Verify closure date in MEDS * If SSI terminates prior to approving application   + Conduct modified look-back (MPPM 304.09.02C) from date SSI was terminated (end of the month in which 90th day falls/1st month with no SSI eligibility) to decision date * If approved prior to 90th day   + No look-back needed for decision * For all, change from PCAT 80 to PCAT 10 at decision |

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

For Nursing Home or Home and Community Based Services (HCBS) applicants who are current Medicaid beneficiaries in the Aged, Blind and Disabled Category (ABD), the DHHS Form 3400-B may be used to expedite the look-back process. The completed form must be submitted by the applicant before an eligibility determination can be made. If the DHHS Form 3400-B indicates that no transfers were made by the applicant below Fair Market Value, request bank statement for the current month and for the three months prior to the request and complete a property check. However, if the completed form reveals that a possible transfer has been made, current policy is to be used to determine the nature of the transfer(s) and whether it/they are sanctionable or meet any exclusions that prevent any impact on eligibility. See **304 APPENDIX I** **Look-back Procedures for ABD Applicants** for current procedures.

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

304.02.02 Requests for Additional Information

(Rev. 07/01/23)

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

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

304.03 Categorical Eligibility Criteria

(Rev. 06/01/08)

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

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

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

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

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

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

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

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

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

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

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

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

[Table of Contents](#_top)

304.04 Non-Financial Eligibility Criteria

(Rev. 04/01/11)

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

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

304.05 Financial Eligibility Criteria

(Eff. 10/01/05)

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

304.05.01 Income

(Rev. 09/01/23)

Current income must be verified at the time of application, re-budget, or annual review. When a beneficiary has not begun receiving Long-Term Care Services at the time of application, income must be verified and budgeted for the month of entry into the facility or program by reviewing interfaces and reported changes. At approval, any Cost-of-Living increases or income reductions must be budgeted (as appropriate) from one year to the next. (See MPPM 303.06.03A for individuals qualifying under ABD income criteria.)

**Example 1**

An applicant meets eligibility based on the income reported at the time of application in the month of 4/2023. The applicant enters the facility in the month of 5/2023, but an increase is received in social security benefits in May. The income increase must be counted and budgeted in the month of entry.

**Example 2**

An applicant meets eligibility based on the income reported at the time of application in the month of 12/2022. The applicant enters the facility in the same month, but an increase is received in social security benefits for 01/2023. Use 2022 income for the month of entry and the new amount for January.

Income Limits

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

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

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

304.05.01A Budgeting DDSN Work Therapy Wages

(Eff. 06/01/18)

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



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

**Start**

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

**Significant Change**

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

**Stop**

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

304.05.02 Resources

(Rev. 01/01/24)

Current resources must be verified and documented at application, and annual review, and reported changes.

* Documentation is the written record and explanation of verified information and methods used to complete the verification. Eligibility Specialists must provide an explanation or justification of methods used for counting or excluding resources on the Documentation Template.

**Example**

If “neighboring” balances are used for the lowest monthly balance for the application month, an explanation/justification is required on the Documentation Template under the comments for the specific resource.

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| **Procedure for Verification:**   * Refer to the resource chapter for acceptable forms of:   + Verification   + Rebuttal evidence * Verify and document any alleged resources.   **Exception**  Verification of value is not required for resources that are totally excluded, regardless of value, but ownership must be verified for excluded Homestead property and excluded automobiles.   * Verify and document any resources revealed through IEVS checks. * A current property check and lookback is required for all Long-Term Care applicants.   **Note:** If each member of a couple has life insurance, each is entitled to the exclusion if the total face values for each insured person are $10,000 or less.  **Example**  Mr. Brown has life insurance totaling $5,000. Mrs. Brown has $4,000 in life insurance. No cash value is counted for either.  **Example**  Mrs. Price has two policies; one insures herself valued at 10,000. The other ensures Mr. Price valued at 10,000. Mr. Price also has two policies valued at 10,000 each. One insures himself. The other ensures Mrs. Price. All four policies are excluded. (See MPPM 302.17 Life Insurance) |

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

Resource Limits

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

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| **Exception**  If an individual’s countable income is below the ABD limit, he/she may have up to $9,430 in countable resources and still qualify for a Nursing Home vendor payment. |

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

304.05.02A Reducing Excess Resources

(Rev. 01/01/24)

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

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

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| **Procedure**   * Average Private Pay Rate per Month – Countable Income = Net Cost per Month * Gross Countable Resources – Resource Limit = Excess Countable Resources * Excess Countable Resources ÷ Net Cost per Month = Reasonable Expectation Reduction Period   The applicant has until the end of the third month to demonstrate they have reduced the countable resources.  **Examples**   1. John is applying for Nursing Home. His financials are as follows:  * Income: $1,500   + $9,243.32 - $1,500 = $7,743.32 * Resources: $18,000   + $18,000 - $2,000 = $16,000   + $16,000 ÷ $7, 743.32 = 2.07 Months   There is a reasonable expectation that John’s resources may be under the limit within the next three months. His application will remain pending   1. Alfie is applying for HCBS. His financials are as follows:  * Income: $2,000   + $9,243.32 - $2,000 = $7,243.32 * Resources: $27,000   + $27,000 - $2,000 = $25,000   + $25,000 ÷ $7,243.32 = 3.45 Months   There is NOT a reasonable expectation that Alfie’s resources may be under the limit within the next three months. His application is denied for Excess Resources.   1. Anna Leigh is applying for Nursing Home. Her financials are as follows:  * Income: $925   + $9,243.32 - $925 = $8,318.32 * Resources: $30,000   + $30,000 - $9,430 = $20,570   + $20,570 ÷ $8,318.32 = 2.49 Months   There is a reasonable expectation that Anna Leigh’s resources may be under the limit within the next three months. Her application will remain pending |

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

[Table of Contents](#_top)

304.05.03 Homestead Property

(Rev. 04/01/24)

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

**Note**

If the individual has returned home during the process of making an eligibility determination, the intent to return is assumed and a DHHS Form 1277 is not needed.

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

The Deficit Reduction Act of 2005 changes the way homestead property is evaluated for individuals applying for long-term care services effective with applications received on or after January 1, 2006. Homestead property for applicants whose spouse, child under age 21, or a child who is blind or disabled lawfully resides in the home is excluded regardless of equity value. The statement of the applicant/beneficiary or authorized representative is adequate verification of an individual lawfully residing in the home. Otherwise, individuals with an equity interest in their home over $713,000 are not eligible for vendor payment or other long-term care services, but may be eligible for MAO-NH, Payment Category 10, or other Medicaid category if all other eligibility criteria are met. (Refer to MPPM 101.04.01.) An applicant may seek to reduce his or her equity value by taking out a loan on the home including reverse mortgage arrangements. Verify the arrangements and the amount of funds the individual receives. The equity value does not decrease until the client actually receives the money from the loan. Any amount of funds received from a loan is an available resource when received. Any such arrangements must be done under a written contractual agreement. Chapter 104, Appendix HH contains additional information about reverse mortgages.

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| **Procedure for Applications Received After January 1, 2006**   1. If an applicant indicates homestead property, complete a DHHS Form 1255 ME, Verification of Real and Personal Property, and obtain the current assessed value of the property. 2. If the applicant has a spouse, a child under age 21, or a child who is blind or disabled that lawfully lives in the home, exclude the value of the home regardless of value, and continue with the eligibility determination. 3. If the applicant does not meet the criteria in step 2, and the assessed value is equal to or less than $713,000, exclude the property, and continue with the eligibility determination. 4. If the applicant does not meet the criteria in step 2, and the assessed value exceeds $713,000, request verification of any mortgages, liens, judgments, or other encumbrances that may reduce the equity value of the property. 5. Subtract the reductions from the assessed value of the property. If the remaining equity value is equal to or less than $713,000, continue with the eligibility determination. If the remaining equity value exceeds $713,000, deny for long-term care services. 6. Determine Medicaid eligibility. |

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

304.06 Level of Care

(Eff. 07/01/17)

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

304.06.01 Level of Care Certification

(Rev. 09/01/17)

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

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

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

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

[Table of Contents](#_top)

304.06.02 When a Level of Care is Required

(Eff. 08/01/07)

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

1. **Nursing Home Assistance**

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

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

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

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

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

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

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

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

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

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

1. **General Hospital**

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

[Table of Contents](#_top)

304.06.03 Client Status Document

(Rev. 09/01/12)

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

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

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

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

304.06.04 Client Status Document From CLTC

(Rev. 10/01/13)

**A. SSI Recipient Enters Waiver**

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

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

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

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

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

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

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

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

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

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

304.06.05 Client Status Document From DDSN

(Rev. 10/01/13)

**A. SSI Recipient Enters Waiver**

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

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

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

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

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

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

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

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

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

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

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

304.06.06 Client Status Document for PACE

(Rev. 10/01/13)

**A. SSI Recipient Enters PACE**

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

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

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

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

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

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

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

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

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

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

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

(Rev. 07/01/15)

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

**A. SSI Recipient Enters Waiver**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

304.07 Standard of Promptness

(Rev. 04/01/24)

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

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

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

While the applicant is waiting to enter a nursing facility or waiver slot, the application should remain in pending status for 90 days.

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

304.07.01 Arranging for Alternate Placement

(Eff. 04/01/06)

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

304.08 Transfer of Assets Prior to February 8, 2006

(Rev. 01/01/10)

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

304.09 Transfer of Assets on or after February 8, 2006

(Eff. 06/01/06)

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

304.09.01 Definitions that Apply to Transfer of Assets and Trusts

(Rev. 10/01/23)

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

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

The following definitions apply to transfer of assets.

| TERM | Definition |
| --- | --- |
| **Open Market Sale** | An economic market in which pricing is determined by competition among private enterprises and not regulated by a government: a free market.  Ex: Listed with a Realtor or multiple listing service (MLS) |
| **Private Sale (Off-Market)** | In an off-market sale, the seller doesn’t list their home on the MLS. Instead, they sell directly to a buyer. This can be done without an agent, such as by requesting an all-cash offer from a house-buying company, or by working with a real estate agent to share the listing with a private network of buyers as an office exclusive.   * Ex: For Sale by Owner; Sales to Family/friends |
| Fair Market Value (FMV): Actual Value of Property  Current Market Value (CMV): Reasonable Amount Received. | **Open Market Sales:**  The amount the resource can be expected to sell for on the open market in the area in which the property is located. Also called, Current Market Value (CMV).  If the property was sold on the open market, assume the individual received FMV. The price paid on the open market establishes the CMV for that property  If a resource sells for more than the value assigned to it, the FMV is equal to the sale price.  **Private Sales (Off-Market) ~~(Bona Fide Effort to Sale)~~:**  Assume that the value received on the sale of property is reasonable if that value is at least two-thirds of the FMV/CMV. Property sold for less than two-thirds of the FMV/CMV is considered a transfer for less than FMV/CMV, absent verification of a lower value from a knowledgeable, third-party source. Transfers for less than FMV/CMV may be subject to a transfer penalty.  Third-party Source Example:   * County Tax Assessor (Netronline/SCDHHS Form 1255, Verification of Real and Personal Property), * Realtor, or * Private Appraiser |
| Institutionalized individual | An individual who is:   * An inpatient in a nursing facility or hospital swing bed; * An inpatient in a medical facility for whom payment is based on a nursing facility level of care; and   An individual participating in a Home and Community Based Services waiver program. |
| Non-institutionalized individual | An individual who is living in the community and not participating in a waiver program. |
| Uncompensated value | The difference between the FMV at the time of transfer (less any encumbrances) and the amount received for the asset. |
| Valuable consideration | What the individual receives in exchange for his/her right or interest in an asset. The object, service, or benefit received must have a value to the individual that is equal to or greater than the value of the transferred asset. |

[Table of Contents](#_top)

304.09.02 Transfer of Assets for Less than Fair Market Value

(Rev. 10/01/06)

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

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

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

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| Procedure – Penalty-Liable Transfer  If an individual or his/her spouse has a penalty-liable transfer but meets all of other eligibility criteria, the eligibility worker must follow the guidelines below.   * For Nursing Home Assistance:   + Deny or terminate the vendor payment (room and board payment.) Use DHHS Form 932,   + The Medicaid Card is authorized or continued. * For Home and Community Based Services (HCBS) or other Waiver service:   + If an individual is applying for or receiving HCBS:     - Determine if the individual qualifies for Medicaid under any other category,     - Notify CLTC/DDSN to deny or terminate services       * If the beneficiary receives services through CLTC, notify the CLTC Case Manager through Phoenix         + The Eligibility Specialist will navigate to the participant’s Dashboard and navigate to the Narratives tab. Once on the Narratives tab page, there will be two subtabs (Narratives and Conversations).   Navigate to the Conversations subtab  Add New Conversation  Service: use the drop-down to select the current Case Management  Subject Line should auto-fill  Message: Notification to terminate services, No longer eligible for waiver or other long-term care services due to a transfer.   * + - * If the beneficiary receives services through DDSN, notify DDSN using the DHHS Form 118A.   + If an individual is already Medicaid eligible under another payment category, such as ABD, continue Medicaid, and notify CLTC/DDSN to deny or terminate services. |

304.09.02A Effective Date of Transfer of Assets Policy

(Eff. 06/01/06)

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

304.09.02B Individuals Affected by Transfer of Assets Provisions

(Eff. 06/01/06)

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

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

304.09.02C Look-Back Date/Period

(Rev. 08/01/20)

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

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

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

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

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

Transfers of assets for less than Fair Market Value are:

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

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

(Rev. 10/01/23)

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

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

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

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| Procedure **Nursing Home**  For initial applications, the start date of the transfer penalty is determined as the date the individual would have been authorized for vendor payment but for the application of the penalty period.  **Example**  Jack Bristow applied for Nursing Home coverage on March 12. He entered Vaughn Acres Nursing Home on April 23. It is determined there was a transfer that will result in a six (6) month penalty period. Mr. Bristow meets all other eligibility criteria. The penalty period for Mr. Bristow will begin April 23, the date he could have been authorized for a vendor payment but for the imposition of the penalty period, and he could be potentially eligible for Nursing Home or other long-term care services after October 23. |
| **Home and Community Based Services**  An application for Home and Community Based Services (HCBS) can trigger the start of a transfer penalty period.  The Eligibility Specialist will process the Waiver application up to the point of a financial determination and ensure that all Exceptions to the Penalty have been explored. The Eligibility Specialist must:   * Complete a manual budget workbook   + Confirm that the applicant meets all the financial criteria but for having a sanctionable transfer.   + Calculate the penalty period using the current date as the effective date of the transfer to determine the length of the penalty on the manual workbook NH-HCBS tab.   **Note**  If the applicant/beneficiary or authorized representative asks about the length of the penalty, a workbook can be used to generate the length (months and days) of the penalty. Eligibility Specialists should not provide a start date and end date for the penalty.   * + Upload the manual budget workbook into OnBase. * Check the System of Record   + In MEDS:     - Make sure all information is correct and up to date     - Do not deny/authorize the pending MAOWV application     - Do not send the DHHS Form 932 (EEMS Policy Coordinator will send the notice)   + In Cúram:     - Update all evidence. Do not add the Medical Institution, Level of Care, or Resource Transfer Evidence (only document on the Documentation Template under the Action summary). These three evidences will be completed by the EEMS Policy Coordinator.     - Complete the Check Eligibility     - Do not authorize the denial decision     - Do not send the DHHS Form 932 (EEMS Policy Coordinator will send the notice) * Submit a Service Manager ticket for case assignment to an EEMS Policy Coordinator who will work with CLTC to impose the penalty. Refer to the **Service Manager Instructions** below * Update the Documentation Template   + Ensure it is thoroughly completed   + Action summary should include:     - Case is financially cleared but for a transfer penalty     - Service Manager Ticket has been submitted for the case to be completed by the Policy Team and no one should touch. Include the Service Manager ticket number * Send the case to Follow-up in OnBase for 30 days. (Prevents case from coming back into workflow) * Pend in Workload Pro. * **Do not take any action in Phoenix.** The Policy Coordinator will complete the necessary actions in Phoenix.   **Note**  The completion of a Phoenix referral and the receipt of an active Application for Community Choice should be verified by Eligibility Specialists.  **Note**  **The EEMS Policy Coordinator will complete the eligibility process; the Eligibility Specialist will not touch the case again until the next annual review.**   |  | | --- | | **Service Manager Instructions**  Eligibility Specialists will use the following temporary procedure to submit a ticket in Service Manager:  Under the ***EEMS (Eligibility Enrollment and Member Services) Category***, select the ***Phoenix and CLTC Corrections*** hyperlink.   * Select the ***Phoenix and CLTC Corrections*** hyperlink/icon * Answer the following questions: * Specialist preferred contact number (Required) * Applicant/Beneficiary Name (Required) * Spouse’s name (if applicable) * Date of Birth (Required) * Medicaid ID (Required)   Enter The Household Number (Current SOR), Application ID, and/or Phoenix ID if available in the appropriate box; separated with commas.  From the Select a Category for this Ticket drop-down select: ***CLTC Eligibility issue.***  In the *Provide Any Additional Details box,* add: **Waiver Applicant with a Transfer Penalty.**  Select Save to complete the ticket submission. Document SM Ticket # on Documentation Template in the appropriate section. |   **Note**  If the penalty is 2 months or longer, the Eligibility Specialist will still submit a Service Manager Ticket as instructed. An EEMS Policy Coordinator will complete the eligibility process by denying the case in Phoenix and in the SOR. The Applicant will need to reapply when the penalty is over if Long-Term Care Services are still needed. The Eligibility Specialist that receives or pulls the new application from Workload Pro after the penalty has ended will not process the same transfer penalty. If the applicant has a new resource transfer penalty, the Eligibility Specialist will only apply the new transfer penalty that does not meet any of the Exceptions to the Penalty policy (MPPM 304.09.03).  CGIS calculates the penalty using a 30-day month. The beginning of the penalty starts on the “but for enrollment” date. EEMS Policy Coordinator working from CGIS will include the “but for enrollment” date as the first day of the penalty period calculation to provide an accurate end date and payment eligibility date to the Notes under the Case Detail tab on the Income Support Case and on the Document Template.  **Example**  Jim Scott applied for HCBS Waiver on May 12th. The Eligibility Specialist found transfers within the look-back. The transfer penalty will be 2 months and 15 days (over 2 months). The “but for enrollment” date provided by CLTC is May 20th. The determination was made on May 20th. Mr. Scott’s penalty period would have ended August 2nd and he would have been eligible for HCBS or nursing home services on August 3rd; however, Mr. Scott’s transfer penalty is over 2 months so he will need to reapply.  Mr. Scott reapplied on August 2nd. No additional transfers were found within the modified look-back from the date of the previous application. Mr. Scott was enrolled in HCBS Waiver (Community Choices) on August 13th. Mr. Scott met the level of care and the 30 consecutive day requirement on September 11th. He was approved for coverage effective August 1st in the system of record. NoteCGIS determines if the applicant needs to reapply based on the current date of processing. In the example above, if the “but for enrollment” date was still in May, but the determination fell in June, Mr. Scott would not have needed to reapply. |
| **Penalty Period for Transfers Occurring After Approval**  If a transfer occurs after an individual has been approved for Nursing Home or HCBS, the start date for the transfer penalty is determined as the first day of the month in which the transfer occurred. Because a beneficiary eligible for HCBS is already receiving waiver services, the start of penalty period is triggered. Once the penalty period is completed, the individual can be approved for institution services if he/she applies. For HCBS Waiver coverage, the participant will lose their Medicaid coverage unless eligible for another full Medicaid coverage.  **Note** The Eligibility Specialist will need to notify CLTC to end the waiver services and follow the procedures that are in MPPM 304.09.02. Eligibility Specialist will need to treat new transfers as instructed in MPPM 304.09.03 to see if the new transfer penalty does not meet any of the Exceptions to the Penalty. |

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

**Multiple Transfers**

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

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

304.09.02E Transfers by a Spouse

(Eff. 06/01/06)

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

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

[Table of Contents](#_top)

304.09.02F Transfers of Jointly Held Assets

(Eff. 06/01/06)

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

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

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

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

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

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

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

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

[Table of Contents](#_top)

304.09.02G Transfers and Lifetime Rights to Property

(Rev. 04/01/24)

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

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

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

When an applicant/beneficiary holds life estate interest and the property is sold, the applicant/beneficiary is entitled to receive the value of the life estate portion of the property from the proceeds of the sale.

* If the applicant/beneficiary does not receive their portion of the funds from the sale, the portion belonging to the applicant (not the whole amount of the sale) will be used to determine the transfer penalty.

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

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| Example 1  Last month, Paul Taylor, age 80, transferred his homestead to his son for $5 love and affection, and retained a life estate. The property is valued at $100,000.  To determine the uncompensated amount to be used to calculate a transfer penalty:  $100,000 x .43659 = $43,659 (life estate value)  $100,000 - $5 (amount rec’d.) - $43,659 (life estate value) = $56,336 (uncompensated amount)  **Example 2**  At the time of his death in 2000, Jane Eyre’s husband left her lifetime rights to the farm then valued at $150,000. She is now applying for nursing home care, and it is discovered she transferred her life estate interest to her son last month. She is currently age 95 and the property has increased in value to $250,000.  To determine the uncompensated amount to be used to calculate a transfer penalty:  $250,000 x .22887 = 57217.50 (uncompensated value of the life estate at the time of transfer)  **Example 3**  John Thomas, age 85, owns life estate in his homestead. Last month the property was sold for $100,000 (FMV). John did not receive any funds for the sale of the property.  To determine the uncompensated amount to be used to calculate a transfer penalty:  $100,000 x .35359 = $35,359 (life estate value & uncompensated amount) This amount will be used to determine the transfer penalty.  **Example 4**  Jane Williams, age 85, owns life estate in her homestead. Last month the property was sold for $100,000 (FMV). Jane received only $10,000 for the sale of the property.  To determine the uncompensated amount to be used to calculate a transfer penalty:  $100,000 x .35359 = $35,359 (life estate value)  $35,359 (life estate value) - $10,000 (amount rec’d) = $ 25,359 (uncompensated amount) |

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

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

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

[Table of Contents](#_top)

304.09.02H Transfer of Assets in Month of Receipt

(Rev. 10/01/06)

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

**Examples**

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

304.09.02I Transfer of Income

(Rev. 03/01/12)

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

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

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

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

304.09.03 Exceptions to the Penalty

(Rev. 04/01/07)

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

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

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

· The spouse of the institutionalized individual;

· A child who:

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

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

– Who provided care which delayed institutionalization.

· A sibling of the individual who:

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

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

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

[Table of Contents](#_top)

1. The assets were transferred:

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

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

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

– Named as the primary beneficiary of the asset, and

– Receives up to the amount paid by Medicaid; and

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

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

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

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

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

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

304.09.04 Waiver of Transfer Penalty Procedure and 30-Day Hold

(Eff. 04/01/07)

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

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

The eligibility worker must obtain the following verifications:

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

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

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

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

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

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

304.09.05 Calculating the Penalty Period

(Eff. 01/01/24)

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

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| Procedure to Calculate the Penalty Period Using the Eligibility Workbook   * Determine the uncompensated value of the transferred asset(s).   + Fair Market Value – amount received = amount transferred   + Amount transferred – amount of legal encumbrance (such as a mortgage or lien) = uncompensated value  1. Total the uncompensated value of all assets transferred by the individual and/or his or her community spouse. 2. Enter the Effective Date of Transfer (refer to MPPM 304.09.02D, Beginning Date of Penalty Period) and the Amount of Transfer into the Transfer Penalty Calculator on the NH-HCBS tab in the eligibility workbook in effect at the time of the decision. 3. The results will display the length of the penalty period, the end date of the penalty period, and the first date the individual may be able to qualify for services.  |  |  |  | | --- | --- | --- | | **Transfer Penalty Calculator** | |  | | Effective Date of Transfer | Amount of Transfer |  | | 1/1/2024 | 25,000.00 |  | |  |  |  | | Length of Transfer Penalty | End of Penalty Period | Date of Vendor Payment Eligibility | | **0 years, 2 months, 22 days** | **3/22/2024** | **3/23/2024** | |
| Procedure to Manually Calculate the Penalty Period  Note  The manual method shown below is included to demonstrate the steps used to determine the penalty. Using the manual method may produce slight differences in the length and end dates of the penalty period due to Excel being able to determine the length of the penalty period with more precision and account for the actual number of days in each month.   * Determine the uncompensated value of the transferred asset(s).   + Fair Market Value – amount received = amount transferred   + Amount transferred – amount of legal encumbrance (such as a mortgage or lien) = uncompensated value * Total the uncompensated value of all assets transferred by the individual and/or his or her community spouse. * Divide by the state’s most current average private pay nursing home rate (Refer to MPPM 103.07A). **Do not** use the average pay rate that was in effect at the time the transfer occurred. * **Do Not** round answer down to the nearest whole number. * Multiply the fractional amount of the month by 30 days to determine the partial month penalty period.  |  |  | | --- | --- | | Uncompensated Amount | = Length of Penalty Period | | Current Average Nursing Home Private Pay Rate |   The result is the period the individual would be ineligible for certain Medicaid services.  **Example**  Alton Gray transferred $10,000. The penalty period is calculated as follows:  $10,000 ÷ $9,243.32 = 1.08 (round to two places)  .23 x 30 = 2 (round down to whole day)  Length of penalty period is 1 month, 2 days |

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| **Example 1**  Sam Mills applied for Nursing Home Assistance on March 27, 2024. He meets level of care and all other eligibility criteria and entered the facility on April 1, 2024. On April 12, 2021, he gave his grandson Rick $10,000. On April 17, 2021, he gave his granddaughter Jean $10,000. On April 28, 2021, he gave his daughter Laura $15,000.   |  |  |  | | --- | --- | --- | | **Transfer Penalty Calculator** | |  | | Effective Date of Transfer | Amount of Transfer |  | | 4/1/2024 | 35,000 |  | | Length of Transfer Penalty | End of Penalty Period | Date of Vendor Payment Eligibility | | **0 years, 4 months, 9 days** | **7/24/2024** | **7/25/2024** |   **Example 2**  Susie Moss gave her grandson an acre of land (FMV $28,000) on February 19, 2021. On May 3, 2021, she gave her granddaughter $25,000. She applies for Nursing Home assistance on June 30, 2024. She meets level of care and all other eligibility criteria and entered the facility on July 15, 2024.   |  |  |  | | --- | --- | --- | | **Transfer Penalty Calculator** | |  | | Effective Date of Transfer | Amount of Transfer |  | | 7/15/2024 | 53,000.00 |  | | Length of Transfer Penalty | End of Penalty Period | Date of Vendor Payment Eligibility | | **0 years, 5 months, 21 days** | **1/4/2025** | **1/5/2025** |   **Example 3**  John Slick transferred $25,000 to his son on February 22, 2023. He meets level of care and all other eligibility criteria and entered Acres Nursing Facility on March 10, 2024. The transfer penalty is calculated as follows:   |  |  |  | | --- | --- | --- | | **Transfer Penalty Calculator** | |  | | Effective Date of Transfer | Amount of Transfer |  | | 3/10/2024 | 25,000.00 |  | | Length of Transfer Penalty | End of Penalty Period | Date of Vendor Payment Eligibility | | **0 years, 2 months, 21 days** | **5/30/2024** | **5/31/2024** |   **Note:** Although the vendor payment cannot be authorized, the applicant may be eligible for MAO-NH, Payment Category 10, or other Medicaid category if all other eligibility criteria are met. Refer to MPPM 101.04.01.  **Example 4**  Frank Purvis was approved for Nursing Home Medicaid effective June 12, 2009. In May 2024 while reviewing the case, his eligibility worker discovers that Mr. Purvis transferred homestead property to his daughter on October 20, 2023. The property is valued at $135,000. The transfer penalty is calculated as follows:   |  |  |  | | --- | --- | --- | | **Transfer Penalty Calculator** | |  | | Effective Date of Transfer | Amount of Transfer |  | | 10/1/2023 | 135,000.00 |  | | Length of Transfer Penalty | End of Penalty Period | Date of Vendor Payment Eligibility | | **1 years, 2 months, 17 days** | **12/17/2024** | **12/18/2024** |   **Note**  The eligibility worker will terminate vendor payment as soon as possible, giving the appropriate notice. An overpayment summary must be completed for any vendor payments made to the facility during the penalty period. The beneficiary’s Medicaid eligibility is not affected. |

304.09.06 Notification of Penalty

(Rev. 04/01/07)

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

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

304.09.07 Medicaid Benefits during Penalty Period

(Rev. 04/01/07)

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

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

304.09.08 Annuities

(Rev. 04/01/07)

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

[Table of Contents](#_top)

304.10 Obtaining Other Assets/Elective Share

(Eff. 06/01/06)

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

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

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

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

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

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

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

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

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

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

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

304.11 Promissory Notes

(Rev. 11/01/23)

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

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

Negotiable Notes

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

Non-Negotiable Notes

* May not be sold or transferred under any circumstances.
* May not be considered a transfer of an asset for less than Fair Market Value if:
  + It is actuarially sound – that is, expected to be paid back during the holder’s lifetime (refer to MPPM [304.11.01](#MPPM_304_17_01))
  + It requires monthly payments that fully amortize it over the life of the loan
    - Equal payments with no balloon payment at the end
    - Payments include both interest and principal
    - Reasonable rate of interest (refer to 304 Appendix K for instructions to determine if a reasonable rate of interest has been met.)
    - May NOT be self-canceling or conditional

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| **Procedure – Promissory Notes**  All Promissory Notes must be forwarded for review by the Division of Policy and Process via a Service Manager Policy ticket under "Document for Review.” The assigned Policy and Process staff will advise the Eligibility Specialist on how to handle the Note.  See [Eligibility - Service Manager Desk Aid.pdf - All Documents (sharepoint.com)](https://schhs.sharepoint.com/sites/EES/Training/Forms/AllItems.aspx?id=%2Fsites%2FEES%2FTraining%2FService%20Manager%2FService%20Manager%20Desk%20Aid%2Epdf&viewid=011298ae%2Dbf47%2D449d%2Dbd39%2Dd6017101a69c&parent=%2Fsites%2FEES%2FTraining%2FService%20Manager) and [Eligibility - Service Manager Ticket Submission Guide.pdf - All Documents (sharepoint.com)](https://schhs.sharepoint.com/sites/EES/Training/Forms/AllItems.aspx?id=%2Fsites%2FEES%2FTraining%2FService%20Manager%2FService%20Manager%20Ticket%20Submission%20Guide%2Epdf&viewid=011298ae%2Dbf47%2D449d%2Dbd39%2Dd6017101a69c&parent=%2Fsites%2FEES%2FTraining%2FService%20Manager) for instructions. |

304.11.01 Actuarially Sound Notes

(Eff. 06/01/06)

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

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

[Table of Contents](#_top)

304.11.02 Transfer of Assets Related to Promissory Notes

(Eff. 01/01/21)

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

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

[Table of Contents](#_top)

304.11.03 Default on Payments

(Eff. 06/01/06)

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

304.11.04 Forgiving Principal Portions of Promissory Notes

(Eff. 06/01/06)

Forgiving Principal Portions of Promissory Notes

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

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

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

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

304.12 Annuities

(Eff. 06/01/06)

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

304.12.01 Periodic Payments

(Eff. 06/01/06)

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

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

304.12.02 Purpose of Annuity

(Rev. 02/01/22)

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

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

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

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

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

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

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

Policy for Annuities on or after February 8, 2006

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

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

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

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

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

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

304.12.03 Transfer penalty

(Eff. 06/01/06)

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

[Table of Contents](#_top)

304.13 Spousal Impoverishment Provisions

(Eff. 06/01/06)

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

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

304.13.01 Definitions

(Rev. 12/01/07)

For purposes of spousal impoverishment, the following definitions apply:

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

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

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

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

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

304.14 Spousal Impoverishment and Resources

(Eff. 05/01/21)

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

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

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

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

**Note**

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

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

[Table of Contents](#_top)

When an institutionalized individual loses eligibility and re-applies:

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

304.14.01 Separated Spouses

(Eff. 08/01/15)

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

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

[Table of Contents](#_top)

304.14.02 Undue Hardship

(Eff. 10/01/13)

Undue hardship may exist if a denial of eligibility would:

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

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

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

304.15 Budgeting Income and Resources Under Spousal Impoverishment Provisions

(Eff. 06/01/06)

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

304.15.01 Eligibility

(Eff. 06/01/06)

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

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

304.15.02 Post-Eligibility

(Rev. 05/01/07)

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

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

304.15.02A Income Allocation

(Rev. 04/01/24)

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

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| **Personal Needs Allowance** | * $100 – Work Therapy Allowance – if the institutionalized individual participates in a work therapy program as a part of the plan of care; or * $30 – Standard Allowance – if the institutionalized individual does not participate in a work therapy program. * $2,829 – Waiver Allowance – for individuals participating in a HCBS waiver |
| **Note:** Individuals receive the $30 personal needs allowance from countable income in addition to any excluded income such as VA Aid and Attendance or the $90 reduced VA pension. | |

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

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| **Community Spouse Income Allowance** | * Institutionalized spouse **must** choose to give the allocation; and * The amount must not exceed $3,853.50 per month. |
| **Procedure to Determine the Amount of the Community Spouse Income Allowance**   * Determine the community spouse’s gross income. * Subtract this amount from $3,853.50. * The difference is the maximum allocation amount.   **Allocation for Spouse Only:**  **Example 1**  Joe, who is applying for nursing home vendor payment, has a gross income with SSA of $2000. He has requested allocation for his community spouse. His spouse, Jane, has a gross income of $3000.  Jane’s allocation:  $3853.50 (Max Allocation Limit)  -$3000.00 (Jane’s Gross Income)  $853.50 (Jane’s Total Allocation)  Total Allocation Awarded: $853.50  **Example 2**  Joe, who is applying for nursing home vendor payment, has a gross income with SSA of $2000. He has requested allocation for his community spouse. His spouse, Jane, has a gross income of $900. However, Jane currently has active ABD-Medicaid Coverage. Jane wants to keep her current coverage while still getting an allocation.  Jane’s allocation:  $3853.50 (Max Allocation Limit)  -$900.00 (Jane’s Gross Income)  $2953.50 (Jane’s Total Allocation)  Calculation for Jane to keep ABD coverage:  $1215.00 (ABD Income Limit)  +$50.00 (General Disregard)  -$900.00 (Jane’s Gross Income)  $365.00 (Allocation allowed for Jane to keep ABD coverage)  Total Allocation Awarded: $365.00  **Note**  A lower amount may be allocated if the community spouse wishes to maintain or establish eligibility for SSI benefits or Medicaid under another payment category such as ABD. The institutionalized individual must actually make the income available to the community spouse in order for it to be deducted. The spouse of a nursing home patient who receives Home and Community Based Services is considered a community spouse for the purposes of the income provisions of spousal impoverishment.  **Procedure – Amount of Community Spouse Allocation Questioned**  If the community spouse disagrees with the amount allocated or needs a higher amount to maintain him/her, the Eligibility Specialist should inform the spouse of his/her right to appeal (Fair Hearing).  The community spouse must justify the need for the additional amount due to exceptional circumstances or significant financial duress. A higher amount can only be allowed if it is ordered through an appeal. | |

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| **Allowance for Other Dependent Family Members** | * Institutionalized individual **must** choose to give the allocation * May include minor children or dependent adults of the institutionalized or community spouse. A dependent adult is an adult family member (such as a mother, father, child, brother, sister) living in the home who depends on the applicant/beneficiary or community spouse for meeting physical, medical, or financial needs. * A signed statement completed by the applicant/beneficiary or authorized representative indicating the relationship of the dependent adult and the nature of the dependency is acceptable verification to provide the allowance. |
| Procedure to Determine the Amount of Income Allowances for Other Dependent Family Members  Dependent(s) residing with Community Spouse   * Determine the gross income of each dependent family member. * Subtract the total gross income of each dependent family member from $3,853.50. * One-third of the remaining amount is each dependent family member’s income allowance. * Add each dependent family member’s income allowance together to determine the total family income allowance. * This is the amount allowed for allocation to dependent family members.   **Allocation for Spouse w/Dependent(s) (Dependent Living with a Community Spouse):**  **Example 1**  Joe, who is applying for nursing home vendor payment, has a gross income with SSA of $2000. He has requested allocation for both his community spouse and his one dependent child who currently lives with Jane. His spouse, Jane, has a gross income of $3000 and his dependent child, Mark, has a gross income of $1000.  Jane’s allocation:  $3853.50 (Max Allocation Limit)  -$3000.00 (Jane’s Gross Income)  $853.50 (Jane’s Total Allocation)  Mark’s allocation:  $3853.50 (Max Allocation Limit)  -$1000.00 (Mark’s Gross Income)  $2853.50    $2853.50  ÷ 3  $951.16 (Mark’s Total Allocation)  Total Allocation Awarded: Jane $853.50  Mark $951.16  Total: $1804.66  **Example 2**  Joe, who is applying for nursing home vendor payment, has a gross income with SSA of $2000. He has requested allocation for both his community spouse and his one dependent child who currently lives with Jane. His spouse, Jane, has a gross income of $4000 and his dependent child, Mark, has a gross income of $1500.  Jane’s allocation:  $3853.50 (Max Allocation Limit)  - $4000.00 (Jane’s Gross Income)  No Allocation Award to Spouse    Mark’s allocation  $3853.50 (Max Allocation Limit)  -$1500.00 (Mark’s Gross Income)  $2353.50  $2353.50  ÷ 3  $784.50 (Mark’s Total Allocation)  Total Allocation Awarded: $784.50  **Example 3**  Joe, who is applying for nursing home vendor payment, has a gross income with SSA of $3715 (Income Trust). He has requested allocation for both his community spouse and his one dependent child who currently lives with Jane. His spouse, Jane, has a gross income of $715 and his dependent child, Mark, has a gross income of $1000.  Joe’s Allowed Deductions:  $30 Personal Needs Allowance  $10 Trust Administration Fee  $20 Bank Service Charge  Jane’s allocation:  $3853.50 (Max Allocation Limit)  - $715.00 (Jane’s Gross Income)  $3138.50 (Jane’s Allocation)    Mark’s allocation:  $3853.50 (Max Allocation Limit)  -$1000.00 (Mark’s Gross Income)  $ 2853.50  $2853.50  ÷ 3  $951.16 (Mark’s Allocation)  Allocation Calculation:  $3715.00 (Joe’s Gross Income)  -$60.00 (Joe’s Allowed Deductions)  $3655.00 (Funds left to give for allocation)  -$3138.50 (Jane’s Allocation)  $516.50 (Remaining Allocation Mark Can receive)  Total Allocation Awarded: $ 3655.00  **Example 4**  Joe, who is applying for nursing home vendor payment, has a gross income with SSA of $2000. He has requested allocation for both his community spouse and his one dependent child who currently lives with Jane. His spouse, Jane, has a gross income of $4000 and his dependent child, Mark, has no income.  Jane’s allocation:  $3853.50 (Max Allocation Limit)  - $4000.00 (Jane’s Gross Income)  No Allocation Award to Spouse  Mark’s allocation  $3853.50 (Max Allocation Limit)  (Mark has no Income)  $3853.50  $3853.50  ÷ 3  $1284.50 (Mark’s Total Allocation)  Total Allocation Awarded: $1284.50  **Dependent(s) residing with someone other than the Community Spouse**   * Determine the gross monthly income of all dependents living together * Compare the gross income of all dependents living together to the TANF/FI Need Standard (PCR Income Limit, refer to MPPM 103.03) for a family of the appropriate size. For example, 2 dependents would use PCR Income Limit for 2. * If gross monthly income is equal to or greater than the standard, no allocation is made. * If gross monthly income is less than the standard, subtract the income from the standard. The resulting figure is the allocation to the dependents.   **NOTE**  The institutionalized individual must actually make the income available to the family in order for it to be deducted.  **Allocation for Dependents (Dependent Not Living with a Community Spouse):**  **Example 1**  Joe, who is applying for nursing home vendor payment, has a gross income with SSA of $2000. He has requested allocation for his one dependent child. Mark is currently living outside of the home and there is no community spouse. His dependent child, Mark, has a gross income of $500.  Mark’s allocation:  $778.10 (2024 PCR Income Limit for a Family of One)  -$500.00 (Mark’s Gross Income)  $278.10 (Mark’s Allocation)  Total Allocation Awarded: $278.10  **Example 2**  Joe, who is applying for nursing home vendor payment, has a gross income with SSA of $2000. He has requested allocation for both his community spouse and his one dependent child who currently does not live with his community spouse. His spouse, Jane, has a gross income of $3000 and his dependent child, Mark, has a gross income of $800.  Jane’s allocation:  $3853.50 (Max Allocation Limit)  -$3000.00 (Jane’s Gross Income)  $853.50(Jane’s Total Allocation)  Mark’s allocation  $778.10 (2024 PCR Income Limit for a Family of One)  -$800.00 (Mark’s Gross Income)  $0.00 (Mark’s Allocation)  Total Allocation Awarded: $853.50  **Example 3**  Joe, who is applying for nursing home vendor payment, has a gross income with SSA of $2000. He has requested allocation for both his community spouse and his two dependent children, Mark and Mary, who currently do not live with his community spouse. His spouse, Jane, has a gross income of $3000. Mark has a gross income of $160 and Mary has a gross income of $200.  Jane’s allocation:  $3853.50 (Max Allocation Limit)  -$3000.00 (Jane’s Gross Income)  $853.50 (Jane’s Total Allocation)  $160.00 Mark’s Income  +$200.00 Mary’s Income  $360.00 (Total Income Together)  Calculating Allocation for Joe’s Children  $1056.06 (2024 PCR Income Limit for a Family of Two)  -$360.00  $696.06 (Total Allocation for Mark and Mary)  Total Allocation Awarded: $1549.56  **NOTE:**  If the institutionalized applicant/beneficiary has chosen not to make his/her income available for allocation to a spouse or other qualified dependent relative at application, but later chooses to do so, the applicant/beneficiary or their authorized representative must provide a signed declaratory statement of the new intent to make the income available for allocation. Once a new written request statement for allocation has been received along with verification of the spouse and any dependents’ gross income, the Eligibility Specialist can re-budget the case granting the allocation back to the date of application. | |

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

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| **Health Insurance Premiums – Medicare Part D, Drug Coverage** | * For individuals approved for Nursing Home coverage who are not already Medicaid eligible, subtract the Medicare Part D Benchmark from the verified Part D premium being paid by the individual and allow the remainder as a Health Insurance Premium deduction from countable income. * For individuals receiving Medicaid who are then approved for Nursing Home coverage, the adjustment for the Medicare Part D Benchmark has already been applied. Allow the Medicare Part D premium being paid by the beneficiary as a Health Insurance Premium deduction from countable income. * At COLA or Annual Review, the adjustment for the Medicare Part D Benchmark has already been applied. Allow the Medicare Part D premium being paid by the beneficiary as a Health Insurance Premium deduction from countable income. * Refer to MPPM 103.07 for the current Medicare Part D Premium Benchmark for South Carolina |
| **Procedure – Health Insurance Premiums**  Verify the Part D Medicare premium   * Is the individual currently Medicaid eligible?   + If Yes, the benchmark adjustment has already been applied. Allow the premium being paid as a Health Insurance Premium deduction in the cost of care calculation   + If No, subtract the benchmark from the premium being paid and allow the remainder as a Health Insurance Premium deduction in the cost of care calculation   **Example**  John Allen is admitted to Happy Trails Nursing Facility on June 23 and approved for Medicaid. He currently has Medicare Part D and pays a $50.71 premium per month.  50.71 (Medicare Part D Premium)  – 45.73 (2024 Part D Benchmark)  $4.98 (Health Insurance Premium deduction)  **Example**  Alice Kramer was approved for Medicaid coverage last year. She has now been admitted to Green’s Awesome Care Nursing Facility on May 12 and approved for coverage. She currently has Medicare Part D and pays a $12.93 premium per month. Allow $12.93 as a Health Insurance Premium deduction in the cost of care calculation. | |

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

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

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| **Cost of Pre-Eligibility Non-Covered Medical Expenses** | * The nursing facility may deduct pre-eligibility non-covered medical expenses. These are expenses:   + Recognized by State or Federal law as medical expenses;   + Not covered by Medicaid, Medicare, or other third-party payers; and   + Incurred by an individual before becoming eligible for Medicaid |
| **Note**  Deductions for non-covered medical expenses cannot exceed a beneficiary’s monthly recurring income and cannot be made if the beneficiary has zero ($0) reported monthly income. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty is limited to zero.  See the SCDHHS [Nursing Facility Services Manual](https://www.scdhhs.gov/providers/manuals/nursing-facility-services-manual), Chapter 7, Non-Covered Medical Expense Deductions, for a list of allowable deductions. | |

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| **Cost of Post Eligibility Non-Covered Medical Expenses** | * The nursing facility may deduct post-eligibility non-covered medical expenses. These are expenses:   + Recognized by State or Federal law as medical expenses;   + Not covered by Medicaid, Medicare, or other third-party payers (Refer to [Appendix B](#Appendix_B)); and   + Incurred by an individual currently Medicaid eligible in a Nursing Home |
| **Note**  Deductions for non-covered medical expenses cannot exceed a beneficiary’s monthly recurring income and cannot be made if the beneficiary has zero ($0) reported monthly income. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty is limited to zero.  See the SCDHHS [Nursing Facility Services Manual](https://www.scdhhs.gov/providers/manuals/nursing-facility-services-manual), Chapter 7, Non-Covered Medical Expense Deductions, for a list of allowable deductions. | |

[Table of Contents](#_top)

304.15.02B Resource Allocation

(Eff. 05/01/21)

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

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

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

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

304.15.02C Changes in Community Spouse’s Resources after Approval

(Eff. 06/01/06)

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

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

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

304.15.03 Prenuptial Agreement

(Eff. 06/01/06)

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

304.15.04 Resource Assessment

(Eff. 06/01/06)

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

An assessment is separate from an application for Medicaid.

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

304.16 30-Consecutive Day Requirement

(Eff. 11/01/23)

To qualify for Medicaid for Nursing Home or Home and Community Based Services, an applicant must meet the 30-consecutive day requirement. Count the date of admission, or the date services begin, as the first day.

An applicant meets the requirement when they:

* Reside in a Nursing Facility or medical facility (in-state or out-of-state) for 30 consecutive days or longer:
  + Must reside for 30 consecutive days or longer; or
* Receive Home and Community Based Services:
  + Must receive waiver services for 30 consecutive days or longer; or
  + Must be certified by CLTC that the applicant is likely to receive waiver services for 30 consecutive days or longer.
* Have been in a hospital for 30 consecutive days or longer;
* Are enrolled in a Program of All-inclusive Care for the Elderly (PACE) for 30 consecutive days or longer; or
* Meet the criteria through a combination of the above.

**Note**

1. An individual who is Medicaid-eligible prior to entering a medical facility or a Home and Community Based Services waiver program or can be determined eligible in a non-LTC full benefit category does not have to meet the 30-day criteria.
2. If an individual dies before the 30 days are met, it is assumed he or she would have continued to receive services for 30 consecutive days or longer.

A person loses institutional status when they:

* Are absent from a medical institution for at least 30 consecutive days, or
* Do not receive HCBS or PACE for at least 30 days.

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| **Likely to Remain**  "Likely to Remain" means there is a reasonable expectation the applicant will be in an institutional setting for 30-consecutive days or longer. Once made, the determination remains valid even if the applicant does not remain institutionalized for 30 days.  **Note**  “Likely to Remain” cannot be applied to transfer penalty cases while an applicant is serving their penalty.  **Home and Community Based Services**  When CLTC or DDSN enrolls an individual in an HCBS or Waiver program and begins to provide services, the enrolling agency will document that the individual is likely to remain in the program for at least 30-consecutive days.  When the Eligibility Specialist confirms the enrollment date for the individual, the specialist will approve Medicaid eligibility for the waiver program on the first day of the month in which they enroll.  If the individual is disenrolled from the program before meeting the 30-day requirement without being admitted into another institutional setting, end eligibility after giving the appropriate notice.  The Eligibility Specialist will process the application to be financially clear for eligibility. Once the case is financially cleared, the Eligibility Specialist is ready to update the Phoenix Community Choices workflow.  **Procedures**  **Phoenix Referral (Community Choices/Waiver/HCBS):**   * During the application process, the Eligibility Specialist will submit a referral (<https://phoenix.scdhhs.gov/cltc_referrals/new>) for service in Phoenix for Nursing Home Placement or Community Choices (Waiver/HCBS): * If a referral was already completed however, Community Choices workflow has not been added to Phoenix and the Eligibility Specialist is ready to tentatively approve the applicant in Phoenix; the Eligibility Specialist should place the case in “Not Finished” for 7 days to give Centralized Intake time to process the referral and place it in Phoenix workflow.   + The Eligibility Specialist should search by using either the applicant’s name and date of birth, SSN, Medicaid number, or Medicare number.   + **Note**   If the referral was submitted more than 30 days ago, the Eligibility Specialist should check the confirmation referral number (<https://phoenix.scdhhs.gov/cltc_referrals/new>).   * + - The Eligibility Specialist will search in “Enter a confirmation number to search for an existing referral:” using the Referral Confirmation Number that was uploaded to OnBase     - If the Referral Confirmation Number pulls up and the “Status” shows “Awaiting Participant Match”, the Eligibility Specialist should email Centralized Intake ([centralizedintake@scdhhs.gov](mailto:centralizedintake@scdhhs.gov)) to escalate the referral. The email should include:       * Applicant’s Full Name       * Medicaid Number       * Referral Confirmation Number   + The Eligibility Specialist will put the case in “Not Finished” until a response comes back from Centralized Intake confirming that the referral was added to the Phoenix workflow.     - Once the response has come back from Centralized Intake confirming that the referral was added to the Phoenix workflow, the Eligibility Specialist will log into Phoenix and tentatively approve the Community Choices workflow (**MPPM 304 APPENDIX J-Phoenix Procedures**):       * **Note**   The Eligibility Specialist must enter all required fields and save approval:   * + - * + Approval Effective On         + Eligibility category         + Eligibility waiting period         + Medicaid number   + If the case has been financially cleared and is ready to be tentatively approved and the referral has **NOT** been added to Phoenix workflow, the Eligibility Specialist should email Centralized Intake ([centralizedintake@scdhhs.gov](mailto:centralizedintake@scdhhs.gov)) to escalate the referral. The email should include:     - Applicant’s Full Name     - Medicaid Number     - Referral Confirmation Number   + Once the Community Choices workflow in Phoenix has been tentatively approved (**Do not approve in SOR**), the Eligibility Specialist will put the case in “Not Finished” for seven (7) days   **Already Tentatively Approved in Phoenix and the Applicant is Participating**  On the 7th day, the Eligibility Specialist will “Resume” the task from their “Not Finished” in Workload Pro. The Eligibility Specialist will first check OnBase to see if the “CLTC Notification Form” (Form 171) was uploaded to the case file.   * If the “CLTC Notification Form” (Form 171) was uploaded to OnBase, the Eligibility Specialist will verify that the letter states “Likely to Remain in waiver services for 30 consecutive days or longer”.   + If “Likely to Remain in waiver services for 30 consecutive days or longer” is stated on the “CLTC Notification Form” (Form 171), the Eligibility Specialist will approve eligibility for the Waiver/HCBS application in the pending SOR (MPPM 304.28).     - **Note** for CGIS: the Eligibility Specialist will follow **CGIS Medical Institution Procedure** listed below.   + If “Likely to Remain in waiver services for 30 consecutive days or longer” is **NOT** on the “CLTC Notification Form” (Form 171), the Eligibility Specialist will put the case in Follow-up for the remaining 30 days from the date the applicant started participating (unless the applicant is already participating/eligible in a full Medicaid payment category). (**MPPM 304 APPENDIX J-Phoenix Procedures**) * If the “CLTC Notification Form” (Form 171) was **NOT** uploaded to OnBase:   + The Eligibility Specialist will log into Phoenix and pull the applicant’s workflow:   + If there is an open Community Choices (Green) workflow:     - The Eligibility Specialist will check to see if the applicant has started participating.     - If participating, the Eligibility Specialist will check Phoenix “Scans” tab (located at the top of the Phoenix dashboard of the participant) to see if CLTC has uploaded “CLTC Notification Form” (Form 171) requesting that the applicant be enrolled into services and if CLTC has advised that the applicant is “Likely to Remain in waiver services for 30 consecutive days or longer”.       * **Note**   The “CLTC Notification Form” (Form 171) is password-protected (**CGIS Manual** **6.03 Phoenix Procedures**), so the Eligibility Specialist must follow CGIS Procedure Manual; 6.03 Phoenix Procedures to open the document.   * + - * “CLTC Notification Form” (Form 171) must be uploaded to the case file in OnBase as “Categorical Verification”.     - If the “CLTC Notification Form” (Form 171) and the indication “Likely to Remain” is stated, then the Eligibility Specialist will approve eligibility for the Waiver/HCBS application in the pending SOR (MPPM 304.28).       * **Note** for CGIS: the Eligibility Specialist will follow **CGIS Medical Institution Procedure** listed below for indicating 30 consecutive days or longer.     - If “Likely to Remain in waiver services for 30 consecutive days or longer” is **NOT** on the “CLTC Notification Form” (Form 171), the Eligibility Specialist will put the case in Follow-up for the remaining 30 days from the date the applicant started participating. (**MPPM 304 APPENDIX J-Phoenix Procedures**)     - If the participant has started participating and the “CLTC Notification Form” (Form 171) is **NOT** in the Phoenix “Scans” tab, the Eligibility Specialist:       * Will notate the SOR and documentation template.       * Put the case in Follow-up for 30 days from the date the applicant started participating. (**MPPM 304 APPENDIX J-Phoenix Procedures**)   **Already Tentatively Approved in Phoenix and the Applicant is NOT Participating**  On the 7th day, the Eligibility Specialist will “Resume” the task from their “Not Finished” in Workload Pro. The Eligibility Specialist will first check OnBase to see if the “CLTC Notification Form” (Form 171) was uploaded to the case file.   * If the “CLTC Notification Form” (Form 171) was **NOT** uploaded to OnBase:   + The Eligibility Specialist will log into Phoenix and pull the applicant’s workflow:   + If there is an open Community Choices (Green) workflow:     - The Eligibility Specialist will check to see if the applicant has started participating.     - If the applicant is still **NOT** participating and the “CLTC Notification Form” (Form 171) is not in Phoenix “Scans”, the Eligibility Specialist will put the case in “Not Finished” for 7 days.       * + On the 7th day, the Eligibility Specialist will “Resume” the task from their “Not Finished” in Workload Pro. The Eligibility Specialist will first check OnBase to see if the “CLTC Notification Form” (Form 171) was uploaded to the case file.         + If Participating, the Eligibility Specialistwill follow **Already Tentatively Approved in Phoenix and the Applicant is Participating**   **Note**  The Eligibility Specialist must check Phoenix for verification that they are still participating in Community Choices.   * + - * + If **NOT** Participating and there has been no contact between CLTC and the applicant,the Eligibility Specialist will follow **Already Tentatively Approved in Phoenix and No Contact Between CLTC and the Applicant**     - If the “CLTC Notification Form” (Form 171) is there and the indication “Likely to Remain” is stated, then the Eligibility Specialist will approve eligibility for the Waiver/HCBS application in the pending SOR (MPPM 304.28).       * **Note** for CGIS: the Eligibility Specialist will follow **CGIS Medical Institution Procedure** listed below.     - If the “CLTC Notification Form” (Form 171) is not uploaded to Phoenix “Scans”, the Eligibility Specialist will check the “Narratives” tab to see if there was contact between CLTC and the participant.       * If the 10-day letter was sent out by CLTC, the Eligibility Specialist will put the case in “Not Finished” for 11 days from the date the 10-day letter was mailed.         + On the 11th day, the Eligibility Specialist will “Resume” the task from their “Not Finished” in Workload Pro and check Phoenix for the Community Choices workflow status:   If the Community Choices workflow has been closed (Inactive) by CLTC, the Eligibility Specialist will deny the case in SOR (Follow MPPM 304.28).  If the Community Choices workflow is still active (GREEN) and there still has been **NO** contact, the Eligibility Specialist will follow MPPM 304.28.  If the Community Choices workflow is still active (GREEN) and there has been contact between CLTC & the applicant, the Eligibility Specialist will follow MPPM 304.28.   * + - * If no contact, the Eligibility Specialist will put the case in “Not Finished” for seven (7) days.         + On the 7th day, the Eligibility Specialist will “Resume” the task from their “Not Finished” in Workload Pro. The Eligibility Specialist will first check OnBase to see if the “CLTC Notification Form” (Form 171) was uploaded to the case file.         + If Participating, the Eligibility Specialistwill follow **Already Tentatively Approved in Phoenix and the Applicant is Participating**   **Note**  The Eligibility Specialist must check Phoenix for verification that they are still participating in Community Choices.   * + - * + If **NOT** Participating and there has been no contact between CLTC and the applicant,the Eligibility Specialist will follow **Already Tentatively Approved in Phoenix and No Contact Between CLTC and the Applicant**   **Already Tentatively Approved in Phoenix and NO Contact Between CLTC and the Applicant**  The Eligibility Specialist will contact the CLTC area office (See Community Long-Term Care Area List) for an update.   * If CLTC informs the Eligibility Specialist that the workflow will be closed due to “No Contact” from the applicant, the Eligibility Specialist will deny the case in SOR (Follow MPPM 304.28). * If CLTC informs the Eligibility Specialist that there has been contact from the applicant and that the Community Choices workflow will stay active to continue communication with the applicant, the Eligibility Specialist will put the case in “Not Finished” for 7 days.   **Note**  The Eligibility Specialist will notate the SOR and documentation template regarding the communication between CLTC and the Eligibility Specialist.  **Already Tentatively Approved in Phoenix and there is Contact Between CLTC and the Applicant**  The Eligibility Specialist will check for the applicant’s participation in the Community Choices workflow.   * If the applicant is still **NOT** participating and the “CLTC Notification Form” (Form 171) is not in Phoenix “Scans”, the Eligibility Specialist will put the case in “Not Finished” for 7 days.   + On the 7th day, the Eligibility Specialist will follow either:     - **Already Tentatively Approved in Phoenix and the Applicant is Participating**   **OR**   * + - **Already Tentatively Approved in Phoenix and the Applicant is NOT Participating**   **CGIS Medical Institution Procedure**  When the Waiver/HCBS application is ready to be approved in CGIS, the Eligibility Specialist will need to update the Medical Institution evidence. Follow the [LTC Waiver Service Job Aid](https://schhs.sharepoint.com/:b:/r/sites/EES/Training/Curam/CGIS/Job%20Aids/LTC_Waivers_Services_JA.pdf?csf=1&web=1&e=ca09jr)   * Click the plus sign to add Medical Institution evidence. * Complete the following information in the Medical Institution Evidence pop-up: * Medical Institution Details Section   + Household Member: Select the member’s name from the drop-down.   + Institution Type: When requesting Waiver services, leave this field blank.   + Waiver Type: Select the appropriate option from the drop-down. * Expected Length of Stay: Select “30 days or more” or “Less than 30 days” from the drop-down.   + If CLTC provides “Likely to Remain in waiver services for 30 consecutive days or longer”, the Eligibility Specialist will complete the field “Expected Length of Stay” and select the drop-down option “30 Days or Longer”. * Placed In Institution By Section * Application Filed By Details Section * Click the Save button   The Eligibility Specialist will process the case with normal procedures ([LTC\_Waivers\_Services\_JA.pdf](https://schhs.sharepoint.com/:b:/r/sites/EES/Training/Curam/CGIS/Job%20Aids/LTC_Waivers_Services_JA.pdf?csf=1&web=1&e=Jm3d76)).  **Note**  If both CLTC and SCDHHS deny and close the application, the applicant will have to reapply with a new 3401 (Application for Nursing Home, Residential or In-Home Care). |

304.16.01 Effective Date of Eligibility

(Rev. 10/01/23)

The individual must meet the 30 consecutive day requirement and be otherwise eligible. The beginning date of eligibility is the first day of the month in which he/she became institutionalized in a medical facility, or a combination of medical facilities, or begins participating in Home and Community-Based Services.

**Note**

The beginning date of eligibility for Home and Community-Based Services typically will not start effective the month the application was received.

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

[Table of Contents](#_top)

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

(Eff. 06/01/06)

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

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

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

(Eff.05/01/23)

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

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

304.17 Permit Days

(Eff. 06/01/06)

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

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

304.18 Vendor Payment

(Eff. 06/01/06)

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

304.18.01 Recurring Income Used to Determine Vendor Payment

(Eff. 01/01/24)

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

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

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

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

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

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| **Personal Needs Allowance** | * $100 – Work Therapy Allowance – if the institutionalized individual participates in a work therapy program as a part of the plan of care; or * $30 – Standard Allowance – if the institutionalized individual does not participate in a work therapy program. * $2,829 – Waiver Allowance – for individuals participating in a HCBS waiver |
| **Note:** Individuals receive the $30 personal needs allowance from countable income in addition to any excluded income such as VA Aid and Attendance or the $90 reduced VA pension. | |

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

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| **Community Spouse Income Allowance** | * Institutionalized spouse **must** choose to give the allocation; and * The amount must not exceed $3,853.50 per month. |
| **Procedure to Determine the Amount of the Community Spouse Income Allowance**   * Determine the community spouse’s gross income. * Subtract this amount from $3,853.50. * The difference is the maximum allocation amount.   **Allocation for Spouse Only:**  **Example 1**  Joe, who is applying for nursing home vendor payment, has a gross income with SSA of $2000. He has requested allocation for his community spouse. His spouse, Jane, has a gross income of $3000.  Jane’s allocation:  $3853.50 (Max Allocation Limit)  -$3000.00 (Jane’s Gross Income)  $853.50 (Jane’s Total Allocation)  Total Allocation Awarded: $853.50  **Example 2**  Joe, who is applying for nursing home vendor payment, has a gross income with SSA of $2000. He has requested allocation for his community spouse. His spouse, Jane, has a gross income of $900. However, Jane currently has active ABD-Medicaid Coverage. Jane wants to keep her current coverage while still getting an allocation.  Jane’s allocation:  $3853.50 (Max Allocation Limit)  -$900.00 (Jane’s Gross Income)  $2953.50 (Jane’s Total Allocation)  Calculation for Jane to keep ABD coverage:  $1215.00 (ABD Income Limit)  +$50.00 (General Disregard)  -$900.00 (Jane’s Gross Income)  $365.00 (Allocation allowed for Jane to keep ABD coverage)  Total Allocation Awarded: $365.00  **Note**  A lower amount may be allocated if the community spouse wishes to maintain or establish eligibility for SSI benefits or Medicaid under another payment category such as ABD. The institutionalized individual must actually make the income available to the community spouse in order for it to be deducted. The spouse of a nursing home patient who receives Home and Community Based Services is considered a community spouse for the purposes of the income provisions of spousal impoverishment.  **Procedure – Amount of Community Spouse Allocation Questioned**  If the community spouse disagrees with the amount allocated or needs a higher amount to maintain him/her, the Eligibility Specialist should inform the spouse of his/her right to appeal (Fair Hearing).  The community spouse must justify the need for the additional amount due to exceptional circumstances or significant financial duress. A higher amount can only be allowed if it is ordered through an appeal. | |

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| **Allowance for Other Dependent Family Members** | * Institutionalized individual **must** choose to give the allocation * May include minor children or dependent adults of the institutionalized or community spouse. A dependent adult is an adult family member (such as a mother, father, child, brother, sister) living in the home who depends on the applicant/beneficiary or community spouse for meeting physical, medical, or financial needs. * A signed statement completed by the applicant/beneficiary or authorized representative indicating the relationship of the dependent adult and the nature of the dependency is acceptable verification to provide the allowance. |
| Procedure to Determine the Amount of Income Allowances for Other Dependent Family Members  Dependent(s) residing with Community Spouse   * Determine the gross income of each dependent family member. * Subtract the total gross income of each dependent family member from $3,853.50. * One-third of the remaining amount is each dependent family member’s income allowance. * Add each dependent family member’s income allowance together to determine the total family income allowance. * This is the amount allowed for allocation to dependent family members.   **Allocation for Spouse w/Dependent(s) (Dependent Living with a Community Spouse):**  **Example 1**  Joe, who is applying for nursing home vendor payment, has a gross income with SSA of $2000. He has requested allocation for both his community spouse and his one dependent child who currently lives with Jane. His spouse, Jane, has a gross income of $3000 and his dependent child, Mark, has a gross income of $1000.  Jane’s allocation:  $3853.50 (Max Allocation Limit)  -$3000.00 (Jane’s Gross Income)  $853.50 (Jane’s Total Allocation)    Mark’s allocation:  $3853.50 (Max Allocation Limit)  -$1000.00 (Mark’s Gross Income)  $2853.50    $2853.50  ÷ 3  $951.16 (Mark’s Total Allocation)  Total Allocation Awarded: Jane $853.50  Mark $951.16  Total: $1804.66  **Example 2**  Joe, who is applying for nursing home vendor payment, has a gross income with SSA of $2000. He has requested allocation for both his community spouse and his one dependent child who currently lives with Jane. His spouse, Jane, has a gross income of $4000 and his dependent child, Mark, has a gross income of $1500.  Jane’s allocation:  $3853.50 (Max Allocation Limit)  - $4000.00 (Jane’s Gross Income)  No Allocation Award to Spouse    Mark’s allocation  $3853.50 (Max Allocation Limit)  -$1500.00 (Mark’s Gross Income)  $2353.50  ÷ 3  $784.50 (Mark’s Total Allocation)  Total Allocation Awarded: $784.50  **Example 3**  Joe, who is applying for nursing home vendor payment, has a gross income with SSA of $3715 (Income Trust). He has requested allocation for both his community spouse and his one dependent child who currently lives with Jane. His spouse, Jane, has a gross income of $715 and his dependent child, Mark, has a gross income of $1000.  Joe’s Allowed Deductions:  $30 Personal Needs Allowance  $10 Trust Administration Fee  $20 Bank Service Charge  Jane’s allocation:  $3853.50 (Max Allocation Limit)  - $715.00 (Jane’s Gross Income)  $3138.50 (Jane’s Allocation)    Mark’s allocation:  $3853.50 (Max Allocation Limit)  -$1000.00 (Mark’s Gross Income)  $ 2853.50  $2853.50  ÷ 3  $951.16 (Mark’s Allocation)  Allocation Calculation:  $3715.00 (Joe’s Gross Income)  -$60.00 (Joe’s Allowed Deductions)  $3655.00 (Funds left to give for allocation)  -$3138.50 (Jane’s Allocation)  $516.50 (Remaining Allocation Mark Can receive)  Total Allocation Awarded: $ 3655.00  **Example 4**  Joe, who is applying for nursing home vendor payment, has a gross income with SSA of $2000. He has requested allocation for both his community spouse and his one dependent child who currently lives with Jane. His spouse, Jane, has a gross income of $4000 and his dependent child, Mark, has no income.  Jane’s allocation:  $3853.50 (Max Allocation Limit)  - $4000.00 (Jane’s Gross Income)  No Allocation Award to Spouse    Mark’s allocation  $3853.50 (Max Allocation Limit)  (Mark has no Income)  $3853.50  $3853.50  ÷ 3  $1284.50 (Mark’s Total Allocation)  Total Allocation Awarded: $1284.50  **Dependent(s) residing with someone other than the Community Spouse**   * Determine the gross monthly income of all dependents living together * Compare the gross income of all dependents living together to the TANF/FI Need Standard (PCR Income Limit, refer to MPPM 103.03) for a family of the appropriate size. For example, 2 dependents would use PCR Income Limit for 2. * If gross monthly income is equal to or greater than the standard, no allocation is made. * If gross monthly income is less than the standard, subtract the income from the standard. The resulting figure is the allocation to the dependents.   **NOTE**  The institutionalized individual must actually make the income available to the family in order for it to be deducted.  **Allocation for Dependents (Dependent Not Living with a Community Spouse):**  **Example 1**  Joe, who is applying for nursing home vendor payment, has a gross income with SSA of $2000. He has requested allocation for his one dependent child. Mark is currently living outside of the home and there is no community spouse. His dependent child, Mark, has a gross income of $500.  Mark’s allocation:  $778.10 (2024 PCR Income Limit for a Family of One)  -$500.00 (Mark’s Gross Income)  $278.10 (Mark’s Allocation)  Total Allocation Awarded: $278.10  **Example 2**  Joe, who is applying for nursing home vendor payment, has a gross income with SSA of $2000. He has requested allocation for both his community spouse and his one dependent child who currently does not live with his community spouse. His spouse, Jane, has a gross income of $3000 and his dependent child, Mark, has a gross income of $800.  Jane’s allocation:  $3853.50 (Max Allocation Limit)  -$3000.00 (Jane’s Gross Income)  $853.50 (Jane’s Total Allocation)  Mark’s allocation  $778.10 (2024 PCR Income Limit for a Family of One)  -$800.00 (Mark’s Gross Income)  $0.00 (Mark’s Allocation)  Total Allocation Awarded: $853.50  **Example 3**  Joe, who is applying for nursing home vendor payment, has a gross income with SSA of $2000. He has requested allocation for both his community spouse and his two dependent children, Mark and Mary, who currently do not live with his community spouse. His spouse, Jane, has a gross income of $3000. Mark has a gross income of $160 and Mary has a gross income of $200.  Jane’s allocation:  $3853.50 (Max Allocation Limit)  -$3000.00 (Jane’s Gross Income)  $853.50 (Jane’s Total Allocation)  $160.00 Mark’s Income  +$200.00 Mary’s Income  $360.00 (Total Income Together)  Calculating Allocation for Joe’s Children  $1056.06 (2024 PCR Income Limit for a Family of Two)  -$360.00  $696.06 (Total Allocation for Mark and Mary)  Total Allocation Awarded: $1549.56  **NOTE:**  If the institutionalized applicant/beneficiary has chosen not to make his/her income available for allocation to a spouse or other qualified dependent relative at application, but later chooses to do so, the applicant/beneficiary or their authorized representative must provide a signed declaratory statement of the new intent to make the income available for allocation. Once a new written request statement for allocation has been received along with verification of the spouse and any dependents’ gross income, the Eligibility Specialist can re-budget the case granting the allocation back to the date of application. | |

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

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| **Health Insurance Premiums – Medicare Part D, Drug Coverage** | * For individuals approved for Nursing Home coverage who are not already Medicaid eligible, subtract the Medicare Part D Benchmark from the verified Part D premium being paid by the individual and allow the remainder as a Health Insurance Premium deduction from countable income. * For individuals receiving Medicaid who are then approved for Nursing Home coverage, the adjustment for the Medicare Part D Benchmark has already been applied. Allow the Medicare Part D premium being paid by the beneficiary as a Health Insurance Premium deduction from countable income. * At COLA or Annual Review, the adjustment for the Medicare Part D Benchmark has already been applied. Allow the Medicare Part D premium being paid by the beneficiary as a Health Insurance Premium deduction from countable income. * Refer to MPPM 103.07 for the current Medicare Part D Premium Benchmark for South Carolina |
| **Procedure – Health Insurance Premiums**  Verify the Part D Medicare premium   * Is the individual currently Medicaid eligible?   + If Yes, the benchmark adjustment has already been applied. Allow the premium being paid as a Health Insurance Premium deduction in the cost of care calculation   + If No, subtract the benchmark from the premium being paid and allow the remainder as a Health Insurance Premium deduction in the cost of care calculation   **Example**  John Allen is admitted to Happy Trails Nursing Facility on June 23 and approved for Medicaid. He currently has Medicare Part D and pays a $50.71 premium per month.  50.71 (Medicare Part D Premium)  – 45.73 (2024 Part D Benchmark)  $4.98 (Health Insurance Premium deduction)  **Example**  Alice Kramer was approved for Medicaid coverage last year. She has now been admitted to Green’s Awesome Care Nursing Facility on May 12 and approved for coverage. She currently has Medicare Part D and pays a $12.93 premium per month. Allow $12.93 as a Health Insurance Premium deduction in the cost of care calculation. | |

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

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

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| **Cost of Pre-Eligibility Non-Covered Medical Expenses** | * The nursing facility may deduct pre-eligibility non-covered medical expenses. These are expenses:   + Recognized by State or Federal law as medical expenses;   + Not covered by Medicaid, Medicare, or other third-party payers; and   + Incurred by an individual before becoming eligible for Medicaid |
| **Note**  Deductions for non-covered medical expenses cannot exceed a beneficiary’s monthly recurring income and cannot be made if the beneficiary has zero ($0) reported monthly income. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty is limited to zero.  See the SCDHHS [Nursing Facility Services Manual](https://www.scdhhs.gov/providers/manuals/nursing-facility-services-manual), Chapter 7, Non-Covered Medical Expense Deductions, for a list of allowable deductions. | |

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| **Cost of Post Eligibility Non-Covered Medical Expenses** | * The nursing facility may deduct post-eligibility non-covered medical expenses. These are expenses:   + Recognized by State or Federal law as medical expenses;   + Not covered by Medicaid, Medicare, or other third-party payers (Refer to [Appendix B](#Appendix_B)); and   + Incurred by an individual currently Medicaid eligible in a Nursing Home |
| **Note**  Deductions for non-covered medical expenses cannot exceed a beneficiary’s monthly recurring income and cannot be made if the beneficiary has zero ($0) reported monthly income. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty is limited to zero.  See the SCDHHS [Nursing Facility Services Manual](https://www.scdhhs.gov/providers/manuals/nursing-facility-services-manual), Chapter 7, Non-Covered Medical Expense Deductions, for a list of allowable deductions. | |

[Table of Contents](#_top)

304.18.02 Protected Income

(Eff. 01/01/12)

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

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

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

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

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

[Table of Contents](#_top)

304.18.03 Medicaid Eligibility and Vendor Payment

(Eff. 01/01/24)

An individual residing in a nursing facility awaiting the expiration of a transfer of assets penalty or whose home equity is over $713,000 may receive Medicaid benefits for payment of non-institutional services if:

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

304.19 Income Trust

(Rev. 07/01/15)

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

304.19.01 Who May Be Covered Under this Provision

(Eff. 06/01/06)

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

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

**Example**

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

304.19.02 Income Trust Requirements

(Rev. 04/01/10)

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

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

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

304.19.03 Explanations and Forms to Give at Intake

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

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

**Note**

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

304.19.04 Establishing an Income Trust

(Eff. 07/01/15)

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

**Note**

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

**Example**

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

304.19.04A Who Can Sign the Trust Document?

(Eff. 07/01/15)

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

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

**NOTE**

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

304.19.04B Review of the Income Trust

(Eff. 07/01/15)

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

Group: Medicaid Eligibility

Category: Medicaid Policy

Category Option: Income Trust Approval

Assignment: Beverly Ashford

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

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

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

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

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

304.19.04C Death of an Applicant

(Eff. 07/01/15)

If an applicant passes away during the application process

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

Group: Medicaid Eligibility

Category: Income Trust Policy

Category Option: Income Trust Policy

Assignment: Ticket Pool

* EEMS will respond with guidance.

[Table of Contents](http://medsweb.scdhhs.gov/mppm/HTML/Section300/Chapter%20304%20%20NH-HCBS-GH.htm#_top)

304.19.05 Funding the Income Trust

(Rev. 03/01/19)

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

A transfer of assets penalty:

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

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

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

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

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

304.19.06 Income Eligibility

(Eff. 06/01/06)

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

**Step One - Eligibility**

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

**Step Two – Post-Eligibility**

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

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

**304.19.06A Allowable Deductions for Nursing Home**

(Rev. 04/01/24)

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

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

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

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| **Community Spouse Income Allowance** | * Institutionalized spouse **must** choose to give; and * The amount must not exceed $3,853.50 per month. |

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| **Procedure to Determine the Amount of the Community Spouse Income Allowance**   * Determine the community spouse’s gross income. * Subtract this amount from $3,853.50. * The difference is the maximum allocation amount.   **Allocation for Spouse Only:**  **Example 1**  Joe, who is applying for nursing home vendor payment, has a gross income with SSA of $2000. He has requested allocation for his community spouse. His spouse, Jane, has a gross income of $3000.  Jane’s allocation:  $3853.50 (Max Allocation Limit)  -$3000.00 (Jane’s Gross Income)  $853.50 (Jane’s Total Allocation)  Total Allocation Awarded: $853.50  **Example 2**  Joe, who is applying for nursing home vendor payment, has a gross income with SSA of $2000. He has requested allocation for his community spouse. His spouse, Jane, has a gross income of $900. However, Jane currently has active ABD-Medicaid Coverage. Jane wants to keep her current coverage while still getting an allocation.  Jane’s allocation:  $3853.50 (Max Allocation Limit)  -$900.00 (Jane’s Gross Income)  $2953.50 (Jane’s Total Allocation)  Calculation for Jane to keep ABD coverage:  $1215.00 (ABD Income Limit)  +$50.00 (General Disregard)  -$900.00 (Jane’s Gross Income)  $365.00 (Allocation allowed for Jane to keep ABD coverage)  Total Allocation Awarded: $365.00  **Note**  A lower amount may be allocated if the community spouse wishes to maintain or establish eligibility for SSI benefits or Medicaid under another payment category such as ABD. The institutionalized individual must actually make the income available to the community spouse in order for it to be deducted. The spouse of a nursing home patient who receives Home and Community Based Services is considered a community spouse for the purposes of the income provisions of spousal impoverishment.  **Procedure – Amount of Community Spouse Allocation Questioned**  If the community spouse disagrees with the amount allocated or needs a higher amount to maintain him/her, the Eligibility Specialist should inform the spouse of his/her right to appeal (Fair Hearing).  The community spouse must justify the need for the additional amount due to exceptional circumstances or significant financial duress. A higher amount can only be allowed if it is ordered through an appeal. |

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| **Allowance for Other Dependent Family Members** | * Institutionalized individual **must** choose to give the allocation * May include minor children or dependent adults of the institutionalized or community spouse. A dependent adult is an adult family member (such as a mother, father, child, brother, sister) living in the home who depends on the applicant/beneficiary or community spouse for meeting physical, medical, or financial needs. * A signed statement completed by the applicant/beneficiary or authorized representative indicating the relationship of the dependent adult and the nature of the dependency is acceptable verification to provide the allowance. |

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| Procedure to Determine the Amount of Income Allowances for Other Dependent Family Members  Dependent(s) residing with Community Spouse   * Determine the gross income of each dependent family member. * Subtract the total gross income of each dependent family member from $3,853.50. * One-third of the remaining amount is each dependent family member’s income allowance. * Add each dependent family member’s income allowance together to determine the total family income allowance. * This is the amount allowed for allocation to dependent family members.   **Allocation for Spouse w/Dependent(s) (Dependent Living with a Community Spouse):**  **Example 1**  Joe, who is applying for nursing home vendor payment, has a gross income with SSA of $2000. He has requested allocation for both his community spouse and his one dependent child who currently lives with Jane. His spouse, Jane, has a gross income of $3000 and his dependent child, Mark, has a gross income of $1000.  Jane’s allocation:  $3853.50 (Max Allocation Limit)  -$3000.00 (Jane’s Gross Income)  $853.50 (Jane’s Total Allocation)    Mark’s allocation:  $3853.50 (Max Allocation Limit)  -$1000.00 (Mark’s Gross Income)  $2853.50  $2853.50  ÷ 3  $951.16 (Mark’s Total Allocation)  Total Allocation Awarded: Jane $853.50  Mark $951.16  Total: $1804.66  **Example 2**  Joe, who is applying for nursing home vendor payment, has a gross income with SSA of $2000. He has requested allocation for both his community spouse and his one dependent child who currently lives with Jane. His spouse, Jane, has a gross income of $4000 and his dependent child, Mark, has a gross income of $1500.  Jane’s allocation:  $3853.50 (Max Allocation Limit)  - $4000.00 (Jane’s Gross Income)  No Allocation Award to Spouse    Mark’s allocation  $3853.50 (Max Allocation Limit)  -$1500.00 (Mark’s Gross Income)  $2353.50  $2353.50  ÷ 3  $784.50 (Mark’s Total Allocation)  Total Allocation Awarded: $784.50  **Example 3**  Joe, who is applying for nursing home vendor payment, has a gross income with SSA of $3715 (Income Trust). He has requested allocation for both his community spouse and his one dependent child who currently lives with Jane. His spouse, Jane, has a gross income of $715 and his dependent child, Mark, has a gross income of $1000.  Joe’s Allowed Deductions:  $30 Personal Needs Allowance  $10 Trust Administration Fee  $20 Bank Service Charge  Jane’s allocation:  $3853.50 (Max Allocation Limit)  - $715.00 (Jane’s Gross Income)  $3138.50 (Jane’s Allocation)    Mark’s allocation:  $3853.50 (Max Allocation Limit)  -$1000.00 (Mark’s Gross Income)  $ 2853.50  $2853.50  ÷ 3  $951.16 (Mark’s Allocation)  Allocation Calculation:  $3715.00 (Joe’s Gross Income)  -$60.00 (Joe’s Allowed Deductions)  $3655.00 (Funds left to give for allocation)  -$3138.50 (Jane’s Allocation)  $516.50 (Remaining Allocation Mark Can receive)  Total Allocation Awarded: $ 3655.00  **Example 4**  Joe, who is applying for nursing home vendor payment, has a gross income with SSA of $2000. He has requested allocation for both his community spouse and his one dependent child who currently lives with Jane. His spouse, Jane, has a gross income of $4000 and his dependent child, Mark, has no income.  Jane’s allocation:  $3853.50 (Max Allocation Limit)  - $4000.00 (Jane’s Gross Income)  No Allocation Award to Spouse    Mark’s allocation  $3853.50 (Max Allocation Limit)  (Mark has no Income)  $3853.50  $3853.50  ÷ 3  $1284.50 (Mark’s Total Allocation)  Total Allocation Awarded: $1284.50  **Dependent(s) residing with someone other than the Community Spouse**   * Determine the gross monthly income of all dependents living together * Compare the gross income of all dependents living together to the TANF/FI Need Standard (PCR Income Limit, refer to MPPM 103.03) for a family of the appropriate size. For example, 2 dependents would use PCR Income Limit for 2. * If gross monthly income is equal to or greater than the standard, no allocation is made. * If gross monthly income is less than the standard, subtract the income from the standard. The resulting figure is the allocation to the dependents.   **NOTE**  The institutionalized individual must actually make the income available to the family in order for it to be deducted.  **Allocation for Dependents (Dependent Not Living with a Community Spouse):**  **Example 1**  Joe, who is applying for nursing home vendor payment, has a gross income with SSA of $2000. He has requested allocation for his one dependent child. Mark is currently living outside of the home and there is no community spouse. His dependent child, Mark, has a gross income of $500.  Mark’s allocation:  $778.10 (2024 PCR Income Limit for a Family of One)  -$500.00 (Mark’s Gross Income)  $278.10 (Mark’s Allocation)  Total Allocation Awarded: $278.10  **Example 2**  Joe, who is applying for nursing home vendor payment, has a gross income with SSA of $2000. He has requested allocation for both his community spouse and his one dependent child who currently does not live with his community spouse. His spouse, Jane, has a gross income of $3000 and his dependent child, Mark, has a gross income of $800.  Jane’s allocation:  $3853.50 (Max Allocation Limit)  -$3000.00 (Jane’s Gross Income)  $853.50(Jane’s Total Allocation)  Mark’s allocation  $778.10 (2024 PCR Income Limit for a Family of One)  -$800.00 (Mark’s Gross Income)  $0.00 (Mark’s Allocation)  Total Allocation Awarded: $853.50  **Example 3**  Joe, who is applying for nursing home vendor payment, has a gross income with SSA of $2000. He has requested allocation for both his community spouse and his two dependent children, Mark and Mary, who currently do not live with his community spouse. His spouse, Jane, has a gross income of $3000. Mark has a gross income of $160 and Mary has a gross income of $200.  Jane’s allocation:  $3853.50 (Max Allocation Limit)  -$3000.00 (Jane’s Gross Income)  $853.50 (Jane’s Total Allocation)  $160.00 Mark’s Income  +$200.00 Mary’s Income  $360.00 (Total Income Together)  Calculating Allocation for Joe’s Children  $1056.06 (2024 PCR Income Limit for a Family of Two)  -$360.00  $696.06 (Total Allocation for Mark and Mary)  Total Allocation Awarded: $1549.56  **NOTE:**  If the institutionalized applicant/beneficiary has chosen not to make his/her income available for allocation to a spouse or other qualified dependent relative at application, but later chooses to do so, the applicant/beneficiary or their authorized representative must provide a signed declaratory statement of the new intent to make the income available for allocation. Once a new written request statement for allocation has been received along with verification of the spouse and any dependents’ gross income, the Eligibility Specialist can re-budget the case granting the allocation back to the date of application. |

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

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| **Health Insurance Premiums – Medicare Part D, Drug Coverage** | * For individuals approved for Nursing Home coverage who are not already Medicaid eligible, subtract the Medicare Part D Benchmark from the verified Part D premium being paid by the individual and allow the remainder as a Health Insurance Premium deduction from countable income. * For individuals receiving Medicaid who are then approved for Nursing Home coverage, the adjustment for the Medicare Part D Benchmark has already been applied. Allow the Medicare Part D premium being paid by the beneficiary as a Health Insurance Premium deduction from countable income. * At COLA or Annual Review, the adjustment for the Medicare Part D Benchmark has already been applied. Allow the Medicare Part D premium being paid by the beneficiary as a Health Insurance Premium deduction from countable income. * Refer to MPPM 103.07 for the current Medicare Part D Premium Benchmark for South Carolina |
| **Procedure – Health Insurance Premiums**  Verify the Part D Medicare premium   * Is the individual currently Medicaid eligible?   + If Yes, the benchmark adjustment has already been applied. Allow the premium being paid as a Health Insurance Premium deduction in the cost of care calculation   + If No, subtract the benchmark from the premium being paid and allow the remainder as a Health Insurance Premium deduction in the cost of care calculation   **Example**  John Allen is admitted to Happy Trails Nursing Facility on June 23 and approved for Medicaid. He currently has Medicare Part D and pays a $50.71 premium per month.  50.71 (Medicare Part D Premium)  – 45.73 (2024 Part D Benchmark)  $4.98 (Health Insurance Premium deduction)  **Example**  Alice Kramer was approved for Medicaid coverage last year. She has now been admitted to Green’s Awesome Care Nursing Facility on May 12 and approved for coverage. She currently has Medicare Part D and pays a $12.93 premium per month. Allow $12.93 as a Health Insurance Premium deduction in the cost of care calculation. | |

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

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

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| **Cost of Pre-Eligibility Non-Covered Medical Expenses** | * The nursing facility may deduct pre-eligibility non-covered medical expenses. These are expenses:   + Recognized by State or Federal law as medical expenses;   + Not covered by Medicaid, Medicare, or other third-party payers; and   + Incurred by an individual before becoming eligible for Medicaid |
| **Note**  Deductions for non-covered medical expenses cannot exceed a beneficiary’s monthly recurring income and cannot be made if the beneficiary has zero ($0) reported monthly income. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty is limited to zero.  See the SCDHHS [Nursing Facility Services Manual](https://www.scdhhs.gov/providers/manuals/nursing-facility-services-manual), Chapter 7, Non-Covered Medical Expense Deductions, for a list of allowable deductions. | |

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| **Cost of Post Eligibility Non-Covered Medical Expenses** | * The nursing facility may deduct post-eligibility non-covered medical expenses. These are expenses:   + Recognized by State or Federal law as medical expenses;   + Not covered by Medicaid, Medicare, or other third-party payers (Refer to [Appendix B](#Appendix_B)); and   + Incurred by an individual currently Medicaid eligible in a Nursing Home |
| **Note**  Deductions for non-covered medical expenses cannot exceed a beneficiary’s monthly recurring income and cannot be made if the beneficiary has zero ($0) reported monthly income. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty is limited to zero.  See the SCDHHS [Nursing Facility Services Manual](https://www.scdhhs.gov/providers/manuals/nursing-facility-services-manual), Chapter 7, Non-Covered Medical Expense Deductions, for a list of allowable deductions. | |

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

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

(Eff. 01/01/24)

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| **Personal Needs Allowance** | * $2,829 – Waiver Allowance – Individuals participating in a HCBS waiver receive a Personal Needs Allowance equal to the Medicaid Cap |

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

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

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| **Community Spouse Income Allowance** | * Institutionalized spouse **must** choose to give; and * The amount must not exceed $3,853.50 per month. |
| **Procedure to Determine the Amount of the Community Spouse Income Allowance**   * Determine the community spouse’s gross income. * Subtract this amount from $3,853.50. * The difference is the maximum allocation amount.   **Procedure – Amount of Community Spouse Allocation Questioned**  If the community spouse disagrees with the amount allocated or needs a higher amount to maintain him/her, the eligibility worker should inform the spouse of his/her right to appeal (Fair Hearing).  The community spouse must justify the need for the additional amount due to exceptional circumstances or significant financial duress. A higher amount can only be allowed if it is ordered through an appeal. | |

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| **Allowance for Other Dependent Family Members** | * Institutionalized individual **must** choose to give the allocation * May include minor children or dependent adults of the institutionalized or community spouse. A dependent adult is an adult family member (such as a mother, father, child, brother, sister) living in the home who depends on the applicant/beneficiary or community spouse for meeting physical, medical, or financial needs. * A signed statement completed by the applicant/beneficiary or authorized representative indicating the relationship of the dependent adult and the nature of the dependency is acceptable verification to provide the allowance. |
| **Procedure to Determine the Amount of Income Allowances for Other Dependent Family Members**  **Dependent(s) residing with Community Spouse**   * Determine the gross income of each family member. * Subtract the total gross income of each family member from $3,853.50. * One-third of the remaining amount is each family member’s income allowance. * Add each family member’s income allowance together to determine the total family income allowance. * This is the amount allowed for allocation to family members.   **Dependent(s) residing with someone other than the Community Spouse**   * Determine the gross monthly income of all dependents living together * Compare the gross income of all dependents living together to the TANF/FI Need Standard (PCR Income Limit, refer to MPPM 103.03) for a family of the appropriate size. For example, 2 dependents would use PCR Income Limit for 2. * If gross monthly income is equal to or greater than the standard, no allocation is made. * If gross monthly income is less than the standard, subtract the income from the standard. The resulting figure is the allocation to the dependents.   **NOTE:**  The institutionalized individual must actually make the income available to the family in order for it to be deducted. | |

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

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| **Health Insurance Premiums – Medicare Part D, Drug Coverage** | * For individuals approved for Nursing Home coverage who are not already Medicaid eligible, subtract the Medicare Part D Benchmark from the verified Part D premium being paid by the individual and allow the remainder as a Health Insurance Premium deduction from countable income. * For individuals receiving Medicaid who are then approved for Nursing Home coverage, the adjustment for the Medicare Part D Benchmark has already been applied. Allow the Medicare Part D premium being paid by the beneficiary as a Health Insurance Premium deduction from countable income. * At COLA or Annual Review, the adjustment for the Medicare Part D Benchmark has already been applied. Allow the Medicare Part D premium being paid by the beneficiary as a Health Insurance Premium deduction from countable income. * Refer to MPPM 103.07 for the current Medicare Part D Premium Benchmark for South Carolina |
| **Procedure – Health Insurance Premiums**  Verify the Part D Medicare premium   * Is the individual currently Medicaid eligible?   + If Yes, the benchmark adjustment has already been applied. Allow the premium being paid as a Health Insurance Premium deduction in the cost of care calculation   + If No, subtract the benchmark from the premium being paid and allow the remainder as a Health Insurance Premium deduction in the cost of care calculation   **Example**  John Allen is admitted to Happy Trails Nursing Facility on June 23 and approved for Medicaid. He currently has Medicare Part D and pays a $50.71 premium per month.  50.71 (Medicare Part D Premium)  – 45.73 (2024 Part D Benchmark)  $4.98 (Health Insurance Premium deduction)  **Example**  Alice Kramer was approved for Medicaid coverage last year. She has now been admitted to Green’s Awesome Care Nursing Facility on May 12 and approved for coverage. She currently has Medicare Part D and pays a $12.93 premium per month. Allow $12.93 as a Health Insurance Premium deduction in the cost of care calculation. | |

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| **Cost of Post Eligibility Non-Covered Medical Expenses** | * The nursing facility may deduct post-eligibility non-covered medical expenses. These are expenses:   + Recognized by State or Federal law as medical expenses;   + Not covered by Medicaid, Medicare, or other third-party payers (Refer to [Appendix B](#Appendix_B)); and   + Incurred by an individual currently Medicaid eligible |
| **Note**  Deductions for non-covered medical expenses cannot exceed a beneficiary’s monthly recurring income and cannot be made if the beneficiary has zero ($0) reported monthly income. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty is limited to zero.  See the SCDHHS [Nursing Facility Services Manual](https://www.scdhhs.gov/providers/manuals/nursing-facility-services-manual), Chapter 7, Non-Covered Medical Expense Deductions, for a list of allowable deductions. | |

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| **Procedure**  **Computing Allowable Deductions for Individuals Receiving Home and Community Based Services**   * Use the [DHHS Form 1729 ME](http://medsweb.clemson.edu/EligibilityForms/FM%201729%20ME.pdf), Income Trust Budget Worksheet, or the IT tab in the Budget Workbook. * Combine any income received outside the trust with any income placed in the trust. * Subtract any allowable deductions   + Waiver Allowance (equal to the Medicaid Cap)   + $10 Trustee Fee   + Court ordered guardianship fees (lesser of 10% of gross income, or $25)   + Actual bank service charges up to $20 per month   + Federal or State Income Tax payment (once per calendar year, IF the trust owes the taxes – not the individual.)   + Family Maintenance Allowance, if any   + Medical Expenses not subject to third-party payment (for the applicant/beneficiary only)     - Health insurance premiums     - Non-covered post eligibility medical expenses (Refer to [Appendix B](http://medsweb.scdhhs.gov/mppm/HTML/Section300/Chapter%20304%20%20NH-HCBS-GH.htm#Appendix_B) of this chapter.)   + The remainder of the income is the cost of care.     - Enter the amount on the [DHHS Form 3229 ME](http://medsweb.clemson.edu/EligibilityForms/FM%203229%20ME.pdf), Notice of Cost of Care, as the amount that will be billed for the waiver services. * Enter a Y in the Income Trust indicator field on MEDS screen ELD02.   **Example**  Mr. Lee Brown applies for Home and Community Based Services. He receives Social Security benefits of $1,349 and a Union Retirement check in the amount of $2,219 per month. He pays a health insurance premium of $185 per month. He establishes an income trust and opens the trust bank account. Upon approval, he has been accepted into the Palmetto SeniorCare a PACE. Mr. Brown is a widow and lives with his daughter at night.  **Treatment**  The LTC worker should use the electronic budgeting workbook or DHHS Form 1729 ME, Income Trust Budget Worksheet, to calculate the maximum cost of care. (**Note:** Be sure to use the side for Waiver Participants.) A copy of the DHHS Form 1729 ME must be given to the trustee.  **Gross monthly income $3,568**  Deductions:  Waiver Allowance $2,829  Trust Administration Fee + 10  Health Insurance Premium + 185  **Total Deductions $3,024**  Gross Income $3,568  Total Deductions - 3,024  **Payable Monthly Recurring Income $544**  **A copy of the DHHS Form 3229 must be emailed to the Division of Accounting to inform them of approval and the beneficiary’s recurring income.** |

[Table of Contents](http://medsweb.scdhhs.gov/mppm/HTML/Section300/Chapter%20304%20%20NH-HCBS-GH.htm#_top)

304.19.07 Billing for Home and Community Based Services Waiver Program Participants

(Eff. 07/01/15)

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

**Failure to Pay for Services**

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

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

Refer to MPPM 304.19.10 regarding non-compliance.

304.19.08 Annual Accounting

(Eff. 06/01/06)

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

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

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

[Table of Contents](http://medsweb.scdhhs.gov/mppm/HTML/Section300/Chapter%20304%20%20NH-HCBS-GH.htm#_top)

304.19.09 Trust Modification: Trustee or Bank Account Change

(Eff. 06/01/06)

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

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

304.19.10 Non-Compliance with Terms of the Income Trust

(Eff. 06/01/06)

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

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

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

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

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

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

304.19.11 Death of Income Trust Principal Beneficiary

(Eff. 06/01/06)

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

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

304.19.12 Income Trust Dissolution

(Rev. 07/01/15)

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

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

304.19.13 Income Trust and Transfer Penalties

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

**NOTE**

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

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

304.19.14 Income Trust Identification/Set up Flow

(Eff. 07/01/15)

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

**Eligibility Determination Reminders With Income Trust:**

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

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

304.20 Other Trusts

(Eff. 06/01/06)

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

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

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

[Table of Contents](#_top)

304.20.01 Undue Hardships and Trusts

(Eff. 02/01/09)

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

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

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

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

===AND===

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

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

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

===OR===

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

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

304.21 Bed Hold Policy

(Eff. 06/01/06)

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

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

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

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

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

304.22 Medicare/Co-Insurance

(Rev. 07/01/07)

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

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

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

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

(Eff. 01/01/10)

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

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

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

304.23.01 Initiation of DHHS Form 181

(Eff. 06/01/06)

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

304.23.02 Signature Requirements

(Eff. 06/01/06)

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

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

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

[Table of Contents](#_top)

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

(Eff. 11/01/07)

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

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

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

304.24.01 PACE Participant Enters a Nursing Home

(Eff. 11/01/07)

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

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

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

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

304.24.02 PACE Participant Enters a Residential Care Facility

(Eff. 01/01/15)

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

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

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

304.24.03 PACE Participant Terminated from Program

(Eff. 11/01/07)

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

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

304.25 Denial of Payment for New Admissions (DPNA)

(Eff. 06/01/06)

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

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

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

304.26 Miscellaneous Facts about Nursing Facilities

(Eff. 06/01/06)

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

304.26.01 Private vs. Semi-Private Rooms

(Eff. 06/01/06)

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

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

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

(Eff. 06/01/06)

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

304.26.03 Sitters

(Eff. 06/01/06)

Medicaid beneficiaries may have sitters; however, the sitters:

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

304.26.04 Condition of Admission

(Eff. 06/01/06)

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

[Table of Contents](#_top)

304.26.05 Continuing Care Retirement Communities (CCRCs)

(Eff. 06/01/06)

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

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

304.27 Estate Recovery

(Rev. 12/01/21)

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

Estate Recovery applies to the following beneficiaries:

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

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

Mail: SCDHHS

Attn: Medicaid Estate Recovery

Post Office Box 100127

Columbia, SC 29202-3127

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

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

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

Questions about Medicaid Estate Recovery should be directed to:

Department of Health and Human Services

Attn: Medicaid Estate Recovery

Post Office Box 100127

Columbia, SC 29202

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

Fax (803) 462-2579

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

[Table of Contents](#_top)

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

(Eff. 04/22/22)

**Application Received/Intake**

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

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

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

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

During the call, the LTC eligibility specialist will:

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

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

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

**Processing**

The LTC eligibility specialist must:

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

**Determination**

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

**NOTE**

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

**NOTE**

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

304.29 Case Record Requirements

(Rev. 01/01/24)

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

**\*\*Note**

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

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

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

|  |
| --- |
| **Example:**  Joe Green has received ABD for the past five years. He has made a referral to CLTC for HCBS and the DHHS Form 118 is sent to the local eligibility office to request a look-back for a transfer of assets. The eligibility worker examines the case record and determines that Mr. Green has a checking account that has been consistent for the entire period, and homestead property. When Mr. Green returns the DHHS Form 3400-B, there is no indication any transfers have occurred.   * A property check is completed and verifies:   + Mr. Green still owns the homestead property   + The value of his homestead is under $713,000.   + He owns no other property   + He did not transfer any property during the look-back period * The file contains bank information from each year in the look-back period. His balances have been consistent during that time. There is no indication of a transfer so additional information is not requested from Mr. Green. * The eligibility worker returns the DHHS Form 118 to CLTC indicating the look-back has been completed. |

304.30 Annual Review Procedures

304.30.01 Nursing Home

(Rev. 11/01/18)

* + - 1. Annual re-determinations are required.
      2. MEDS generates a review form based on the Date of Next Review.
      3. Eligibility Worker Responsibilities:
* Acknowledge the receipt of the review form into MEDS
* Comparing the information on the form to the CR history
  + Noting any alleged changes or discrepancies
  + Contacting PI/AR to clarify information or request any verification
  + Obtain current verification of all Income and Resources through such methods as:
    - Requesting verification from the PI/AR
    - Obtaining necessary information/verification from third parties through such methods as
      * Sending forms and letters, such as:
        + Asset Verification (AVS) request for bank accounts;
        + [DHHS Form 1253 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201253%20ME.pdf), Request for Financial Verification (Only if unable to verify with AVS);
        + [DHHS Form 1255 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201255%20ME.pdf), Verification of Real and Person Property;
        + [DHHS Form1280 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201280%20ME.pdf), Verification of Life Insurance Values;
        + [DHHS Form 1212 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201212%20ME.pdf), Request for Verification of Veterans Information;
        + letter to a funeral home;
        + Civil Service
      * Telephone contact – make sure to document the following: Date of Contact; Company/Business name; Phone Number; Individual’s name (and title, if possible) that provided the verification
      * On Line Internet searches such as Property search; verification of Car Values
    - Checking all available data matches, such as: IEVS (Bendex; SDX); State Retirement; ESC Wage Match; Unemployment; CHIP; and Person Composite Service (PCS) Wage Verification
  + Once all verifications have been obtained and documented, do budget to determine continual eligibility:
  + If continually eligible,
    - Update MEDS information – Important: Next Review Date
    - If there is a change in recurring income, advise the PI/AR and facility of the change
      * DHHS Form 181
      * Cost of Care Letter ([DHHS Form 3229 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%203229%20ME.pdf)) to advise the facility and the PI/AR of the new amount
  + If ineligible
    - Begin closure actions in MEDS
    - Send a [DHHS Form 181](http://medsweb.scdhhs.gov/EligibilityForms/FM%20181.pdf) to the facility
  + Determines if the individual would be eligible in any other Payment Category. If so, take appropriate actions to change category.

304.30.02 Home and Community Based Services

(Rev. 11/01/18)

* + - 1. Annual re-determinations are required.
      2. MEDS generates a review form based on the Date of Next Review.
      3. Eligibility Worker Responsibilities:
* Acknowledge the receipt of the review form into MEDS
* Comparing the information on the form to the CR history
  + Noting any alleged changes or discrepancies
  + Contacting PI/AR to clarify information or request any verification
  + Obtain current verification of all Income and Resources through such methods as:
    - Requesting verification from the PI/AR
    - Obtaining necessary information/verification from third parties through such methods as
      * Sending forms and letters, such as:
        + Asset Verification (AVS) request for bank accounts;
        + [DHHS Form 1253 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201253%20ME.pdf), Request for Financial Verification (Only if unable to verify with AVS);
        + [DHHS Form 1255 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201255%20ME.pdf), Verification of Real and Person Property;
        + [DHHS Form1280 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201280%20ME.pdf), Verification of Life Insurance Values;
        + [DHHS Form 1212 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201212%20ME.pdf), Request for Verification of Veterans Information;
        + letter to a funeral home;
        + Civil Service
      * Telephone contact – make sure to document the following: Date of Contact; Company/Business name; Phone Number; Individual’s name (and title, if possible) that provided the verification
      * On Line Internet searches such as Property search; verification of Car Values
    - Checking all available data matches, such as: IEVS (Bendex; SDX); State Retirement; ESC Wage Match; Unemployment; CHIP; and Person Composite Service (PCS) Wage Verification
  + Once all verifications have been obtained and documented, do budget to determine continual eligibility:
  + If continually eligible,
    - Update MEDS information—Important: Next Review Date
    - For Income Trust Cases: if there is a change in recurring income,
      * Advise the PI/AR by sending Cost of Care Letter ([DHHS Form 3229 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%203229%20ME.pdf))
      * Send a copy of the DHHS Form 3229 ME and [DHHS Form 1729 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201729%20ME.pdf), Income Trust Budget sheet to the Bureau of Eligibility and Program Oversight.
  + If ineligible, begin closure actions in MEDS.
  + Determines if the individual would be eligible in any other Payment Category. If so, take appropriate actions to change category.

[Table of Contents](#_top)

304.31 Introduction to General Hospital

(Eff. 06/01/06)

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

304.31.01 General Hospital vs. Nursing Home Assistance

(Rev. 05/01/09)

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

304.31.02 Non-Financial Eligibility Criteria

(Eff. 06/01/06)

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

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

304.31.03 Categorical Eligibility Criteria

(Rev. 09/01/23)

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

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

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

* Meet a Level of care – presumed because the hospital’s Utilization Review Board completes a treatment plan to justify the stay.
* Be Aged, Blind, or Disabled
* Children under age 19 are treated as part of the family for an admission lasting less than 30 days. Beginning on the 31st day, the child is considered an individual and can be authorized for coverage back to the first day of admission into the hospital. If the child can be authorized for partners for Health Children (PHC) coverage, there is no need to backdate the General Hospital coverage. Process General Hospital coverage for any retroactive coverage dates for which PHC could not be authorized.
* Infants born in and remaining in the hospital after birth can be processed for General Hospital coverage because the household has not been established for PHC. The infant is considered an individual and is processed as any other General Hospital applicant is processed.

**Note**

**Do not** end the PHC coverage on the 31st day if the beneficiary still qualifies for coverage unless a change is reported that impacts eligibility. Any child under the age of 19 who does not qualify for PHC or ABD coverage must be processed for General Hospital coverage if they have met the 31-day requirement or have passed away in the hospital.

|  |
| --- |
| **Adult Examples**  **Example #1**  Sarah Phillips was admitted to the hospital on January 6 and was discharged on February 28. The 30-day requirement was met.  **Example #2**  A General Hospital application was filed for Jimmy Wood. Mr. Wood was admitted to Memorial Hospital on March 10 after breaking his hip. He was transferred to Manor Care Nursing Home under Medicare for therapy on March 31. On April 13, he was discharged home from Manor Care. The 30-day requirement was met in the combined admissions.  **Example #3**  Hannah Green was admitted to County Hospital on April 3 and passed away on April 22, while still a patient. The General Hospital category may still be considered as it is assumed that she would have remained in the hospital for 30 days had she lived.  **Example #4**  The DHHS Medicaid office received a General Hospital application on Stan Smart. Mr. Smart was a patient at Doctor’s Hospital from February 20 until his discharge home on March 20. He did not meet the 30-day criteria, so eligibility could not be established under the General Hospital category. The eligibility worker must determine if he may qualify under another payment category.  **Note**  In all of the above examples, the categorical eligibility of each of the applicants was established (that is, the individuals are aged or have been determined to be blind or disabled). |
| **Infant and Children Examples**  **Example 1**  Lily Smith was born in the hospital on August 15. Her original application was for PHC. She is presently still in the hospital on September 18. Lily does not qualify for any other coverage but meets all eligibility criteria for General Hospital. Only Lily’s income and resources were countable. **Do not** use the deeming process. The 30 consecutive day requirement has been met. Lily is authorized for coverage beginning August 1.  **Example 2**  Jake Hill was born in the hospital on September 12. He was discharged home on September 18. On September 21, a General Hospital application was received because he returned to the hospital on September 19 and is expected to remain for 31 days. He does not qualify for any other coverage because his deemed income is over the income limit for ABD. Since Jake’s parents’ income is not used to determine eligibility for the General Hospital category, Jake meets all eligibility requirements for General Hospital coverage except the 30 days consecutive days. The eligibility specialist placed the case in follow-up until the 31st day of hospital admittance. If still in the hospital on the 31st day, Jake can be authorized for General Hospital beginning September 1.  **Example 3**  Lacy Gray is a child who was admitted to the hospital from home on June 3. Her application was received on September 5, and retroactive coverage was requested. On October 15, Lacy is still in the hospital. Lacy qualifies for PHC beginning September 1. Lacy needs General Hospital coverage for the retroactive months because her parents were over the income limit for PHC Medicaid in the Retroactive months. She does not qualify for any other coverage because her deemed income is over the income limit for ABD. Since Lacy’s parents’ income is not used to determine eligibility for the General Hospital category, Lacy meets all eligibility requirements for General Hospital coverage. Lacy was authorized for general hospital coverage beginning June 1st and ending August 31. Her PHC was authorized beginning September 1.  **Note**  In all of the above examples, the categorical eligibility of each of the applicants was established (that is, the individuals have been determined to be blind or disabled). |

[Table of Contents](#_top)

304.31.04 Financial Criteria

(Eff. 06/01/06)

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

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

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

Liberalized income and resource policy applies.

304.31.05 Continued Eligibility

(Rev. 07/01/10)

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

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

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

304.31.06 Basic Application Process

304.31.06A Receipt of Application/Intake

(Rev. 07/01/15)

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

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

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

304.31.06B Processing of Application

(Eff. 09/01/16)

The eligibility worker must:

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

304.31.06C Determination of Eligibility/Ineligibility

(Eff. 10/01/13)

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

[Table of Contents](#_top)

304.31.06D Continued Eligibility

(Rev. 09/01/16)

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

304.32 Palmetto Coordinated System of Care (PCSC) Waiver

(Eff. 11/01/20)

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

**Application**

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

**Scanning and Indexing**

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

**Procedures for Processing PCSC Applications**

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

304 Appendix A Life Expectancy Table

(Eff. 10/01/05)

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

[Table of Contents](#_top)

304 Appendix B Non-Covered Medical Expenses and Allowable Deductions

(Rev. 11/01/23)

See the SCDHHS [Nursing Facility Services Manual](https://www.scdhhs.gov/providers/manuals/nursing-facility-services-manual), Chapter 7, Non-Covered Medical Expense Deductions, for a list of allowable deductions.

[Table of Contents](#_top)

304 Appendix C DHHS Form 181

(Eff. 10/01/05)

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

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

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

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

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

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

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

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

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

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

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

Item 10 Enter the date the form was prepared.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Item 12 (F) Enter other changes or information.

**Note**

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

[Table of Contents](#_top)

304 Appendix D Current Average Monthly Nursing Facility and Medicaid Payment Rates

(Eff. 01/01/24)

**Note:** The current average private pay nursing home rate in South Carolina is $9,243.32 per month ($303.89 per day).

| AVERAGE MONTHLY NURSING FACILITY AND MEDICAID PAYMENT RATES  Payment Rates Effective January 1, 2024 | | |
| --- | --- | --- |
| MMIS Provider # | MMIS Facility Name | Average Monthly  Medicaid Cost |
| 0098SB | ABBEVILLE COUNTY MEMORIAL | 7,520.00 |
| 330090 | ABBEVILLE NURSING HOME INC | 6,107.00 |
| NF1126 | AIKEN REHABILITATION AND H | 7,347.00 |
| 0041SB | ALLENDALE COUNTY HOSPITAL | 7,520.00 |
| NF1118 | ANCHOR POST ACUTE | 9,157.00 |
| NF1112 | ANGEL OAK NURSING AND REHA | 7,794.00 |
| 0189NF | BETHEA HEALTH CARE CENTER | 8,214.00 |
| NF1064 | BLUE RIDGE IN GEORGETOWN L | 5,850.00 |
| NF1063 | BLUE RIDGE OF SUMTER LLC | 6,410.00 |
| 173286 | BRIAN CTR ST ANDREWS | 7,112.00 |
| NF1138 | BROOKVIEW HEALTHCARE CENTE | 5,973.00 |
| NF1070 | BRUSHY CREEK POST ACUTE | 9,070.00 |
| NF1075 | CARLYLE SENIOR CARE OF AIK | 6,249.00 |
| NF1142 | CARLYLE SENIOR CARE OF BLA | 6,039.00 |
| NF1073 | CARLYLE SENIOR CARE OF FLO | 6,464.00 |
| NF1072 | CARLYLE SENIOR CARE OF FOR | 5,684.00 |
| NF1074 | CARLYLE SENIOR CARE OF FOU | 8,092.00 |
| NF1076 | CARLYLE SENIOR CARE OF KIN | 6,376.00 |
| NF1141 | CARLYLE SENIOR CARE OF WIL | 7,064.00 |
| NF1079 | CAROLINA HEALTHCARE INC | 7,210.00 |
| 0878NF | CHARLESTON MEDICAL INVESTO | 7,011.00 |
| 0602NH | CHERAW HEALTHCARE INC | 6,223.00 |
| 0738NF | CLARENDON MEMORIAL HOSPITA | 8,424.00 |
| 0736NF | CLARENDON MEMORIAL HOSPITA | 8,021.00 |
| 291168 | COMMUNITY SERVICES FOR THE | 7,552.00 |
| NF1108 | CONDOR HEALTH ANDERSON | 6,294.00 |
| 0899NF | CONWAY MANOR LLC | 5,383.00 |
| 0897NF | DUNDEE MANOR LLC | 6,082.00 |
| NF1119 | EDGEFIELD POST ACUTE | 7,991.00 |
| NF1055 | EDISTO POST ACUTE | 8,475.00 |
| NF1065 | ELLEN SAGAR | 7,925.00 |
| 0927NF | FAITH HEALTHCARE CENTER | 6,542.00 |
| NF1113 | FLEETWOOD POST ACUTE | 7,970.00 |
| NF1045 | GOLDEN AGE - INMAN | 6,654.00 |
| NF1056 | GREENVILLE POST ACUTE | 8,047.00 |
| NF1114 | GREER POST ACUTE | 7,678.00 |
| NF1105 | HALLMARK HEALTHCARE CENTER | 7,376.00 |
| 0027SB | HAMPTON REGIONAL MEDICAL C | 7,520.00 |
| 0918NF | HEALTHCARE PANASCOPE | 6,284.00 |
| 0952NF | HEARTLAND HEALTH CARE CENT | 6,905.00 |
| 0953NF | HEARTLAND HEALTH CARE CENT | 7,294.00 |
| NF1000 | HEARTLAND HEALTH CARE CENT | 7,882.00 |
| NF1002 | HEARTLAND OF COLUMBIA REHA | 8,057.00 |
| 0450NH | HERITAGE HOME OF FLORENCE | 6,302.00 |
| 117042 | HONORAGE NURSING CENTER | 7,892.00 |
| NF1044 | INMAN HEALTH OPERATING COM | 6,648.00 |
| NF1120 | IVA POST ACUTE | 8,349.00 |
| NF1032 | JF HAWKINS NURSING HOME | 6,646.00 |
| 118285 | JOHN EDWARD HARTER NURSING | 7,499.00 |
| NF1052 | JOHNS ISLAND POST ACUTE | 7,709.00 |
| 0929NF | JOLLEY ACRES HEALTHCARE CT | 7,222.00 |
| 332258 | KERSHAWHEALTH KARESH LONG | 8,679.00 |
| 0928NF | LAKE CITY SCRANTON HEALTHC | 7,024.00 |
| NF1061 | LANCASTER HEALTH CARE LLC | 6,591.00 |
| 0730NF | LEXMED INC | 8,948.00 |
| 0725NF | LIFE CARE CENTERS OF AMERI | 5,306.00 |
| NF1117 | LINLEY PARK POST ACUTE | 8,554.00 |
| NF1057 | LORIS REHAB AND NURSING CE | 9,087.00 |
| 332134 | LUTHERAN HOMES OF SC INC | 7,430.00 |
| NF1102 | MANNA REHABILITATION AND H | 8,523.00 |
| NF1104 | MCCORMICK REHABILITATION A | 6,523.00 |
| NF1077 | MCCOY MEMORIAL NURSING CEN | 5,958.00 |
| 0681SB | MCLEOD HEALTH CHERAW | 7,520.00 |
| 0930SB | MCLEOD HEALTH CLARENDON | 7,520.00 |
| 0384SB | MCLEOD MEDICAL CENTER DARL | 7,520.00 |
| 0854SB | MCLEOD MEDICAL CENTER DILL | 7,520.00 |
| 0891NF | MEDFORD NURSING CENTER | 8,668.00 |
| 0881NF | MORRELL NURSING CENTER LLC | 7,701.00 |
| 0896NF | MOUNT PLEASANT MANOR LLC | 6,532.00 |
| 0895NF | MUSC HEALTH CHESTER NURSIN | 8,599.00 |
| NF1010 | MUSC HEALTH MULLINS NURSIN | 8,930.00 |
| 0028SB | MUSC MARION MEDICAL CENTER | 7,520.00 |
| 262441 | NHC HEALTHCARE ANDERSON LL | 7,237.00 |
| NF1008 | NHC HEALTHCARE BLUFFTON LL | 9,090.00 |
| NF1110 | NHC HEALTHCARE CHARLESTON | 7,516.00 |
| 0601NH | NHC HEALTHCARE CLINTON LLC | 7,634.00 |
| 0574NH | NHC HEALTHCARE GARDEN CITY | 7,999.00 |
| 0570NH | NHC HEALTHCARE GREENVILLE | 8,665.00 |
| 400227 | NHC HEALTHCARE GREENWOOD | 7,003.00 |
| 155210 | NHC HEALTHCARE LAURENS LLC | 6,329.00 |
| 0629NH | NHC HEALTHCARE LEXINGTON L | 8,101.00 |
| 0732NF | NHC HEALTHCARE MAULDIN LLC | 8,187.00 |
| 0569NH | NHC HEALTHCARE NORTH AUGUS | 7,969.00 |
| 0722NF | NHC HEALTHCARE PARKLANE LL | 8,533.00 |
| 0471NH | NHC HEALTHCARE SUMTER | 6,429.00 |
| NF1086 | OAKBROOK HEALTH AND REHABI | 6,906.00 |
| 0890NF | OAKHAVEN NURSING CENTER LL | 7,669.00 |
| NF1116 | PATEWOOD POST ACUTE | 8,305.00 |
| NF1068 | PEACHTREE CENTRE | 7,821.00 |
| 0861NF | PHYSICAL REHABILTATION AN | 7,614.00 |
| NF1115 | PIEDMONT POST ACUTE | 7,792.00 |
| 0737NF | POCOTALIGO RIVER HEALTH AN | 8,655.00 |
| NF1122 | POWDERSVILLE POST ACUTE | 7,637.00 |
| NF1034 | PRESBYTERIAN COMMUNITIES O | 7,516.00 |
| 0930NF | PRINCE GEORGE HEALTHCARE | 7,012.00 |
| NF1062 | PRISMA HEALTH LILA DOYLE | 7,916.00 |
| NF1096 | PRUITTHEALTH - CONWAY | 8,687.00 |
| 0942NF | PRUITTHEALTH AIKEN LLC | 8,410.00 |
| NF1007 | PRUITTHEALTH BAMBERG | 10,145.00 |
| NF1011 | PRUITTHEALTH BARNWELL LLC | 9,239.00 |
| 0880NF | PRUITTHEALTH COLUMBIA LLC | 8,088.00 |
| 0835NF | PRUITTHEALTH DILLON LLC | 6,520.00 |
| 0922NF | PRUITTHEALTH ESTILL LLC | 6,991.00 |
| 0943NF | PRUITTHEALTH MONCKS CORNER | 7,359.00 |
| NF1004 | PRUITTHEALTH NORTH AUGUSTA | 9,544.00 |
| NF1006 | PRUITTHEALTH ORANGEBURG | 7,991.00 |
| NF1005 | PRUITTHEALTH PICKENS | 9,657.00 |
| 0710NF | PRUITTHEALTH RIDGEWAY LLC | 7,145.00 |
| 0836NF | PRUITTHEALTH ROCK HILL LLC | 7,893.00 |
| 0711NF | PRUITTHEALTH WALTERBORO | 6,931.00 |
| 0634NF | RCM COLUMBIA | 5,362.00 |
| NF1058 | REHAB CENTER OF CHERAW LLC | 6,402.00 |
| NF1144 | RESORTS AT BEAUFORT | 7,666.00 |
| NF1123 | RIDGELAND NURSING AND REHA | 7,390.00 |
| NF1087 | RIDGEWAY MANOR HEALTHCARE | 7,517.00 |
| NF1091 | RIVER FALLS REHABILITATION | 7,362.00 |
| NF1071 | ROCK HILL HEALTHCARE INC | 6,925.00 |
| NF1059 | SAINT MATTHEWS HEALTH CARE | 6,127.00 |
| 421834 | SALUDA NURSING CENTER | 8,496.00 |
| NF1121 | SANDPIPER POST ACUTE | 8,492.00 |
| NF1109 | SEDGEWOOD MANOR HEALTHCARE | 6,992.00 |
| NF1130 | SENECA HEALTH AND REHABILI | 6,948.00 |
| NF1111 | SENIOR CARE OF MARION LLC | 7,516.00 |
| NF1134 | SIMPSONVILLE POST ACUTE | 6,881.00 |
| 0435NF | SOUTH CAROLINA BAPTIST MIN | 7,796.00 |
| 0549NH | SOUTH CAROLINA DEPT OF MEN | 8,158.00 |
| 0921NF | SOUTH CAROLINA DEPT OF MEN | 9,385.00 |
| 136078 | SOUTH CAROLINA DEPT OF MEN | 12,006.00 |
| 0726NF | SOUTH CAROLINA DEPT OF MEN | 14,117.00 |
| NF1078 | SOUTHERN CHARM HEALTHCARE | 7,259.00 |
| NF1128 | SOUTHLAND HEALTH CARE CENT | 7,608.00 |
| NF1060 | SPARTANBURG HEALTH CARE LL | 6,635.00 |
| 0925NF | SPRINGDALE HEALTHCARE CTR | 7,049.00 |
| NF1082 | ST GEORGE HEALTH CARE LLC | 7,661.00 |
| NF1066 | STONEY HILL HEALTHCARE INC | 9,123.00 |
| NF1129 | SUMTER EAST HEALTH AND REH | 6,964.00 |
| NF1131 | THE OAKS HEALTHCARE | 7,407.00 |
| NF1012 | THE OAKS OF BLYTHEWOOD INC | 9,785.00 |
| NF1127 | THE PALMS AT FLORENCE | 7,295.00 |
| 0859NF | THI OF SOUTH CAROLINA AT | 7,037.00 |
| 0870NF | THI OF SOUTH CAROLINA AT C | 7,005.00 |
| 0868NF | THI OF SOUTH CAROLINA AT C | 7,188.00 |
| 0862NF | THI OF SOUTH CAROLINA AT C | 6,973.00 |
| 0860NF | THI OF SOUTH CAROLINA AT G | 6,236.00 |
| 0866NF | THI OF SOUTH CAROLINA AT G | 6,948.00 |
| 0869NF | THI OF SOUTH CAROLINA AT M | 7,187.00 |
| 0863NF | THI OF SOUTH CAROLINA AT M | 6,176.00 |
| 0867NF | THI OF SOUTH CAROLINA AT S | 6,420.00 |
| NF1125 | VIVIANT HEALTHCARE OF CHAR | 8,082.00 |
| NF1124 | VIVIANT HEALTHCARE OF HANA | 8,322.00 |
| 271877 | WESLEY COMMONS | 10,353.00 |
| NF1137 | WEST VILLAGE POST ACUTE | 6,992.00 |
| 0466NH | WHITE OAK ESTATES | 8,776.00 |
| 0458NH | WHITE OAK MANOR CHARLESTON | 8,280.00 |
| 0461NH | WHITE OAK MANOR COLUMBIA | 8,301.00 |
| NF1081 | WHITE OAK MANOR INC | 9,993.00 |
| 0508NH | WHITE OAK MANOR LANCASTER | 8,268.00 |
| 0462NH | WHITE OAK MANOR NEWBERRY | 6,773.00 |
| 0460NH | WHITE OAK MANOR SPARTANBUR | 9,870.00 |
| 0565NH | WHITE OAK MANOR YORK | 8,894.00 |
| 0459NH | WHITE OAK MANOR-ROCK HILL | 8,948.00 |
| NF1085 | WOODRUFF MANOR | 7,000.00 |

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

(Eff. 01/01/24)

|  |  |  |  |
| --- | --- | --- | --- |
| Comparison of Applicable Required Elements for Institutional Programs | | | |
| Element | Nursing Home | HCBS | General Hospital |
| 30 Consecutive Day Criteria | Required, UNLESS Medicaid-eligible in another category | Required, UNLESS Medicaid-eligible in another category | Required |
| Look-back; Transfer of Assets Penalty | Applicable | Applicable | Not Applicable |
| Categorical Eligibility | Aged, Blind or Disabled | Aged, Blind or Disabled | Aged, Blind or Disabled |
| Estate Recovery | Applicable | Applicable | Not Applicable |
| Income Limit | Medicaid Cap  IF income exceeds the Medicaid Cap, an Income Trust must be established. | Medicaid Cap  IF income exceeds the Medicaid Cap, an Income Trust must be established. | Medicaid Cap  An Income Trust is not an option. |
| Level of Care | Certification required, UNLESS entering  facility under  Medicare Sponsorship | Certification required | Level of Care  is presumed. |
| Obtaining  Other Assets/  Elective Share | Applicable | Applicable | Not Applicable |
| Recurring Income (Cost of Care) | Applicable | Not applicable, UNLESS an Income Trust  must be established | Not Applicable |
| Resource Limit | $2,000  $9,430 - IF eligibility can be established under the ABD program. | $2,000  $9,430 - IF eligibility can be established under the ABD program. | $2,000 |
| Spousal Resource Provisions | Applicable | Applicable | Applicable |
| Standard of Promptness | 45 days  May be extended to  90 days, IF eligible but  a bed is not available. | 45 days  May be extended to  90 days, IF eligible but  a slot is not available. | 45 days |
| Vendor Payment | Applicable | Not Applicable | Not Applicable |

[Table of Contents](#_top)

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

(Eff. 01/01/24)

| Allowable Deductions When Calculating Recurring Income | | | | |
| --- | --- | --- | --- | --- |
|  | Nursing Home Case | | HCBS Case | |
| **Deduction** | Standard | **Income Trust** | **Standard** | **Income Trust** |
| Bank  Service Charge | Not Applicable | Actual amount –  up to $20/mo. | Not Applicable | Actual amount –  up to $20/mo. |
| Family Income Allocation | Allowed – (Refer to [304.15.02](#MPPM_304_15_02).) | Allowed – (Refer to [304.15.02](#MPPM_304_15_02).) | Not Applicable | Allowed – (Refer to [304.15.02](#MPPM_304_15_02).) |
| Health Insurance Premiums | Actual amount –  IF paid for, and by the beneficiary | Actual amount –  IF paid for, and by the beneficiary | Actual amount –  IF paid for, and by the beneficiary | Actual amount –  IF paid for, and by the beneficiary |
| Home Maintenance Allowance | Actual amount –  up to SSI FBR  Allowed up to 6 months, IF a physician certifies beneficiary is expected to return home within  6 months | Actual amount –  up to SSI FBR  Allowed up to 6 months, IF a physician certifies beneficiary is expected to return home within  6 months | Not Applicable | Not Applicable |
| Income Tax Payments | Not Applicable | Allowed once per year, IF owed by the trust, not the beneficiary | Not Applicable | Allowed once per year, IF owed by the trust, not the beneficiary |
| Non-Covered Medical Expenses | Limited amount - deducted by  the facility | Limited amount - deducted by  the facility | Not Applicable | Limited amount deducted by the eligibility worker |
| Personal Needs Allowance | $30/mo.  or  $100/mo.- IF has earnings from Work Therapy | $30/mo.  or  $100/mo. - IF has earnings from Work Therapy | Equal to the Medicaid Cap | Equal to the Medicaid Cap |
| Protected Income | Allowed month of entry and/or discharge from a community setting | Not Allowed | Not Applicable | Not Applicable |
| Spousal Income Allocation | Up to a max. of $3,853.50/mo. | Up to a max. of $3,853.50/mo. | Not Applicable | Up to a max. of $3,853.50/mo. |
| Trustee Fee | Not Applicable | $10/mo. | Not Applicable | $10/mo. |

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

[Table of Contents](#_top)

304 Appendix G Home Equity Procedures Flowchart

(Eff. 01/01/24)

Diagram

Description automatically generated

304 Appendix H Waiver Programs Comparison Chart

(Rev. 01/01/20)

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

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

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

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

304 Appendix I Look-back Procedures for ABD Applicants

(Rev. 09/01/22)

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

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

304 Appendix J Phoenix Procedures

(Eff. 03/01/17)

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

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

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

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

304 Appendix K Determining a Reasonable Rate of Interest for Promissory Notes

(Eff. 11/01/23)

For a Promissory Note to meet the requirements of being actuarially sound, a loan/note must call for a reasonable rate of interest. Use the following instructions to determine if the interest indicated in the terms of the loan/note meet the reasonable rate of interest requirement.

The Applicable Federal Rate (AFR) is used by the IRS as a point of comparison to determine the minimum interest rate for loans between related parties, such as family members. These rates change monthly.

* Select the IRS hyperlink <https://apps.irs.gov/app/picklist/list/federalRates.html>,
* Identify the month and year the Promissory Note was created and select the time frame.
  + Less than or equal to three years—Short-term
  + Greater than three and less than or equal to nine years—Mid-term
  + Greater than nine years—Long-term.
* Determine how the interest is compounded - annually, semi-annually, quarterly, or monthly. This information can be found in the terms of the loan agreement/note.
* Go to the appropriate section based on the term length of the loan and use the 100% AFR figures for the corresponding column that identifies the period of interest compounded.

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| **Example**  Promissory Note was created on 03/11/2018. The term of repayment is 6 years, and the interest is compounded monthly. The reasonable rate of interest for these specifications is 2.54%.      **Note**  Short-Term loans/notes are bonds with maturity dates that are 3 years or less. Mid-term loans/notes are bonds with maturity dates that are 3 to 9 years. Long-term loans/notes are bonds with maturity dates that are more than 9 years. |

# **CHAPTER 305—Katie Beckett (TEFRA)**

[305.01 Introduction 404](#_Toc395515867)

[305.02 Processing and Maintaining TEFRA Cases 404](#_Toc395515868)

[305.03 Non-Financial Criteria 404](#_Toc395515869)

[305.04 Categorical Criteria 405](#_Toc395515870)

[305.04.01 Age 405](#_Toc395515871)

[305.04.02 Disability 405](#_Toc395515872)

[305.04.03 Level of Care Determination 406](#_Toc395515873)

[305.04.04 Living Arrangements 407](#_Toc395515874)

[305.05 Cost Effectiveness 408](#_Toc395515875)

[305.06 Financial Eligibility 408](#_Toc395515876)

[305.06.01 Income 408](#_Toc395515877)

[305.06.02 Resources 409](#_Toc395515878)

[305.07 Denial of Application 409](#_Toc395515879)

[305.08 Continued Financial Eligibility 409](#_Toc395515880)

[305.09 Right to Appeal 409](#_Toc395515881)

[305.10 Case Examples 409](#_Toc395515882)

305.01 Introduction

(Eff. 02/01/06)

Section 134 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 (Public Law 97-248) provides states with the option to make Medicaid benefits available to certain disabled children who would otherwise require institutional care to attain eligibility and who would not ordinarily be eligible for Supplemental Security Income (SSI) because their parent’s income and/or resources exceed the limit.

These children are generally called Katie Beckett or TEFRA children. This is an eligibility option, not a waiver category. South Carolina began covering these children effective January 1, 1995. DHHS Form Letter 3292 provides an overview of the TEFRA program and the application process for individuals applying and considering applying for this category.

305.02 Processing and Maintaining TEFRA Cases

(Rev. 10/01/10)

Applications for TEFRA may be received at any local Medicaid Eligibility Office. The Division of Central Eligibility Processing is responsible for processing and maintaining all of these cases.

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| Procedure Applications taken or received in a local Medicaid eligibility office should be forwarded to the Division of Central Eligibility Processing:  Mailing Address Division of Central Eligibility Processing  PO Box 100101  Columbia, SC 29202-3101  Courier Address Division of Central Eligibility Processing  1801 Main St  Columbia, SC 29202 |

305.03 Non-Financial Criteria

(Rev. 02/01/20)

An individual must meet the following non-financial requirements referenced in MPPM Chapter 102.

* Identity MPPM 102.02
* State Residency MPPM 102.03
* Citizenship/Alienage MPPM 102.04
* Enumeration/SSN MPPM 102.05
* Assignment of Rights to Third Party Medical Payments MPPM 102.07
* Applying for and Accepting other Benefits MPPM 102.08

For applications filed on or after January 1, 2018, children who are lawfully present but have not met the 5-year/40 quarter requirements can be approved for full Medicaid coverage as long as they meet all other eligibility criteria. Unless the child attains satisfactory immigration status, eligibility must be terminated once the child turns age 19.

In order for the applicant to be approved correctly, the eligibility specialist must submit a Medicaid Policy ticket in Service Manager. 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.

305.04 Categorical Criteria

(Eff. 02/01/06)

Applicants/Beneficiaries must meet certain categorical eligibility requirements.

305.04.01 Age

(Rev. 11/01/20)

To become eligible and remain eligible as a TEFRA child, the applicant/ beneficiary must be under age 19. Accept the applicant’s allegation of age, unless the information is questionable, and then it must be verified. When a child reaches age 19, eligibility for continuing benefits under another Medicaid category must be determined using appropriate criteria (Refer to MPPM 101.08.06.)

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| **Note**  If the child is age 18, the eligibility worker should refer him/her to the Social Security Administration (SSA) to apply for SSI benefits. However, this is not an eligibility requirement. |

305.04.02 Disability

(Eff. 02/01/06)

An applicant/beneficiary must meet the SSI disability definition of disability. Refer to MPPM 102.06.02, 102.06.02A, 102.06.02B, and 102.06.02C.

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| **Note**  The applicant/beneficiary must sign a [DHHS Form 921](http://medsweb.scdhhs.gov/EligibilityForms/FM%20921.pdf), Authorization to Disclose Health Information, for the number of providers listed on the [DHHS Form 3218-D ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%203218-D%20ME.pdf), Child Under Age 19 Disability Report. In addition, the applicant/beneficiary must sign and date, five (5) blank “Authorization to Disclose Health Information” forms. The DHHS Form 921 must be signed and dated by the applicant/beneficiary. For applicants/beneficiaries under age 12, an individual with legal authority to act on behalf of the applicant/beneficiary must sign and date the release. When the applicant/beneficiary is a child age 12 or older (still considered a minor) who is capable of assisting with the application process, both the child and his parent (or individual legally authorized to act on his behalf) must sign and date the DHHS Form 921. |

[Table of Contents](#_top)

305.04.03 Level of Care Determination

(Rev. 11/01/20)

Individuals requesting coverage under the TEFRA group must be certified to be in need of institutional care under one of the following levels:

* Intermediate care,
* Intermediate care for the Intellectually Disabled (ICF-ID),
* Skilled care, or
* A level of care provided in a hospital.

A TEFRA application must be screened for each of the levels of care before the case can be denied for not meeting level of care. The TEFRA coordinator will request a level of care determination be completed.

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| Procedure  A copy of the level of care notification must be on file before authorization of TEFRA eligibility.  **Process for requesting a Level of Care**   1. The TEFRA Coordinator must:  * Complete a [DHHS Form 1231 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201231%20ME.pdf), Request for Assessment for Level of Care. Include the following, if available: * A copy of the DHHS Form 3218-D ME, Disability Report, Child Under Age 19, * Copies of any medical records sent by the parent(s) * Submit the information to the Community Long Term Care (CLTC) Area Office  1. Community Long Term Care (CLTC)  * Complete a determination Nursing Home Level of Care (Skilled or Intermediate) * If the NH level of care is met, CLTC sends certification letter to the TEFRA coordinator * If the NH level of care is not met, CLTC informs the TEFRA coordinator; the TEFRA coordinator forwards all information to the Department of Disabilities and Special Needs (DDSN) for a determination of ICF-ID level of care.  1. Department of Disabilities and Special Needs  * Makes an ICF-ID level of care determination * If the ICF-ID level of care is met, DDSN sends the level of care approval to the TEFRA coordinator * If the ICF-ID level of care is not met, DDSN sends the level of care denial and the complete level of care record to the TEFRA coordinator, the TEFRA coordinator forwards all information to the CLTC for a determination of Hospital level of care.  1. Community Long Term Care  * Determines if a hospital level of care is met * If hospital level of care is met, CLTC sends a certification to the TEFRA coordinator. * If hospital level of care is not met, CLTC sends a denial letter to the TEFRA coordinator verifying the following:   + All level of care have been evaluated, and   + The child does not meet any level of care.  1. If the applicant/authorized representative feels that DHHS has made an error in processing the case, the authorized representative may ask for a fair hearing before the South Carolina Department of Health and Human Services (refer to MPPM 101.12.11.)   At annual review of Medicaid eligibility, the eligibility worker must check the level of care determine if it has expired. If the level of care has expired, a referral for a level of care must be completed and sent to the agency that last established the beneficiary’s level of care using the procedure listed below.  When the eligibility worker is completing a continuing disability review (CDR), a referral for a level of care must be completed and sent to the agency that last established the beneficiary’s level of care using the procedure listed below. If it is determined the beneficiary no longer meets level of care as originally determined, the review must screened for the remaining the levels of care before the case can be closed for not meeting level of care. |

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| **Procedure**   * If DDSN initially determined the level of care, complete the following: * Send a letter to notify the family that a level of care review will be done along with the following: * DDSN Permission to Evaluate TEFRA Applicant form, * Allow the beneficiary at least fifteen (15) days to return the information * Once the information has been returned, send the paperwork to the local Disabilities and Special Needs Board. * If CLTC initially determined the level of care, complete the following:   + Complete a DHHS Form 1231 ME and forward to the local CLTC office. |

305.04.04 Living Arrangements

(Eff. 03/01/23)

A TEFRA eligible child cannot reside in an institution. The case record must contain medical certification that **in home care** is appropriate.

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| **Acceptable Verification**  **For applications with a Level of Care determination made on or after March 1, 2023**  One of the following methods may be used to certify that in home care is appropriate for the child:   * The agency determining the Level of Care will provide certification that in home care is appropriate for the child. The certifying statement will be documented on the Level of Care. If necessary, the agency may consult the child’s physician to make the determination. * The DHHS Form 3291 as shown below in **“For applications with a Level of Care made before March 1, 2023”**   **For applications with a Level of Care determination made before March 1, 2023**   * [DHHS Form 3291 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%203291%20ME.pdf), TEFRA In-Home Care Certification, must be completed by a physician; or * A physician’s written statement that “it is appropriate to care for the child at home” and filed in the case record. * A child may receive waiver services under TEFRA. |

305.05 Cost Effectiveness

(Eff. 02/01/06)

The TEFRA category of assistance is available only to children who would ordinarily require care in a medical institution, but who are appropriately maintained and served in the home setting.

The cost of caring for the child in the community is expected to be less that the estimated cost of providing care in a medical institution. Federal statute requires that the state provide assurances of that. This is accomplished as follows:

* At initial application, it is “assumed” that the estimated cost of caring for the child at home will not exceed the estimated cost of institutional care.
* State DHHS evaluates cost effectiveness:
  + At the end of the first year, or
  + At their discretion.
* State DHHS notifies the TEFRA coordinator if the home care is not cost effective.

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| **Note**  State DHHS will notify the TEFRA coordinator in writing of any decisions affecting the child’s status. If it is determined that care of the child in the home is not cost effective, the TEFRA coordinator will initiate closure of the TEFRA case and determine if eligibility can be established under another payment category. |

[Table of Contents](#_top)

305.06 Financial Eligibility

(Eff. 02/01/06)

To qualify for Medicaid under the TEFRA program, the child must meet established income and resource guidelines.

305.06.01 Income

(Eff. 02/01/06)

Income is the receipt of any assets, payments, or property in a specified period, which the beneficiary may use to meet his basic needs for food or shelter. Such use may be through sale or conversion. Do not count any payments made to the child that do not meet the statutory definition of income.

* Countable income must be equal to or less than the Medicaid Cap (3 times the SSI Federal Benefit Rate) Refer to MPPM 103.07.
* Only the child’s income is considered; parent’s income is not counted
* Count gross income amounts. No deductions apply.

Refer to MPPM Chapter 301 for specific income policy.

305.06.02 Resources

(Eff. 02/01/06)

Resources are generally defined as those assets, including both real and personal property, which an individual or couple owns and can apply, either directly or by sale or conversion, to meet the basic needs of food and shelter.

* The countable resource limit is $2000.
* Only the child’s resources are considered; parent’s resources are not counted.
* Transfer of assets:
  + There is no penalty for transfers of assets for less than fair market value,
  + However, if waivered services are requested, transfer policy does apply.

Countable resources are those remaining after all exclusions have been applied. In determining “countable resources,” apply the same disregards used in determining eligibility for an individual applying for institutional care.

Refer to MPPM Chapter 302 for specific resource policy.

305.07 Denial of Application

(Eff. 04/01/07)

The level of care and the disability determination must be completed before an application can be denied. If an application is denied, all of the reasons for the denial must be included in the notice with a citation of the appropriate MPPM section supporting the denial.

305.08 Continued Financial Eligibility

(Rev. 04/01/07)

A re-determination of financial eligibility must be completed every twelve (12) months. TEFRA cases should be partially reviewed/rebudgeted if changes occur during the 12-month period between re-determinations.

305.09 Right to Appeal

(Rev. 11/01/20)

Any action or decision that affects an applicant’s/beneficiary’s eligibility for Medicaid may be appealed. Refer to MPPM 101.12.11.

305.10 Case Examples

(Rev. 10/01/13)

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| **Example #1**  Chelsea Johnson is 10-years old. She has been a disabled child due to congenital birth defects. Her SSI will be terminated due to her parent’s excess income. They apply for TEFRA. Chelsea has no income. She does have a bank account with a balance of $1200.  **Processing Steps**   * Disability is already established as SSI terminated due to financial reasons. * The TEFRA coordinator:   + Sends a level of care request (DHHS Form 1231 ME) to Community Long Term Care (CLTC)   + Requests the parents to provide:     - Bank statement to verify balance for child’s bank account     - Physician’s statement verifying the appropriateness of in home care, or a completed DHHS Form 3291 ME   + Check IEVS     - Should verify SSI termination     - Check for other verified or lead information regarding income and resources. * Verifications received   + Certification of Intermediate Level of Care from CLTC   + DHHS Form 3291 ME completed and signed by physician certifying in home care is appropriate   + Current bank statement verifying a balance of $1211.00 in a saving account accruing an average quarterly interest of $2.26 * Budgeting – Use the Automated Budget Workbook   + Income – $0 (interest is excluded as income)   + Resources – $1211 |
| **Example #2**  Jamey Haney is 7-years old and has Down Syndrome. He lives with his mother, Debbie. Debbie has an annual salary of $35,000. Jamey’s father, John D Haney, passed away in January, and in March, Jamey began to receive $825 a month survivor’s benefits from Social Security. Jamey has a savings account with $1500. A TEFRA application was filed on June 1 requesting retroactive coverage for March, April, and May.  **Processing Steps**   * On June 2, the TEFRA coordinator:   + Pends case in Cúram-CGIS   + Sends a DHHS Form 1231 checklist to Ms. Haney requesting the following by June 12:     - DHHS Form 3218-D ME packet completed and releases signed     - Bank statements for March, April, May, and current month for Jamey’s saving account     - Verification of Social Security benefits or claim number     - Have Jamey’s physician complete the DHHS Form 3291 ME, or provide a written statement indicating in home care is appropriate.   + Third Party Information     - Data Matching (no hits)     - DHHS Form 1255 ME to check father’s probate records. * On June 10:   + Ms. Haney returns the Disability packet, the bank statements, a DHHS Form 3291 ME, and the SSA claim number.   + The TEFRA coordinator:     - Makes two copies of the disability packet       * Retains one copy for the Case File       * Sends original disability packet to the Disability Determination Unit at State DHHS     - Sends a DHHS Form 1231 ME, attaching the second copy of the disability packet, to CLTC requesting a level of care determination. * CLTC determines Jamey does not meet an Intermediate or Skilled Level of Care * The TEFRA coordinator send the DHHS Form 1231 with the copy of the disability packet to DDSN requesting a determination for level of care * DDSN determines Jamey meets the ICF-ID Level of Care, and sends a level of care approval to the TEFRA coordinator. * The TEFRA coordinator rechecks IEVS, and verifies the SSA amount * Other verifications received:   + ICF-ID Level of Care certification from DDSN   + Disability allowance (received in October) with an onset date of March 1   + DHHS Form 1255 ME from the probate court verifying Ms. Haney was the sole beneficiary of her husband’s will * Budgeting – use DHHS Form 1296-A ME or the Automated Budgeting Workbook:   + Income:     - $825 SSA income for each month     - $825 < Medicaid Cap, therefore income test passed   + Resources     - A Separate determination is made for each month       * March $1236 < $2000       * April $1355 < $2000       * May $1500 < $2000       * June $1586 < $2000 * All eligibility criteria are met, and the Medicaid is approved effective March. |

# **CHAPTER 307—Working Disabled**

[307.01 Introduction 413](#_Toc395517133)

[307.02 Eligibility Criteria 413](#_Toc395517134)

[307.02.01 Categorical Criteria 413](#_Toc395517135)

[307.02.02 Non-Financial Criteria 413](#_Toc395517136)

[307.02.03 Financial Criteria 413](#_Toc395517137)

[307.03 Family Composition 414](#_Toc395517138)

[307.04 Financial Eligibility Determination 414](#_Toc395517139)

[307.04.01 Income 414](#_Toc395517140)

[307.04.02 Resources 415](#_Toc395517141)

[307.05 Application Process 416](#_Toc395517142)

[307.06 Continued Eligibility 417](#_Toc395517143)

[307.06.01 Annual Review 417](#_Toc395517144)

[307.08 Budgeting Examples 418](#_Toc395517145)

307.01 Introduction

(Eff. 10/01/05)

Section 4733 of the Balanced Budget Act of 1997 created an optional coverage group for working disabled individuals with family income below 250% of the Federal Poverty Level (FPL). This provision enabled states to provide the full range of Medicaid services to working disabled individuals with relatively high income. South Carolina adopted this option in its 1998 Appropriations Act. The South Carolina Medicaid program began covering these individuals effective 10/01/98.

307.02 Eligibility Criteria

(Eff. 10/01/05)

To qualify for Medicaid under the Working Disabled category, an individual must meet certain categorical, non-financial, and financial requirements.

307.02.01 Categorical Criteria

(Rev. 01/01/08)

To meet the categorical requirements for this category, the individual must be:

* Under age 65; and
* Disabled, according to a modified Supplemental Security Income (SSI) definition of disability. Disability determination should not consider whether the individual is engaged in Substantial Gainful Activity (SGA).

307.02.02 Non-Financial Criteria

(Rev. 10/01/12)

To qualify for assistance in this category, the individual must meet the following non-financial requirements, as explained in the corresponding chapters.

* Identity MPPM 102.02
* State Residency MPPM 102.03
* Citizenship/Alienage MPPM 102.04
* Enumeration/Social Security Number MPPM 102.05
* Assignment of Rights to Third Party Medical Payments MPPM 102.07
* Applying for and accepting other benefits MPPM 102.08
* Not be an inmate of a public institution MPPM 102.09.01

Additionally, the individual must be working and earning an income.

307.02.03 Financial Criteria

(Rev. 03/01/20)

To qualify for assistance in this category, the individual must meet the following financial requirements: The applicant must:

* Have a net family income at or below 250% of the Federal Poverty Level (Refer to MPPM 103.09);
* Be working and have earned income;
* Have unearned income at or below 100% of the Federal Poverty Level (if receiving any); and
* Have countable resources less than or equal to the limit (Refer to MPPM 103.14).

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| **Note**  If the individual is clearly ineligible due to excess income, it is not necessary to verify disability since the application will be denied. |

307.03 Family Composition

(Eff. 10/01/05)

A “family” is defined as the applicant, his/her spouse and their minor children (natural or adopted).

[Table of Contents](#_top)

307.04 Financial Eligibility Determination

(Eff. 10/01/05)

307.04.01 Income

(Eff. 01/01/24)

The income eligibility determination is a two-step process. The eligibility worker must:

1. Determine if the family’s total net income, after certain deductions, is at or below 250% of the Federal Poverty Level for a family of that size; and
2. Determine if the individual’s unearned income is at or below 100% of the Federal Poverty Level (FPL) for an individual.

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| **Procedure – Financial Eligibility Determination**  **Step 1**   * Determine family composition. * Determine the total income (earned and unearned) of all family members. * Subtract all applicable SSI deductions and exclusions in the following order:   + Income authorized by other Federal laws, such as Agent Orange payments, certain reparations payments, certain payments to Native Americans);   + Earned income tax credit payments;   + Up to $30 per quarter of infrequent or irregular earned income;   + Up to $2,290 per month, but not more than $9,230 in a calendar year, of the earned income of a blind or disabled student child;   + Any portion of the $20 monthly general income exclusion which has not already been excluded;   + $65 of earned income in a month;   + Earned income of disabled individuals used to pay impairment-related work expenses;   + One-half of remaining earned income in a month;   + Earned income of blind individuals used to meet work expenses; and   + Any earned income used to fulfill an approved Plan to Achieve Self-Support. * The RESULT is Countable Earned Income.   (Refer to MPPM Chapter 301 for additional information regarding the treatment of income. Refer to MPPM 301.04.08 for earned income verification procedures on reported income.)   * Compare the family’s total combined countable income against 250% of the Federal Poverty Level for a family of that size. * If the family’s net income is at or below 250% FPL, go to Step 2.   **Step 2**   * Determine the amount of Unearned Income for the Individual. * Subtract $20 from unearned income amount. * If the individual’s unearned income is at or below 100% of the FPL, he/she is income eligible.   **Note**   * Rules for valuing in-kind support and maintenance are not applied. * Each applicant is considered an individual in the second step. * Deeming rules do not apply. |

307.04.02 Resources

(Rev. 03/01/20)

To be eligible for Working Disabled, an individual’s resources must be considered. (Refer to MPPM Chapter 302, Liberal SSI Resource Policy, for general information on what a resource is, liquid vs. non-liquid resources, and resource exclusions.) The applicant/ beneficiary’s countable resources must be less than or equal to the limit. (Refer to MPPM 103.14). The cash value of all life insurance, regardless of face value, is disregarded.

Resources must be verified and documented in the case record.

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

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| **Procedure for Verification:**   * Refer to the resource chapter for acceptable forms of:   + Verification   + Rebuttal evidence * Verify and document any alleged resources.   (**Exception:** Verification is not required for resources that are totally excluded, regardless of value.)   * Verify and document any resources revealed through IEVS checks. * Property checks are not required if ownership is not alleged.   **Note:** The cash value of all life insurance, regardless of face value, is disregarded. |

[Table of Contents](#_top)

307.05 Application Process

(Eff. 10/01/13)

The [DHHS Form 3400](https://www.scdhhs.gov/sites/default/files/Form%203400%20Application.pdf), Healthy Connections Application, and the [DHHS Form 3400-A](https://www.scdhhs.gov/sites/default/files/3400_A_AddendumForSpecialtyPrograms.pdf), Additional Information for Select Medicaid Programs, are used to collect information.

A face-to-face interview is not required; however, if one is conducted, either the applicant or the authorized representative is interviewed. During the interview, the eligibility worker must:

* Ask relevant questions needed to determine eligibility, and
* Share information about the eligibility process to include:
  + Verifications needed and why, and
  + A beneficiary’s Rights and Responsibilities.

If there is no face-to-face interview, the eligibility worker must:

* Ensure all necessary information is gathered by contacting the applicant or authorized representative if:
  + There are any unanswered questions, and/or
  + There are any discrepancies found on the current application and/or any past applications.
* Share information about the eligibility process, to include:
  + Verifications needed and why;
  + A beneficiary’s Rights and Responsibilities; and
  + The Standard of Promptness eligibility determination timeline of 45 days, or 90 days if a disability determination is required.

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| **Procedure**  **Processing Application:**   * Pend case in Cúram-CGIS within 3 working days of receipt. * Ensure all third-party verifications are requested, to include:   + Property search   + Bank forms   + Income requests: such as VA, Railroad, Civil Service * Perform data matching on computer system and follow up on lead/verified information:   + - BENDEX     - SDX     - ESC     - State Retirement * Assess all the verifications provided by the applicant or authorized representative and obtained from third parties, then determine if:   + Any clarification is needed   + There are any discrepancies between the reported and the verified information, if so:     - Contact appropriate party to clarify. * Apply all financial and non-financial policy to the specific situation. * Request clarifications from supervisor or trainer as needed.   **Determination of Eligibility**   * Financial Determination   + Apply all income and resource exclusions.   + Budget countable income and resources.     - Calculate income andresources.     - Apply all appropriate disregards or exclusions to determine countable income and resources.     - Compare countable income and resources to established limits. * Non-Financial Determination   + Ensure that all of the non-financial criteria has been met.     - Categorical (aged, blind, disabled)     - Common non-financial (citizenship, residency, enumeration, identity)   **Note:** If the case is not eligible for some reason, complete an exparte determination.   * Approve or deny application in MEDS. Change to appropriate payment category, if necessary. MEDS generates the approval or denial notice. * Notify other agencies and departments as needed, such as Third-Party Liability (TPL). If the Medicaid beneficiary has health insurance, notify TPL by completing a [DHHS Form 3230 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%203230%20ME.pdf), Third Party Liability Data Collection Form, and forward to:   DHHS  Medical Insurance Verification Services  PO Box 100127  Columbia, SC 29202-3127 |

[Table of Contents](#_top)

307.06 Continued Eligibility

(Eff. 10/01/05)

An annual review is required for continued eligibility for the Working Disabled program. Partial reviews and/or re-budgets are required when a change occurs.

307.06.01 Annual Review

(Rev. 11/01/18)

The steps for the annual review are outlined in the chart below.

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| **Procedure – Annual Review**   1. MEDS generates a review form based on the Date of Next Review. 2. Eligibility Worker Responsibilities:  * Acknowledge the receipt of the review form into MEDS. * Compare the information on the form to the case record history:   + Note any alleged changes or discrepancies;   + Contact the beneficiary or authorized representative to clarify information or request any verification;   + Ensure income and resource verifications are current through such methods as:     - Requesting verification from the beneficiary or authorized representative;     - Obtaining necessary information/verification from third parties through such methods as:   – Sending forms and letters (such as, [DHHS Form 1253 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201253%20ME.pdf), Request for Financial Investigation; [DHHS Form 1255 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201255%20ME.pdf), Verification of Real and Personal Property; [DHHS Form 1280 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201280%20ME.pdf), Verification of Life Insurance Values; [DHHS Form 1212 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201212%20ME.pdf), Request for Verification of Veterans Information; letter to a funeral home; Civil Service.)  – Telephone contact – make sure to document the following: Date of Contact; Company/Business Name; Phone Number; Individual’s Name (and Title, if possible) that provided the verification.  – Online Internet searches such as property search; verification of car values  – Checking all available data matches, such as: IEVS (BENDEX; SDX); State Retirement; ESC Wage Match; Unemployment; CHIP; and Person Composite Service (PCS) Wage Verification   * Once all verifications have been obtained and documented, do budget to determine continual eligibility:   + If continually eligible, update MEDS information – indicate Date of Next Review.   + If ineligible, begin closure actions in MEDS.   + Determine if the individual would be eligible in any other payment category; if so, take appropriate action to change category. |

[Table of Contents](#_top)

307.08 Budgeting Examples

(Rev. 03/01/24)

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| **Example #1**  Tom Hope applies for the Working Disabled program. He works at Cribb’s Sweet Shop earning $300 per week and receives a Social Security Disability check of $1,050. His wife, Alice, earns $225 per week babysitting. They have two children who each receive $75 per month in Social Security.  **Step 1 Family Income**  Unearned Income: $1,050 + $75 + $75 = $1,200  Less Deductions: $1,200 – $50 (general income disregard) = $1,150  Earned Income:  TOM’s ALICE’s  $300 x 52 = $15,600 $225 x 52 = $11,700  $15,600 ÷ 12 = $1,300 $11,700 ÷ 12 = $975    Total Earned Income: $1,300 + $975 = $2,275  Less Deductions: $2,275 - $65 (earned income disregard) = $2,210  Countable Earned Income: $2,210 ÷ 2 = $1,105  Total Countable Income: $1,150 + $1,105 = $2,255  250% FPL for HH of (4): $6,500  $2,255 < $6,500, so proceed to Step 2.  **Step 2 Individual Unearned Income**  Tom’s countable unearned income of $1,000 is less than the 100% FPL for one, so Tom is eligible for the Working Disabled program.  Tom’s Unearned Income $1,050 - $50 (general income disregard) = $1,000  $1,000 < $1,255 |
| **Example #2**  Sally Jones applied for Medicaid under the Working Disabled program. She is working at Piggly Wiggly earning $350 per week. She also receives a Social Security Disability check of $1,600 dollars per month. Her 10-year-old daughter receives a Social Security check of $150 per month.  **Step 1 Family Income**  Unearned Income: $1,600 + $150 = $1,750  Less Deductions: $1,750 - $50 (general income disregard) = $1,700  Earned Income: $350 x 52 = $18,200  Total Earned Income: $18,200 ÷ 12 = $1,516.66  Less Deductions: $1,516.66 – $65 (earned income disregard) = $1,451.66  Countable Earned Income: $1,451.66 ÷ 2 = $725.83  Total Countable Income: $1,700 + $725.83 = $2,425.83  250% FPL for HH of (2): $5,380  $2,425.83< $5,380.00, so proceed to Step 2.  **Step 2 Individual Unearned Income**  Sally’s countable unearned income of $1,550 is greater than the 100% FPL for one, so she is not eligible for the Working Disabled program.  Sally’s Unearned Income $1,600 - $50 (general income disregard) = $1,550  $1,550 > $1,255 |
| **Example #3**  Lynn White earns $5,000 per month. Her husband, Marty, earns $4,000 per month and receives Social Security Disability of $1,000. Their son, Dillon, receives $350 in SSA.  **Step 1 Family Income**  Unearned Income: $1,000 + $350 = $1,350  Less Deductions: $1,350 - $50 (general income disregard) = $1,300  Earned Income: $5,000 + $4,000 = $9,000  Less Deductions: $9,000 - $65 (earned income disregard) = $8,935  Countable Earned Income: $8,935 ÷ 2 = $4,467.50  Total Countable Income: $1,300 + $4,467.50 = $5,767.50  250% FPL for HH of (3): $5,380  $5,767.50 > $5,380.00, so do not proceed to Step 2.  Mr. White does not qualify financially for the Working Disabled program. |

# **CHAPTER 308—Qualified Disabled and Working Individual (QDWI)**

[**308.01** **Introduction 417**](#_Toc395517244)

[**308.02** **Eligibility Criteria 417**](#_Toc395517245)

[**308.03** **Eligibility Determination 417**](#_Toc395517246)

[**308.04** **Application Process 417**](#_Toc395517247)

**308.01 Introduction**

(Eff. 12/01/05)

Section 6408 of the Omnibus Budget Reconciliation Act of 1989 requires state Medicaid programs to pay the Medicare Part A premiums for persons who meet certain criteria. The provision became effective July 1, 1990. These individuals would be eligible only for payment of their Part A premium and no other Medicaid benefits. These individuals are called Qualified Disabled and Working Individuals (QDWI’s).

**308.02 Eligibility Criteria**

(Rev. 04/01/10, Eff. 01/01/10)

To be eligible, an individual must meet the following criteria:

* Be disabled (that is, must have been entitled to disability insurance benefits under Title II);
* Be less than 65 years of age;
* Have been terminated from Medicare solely because earnings exceeded the substantial gainful activity amount as used in the Social Security disability determination process;
* Have income at or below 200% of the federal poverty level;
* His/her countable resources are below $4,000 for an individual and $6,000 for a couple; and
* Not be otherwise eligible for Medicaid; and
* Continue to have a disabling physical or mental condition.

**308.03 Eligibility Determination**

(Eff. 12/01/05)

The Social Security Administration (SSA) will determine disability and decide if an applicant/beneficiary qualifies for Qualified Disabled Working Individual (QDWI) status. Persons who have lost or are losing their Medicare benefits due to their income exceeding the SGA amount, and who wish to apply for Medicaid as a QDWI, must first apply for Part A coverage through the SSA. Application must be made during the initial enrollment period, which will be identified in the notice sent from SSA. If application is not made during the specified time frame, the applicant/beneficiary must wait until the general enrollment period, which is January through March, of the following year to apply.

If the applicant/beneficiary is accepted as a Part A enrollee, the SSA will do a cursory review of his/her income and resources and, if deemed appropriate, make a referral to the Department of Health and Human Services for a determination of Medicaid eligibility as a QDWI.

**308.04 Application Process**

(Eff. 10/01/10)

Financial eligibility for QDWI is determined based on income being at or below 200% of the Federal Poverty Level for the individual. Non-financial requirements for eligibility must also be met (such as, furnishing of or application for a Social Security number, citizenship, residency and assignment of rights to medical support. Refer to MPPM Section 102.01.)

The effective date of benefits under this coverage group is based on the date of application and the date on which all eligibility criteria are satisfied.

Eligibility as a QDWI may terminate because the applicant/beneficiary no longer meets any eligibility factor. These include termination because Medicare Part A benefits have been reinstated as an entitlement, countable income exceeds 200% of poverty; countable resources exceed $4,000 for an individual or $6,000 for a couple; applicant/beneficiary moves out of state or becomes eligible under another coverage group.

A State Verification and Exchange System (SVES) match must be completed on each QDWI applicant/beneficiary.

**Individuals determined eligible, as a QDWI are not eligible for the full range of Medicaid benefits. These individuals are only eligible for Medicaid to pay their Medicare Part A premium. A Medicaid card will not be issued.**