102.01 INTRODUCTION

This chapter discusses non-financial criteria which must be met in order for an individual to qualify in the Aged, Blind and Disabled (ABD) or Families, Children and CHIP (FCC) programs and the acceptable methods and procedures which may be used to establish eligibility.

In each section, policy or procedures which are specific to one program or the other are discussed separately under a heading for that program.

102.01.01 VERIFICATION OF NON-FINANCIAL REQUIREMENTS

Verification other than client statement is required to document non-financial factors such as citizenship, alien status or proof of enumeration when a Social Security Number has not been assigned. However, for those eligibility factors which may be verified by self-declaration or client statement, no additional verification is necessary unless information provided by self-declaration is confusing or contradictory to other information available to the regional office and documented in the record.

Information is considered questionable and subject to additional verification when:

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

102.02 IDENTITY

The identity of all applicants must be verified. When the person filing the application is not also an applicant, such as a non-applicant head of household or representative, efforts must be made to verify his identity.

The specific identify verification requirements for applicants, non-applicant heads of household and authorized representatives are discussed in Section 102.04.02.

102.03 STATE RESIDENCY

Medicaid must be available to eligible residents of the state. A resident is someone who voluntarily lives in Mississippi with the intention to remain permanently or for an indefinite period of time, or someone living in Mississippi, having entered with a job commitment or for the purpose of seeking employment, whether or not the individual is currently employed.

102.03.01 RESIDENCY REQUIREMENTS

The individual must live in Mississippi and meet all other eligibility requirements in order to receive Medicaid benefits. A spouse and children living in the same household with the individual are also considered MS residents.

No Permanent MS Address

An individual, including someone with no permanent address, is a resident of MS if he lives in the state and is capable of stating and does state intent to remain here permanently or for an indefinite period of time. Indefinite indicates the individual does not have a date in mind when he will no longer be a resident of the state.

Residing in Another State

An individual who claims to be a resident of MS, but is residing in another state, must show an established address or place of residence in MS before he can be considered temporarily absent from MS for Medicaid purposes.

Incapable of Stating Intent

An individual who is incapable of stating intent to reside is a resident of the state in which he is physically located. No statement of intent is needed. Refer to Section 102.03.07.

Stating Intent to Reside

A person is considered capable of stating intent to reside unless he has an IQ of 49 or less or has a mental age of seven or less based on tests acceptable to the Department of Education; or is judged legally incompetent; or is found incapable of indicating intent based on medical documentation obtained from a physician, psychologist or other individual licensed by the state in the field of mental retardation.

102.03.02 SPECIFIC RESIDENCY PROHIBITIONS

An individual cannot be denied Medicaid based on residency for the following reasons:

- The individual has not resided in MS for a specified period of time. There is no durational requirement for residency.
- The individual is temporarily absent from MS and intends to return when the purpose of the absence has been accomplished. However, if another state has accepted him as a resident for Medicaid purposes, the individual cannot be considered a MS resident.

102.03.03 TEMPORARY ABSENCE FROM THE STATE

The recipient is responsible for reporting a temporary absence from Mississippi and for giving information on his purpose, plans and dates of departure and return. The recipient's eligibility must be reviewed every three (3) months to determine the recipient's continued intent to reside in MS.

No limit is place on the length of the out-of-state visit.; however, if it is determined that an individual has left the state with no declared intention to return, the individual will be deemed to have given up MS residency and his eligibility will be terminated. Refer to 102.03.10 for further discussion.

102.03.04 INDIVIDUALS RECEIVING A STATE SUPPLEMENTARY PAYMENT

An individual receiving a state supplementary payment (optional or mandatory), such as state adoption assistance or state foster care payment, is a resident of the state making the supplementary payment. However, if the state making the payment is a member of the Interstate Compact on Adoption and Medical Assistance (ICAMA) and an agreement is in effect, the child is a resident of the state in which he is living.

Mississippi is a member of ICAMA; however, Medicaid eligibility through the Mississippi Department of Human Services (MDHS) is not automatic. The placing state must coordinate with MDHS to authorize Medicaid eligibility through an ICAMA agreement for the child to be covered through MDHS.

If the family files an application for the child with the regional office, supplementary payments made by another state must be counted as income. In addition, parental income must be included along with the income of any siblings included in the application, if applicable.

102.03.05 INDIVIDUALS RECEIVING A TITLE IV-E PAYMENT

An individual, who is receiving a Title IV-E foster care or adoption assistance payment, is a resident of the state in which the child is currently residing.

When a child receiving a Title IV-E payment moves to MS from another state, Medicaid eligibility is possible through the Mississippi Department of Human Services (MDHS); however, it is not automatic. The placing state must coordinate with MDHS for Medicaid eligibility through the foster care or adoption assistance programs to be authorized by MDHS.

If the family files an application for the child with the regional office, parental income must be included along with the income of any siblings included in the application, if applicable. Title IV-E foster care and adoption assistance payments are federal payments which are disregarded income in determining Medicaid and CHIP eligibility.

102.03.06 DETERMINATION OF RESIDENCY (UNDER AGE 21)

Use the instructions in this section to determine residency for persons under age 21:

Not in an Institution or Under Parental Care and Control

If a non-institutionalized individual under age 21 is emancipated from his/her parents or is married and capable of stating intent, the state of residence is where the individual is living with the intent to remain permanently or for an indefinite period.

Blind or Disabled Not in an Institution

An individual, under age 21 and in a private living arrangement, whose eligibility is based on blindness or disability, is a resident of the state where the individual is actually living.

Others Under 21 Not Living in an Institution

The state of residence is the state in which the parent(s) resides if the individual is still considered a minor.

Under 21, In an Institution and Under Parental Care and Control

The state of residence is:

- The parent's state of residence at the time of placement; however, if a legal guardian has been appointed and parental rights have been terminated, the state of residence of the legal guardian is used instead of the parents; or.
- The current state of residence of the parent who files the application, if the individual is residing in an institution in that state. However, if a legal guardian has been appointed and parental rights have been terminated, the state of residence of the guardian is used instead of the parents; or
- The state of residence of the individual or party that files an application if the individual:

    (1) Has been abandoned by his parent(s),

    (2) Does not have a legal guardian and

    (3) Is residing in an institution in that state.

102.03.07 DETERMINATION OF RESIDENCY (AGE 21AND OLDER)

Use the instructions in this section to determine residency for individuals age 21 and older.

Not in an Institution

The state of residence is where the individual is living with the intent to remain there permanently or for an indefinite period, or the state where the individual is living because the individual had a job commitment or is seeking employment, either currently employed or not. If the individual is incapable of stating intent, the state of residence is where the individual is living.

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

The state of residence is:

- The state of residence of the parent who is applying for Medicaid on the individual's behalf. If a legal guardian has been appointed and parental rights have been terminated, the state of residence of the legal guardian is used instead of the parent.
- The state of residence of the parent at the time of placement. If a legal guardian has been appointed and parental rights have been terminated, the state of residence of the guardian is used instead of the parents.
- The current state of residence of the parent or legal guardian who files the application, if the individual is residing in an institution in that state. If a legal guardian has been appointed and parental rights have been terminated, the state of residence of the guardian is used instead of the parents.
- The state of residence of the individual or party that files an application if the individual:

    (1) has been abandoned by his parent(s),

    (2) does not have a legal guardian and

    (3) is residing in an institution in that state.

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

The state of residence is where the individual is physically present, except in instances where another state made the placement.

Any Other Individual in an Institution

The state of residence is where the individual is living permanently or for an indefinite period of time.

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

102.03.08 STATE PLACEMENT IN AN OUT-OF-STATE INSTITUTION

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

The following actions are not considered state placement:

- Providing basic information to individuals about another state's Medicaid program and information about healthcare services and facilities in another state or
- Providing information regarding institutions in another state if the individual is capable of indicating intent and decides to move.

102.03.09 OUT-OF-STATE PLACEMENTS

There are two circumstances under which Mississippi will pay for placement in an out-of-state nursing facility.

(1) If the agency has a part in the placement or otherwise approves or authorizes an out-of-state placement, regional offices will be notified on an individual case basis.

(2) When a MS resident moves to a nursing facility in another state, only the partial month of the move can be paid if the facility enrolls as a MS provider. The individual is considered a resident of the new state effective with the first full month of residence and has to qualify for Medicaid eligibility and vendor payment in the new state.

OUT-OF-STATE PLACEMENTS (Continued)

If an individual moves to Mississippi, he would apply for benefits here and meet all eligibility requirements. If he is transferred directly from one medical facility to another, the time spent in the out-of-state facility can be used to meet the 30 consecutive day requirement.

102.03.10 RESIDENCY ISSUES

Termination of Benefits in the Former State of Residence

An individual coming to MS from another state may be considered a resident of MS in the month of the move, provided the individual intends to reside in MS. However, individuals are not entitled to duplication of Medicaid services from both the former state and Mississippi. When a Medicaid recipient moves from one state to another, the former state initiates the change effective the first month in which it can administratively terminate the case in accordance with timely and adequate notice regulations.

Request for MS Medicaid Prior to Termination in Former State

There will be occasions when a recipient requests that eligibility in Mississippi begin prior to the effective date of closure in the former state. Neither state can deny coverage because of administrative requirements or time constraints needed to take action to terminate benefits in the former state.

However, when an individual is no longer a resident of a state, that state is not required to pay for any services incurred in Mississippi. If the former state will pay out of state claims, Mississippi cannot approve eligibility until the former state has terminated services. If the former state will not pay out of state claims, duplication of services is not an issue and Medicaid eligibility in Mississippi can potentially begin with the month of the move.

102.03.11 OUT-OF-STATE RECIPIENT MOVING TO MS

If an applicant who was receiving Medicaid in another state before moving to MS does not have verification of termination of benefits in the other state, the Medicaid Specialist is responsible for contacting the previous state to:

- Notify the state of the individual's move to MS;
- Request that eligibility in the other state be terminated so eligibility for MS Medicaid can be determined; and
- Follow up with the out-of-state agency until a response is received.

The Medicaid Specialist will include any letters/documents or telephone contact information with the out-of-state agency in the case record to verify the eligibility status of the applicant.

MS Coverage Requested Prior to Effective Date of Closure in Other State

When the individual requests coverage in MS prior to the effective date of closure in the former state, the Medicaid Specialist must determine if the other state will pay out of state claims. If the former state will **not** pay out-of-state claims, MS Medicaid benefits can be authorized beginning with the month of the move, if the applicant is otherwise eligible.

If the former state **will** pay out of state claims, MS Medicaid will not be authorized even if a MS provider refuses to file the client's claims with the other state. If the former state will pay for partial months or any subsequent months for nursing home recipients, eligibility for MS Medicaid cannot begin until the former state specifies their payment(s) will stop.

The case record must be documented to support the action taken.

NOTE: When two or more states cannot agree on residence, the state where the individual is physically located is his residence. Coordination efforts should ensure that an eligible person does not experience a discontinuation of benefits.

102.03.12 MS RECIPIENT MOVING TO ANOTHER STATE

A Mississippi recipient who moves to another state with the intent to remain is no longer eligible to receive benefits from MS. Changes in residency may be received from the recipient, head of household, authorized representative, out-of-state agencies, post office, providers and other community sources.

The type of action needed in response to the report depends in large part upon the source of the information. Follow the procedures below to take action on the change.

Procedures When a Mississippi Recipient has Moved from the State

- Change Reported by Recipient or Representative

When the loss of residency is reported by the recipient, the head of household, responsible adult or authorized representative, the information is verified.

- Change Reported by Out of State Agency

When an out-of-state agency reports a MS recipient has applied for benefits in that state, loss of MS residency is verified.

- Taking Action on Verified Change

The specialist will document the contact and obtain the new address. When multiple family members are involved, the specialist must determine whether all members have left the state. Action will be taken to terminate the eligibility of the recipients who are no longer state residents.

  - The closure notice will be sent to the primary person for the case at the appropriate address.
  - A child who remains in MS has continuous eligibility and will not be terminated when he moves from one household to another within the state.
  - If an adult recipient continues to reside in MS, a review may be needed to determine the adult's continued eligibility apart from the non-resident spouse and/or children.

Procedures When a Mississippi Recipient has Moved from the State (Continued)

- <u>Unverified Change Reported by Other Sources</u>

When loss of residency is reported by other sources, the specialist must first verify the accuracy of the information prior to taking action on the case:

- Attempt a telephone contact using the telephone number in the case record to verify the information received.
- If telephone contact cannot be made, send a 307 to the address on file in the record and to the out-of-state address, if one is known.
- If it is subsequently verified some or all recipients have moved from the state, take action to terminate eligibility for the appropriate individuals and send the termination notice to the primary person for the case at the appropriate address.
  - A child who remains in MS has continuous eligibility and will not be terminated when he moves from one household to another within the state.
  - If an adult recipient continues to reside in MS, a review may be needed to determine the adult's continued eligibility apart from the non-resident spouse and/or children
- If there is no response to the 307 and the information cannot be verified or reasonable attempts to locate the household have failed, take action to close the case.
  - The closure notice should be sent to the primary person for the case at the in-state address and the out-of-state address, if one is known.

102.03.13 <u>MIGRANT/SEASONAL FARM WORKERS</u>

An individual involved in work of a transient nature or someone who goes to another state seeking employment as a migrant or seasonal worker can choose to either:

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

102.03.14 HOMELESS INDIVIDUALS

If otherwise eligible, a person who is homeless or who frequently moves from one address to another can qualify for Medicaid. Medicaid cards must be available to individuals with no fixed home or mailing address.

Medicaid cards for homeless individuals can be mailed to a specific shelter, facility or the Regional Medicaid Office based upon the mutual agreement of the parties. The recipient should be advised of the time and place the card will be available.

102.03.15 VERIFICATION OF STATE RESIDENCY

State residency is generally verified by self-declaration. Only if the self-declaration is questionable, should documents such as those listed below be used to verify residency (Refer to 102.01.01):

- Current driver's license
- State ID card
- Mortgage or rent receipts
- Utility bills
- Employer's statement

102.04 UNITED STATES CITIZENS

An eligible individual must either be a citizen of the United States or a qualified alien, discussed in Section 102.05. Most United States citizens are natural-born citizens, meaning they were born in the United States or were born to United States citizens overseas.

Individuals born in the United States, which includes the 50 states, the District of Columbia, Puerto Rico, Guam, the U. S. Virgin Islands, the Northern Marinara Islands and the Panama Canal Zone before it was returned to Panama, are U. S. citizens at birth (unless born to foreign diplomatic staff), regardless of the citizenship or nationality of the parents. Nationals from American Samoa or Swain's Island are citizens for Medicaid purposes.

Child Citizenship Act of 2000

The Child Citizenship Act of 2000, enacted February 21, 2001, amended the Immigration and Naturalization Act to provide automatic acquisition of U. S. citizenship by operation of law to certain foreign born children, including orphans with a full and final adoption by U. S. citizens, either abroad or in the U. S., and the biological or legitimated children of U. S. citizens. Prior to the implementation of this act, these children had to go through the naturalization process to become citizens.

Procedures to Verify Citizenship under the Child Citizenship Act of 2000

The child will automatically acquire U. S. citizenship on the date that all of the following requirements are met:

(1) The child must have at least one natural or adoptive parent who is a U. S. citizen by birth or naturalization; and

(2) The child must be under 18 years of age; and

(3)The child must currently permanently reside in the United States in the legal and physical custody of citizen parents; and

(4)The child must be admitted to the U. S. as a lawful permanent resident or acquire this status through readjustment of status; and

(5) If adopted, child meets the requirements applicable to adopted children under immigration law as discussed below.

IR-3 Status – Citizen Upon Entry

When the child's adoption was finalized abroad and both parents met the child before or during the foreign adoption proceeding, an Immediate Relative IR-3 entry Visa is issued. A child entering as IR-3 child will be issued a Certificate of Citizenship within 45 days of entry into the United States. A Permanent Resident Alien card is not issued to an IR-3 child since the child is a citizen upon entry. The child's parents do not have to apply separately for the Certificate of Citizenship.

IR-4 Status- Permanent Resident Alien

A status of IR-4 is assigned when the child's adoption was either not finalized abroad or both adopting parents did not meet the child before or during the foreign adoption proceeding. A Permanent Resident Alien card is issued to a child in IR-4 status upon entry. When the adoption or re-adoption, if required, in the U. S. is final, the parents do have to apply for a Certificate of Citizenship.

102.04.01 CITIZENSHIP

The Deficit Reduction Act (DRA) of 2005 amended the citizenship verification rules for applications and reviews on and after July 1, 2006, requiring documentary evidence of citizenship for individuals declaring to be U. S. citizens or nationals of the United States.

Requirement for Original or Certified Documents

The documents used to verify citizenship must be originals or copies certified by the issuing agency. Uncertified copies, including notarized copies, are unacceptable. Copies of original documents must be retained in the case record as a permanent part of the case record for audit and review purposes. The record copy should be noted "Original Document Viewed" and initialed and dated by the supervisor or Medicaid Specialist who viewed the original.

Return of Original Documents

Original documents can usually be returned immediately. However, documents received in the mail or at out-stationed sites, which cannot be returned to the applicant/recipient the same day, must be mailed back to the individual within two working days. Extreme care must be taken to ensure these important personal documents are not lost, misplaced or misrouted.

One-Time Verification Requirement

Documentation of citizenship is generally a one-time requirement. The individual is not required to provide verification again unless (1) there is a valid reason to question the accuracy of the initial determination or (2) a reapplication is filed after the record retention period and the case has been destroyed. Certain applicants and beneficiaries are exempt from verification of citizenship and identity. Refer to Section 102.04.04.

102.04.02 IDENTITY

The identity of the responsible person filing the application must be verified. If this person is also an applicant, identity will be verified according to verification procedures for applicants discussed later in this section and in Section 102.04.06.

Identity Verification for Non-Applicants

However, if the responsible person is a non-applicant parent, relative, non-relative or an authorized representative filing the application on behalf of others, the identity of the non-applicant must be verified by either (1) picture identification, or (2) two different forms of non-picture identification, including such documents as EBT, WIC or other benefit cards or notices, credit or bank cards, employment badges, check stubs or other wage verification, insurance cards, etc., or (3) personal knowledge of a Medicaid staff member. Non-applicants must not be asked to provide any document which discloses their own citizenship, immigration status or Social Security Number (SSN); however, such documents may be provided voluntarily.

Good Cause Determination for Non-Applicants

If the regional office determines a non-applicant head of household or authorized representative cannot meet the identity verification requirement, the regional bureau director will review case circumstances and make a good cause determination. If good cause exists, the director can decide to (1) accept one form of non-picture ID when the individual can present only one or (2) waive the requirement altogether. An applicant's eligibility cannot be adversely affected when a non-applicant is unable or refuses to verify their own identity.

The Deficit Reduction Act (DRA) of 2005 amended the verification rules for applicants and beneficiaries for applications and reviews on and after July 1, 2006.

Requirement for Original or Certified Documents

To establish identity, applicants must provide original documents or copies certified by the issuing agency. Other copies, including faxed or notarized copies of documents, are unacceptable. Like the documents used to verify citizenship, copies of the original identity documents must be certified by the supervisor or Medicaid Specialist who viewed them and retained as a permanent part of the case record for review and audit purposes.

Return of Original Documents

Most of the time original documents can be returned immediately. However, documents received in the mail or at out-stationed sites, which cannot be returned to the applicant/recipient the same day, must be mailed back to the individual within two working days. Extreme care must be taken to ensure these important personal documents are not lost, misplaced or misrouted. The case must be documented confirming the documents were returned and the date and method of return.

One Time Verification Requirement

Documentation of identity is generally a one-time requirement. The individual is not required to provide verification again unless (1) there is a valid reason to question the accuracy of the initial determination or (2) a reapplication is filed after the record retention period and the case has been destroyed or (3) an individual, whose identity was verified by affidavit as a child, moves as a child to another household or becomes eligible as an adult in his/her own case or in a spouse's case. Refer to Section 102.04.04 for persons exempt from citizenship and identity verification requirements.

102.04.03 VERIFICATION OF CITIZENSHIP AND IDENTITY

The verification requirements found in this section pertain only to applicants declaring to be U. S. citizens. Aliens applying for Emergency Medicaid services only are not required to provide information about citizenship, immigration status or Social Security Number and should not be asked to do so. Refer to Section 102.05 for handling applicants who are qualified or non-qualified aliens.

Hierarchy of Evidences

The evidences of citizenship are divided into a hierarchy of primary, secondary, third level and fourth level documents. Primary evidence has the highest reliability and conclusively establishes both a person's citizenship and identity. When the individual has secondary, third or fourth level documentation of citizenship, additional verification must be provided to establish identity. The evidences of identity are not prioritized.

Available Documents

The highest level of verification must be used if it is available. "Available" means the document exists and can be obtained within the time period allowed for providing information, i.e., 30, 45 and 90 days based on application type. Therefore, when a higher level document is not available, it is permissible to use a lower level document.
For example, a U. S. Passport is primary evidence of citizenship and identity. If the individual possesses a passport, it must be provided. However, if the individual does not already have a passport, the document is generally considered unavailable due to the time required to process a passport application so the individual can meet verification requirements by providing a lower level document, such as a birth certificate, secondary evidence of citizenship, and a driver's license or other picture identification to verify identity.

Economic Hardship

It is generally the individual's responsibility to provide required documents and pay associated fees to obtain them. However, when individuals are economically disadvantaged and unable to pay fees associated with obtaining necessary documents, lower level evidences of citizenship and identity will be accepted.

Reasonable Opportunity

Applicants must be provided a reasonable opportunity to provide verification of citizenship and identity. When verification of citizenship and identity is needed, the Medicaid Specialist will issue the required written request for the information. If an applicant subsequently requests additional time, an extension may be granted when the individual is making a good faith effort to obtain the information and timely processing standards for the application can still be met. An application cannot be approved if required citizenship and identity verification has not been provided. Beneficiaries must also be given a reasonable opportunity to provide documentary evidence of citizenship and identity. When verification of citizenship and identity is needed at review, the Medicaid Specialist will issue the required written request for the information.

Reasonable Opportunity (Continued)

If the recipient subsequently requests additional time, an extension may be granted when the individual is making a good faith effort to obtain the information and timely processing standards for the review can still be met. When an extension is granted, eligibility can continue if the beneficiary has met all eligibility requirements except verification of citizenship and/or identity.

Providing Assistance

When an applicant or beneficiary, who is homeless, an amnesia victim, mentally impaired or physically incapacitated and lacks someone to act for them, does not have the required verifications, the Medicaid Specialist must assist the individual to document U.S. citizenship and/or identity.

In addition, staff must attempt to contact and provide assistance to any applicant or recipient who is known to be deaf, hard of hearing, blind, mentally or visually impaired, physically incapacitated or otherwise disabled, illiterate, limited English proficient, homeless and/or requires communication assistance with reading agency notices and other written correspondence prior to denying or terminating their case.

The case record must be documented with all efforts taken by specialists to provide assistance to individuals with special needs, conditions and/or barriers. Eligibility will not be denied or terminated until all avenues of verification have been exhausted.
However, when the individual has been given a reasonable opportunity to provide the information and all avenues of assistance have been exhausted and documented by the specialist, eligibility must be denied or terminated if needed information is not provided.

102.04.04 EXEMPTIONS FROM REQUIREMENTS

Individuals declaring to be U. S. citizens are exempt from citizenship and identity documentation requirements if they are in one of the following categories:

- **Medicare recipients** entitled to, or enrolled in, Medicare Part A or B under any claim number are exempt from the verification requirements. A copy of the Medicare card should be requested and a copy retained in the case record. However, if the individual cannot provide the Medicare card, agency verification of enrollment in Medicare may be used, if it is available.

EXEMPTIONS FROM REQUIREMENTS (Continued)

- **Individuals receiving Social Security benefits under "A" claim number** based on their own disability are exempt from the verification requirements. The individual must be a current recipient of Social Security Disability. Prior receipt of disability does not qualify an individual for this exemption. In addition, this exemption does not apply to individuals receiving early retirement or to dependents drawing off of the disabled individual's record**.**

- **Individuals receiving SSI benefits** are exempt. The individual must be a current SSI recipient. Prior receipt of SSI does not qualify a person for this exemption. Former SSI recipients applying for Medicaid must provide evidence of citizenship and identity. However, current SSI recipients applying only for retroactive coverage are exempt.

- **Children in receipt of Title IV-B services or Title IV-E Adoption Assistance or foster care payments** are exempt. Medicaid eligibility determinations for children in this category are made by the Department of Human Services.

- **Deemed eligible children** are exempt from citizenship and identity verification requirements until the end of the deemed year. All eligibility factors, including documentation of citizenship and identity, must be met for eligibility to continue beyond the first year.

102.04.05 EVIDENCES OF U. S. CITIZENSHIP

Primary evidence has the highest reliability. Therefore, when the applicant or beneficiary presents any of the following primary documents: current or expired U. S. passport (without limitation), Certificate of Naturalization or a Certificate of Citizenship, the requirements for both citizenship and identity have been met and no further verification is needed. If any other level of evidence is used to verify U. S. citizenship, a second document verifying identity must be obtained. The following documents may be accepted as primary proof of an individual's citizenship and identity.

Primary Documents	Explanation
U. S. Passport	A U. S. passport does not have to be currently valid to be accepted as evidence of U. S. citizenship as long as it was originally issued without limitation. On an emergency basis, the passport office will issue a U. S. passport without proof of citizenship. In this instance, the passport is issued with the limitation that it is valid for one year rather than the usual 5 or 10 years. When the holder of a passport with limitations returns to the country, he has to provide proof of citizenship to have the passport reissued without limitation. To determine if a passport was issued with limitation, compare the issuance date with the expiration date. If the expiration date is less than five years from the issuance date, the passport was issued with limitation and cannot be used as proof of citizenship. Each passport presented must be examined closely to determine whether or not the passport was issued with limitation. Spouses and children were sometimes included on one passport through 1980. U. S. passports issued after 1980 show only one person. Consequently, the citizenship and identity of the included person can be established when one of these passports is presented. NOTE: Do not accept any passport as evidence of U. S. citizenship when it was issued with a limitation. However, such a passport may be used as proof of identity.
Certificate of Naturalization (N-550 or N-570)	Issued by Department of Homeland Security (DHS) for Naturalization.
Certificate of Citizenship (N-560 or N-561)	Issued By DHS to individuals who derive citizenship through a parent.

Secondary evidence of citizenship is documentary evidence of satisfactory reliability that is used when primary evidence of citizenship is not available within the reasonable opportunity period. In addition, a second document establishing identity must be presented.

Secondary Documents	Explanation
A U.S. public birth record showing birth in one of the following: • One of the 50 U.S. States; • District of Columbia; • American Samoa • Swain's Island • Puerto Rico (if born on or after January 13, 1941); • Virgin Islands of the U.S. (on or after January 17, 1917); • Northern Mariana Islands (after November 4, 1986 (NMI local time); • Guam (on or after April 10, 1899)	A birth certificate may be issued by the State, Commonwealth, territory, or local jurisdiction. The birth record must have been recorded before the person was 5 years of age. A delayed birth record document recorded after 5 years of age is considered fourth level evidence of citizenship. ***NOTE: If the document shows the individual was born in Puerto Rico, the Virgin Islands of the U.S. or the Northern Marinara Islands before these areas became part of the U.S. the individual may be a collectively naturalized citizen. Collective naturalization occurred on certain dates listed for each of the territories. Refer to the Citizenship Addendum at the end for information on collective naturalization.
Verification through SAVE for a Naturalized Citizen	Verification through the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) database to verify U. S. citizenship for a naturalized citizen when original naturalization papers are not available.
Eligible under the Child Citizenship Act of 2000	When a child derives U. S. citizenship from a parent and meets the requirements of the Child Citizenship Act of 2000, establish (1) the parent's U. S. citizenship and (2) the child's legal immigration status, if applicable, through SAVE to verify the child's citizenship. Primary verification through a Certificate of Citizenship should be available if child was issued a Visa rather than a Permanent Resident Alien card upon entry into the country.

Secondary Documents	Explanation
Certification of Report of Birth Abroad (FS-1350)	The Department of State issues a DS-1350 to U. S. citizens who were born outside the U. S. and acquired citizenship at birth, as verified by the information recorded on the FS-240, Consular Report of Birth Abroad. When the birth was recorded on the FS-240, certified copies of the Certification of Report of Birth Abroad can be obtained from the Department of State. The DS-1350 contains the same information as recorded on the current version of the Consular Report of Birth, FS-240. The DS-1350 is not issued overseas and can be obtained from the Department of State in Washington DC.
Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240)	The Department of State consular office prepares and issues this document. A Consular Report of Birth can only be prepared at an American consular office overseas while the child is under the age of 18. While original FS-240's are not issued within the U.S, lost or mutilated documents can be replaced through the Department of State in Washington DC. Children born to military personnel are usually issued an FS-240.
Certification of Birth Abroad (FS-545)	Before November 1, 1990, the Department of State consulates also issued Form FS-545 along with the prior version of the FS-240. In 1990, U.S. consulates ceased to issue Form FS-545. Treat an FS-545 the same as a DS-1350.
U. S Citizen ID Card (I-197) or prior version I-179	The former Immigration and Naturalization Service (INS) issued the I-179 from 1960 until 1973. It revised the form and renumbered it as form I-197. INS issued the I-197 from 1973 until April 7, 1983. INS issued Form I-179 and I-197 to naturalized U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossings. Although neither form is currently issued, either form that was previously issued is still valid.
American Indian Card (I-872) and Documents Issued by a Federally-Recognized Indian Tribe	DHS issues an American Indian Card to identify a member of the Texas Band of Kickapoos. A classification code "KIC" and a statement on the back denote U.S. citizenship. In addition, tribal enrollment or certificate of degree of Indian blood documents meet the citizenship requirement.
Northern Mariana Card (I-873)	INS issued the I-873 to a collectively naturalized citizen of the U.S. who was born in the NMI before November 4, 1986. The card is no longer issued, but those previously issued are still valid.
Final adoption decree	The adoption decree must show the child's name and U.S. place of birth. In situations where an adoption is not finalized **and** the State in which the child was born will **not** release a birth certificate prior to final adoption, a statement from a State-approved adoption agency that shows the child's name and U.S. place of birth is acceptable. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.

Secondary Documents	Explanation
Evidence of civil service employment by the U.S. government	The document must show employment by the U.S. government before June 1, 1976.
Official military record of service	The document must show a U.S, place of birth (for example a DD-214 or similar official document showing a U.S. place of birth).

Third level evidence of citizenship is documentary evidence of satisfactory reliability that is used when primary or secondary evidence of citizenship is not available. Third level evidence may only be used when primary and secondary evidence does not exist or cannot be obtained and the applicant/beneficiary alleges being born in the U.S. In addition, a second document establishing identity must be obtained.

Third Level Documents	Explanation
An extract, i.e., part(s) of one or more documents from medical records of a hospital, on hospital letterhead established at the time of the person's birth and was created 5 years before the initial application date and shows a U. S. place of birth.	Do not accept a souvenir "birth certificate" issued by the hospital. NOTE: For children under 16, the document must have been created near the time of birth **or** 5 years before the application date.
Life or health or other insurance record which shows a U.S. place of birth and was created at least 5 years before the initial application date.	Life or health insurance records may show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth. NOTE: For children under 16, the document must have been created near the time of birth **or** 5 years before the application date.
Religious record recorded in the U. S. within 3 months of birth showing birth occurred in the U. S. and showing either the individual's birth date or age at the time the record was recorded.	The record must be an official record with a religious organization. In questionable cases, i.e., religious document recorded near an international border, the religious record must be verified and/or verify that the mother was in the U. S. at time of birth. NOTE: Entries in a family Bible are not considered religious records.
Early school record showing a U. S. place of birth.	The record must show the name of the child, the date of admission to the school, the date of birth (or age at the time record was created), a U. S. place of birth and the name(s) **and** place(s) of birth of the child's parents.

<u>Fourth level evidence</u> of citizenship is of the lowest reliability. It should only be used in the rarest of circumstances. It is used when primary evidence is not available and both secondary and third level evidence do not exist or cannot be obtained within the reasonable opportunity period and the applicant alleges a U. S. place of birth. <u>In addition, a second document establishing identity must be obtained</u>.

Accept any of the following documents as fourth level evidence of U. S. citizenship if the document meets the listed criteria, the applicant/beneficiary alleges U. S. citizenship and there is nothing indicating the person is not a U. S. citizen or lost U. S citizenship. Fourth level evidence consists of documents established for a reason other than to establish U. S. citizenship and showing a U. S. place of birth. The U. S. place of birth on the document and documented place of birth on the application must agree. The written affidavit may be used only when the specialist is unable to secure evidence of citizenship in any other chart.

Fourth Level Documents	Explanation
Federal or State census record showing U.S. citizenship or a place of birth (generally for persons born 1900 through 1950).	The census record must also show the applicant's age. NOTE: Census records from 1900 through 1950 contain certain citizenship information. To secure this information the applicant, beneficiary, or State should complete a Form BC-600, Application for Search of Census Records for Proof of Age. ADD in the remarks portion "U.S. citizenship data requested." Also, add that the purpose is for Medicaid eligibility. This form requires a fee.
Other Documents - To be valid, the documents in this section must have been created at least 5 years before the application for Medicaid (or for children under 16, the document must have been created near the time of birth **or** 5 years before the application date.)	This document must show a U.S. place of birth: • Seneca Indian tribal census record. • Bureau of Indian Affairs tribal census records of the Navaho Indians. • U.S. State Vital Statistics official notification of birth registration. • A delayed U.S. public birth record that is recorded more than 5 years after the person's birth. • Statement signed by the physician or midwife who was in attendance at the time of birth. • Bureau of Indian Affairs Roll of Alaska Natives

<table>
<tr><th>Fourth Level Documents</th><th>Explanation</th></tr>
<tr><td>Medical (clinic, doctor or hospital) record and was created at least 5 years before the initial application date (for children under 16, record was created near time of birth or 5 years before the application date) and indicates a U. S. place of birth.</td><td>Medical records generally show biographical information for the person including place of birth; the record can be used to establish U. S. citizenship when it shows a U. S. place of birth.

NOTE: Immunization records maintained by the family or a school are not considered a medical record for purposes of establishing U. S. citizenship. However, such records maintained by a clinic, doctor or hospitals are considered medical records.</td></tr>
<tr><td>Institutional admission papers from a nursing home, skilled nursing facility or other institution that were created at least 5 years before the initial application date and indicate a U. S. place of birth.</td><td>Admission papers generally show biographical information for the person including place of birth; the record can be used to establish U. S. citizenship when it shows a U. S. place of birth.</td></tr>
<tr><td>Written Affidavit</td><td><u>Written affidavits may be used as fourth level evidence only in rare circumstances when no other acceptable evidence of citizenship is available.</u>

• The affidavits may be used for U. S. citizens, including naturalized citizens.
• Affidavits must be supplied by the applicant/recipient and at least 2 additional individuals, one of whom is not related to the applicant or recipient.
• Each of the 2 additional individuals must attest to having personal knowledge of the event(s) establishing the applicant's or recipient's claim of citizenship.
• The individuals providing supporting affidavits must be able to prove their own U. S. citizenship and identity for the affidavit to be accepted.
• The applicant/recipient (or guardian or representative for a child) also submits a separate affidavit explaining why other documentary evidence is not available.
• Affidavits are signed under penalty of perjury, but do not have to be notarized.

NOTE: For a child, an affidavit cannot be used to verify both identity and citizenship.</td></tr>
</table>

Citizenship Addendum	Explanation
If the document used to verify U. S. citizenship indicates the individual was born in Puerto Rico, the Virgin Islands of the U.S. or the Northern Marinara Islands before these areas became part of the U.S. the individual may be a collectively naturalized citizen. Collective naturalization occurred on certain dates listed for each of the territories.	Puerto Rico: Evidence of birth in Puerto Rico on or after April 11, 1899 and the applicant/beneficiary's statement that he or she was residing in the U.S. possession or Puerto Rico on January 13, 1941; or Evidence that the applicant/beneficiary was a Puerto Rican citizen and the applicant/beneficiary's statement that he or she was residing in Puerto Rico on March 1, 1917 and that he or she did not take an oath of allegiance to Spain. U.S. Virgin Islands: Evidence of birth in the U.S. Virgin Islands and the applicant/beneficiary's statement of residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927; The applicant/beneficiary's statement indicating resident in the U.S. Virgin Islands as a Danish citizen on January 17, 1917 and residence in the U.S., a possession or the U.S. Virgin Islands on February 25, 1927 and that he or she did not make a declaration to maintain Danish citizenship; or Evidence of birth in the U.S. Virgin Islands and the applicant/beneficiary's statement indicating residence in the U.S., a U.S. possession or territory or the Canal Zone on June 28, 1932. Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI)) Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. territory or possession on November 3, 1986 (NMI local time) and the applicant/beneficiary's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time);Evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration prior to January 1, 1975 and the applicant/beneficiary's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); or Evidence of continuous domicile in the NMI since before January 1, 1974 and the applicant/beneficiary's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time). NOTE: If a person entered the NMI as a nonimmigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile and the individual is not a U.S. citizen.

102.04.06 EVIDENCES OF IDENTITY

Proof of identity is required when primary evidence of citizenship cannot be obtained and a secondary, third or fourth level evidence is used.

Identity Documentation	Explanation
The identity of all applicants and recipients must be verified. When a child younger than age 16 or a disabled individual living in a residential care facility does not have one of the following documents available to verify identity, an alternate document indicated below may be used.	This section includes the following acceptable documents which may be used to verify the identity of any applicant or recipient. Documents may be recently expired provided there is no reason to believe the document does not match the individual. • A current state driver's license bearing either the individual's picture or containing other identifying information such as name, age, sex race, height, weight or eye color. • School identification card with a photograph of the individual. (ID cards issued by IDENT-A-KID Services of America, ID CONCEPTS, GUARD-A-KID, Safe Kids ID or Child Identification Sheet created by local law enforcement are also acceptable) • U.S. military card or draft record. • Identification card issued by the Federal, State, or local government containing the same information included on driver's licenses. • Military dependent's identification card. • Certificate of Indian blood or other U. S. American/Alaska Native tribal document if the document carries a photograph of the individual, or has other personal identifying information relating to the individual such as age, weight, height, race, sex, eye color. • U.S. Coast Guard Merchant Mariner card. • Three or more corroborating documents such as marriage licenses, divorce decrees, high school diplomas (including general education or equivalency diplomas), employer ID cards, property deeds/titles or other similar types of documents issued by local or state governmental entities when no other higher-level evidence is available to verify identity. All documents must be originals or certified copies. They must include at a minimum, the individual's name plus any additional information to establish identity. Use only when second or third level, but not fourth level, evidence of citizenship was obtained.

Identity Documentation	Explanation
	Exception: Do not accept a Voter Registration Card or Canadian Driver's License as identity verification.
Children under age 16 When another document is not available to verify the identity of a child under the age of 16, alternate verification from this list may be used.	• School record including report card, daycare or nursery school record. NOTE: If a school record is used, it must be verified with the issuing school. • Clinic, doctor, or hospital record, showing a date of birth. This includes an immunization record maintained by the medical provider if it shows a date of birth. • If none of the above documents are available, an affidavit signed under penalty of perjury by a parent, guardian or caretaker relative attesting to the child's identity and stating the child's date and place of birth may be obtained. The Statement of Child's Identity should be used as an application attachment for this purpose. It is not necessary to have this form notarized. The form is completed one time to verify a child's identity. A new form is required only if new children are added to the case. The Statement of Child's Identity cannot be used if an affidavit for citizenship was provided. NOTE: For a child, an affidavit cannot be used for both citizenship and identity.
Disabled individual in residential care facility When another document is not available to verify the identity of a disabled individual living in a residential care facility, an affidavit may be used.	Disabled individuals in residential care facilities may have identity attested to by the facility director or administrator when the individual has no other acceptable document available. The affidavit is signed under penalty of perjury, but need not be notarized. All other means of verifying identity must be pursued prior to use of an affidavit.

NOTE: Citizenship and/or identity do not have to be verified if the applicant is not otherwise eligible.

102.05 ALIENS

The purpose of this section is to provide information and instructions for determining alien status and level of Medicaid coverage. In general, eligibility and level of coverage is based on the alien's date of entry into the U. S., the date qualified alien status was obtained and/or the alien's immigration status.

Qualified Aliens

Individuals living in the United States, who are not citizens, by birth or acquisition, and are not U. S. Nationals, are aliens. For Medicaid purposes, certain aliens are referred to as "qualified", meaning they are potentially eligible for full Medicaid services just like U. S. citizens. Each applicant declaring to be a qualified alien is responsible to provide, or cooperate in obtaining, documentation of alien status.

Non-Qualified Aliens

"Non-qualified aliens" are non-citizens are potentially eligible only for Emergency Medicaid services; however, there may be exceptions. Non-citizens applying for Emergency Medicaid services are not required to disclose information regarding citizenship, alien status or enumeration and should not be requested to do so. All applicable program requirements must be met before an alien is eligible for either full Medicaid or Emergency Medicaid services.

102.05.01 GRANDFATHERED ALIENS

Effective 8/22/96, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) limited alien eligibility for Medicaid and other federal programs. However, Mississippi elected to "grandfather in" aliens who were receiving and eligible for Medicaid on that date.

This means the grandfathered alien, who is lawfully residing in the U. S., has the right to have his eligibility continue under the alien policy in effect prior to 8/22/96. He also retains grandfathered rights if benefits are terminated and eligibility is later reestablished.

VERIFICATION PROCEDURES FOR GRANDFATHERED ALIENS

A "grandfathered alien" is an individual who is lawfully residing in the U. S. and was receiving and eligible for Medicaid on 8/22/96. When there is an indication an alien is potentially "grandfathered", the specialist must:

VERIFICATION PROCEDURES FOR GRANDFATHERED ALIENS (Continued)

(1) request immigration documents,
(2) verify alien status through the Systematic Alien Verification for Entitlements system and
(3) establish eligibility on 8/22/96 in MS or another state.

If the individual received Medicaid in Mississippi, check for eligibility on 8/22/96 in the Medicaid Management Information System (MMIS). If the individual received Medicaid in another state, verify eligibility on 8/22/96 with the other state. Documentation of a telephone contact with the other state is adequate verification.

If the returned SAVE form indicates the alien is lawfully residing in the U. S. and the eligibility check revealed the alien was eligible for and receiving Medicaid 8/22/96, the individual is eligible for full Medicaid, provided other program eligibility factors are met.

If the alien was receiving Medicaid on 8/22/1996, but was subsequently determined to be ineligible, his status as a qualified alien must be determined for full Medicaid coverage. If he is not a qualified alien, he may be eligible for Emergency Medicaid services.

102.05.02 CLASSIFICATIONS OF QUALIFIED ALIENS

There are nine classifications of qualified aliens. Seven are based on INS alien status, one is based on battery or extreme cruelty and INS alien status, and one is based on severe forms of trafficking and certification by U. S. Health and Human Services. Refer to the Alien Status Chart in Section 102.05.15 for documents and eligibility status of the classifications listed below:

(1) AN ALIEN LAWFULLY ADMITTED FOR PERMANENT RESIDENCE (LPR) - Under the Immigration and Nationality Act (INA);
(2) A REFUGEE - Admitted under Section 207 of the INA;
(3) AN ALIEN GRANTED ASYLUM - Under Section 208 of the INA;
(4) A CUBAN AND HAITIAN ENTRANT - As defined in section 501(e) of the Refugee Education Assistance Act of 1980;
(5) AN ALIEN GRANTED PAROLE FOR AT LEAST ONE YEAR - Under Section 212(d)(5) of the INA;
(6) AN ALIEN WHOSE DEPORTATION IS BEING WITHHELD - Under (1) Section 243(h) of the INA as in effect prior to April 1, 1997; or (2) Section 241(b)(3) of the INA, as amended;
(7) AN ALIEN GRANTED CONDITIONAL ENTRY - Under Section 203(a)(7) of the INA in effect before April 1, 1980;
(8) A BATTERED ALIEN - Meeting the conditions set forth in Section 431(c) of PRWORA, as added by Section 501 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 PL 104-208(IIRIRA), and amended by Section 5571 of the Balanced Budget Act of 1997, PL 105-33(BBA) and Section 1508 of the Violence Against Women Act of 2000, PL106-386. Section 431(c) of PRWORA, as amended, is codified at 8 USC 1641(e);
(9) A VICTIM OF A SEVERE FORM OF TRAFFICKING In accordance with Section 107(b)(1) of the Trafficking Victims Protection Act of 2000, PL 106- 86.

Verification And Documentation Of Qualified Alien Status

The Systematic Alien Verification for Entitlements (SAVE) process is used to verify

(1) the authenticity of the alien's USCIS documents,
(2) his date of admission to the U.S. and
(3) current immigration status.

Aliens Not Subject to SAVE Verification

SAVE is used for documented aliens who are applying for benefits. **Victims of a severe form of trafficking** and **aliens applying for Emergency Medicaid services only** are not subject to the SAVE verification process.

PROCEDURES FOR VERIFYING ALIEN STATUS THROUGH SAVE

Medicaid Specialist Responsibilities:

- Request the alien's original immigration documents issued by the immigration agency. Currently, the United States Citizenship and Immigration Services (USCIS), within the Department of Homeland Security is responsible for immigration.
- Complete the SAVE cover sheet for each documented alien requesting benefits, providing the person's full name, Medicaid ID number, alien registration number, nationality, date of birth, Social Security Number, and county of residence.
- Attach front and back copies of original immigration documents and attach a copy of the alien's Social Security card.
- Submit the information to state office.

State Office Responsibilities:

When the information to be submitted for SAVE verification is received in state office, it is submitted electronically to the Department of Homeland Security.

When a response is received back, it is reviewed initially at the state level. The reviewer notes the following:

- Whether or not the alien is qualified, and
- If he is a qualified alien, whether the 5-year disqualification or 7-year eligibility time limit appears applicable.
- If either the 5- year ban or 7-year eligibility period appears applicable, the reviewer notes the beginning and ending dates and forwards the information to the regional office.

Medicaid Specialist Responsibilities Continued:

- When the SAVE verification sheet is received from state office and the alien is not in a qualified alien classification, he is eligible only for Emergency Services.
- When the SAVE verification sheet is received from state office and the alien is in a qualified status, review it and compare the SAVE information and case record information with the chart in Section 102.05.05 to determine alien eligibility and correct level of Medicaid eligibility.

PROCEDURES FOR VERIFYING ALIEN STATUS THROUGH SAVE (Continued)

- The state reviewer does not have access to all information in the case record; therefore, it is very important that the specialist considers information from all applicable sources and applies the correct policy to make an eligibility determination.

  Example: The SAVE verification sheet from the Department of Homeland Security verifies an alien was Lawfully Admitted for Permanent Residence and is in the 3rd year of the 5-year ban. The state reviewer notes the following on the form "LPR, 5-year ban period May 1, 2005 – April 30, 2010.'

  However, the case contains verification that the alien is the pregnant spouse of an honorably discharged veteran. The specialist determines the qualified alien is exempt from the 5-year disqualification and eligible for Medicaid as a pregnant woman in a full service COE.

Re-Verification of Alien Status Through SAVE

Once alien status has been verified, it is not necessary to re-verify unless the alien status is subject to change. Examples of when alien status is subject to change include, but are not limited to, the following:

1) An individual admitted under a temporary status may change to lawful permanent resident status.

2) An individual admitted under a temporary status that has expired may have updated his status.

3) A refugee may change his alien status to lawful permanent resident status.

4) An individual may meet requirements as a battered alien or some other type of qualified alien status.

5) An illegal alien may change to a legal status.

102.05.03 5-YEAR DISQUALIFICATION PERIOD

Unless an exemption is met, qualified aliens admitted to the U. S. on or after August 22, 1996, are disqualified from receiving public benefits for:

- The first five years from the date they entered the country or
- The first five years from the day they obtained qualified alien status, **whichever is later**.

During this 5-year ban or disqualification period, these aliens are eligible only for emergency services if they meet all other eligibility requirements.

Requirement for 40 Qualifying Quarters

At the end of the 5-year disqualification period, an alien classified as lawfully admitted for permanent residence (LPR) is potentially eligible for full Medicaid benefits only if he has 40 qualifying quarters (QQs) of earnings covered by Social Security or can be credited with 40 QQs which satisfy the requirement. If 40 QQ's cannot be credited, the LPR remains potentially eligible for Emergency Medicaid only.

NOTE: Aliens classified as: 1) granted parole for at least 1 year, or 2) battered aliens, or 3) conditional entrants are not required to have 40 QQ's

LPR's are not eligible for full Medicaid for the first 5 years, even if they can be credited with 40 qualifying quarters prior to or during the 5-year disqualification period. The disqualification period must be imposed before an assessment of eligibility based on the 40-quarter requirement.

102.05.04 40 QUALIFYING QUARTERS OF EARNINGS

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

- All the qualifying quarters worked by the spouse of the alien during their marriage, provided the alien remains married to the spouse or the marriage ended by death and not divorce, and
- All of the qualifying quarters worked by a parent of an alien while the alien was under age 18. The alien does not have to be under 18 at the time of the application.

Combining Quarters

Subject to the limitations above, the alien's own QQs can possibly be combined with those of his parent(s) and/or spouse to attain the required 40 quarters.

Receipt of Means-Tested Benefits

After December 31, 1996, any quarter in which any of these individuals, i.e., the LPR, his parent(s) and/or spouse, received Federal means-tested benefits, such as TANF, SSI and Medicaid, cannot be credited to meet the 40 quarter requirement.

When total qualifying quarters have been verified, quarters in which Federal means-tested benefits were received by any person contributing quarters should be subtracted from the total to determine the number of countable qualifying quarters.

PROCEDURES TO VERIFY 40 QUALIFYING QUARTERS OF EARNINGS

- Determine the individuals whose quarters can be included in the quarter coverage count based on the requirements and limitations discussed above in Section 102.05.03.

    1. Question the applicant to determine that proper relationships exist, the date of birth of the applicants and request Social Security Numbers for each individual included.

- Determine if it is possible for the applicant to meet the requirement.

    1. Ask how many years the applicant and each individual included in the quarter coverage calculation have lived in the United States. If the total number of years is less than 10 years (40 quarters), the applicant cannot meet the requirement.

- If the total number of years is at least 10, determine how many years included earnings.

    1. Always determine the applicant's own quarters first. Many applicants may have sufficient quarters on their own record and it will not be necessary to request earnings history for other individuals. If the applicant does not have sufficient quarters, determine the quarters for the other individuals.

- Request a quarter coverage history from Social Security unless it is clear from the interview that the applicant, or applicant in combination with others, cannot meet the 40-quarter requirement. However, if the applicant still believes he meets the 40 quarter requirement, request a quarter coverage history.

- When verification is received from Social Security, total the quarters. Do not count any quarter(s) in which federal means-tested benefits were received by the individual as a qualifying quarter.

102.05.05 ALIEN CLASSIFICATIONS SUBJECT TO 5-YEAR BAN

Non-exempt aliens in the following classifications, admitted to the U. S. on or after 8/22/96, are subject to the 5-year disqualification.

- Lawful Permanent Resident Aliens;
- Aliens Granted Parole for at Least One Year;
- Battered Aliens

NOTE: Aliens granted conditional entry under Section 203(a)(7) in effect before April 1, 1980, are not exempt from the 5-year disqualification per se; however, as a practical matter the disqualification will never apply since by definition, they entered the United States and obtain qualified alien status prior to 8/22/96.

During the disqualification period they are potentially eligible only for Emergency Medicaid services.

102.05.06 ALIEN CLASSIFICATIONS EXEMPT FROM 5-YEAR BAN

Refugees, Asylees, Amerasian immigrants, Cuban/Haitian entrants, aliens who have been granted withholding of deportation, victims of trafficking and qualified aliens who are honorably discharged veterans or active duty military and certain of their family members are among the aliens exempt from the 5-year disqualification.

Seven-Year Eligibility Limit

However, aliens in some of the above classifications have a 7-year time limit imposed on eligibility. When the 7-year period ends, eligibility terminates the following month unless the alien's status has changed or he meets an exemption.

Status Adjustments to LPR

When the time-limited alien's status adjusts to LPR during the 7-year period, the alien can continue to be eligible for the remainder of his 7-year period.

However, to continue to be eligible beyond the 7-year period, the alien adjusted to LPR must be credited with 40 QQs or meet an exemption. If that is not the case, his eligibility ends the first month after the 7-year period ends.

Alien Classifications Subject to Seven Year Limit on Eligibility

The 5-year disqualification does ***not*** apply to aliens in the following classifications, but these aliens are subject to the 7-year eligibility limit:

- **REFUGEES** - Qualify until 7 years after date of entry into the U. S.;
- **ASYLEES** - Qualify until 7 years after the grant of asylum;
- **CUBAN AND HAITIAN ENTRANTS** - Qualify until 7 years after grant of that status;
- **ALIENS WHOSE DEPORTATION IS BEING WITHHELD** - Qualify for the first 7 years after grant of deportation withholding;
- **ALIENS ADMITTED TO THE COUNTRY AS AMERASIAN IMMIGRANTS** - Qualify for 7 years from entry into the U. S.;
- **VICTIMS OF TRAFFICKING AND THEIR DERIVATIVE BENEFICIARIES** - Qualify during the first 7 years after obtaining the status

Qualified Aliens Not Subject to Eligibility Restrictions

The following groups of qualified aliens are exempt from both the 5-year disqualification and the 7-year eligibility time limit and if otherwise eligible, qualify for full Medicaid:

- Non-citizen members of a Federally-recognized Indian tribe, as defined in 25 U.S.C 450(b)(e); and American Indians born in Canada to whom Section 289 of the INA applies;
- Any qualified alien who is also

  (1) An honorably discharged veteran or
  (2) On active duty in the U. S. military or
  (3) The spouse (including a surviving spouse who has not remarried) or
  (4) An unmarried dependent child of an honorably discharged veteran or individual on active duty in the military;

- Grandfathered aliens, i.e., those eligible for and receiving Medicaid on 8/22/96;
- Aliens who entered the U. S. and obtained qualified status prior to 8/22/96;
- Aliens who entered the U. S. prior to 8/22/96 , but obtained qualified status on or after that date, and remained "continuously present" in the U. S. from their last entry date into the country prior to 8/22/96 until becoming a qualified alien.Refer to Section 102.05.07 below for the definition of "continuously present".

NOTE: Aliens filing an application for Emergency Medicaid services only are not subject to either the 5-year disqualification or 7-year time limit.

102.05.07 CONTINUOUSLY PRESENT IN THE U. S

As previously indicated, a qualified alien who entered the U. S. prior to 8/22/96 and obtained qualified status on or after that date, must have remained "continuously present" in the U. S. from their last entry date into the country prior to 8/22/96 until becoming a qualified alien. "Continuously present" in the U. S. is defined as

- The alien had no single absence from the U.S. of more than 30 days and
- The alien had no total of aggregate absences of more than 90 days.

The qualified alien who meets the above definition is deemed to have entered the U. S. prior to 8/22/96 and if otherwise eligible, qualifies for full Medicaid.

Not Continuously Present

Aliens who were not "continuously present" are considered to have entered the U. S. on or after 8/22/96 and unless an exemption is met, are subject to the 5-year disqualification period from the date qualified status was obtained and the 40 QQ requirement.

102.05.08 VICTIMS OF SEVERE FORMS OF TRAFFICKING

Trafficking victims are not included in the statutory definition of qualified alien. Under Section 107(b) (1) (A) of the Trafficking Victims Protection Act, however, they are eligible for means-tested benefits to the same extent as refugees, i.e., victims of trafficking and their derivative beneficiaries qualify for Medicaid during the first 7 years after obtaining this qualified status.

Certification by Office of Refugee Resettlement

The qualified status of a trafficking victim is not based on immigration status. The Office of Refugee Resettlement (ORR) issues a certification letter for an adult who has been subjected to a severe form of trafficking and meets statutory certification requirements. The ORR also issues a similar eligibility letter for children.

Other agencies may issue letters or documents to victims of severe forms of trafficking; however, the ORR letter is the acceptable verification. Victims of trafficking are not required to provide immigration documents. SAVE verification is not required.

102.05.09 BATTERED ALIENS

Battered aliens were not initially included in PRWORA's definition of qualified aliens. In passing Section 501 IIRIRA, Congress added a new Section 4319(c), which provides that the term "qualified alien" shall include such immigrants.

- The alien must be either
  - The person battered,
  - The parent of a child who is battered or
  - A child whose parent has been battered.
- The battered alien must not be residing in the same household with the person responsible for the battery or extreme cruelty.
  - If the battered alien resumes living with the one who is responsible for the battery or extreme cruelty, the battered alien's eligibility will end the month after the month of reconciliation.
- The alien must be the beneficiary of a petition for
  - Immediate relative status;
  - Classification to immigrant status based on relationship to a lawful permanent resident alien; or
  - Suspension of deportation and adjustment to lawful permanent resident status.
- The alien must also be able to show a substantial connection between the battery or extreme cruelty and the alien's need for Medicaid.
    - This may include such reasons as Medicaid is needed to obtain medical attention or mental health counseling caused by abuse, to replace medical coverage and/or health services lost when the individual separated from the abuser, to enable the individual to become self-sufficient following separation from the abuser or to provide medical care during a pregnancy resulting from the abuser's sexual assault or abuse of, or relationship with, the individual.

102.05.10 VETERAN OR ACTIVE DUTY MILITARY

To be eligible as a veteran, the qualified alien must have been honorably discharged, not based on alienage, and must have fulfilled minimum active duty service requirements. A qualified alien who is an active duty member of the Armed Forces, but not on active duty for training purposes only, can also be eligible.

A qualified alien who is the spouse of a veteran or active duty service member may be eligible. The veteran's exemption also includes the unmarried surviving spouse of a veteran or active duty military person.

To qualify as a surviving spouse, at least one of the following conditions must be met:

- The spouse must have been married to the veteran for at least one year; or
- The spouse must have had a child with the veteran, or
- The veteran's death must have been due to an injury or illness incurred during military service and the marriage must have been in existence sometime within 15 years after the period of service in which the injury or disease was incurred or aggravated.

Loss of Exemption

Surviving spouses who remarry lose the benefit of this exemption the month after the month of the remarriage. Spouses whose marriage ended in divorce lose the benefit of this exemption the month after the month of divorce.

Qualifying Children

To qualify as a child of a veteran or active duty service person, the biological, adopted or stepchild must be

- Unmarried and claimable as a dependent on the military person's tax return and Under 18 years of age or under 22 and a student regularly attending school; or
- A child with disabilities who is over 18, if the child had a disability and was dependent on the veteran or active duty service member before the child's 18th birthday; or
- A surviving unmarried minor child of a veterans or person killed in active duty and dependent on the veteran at the time of the veteran's death.

102.05.11 NON-QUALIFIED ALIENS

An alien who does not meet the specific requirements of a qualified alien is a non-qualified alien for Medicaid purposes. A non-qualified alien who meets MS residency requirements and other applicable eligibility factors can receive Medicaid Emergency Services only. An applicant for Emergency Medicaid services is not required to provide information regarding citizenship, immigration or enumeration and should not be requested to do so. The SAVE process is not used for a non-qualified alien.

Illegal Aliens

Illegal aliens are non-qualified aliens. This group of individuals includes:

- Undocumented aliens who entered illegally without knowledge of USCIS; or
- Aliens who were admitted for a limited period of time and did not leave the U. S. when the period of time expired.

These individuals, if they meet all eligibility criteria except citizenship/alien status, are entitled to Medicaid only for treatment of an emergency medical condition. The specialist must accept the applicant's statement if they say they have no documentation and assess the alien for emergency services only.

Undocumented and illegal aliens do not have to provide a Social Security Number or provide information regarding citizenship or immigration status. The alien status of an illegal alien is not verified through the SAVE process.

Ineligible Aliens

Ineligible aliens may be lawfully admitted to the U. S., but only for a temporary or specified period of time. These aliens are never qualified aliens, Because of the temporary nature of their admission status, most ineligible aliens are not entitled to any Medicaid benefits, including emergency services.

However, in some instances, an alien in a currently valid non-immigration status may meet state residency requirements, such as intent to reside in MS for purposes of employment. If state residency requirements are met, the alien is potentially eligible for Emergency Medicaid services only.

Examples of Ineligible Aliens Who are Lawfully Admitted	
Foreign Students Visitors Tourists Foreign government representatives on official business and their families and servants Crewmen on shore leave International organization representatives and their families and servants Temporary workers (individuals allowed entry temporarily for employment purposes) Members of the foreign press, radio, film, etc., and their families Short-term parolees	Visa, Passports or Form I-766 OR Form I-94, Arrival/Departure Record annotated with A to M OR Form I-688, Temporary Resident Card annotated with Section 210 or 245A OR Form I-688 A and B, Employment Authorization Card OR Form I-185, Canadian Border Crossing Card OR Form I-186, Mexican Border Crossing Card OR Form SW 434, Mexican Border Visitor's Permit OR Form I-95-A, Crewman's Landing Permit **Note: Form I-94, Arrival-Departure Record, is also issued for refugees and other related statuses.**

Other Aliens

Aliens who are admitted legally to the U. S., but do not fall into one of the specific categories of qualified aliens are non-qualified aliens. These individuals may include Legal Temporary Residents (LTR's), as well as individuals who are given temporary administrative statuses, i.e., a stay of deportation or voluntary departure until they can formalize permanent status or individuals who are paroled for less than one year or aliens under deportation procedures.

Immigration Reporting

Applicants who are found to be in the U. S. illegally through the application process are not subject to immigration reporting requirements. Persons who apply for benefits on behalf of others, i.e., a mother applying for her children, are not subject to immigration reporting requirements. Declining to provide documentation of immigration status is not a valid reason to report an alien to immigration.

The alien applicant who declines to present documentation of qualified alien status or a Social Security Number will only be able to receive Emergency Medicaid, if otherwise eligible. In this instance, there is no reason to seek further verification of alien status beyond interviewing the applicant. All rules of confidentiality must be applied in regard to an individual's alien status.

102.05.12 Criteria for Approval of Emergency Services

Aliens who are not entitled to full Medicaid benefits (refer to Section 102.05.04) may be eligible for emergency services only, if the following conditions exist:

- All other eligibility requirements are met except satisfactory immigration status;
- Care and services needed are not related to an organ transplant procedure or routine prenatal or postpartum care;
- The alien has, after sudden onset, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
  - Placing the patient's health in serious jeopardy,
  - Serious impairment to bodily functions,
  - Serious dysfunction of any bodily organ or part, or
  - Is for labor and delivery

NOTE: The services provided in this situation must relate to the injury, illness, or delivery causing the emergency. Services that are not directly related to the injury, illness, or delivery are not compensated by Medicaid. Once the medical condition is stabilized, even if it remains serious or results in death, it is no longer an emergency.

Procedures for Processing Eligibility for Emergency Medicaid Services

At the point of application, the Medicaid eligibility worker must explain to the applicant, who is a non-qualified alien or a qualified alien subject to 5-year disqualification, that if all applicable program eligibility requirements are met, Medicaid may reimburse for emergency services only (including labor and delivery) after the services have been received.

Determining Eligibility for Emergency Medicaid Services

When determining eligibility for Medicaid coverage for treatment of an emergency medical condition only, the specialist will obtain information to

(1) Establish eligibility based on emergency services criteria, such as a copy of the hospital bill or other documentation from the hospital indicating treatment or services received, dates of service and the diagnosis for the individual's condition and

Procedures for Processing Eligibility for Emergency Medicaid Services (Continued)

(2) Establish eligibility on technical factors, except citizenship, alien status and enumeration, and financial factors.

Not Financially Eligible

If the alien is not financially eligible, the application will be denied by the specialist.

Applicant Appears Eligible for Emergency Medicaid Services

If the specialist determines the individual appears eligible for emergency services, the case will be referred to state office for a final review and decision. Pertinent material from the case record, including a copy of the application, a budget and medical documentation, will be sent to state office.

State Office Responsibilities

The state office worker will make the final determination of whether the individual is categorically eligible and whether the service is an emergency. If Emergency Medicaid services are approved, the state office worker is responsible for notification and input of eligibility data.

102.05.13 BUDGETING FOR CITIZEN CHILDREN OF NON-QUALIFIED ALIEN(S)

Children born in the United States to parent(s), who is a non-qualified alien as discussed in Section 102.05.04, may be eligible for full Medicaid. To determine eligibility, count the needs and income, less disregards, of the parent(s) as well as any siblings the parent wants to include in the application. The parent(s) and any sibling(s) who are non-qualified aliens cannot be eligible for full Medicaid benefits; however, they may be assessed for Emergency Medicaid Services. A child born to a mother eligible for emergency services for labor and delivery is deemed eligible for Medicaid through the month of the child's first birthday, provided the child remains a member of the mother's household and a resident of the state.

When the child reaches the age of one, a review is required. Verifications postponed during the deemed eligible child's first year must be provided. To determine eligibility after the deemed period, count the needs and income, less disregards, of the parent(s) as well as any siblings the parent wants to include in the application. The parent(s) and any sibling(s) who are non-qualified aliens cannot be eligible for full Medicaid benefits; however, they may be assessed for Emergency Medicaid Services.

102.05.14 PUBLIC CHARGE

Aliens who seek admission to the U.S. must establish that they will not become 'public charges.' A "public charge" is an alien who has become (for deportation purposes), or who is likely to become (for admission/adjustment purposes), **solely** dependent on government assistance as demonstrated by either (1) Receipt of public cash assistance for income maintenance (including Work First or SSI), or (2) Institutionalization for long-term care at government expense. Institutionalization for short periods of rehabilitation does not constitute primary dependence.

Many aliens establish that they will not become public charges by having 'sponsors' who pledge to support them. Aliens may ask staff about the consequences of becoming a public charge by applying for assistance. This is of concern to aliens who want to become Legal Permanent Residents and obtain a Green Card. It should be noted that refugees and persons granted asylum may receive any benefit, including Work First, without affecting their chances of becoming a Legal Permanent Resident (LPR) or a U.S. citizen. Long term institutionalized care under Medicaid may result in a public charge determination; however, this does not include short-term rehabilitation stays in long-term care facilities.

However, being institutionalized for long-term care does not automatically make an individual inadmissible to the U.S., ineligible for legal permanent resident status, or deportable on public charge grounds. The law requires that USCIS officials consider several additional issues. Each determination is made on a case-by-case basis and the regional office is not involved in this determination. Specialists will determine eligibility for these persons person following all requirements in Medicaid.

NOTE: "Income Maintenance" does **not** include one-time cash payments for emergency assistance or Benefit Diversion. The receipt of public cash assistance for income maintenance for a child does **not** create a public charge problem for the parent **unless** that cash assistance is the only source of income for the family.

102.05.15 ALIEN STATUS CHART

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

OVERVIEW OF ALIEN ELIGIBILITY FOR MEDICAID		
VERIFICATION DOCUMENTATION	*ALIEN STATUS*	ELIGIBILITY STATUS
• **I-551** (Alien Registration Receipt Card) commonly referred to as the "green card" • **Foreign passport** stamped with an un-expired temporary I-551 stamp • **I-94** annotated stamped with a temporary I-551 stamp (for recent arrivals or aliens who have applied for a replacement I-551)	LAWFULLY ADMITTED FOR PERMANENT RESIDENCE (LPR)	Eligible for full Medicaid benefits if "grandfathered in" or entered the U.S. before August 22, 1996, and obtained qualified status prior to that date or obtained qualified status after 8/22/96 and was continuously present in the U. S. from 8/22/96 until qualified alien status obtained. If entered the U. S. on or after August 22, 1996, disqualified for full Medicaid benefits for 5 years from the date entered the country or obtained qualified status, whichever is later. Eligible for emergency services only during the 5-year disqualification period. Eligible for full Medicaid benefits after the 5-year disqualification period only if they have 40 QQs.
• **I-94** stamped showing admission under section 207 of the INA and date of entry to the United States • **I-688B** (Employment Authorization Card) annotated 274a.12(a)(3) • **I-766** (Employment Authorization Document) annotated "A3" • **I-571** (Refugee Travel Document)	REFUGEE	Can qualify for full Medicaid until 7 years after date of entry even if adjusts to LPR status during the 7-year period. After 7 years, must have adjusted to LPR with 40 QQs or be exempt from this requirement to establish continued eligibility.

OVERVIEW OF ALIEN ELIGIBILITY FOR MEDICAID		
VERIFICATION DOCUMENTATION	*ALIEN STATUS*	ELIGIBILITY STATUS
REFUGEE (Continued) Refugees become eligible to apply for adjustment to LPR status after 12 months in the U. S., but it takes another 6 – 12 months to be approved. They are still considered refugees for eligibility purposes when they have an I-551 with a code of RE-6, RE-7, RE-8 or RE-9)		5-Year disqualification period does not apply. If they do not meet categorical requirements, then they are eligible for full benefits for 8 months beginning with date of entry through the Refugee Assistance Program.
• **I-94** stamped showing grant of asylum under section 208 of the INA and date of entry • **A grant letter** from the Asylum Office of the USCIS • **I-688B** (Employment Authorization Card) annotated "274a.12(a)(5)" • **I-766** (Employment Authorization Document) annotated "A5" • **Court order** of an immigration judge showing asylum granted under section 208 of the INA	ASYLEE	Can qualify for full Medicaid until 7 years after the grant of asylum even if adjusts to LPR status during the 7 year period. After 7 years, must have adjusted to LPR with 40 QQs or be exempt from this requirement to establish continued eligibility. 5-Year disqualification period does not apply. If they do not meet categorical requirements, then they are eligible for full benefits for 8 months beginning with date of entry through the Refugee Assistance Program.
• **Order** of an immigration judge showing deportation withheld under section 243(h) of INA as in effect prior to April 1, 1997, or removal withheld under Sec. 241(b)(3) of the INA and date of grant • **I-688B** (Employment Authorization Card) annotated 274a.12(a)910) • **I-766** (Employment Authorization Document) annotated "A10"	DEPORTATION WITHHELD	Can qualify for full Medicaid until 7 years after the grant of withholding even if adjusts to LPR during the 7-year period. After 7 years, must have adjusted to LPR with 40 QQs or be exempt to establish continued eligibility. The 5-Year disqualification period does not apply.
• **I-94** annotated with stamp showing grant of parole under 212(d)(5) and a date showing granting of parole for at least one year. (Applicant cannot aggregate periods of admission for less than one year to meet the one-year requirement)	PAROLEE	Eligible for full Medicaid benefits if "grandfathered in" or entered the U.S. before August 22, 1996, and obtained qualified status prior to that date or

OVERVIEW OF ALIEN ELIGIBILITY FOR MEDICAID		
VERIFICATION DOCUMENTATION	*ALIEN STATUS*	ELIGIBILITY STATUS
		PAROLEE (Continued) Obtained qualified status after 8/22/96 and was continuously present in the U. S. from 8/22/96 until qualified alien status obtained. If entered the U. S. on or after August 22, 1996, disqualified for full Medicaid benefits for 5 years from the date entered the country or obtained qualified status, whichever is later. Eligible for emergency services only during the 5-year disqualification period. Eligible for full Medicaid benefits after the 5-year disqualification period.
• **I-94** with stamp showing admission under 203(a)(7) of the INA, refugee-conditional entry • **I-688B** (Employment Authorization Card) annotated 274a.12(a)(3) • **I-766** (Employment Authorization Document) annotated “A3”	CONDITIONAL ENTRANT	Eligible for full Medicaid benefits if “grandfathered in” or entered the U.S. before August 22, 1996, and obtained qualified status prior to that date or obtained qualified status after 8/22/96 and was continuously present in the U. S. from 8/22/96 until qualified alien status obtained.

OVERVIEW OF ALIEN ELIGIBILITY FOR MEDICAID		
VERIFICATION DOCUMENTATION	*ALIEN STATUS*	ELIGIBILITY STATUS
• **I-551** (Alien Registration Receipt Card) with the code CU6, CU7, or CH6 • **Foreign passport** stamped with an unexpired temporary I-551 stamp with the code CU6 or CU7 • **I-94** stamped with an unexpired temporary I-551 stamp with the code CU6 or CU7 • **I-94** with stamp showing parole as "Cuban/Haitian Entrant" under Section 212(d)(5) or the INA.	CUBAN/HAITIAN ENTRANT	Can qualify for full Medicaid until 7 years after the grant of this status. After 7 years, must have adjusted to LPR with 40 QQs or be exempt from this requirement to establish continued eligibility. 5-Year disqualification period does not apply. If they do not meet categorical requirements, then they are eligible for full benefits for 8 months beginning with date of entry through the Refugee Assistance Program.
• **I-551** with code AM6, AM7, or AM8 • **Foreign passport** stamped with an unexpired temporary I-551 stamp with the code AM1, AM2, or AM3 • **I-94** stamped with an unexpired temporary I-551 stamp with the code AM1, AM2, or AM3	AMERASIAN IMMIGRANTS	Can qualify for full Medicaid until 7 years after the entry to the United States. After 7 years, must have adjusted to LPR with 40 QQs or be exempt to establish eligibility. 5-Year disqualification period does not apply. If they do not meet categorical requirements, then they are eligible for full benefits for 8 months beginning with date of entry through the Refugee Assistance Program.
Office of Refugee Resettlement(ORR) certification letter	VICTIM OF A SEVERE FORM OF TRAFFICKING	Eligible for benefits to the same extent as a refugee. Eligible for any Medicaid category if meets all other eligibility criteria. Victims of Trafficking and their derivative beneficiaries qualify during the first 7 years after status is obtained. 5-Year disqualification period does not apply.

OVERVIEW OF ALIEN ELIGIBILITY FOR MEDICAID		
VERIFICATION DOCUMENTATION	*ALIEN STATUS*	ELIGIBILITY STATUS
I-797 indicating filing under one of the provisions listed below and approval of the petition or a finding that a prima facie case has been established. • **Case Type: I-130** petition approved • **Case Type: I-360** petition approved • **I-551** (Resident Alien Card or Alien Registration with one of the following class of admission (COA) codes stamped on lower left side of the back of a pink card demonstrates approval of a petition under C.3.j.(1)3. Above: IB1-IB3, IB6-IB8, B11, B12, B16, B17, B20-B29, B31-B33, B36-B38, BX1-BX3, or BX6-BX8 • **Order** from an immigration judge (EOIR) or the Board of Immigration Appeals granting suspension of deportation or cancellation of removal under VAWA (EOIR) Form 42B or an order from an immigration judge (EOIR) or Board of Immigration For battered aliens, the codes, types and stamps in foreign passports or on the I-94 that demonstrate an approved petition, or application under one of the provisions are too numerous to describe here. If an alien claiming pending or approved status presents a code different than those listed, or if you cannot determine the class of admission from the I-551 stamp, send a copy of the document(s) presented to USCIS with completed SAVE cover sheet to state office for submission of a G845-S.	<u>BATTERED ALIEN</u> Includes battered alien's child and parent of a battered alien child	Eligible for full Medicaid benefits if "grandfathered in" or entered the U.S. before August 22, 1996, and obtained qualified status prior to that date or obtained qualified status after 8/22/96 and was continuously present in the U. S. from 8/22/96 until qualified alien status obtained. If entered the U. S. on or after August 22, 1996, disqualified for full Medicaid benefits for 5 years from the date entered the country or obtained qualified status, whichever is later. Eligible for emergency services only during the 5-year disqualification period. Eligible for full Medicaid benefits after the 5-year disqualification period.
• **Green Form DD-2** marked "ACTIVE" OR • **Current orders** showing the individual is on full-time duty in the US Army, Navy, Air Force, Marine Corps, or Coast Guard (Reserves are not considered active duty.)	<u>ACTIVE DUTY MILITARY</u> Includes spouse and unmarried dependent children under 18 or under 22 and a student	Eligible for any Medicaid category if meet all other eligibility criteria. 5-Year disqualification period does not apply.
• **DD-214** indicating honorable discharge, OR **Discharge papers** indicating honorable discharge	<u>VETERAN</u> Includes spouse and unmarried dependent children under 18 or under 22 and a student	Eligible for any Medicaid category if meet all other eligibility criteria. 5-Year disqualification period does not apply.

OVERVIEW OF ALIEN ELIGIBILITY FOR MEDICAID		
VERIFICATION DOCUMENTATION	*ALIEN STATUS*	**ELIGIBILITY STATUS**
• **I-551** (Alien Registration Receipt Card) with code S13 • Canadian passport stamped with an unexpired temporary I-551 stamp with the code S13 • **I-94** stamped with unexpired temporary I-551 stamp with code S13 • A letter or other tribal document certifying at least 50% American Indian blood, as required by section 289 of INA combined with a birth certificate or other satisfactory evidence of birth in Canada	AMERICAN INDIAN BORN IN CANADA	Eligible for any Medicaid category if meet all other eligibility criteria. 5-Year disqualification does not apply for Medicaid.
• Membership card or other tribal document demonstrating membership in a federally-recognized Indian tribe under section 4(e) of the Indian Self-Determination and Education Assistance Act	AMERICAN INDIAN	5-Year disqualification does not apply for Medicaid. Eligible for any Medicaid category if meet all other eligibility criteria. This does not include a spouse of child of the individual. It also does not include a noncitizen whose membership in an Indian tribe or family is created by adoption, unless he is of at least 50% or more American Indian blood.

102.06 SOCIAL SECURITY NUMBER (SSN)

Enumeration is the process of assigning Social Security Numbers. In general, applicants for Medicaid must be enumerated as a condition of eligibility by either

- Furnishing their Social Security Number - The applicant can verbally provide the SSN when they do not have a card or other document with the number on it; or

- Providing verification of an application for a Social Security Number when a number has not already been assigned.

Assistance cannot be denied, delayed or discontinued if the applicant, beneficiary or his representative cooperates in providing the SSN of the applicant or applying for the applicant's number. However, if the applicant/beneficiary or his representative refuses to disclose a valid number for the applicant or refuses to apply for the applicant's number, the applicant's or recipient's eligibility will be denied or terminated.

102.06.01 EXCEPTIONS TO THE ENUMERATION REQUIREMENT FOR APPLICANTS

There are four exceptions to the enumeration requirement for Medicaid applicants.

- Non-qualified aliens applying for Emergency Medicaid services only do not have to provide a Social Security Number or provide proof of an application for a number as a condition of eligibility for emergency benefits.

- The requirement is postponed for deemed eligible children until the first redetermination.

- The Social Security Administration (SSA) does not issue SSN's to deceased individuals. The enumeration requirement is applicable if the SSN was issued prior to death.

- The enumeration requirement may be waived for an applicant who, because of well-established religious objections, refuses to obtain a Social Security Number.

    - The specialist will obtain the applicant's written statement which includes his religious affiliation and reasons for objecting to the requirement. The statement will be forwarded to the state office for a final determination.

102.06.02 NON-APPLICANTS AND ENUMERATION

Non-applicants cannot be required to disclose their own SSN as a condition of eligibility. For example, a mother who is applying for Medicaid only for her children cannot be required to provide her SSN even though she has financial responsibility for the children.

Medicaid Specialists should explain that the voluntary disclosure of the SSN will enable the agency to make a more accurate eligibility determination and ensure correct benefits. The application must not be denied solely because a non-applicant's SSN is not disclosed. If the non-applicant's income is countable in the budget and is from a source usually verified using the SSN, alternate verification will have to be provided.

102.06.03 USE OF SSNs

SSN's will be matched with the following agencies:

- Employment Security to obtain data regarding wages and unemployment compensation;
- Social Security to obtain net earnings from self-employment, wage and retirement information and Title II (RSDI) and Title XVI (SSI) benefit information; and
- Internal Revenue Service (IRS) to obtain unearned income information such as interest, dividends, etc.

Within 45 days of receipt of SSN matches with the above agencies, the information must be compared with the case record to determine whether it affects eligibility. If no action is needed, the case should be documented to this effect. If the information could result in adverse action, independent verification will be required for income and resource information received before any action is taken. This includes verification of:

- The amount of the income and resource that generated the income involved;
- Whether the client actually has or had access to the resource or income (or both) for his/her own use;
- The period of time when the individual had access to the income/resource.

102.06.04 APPLICATION FOR A SOCIAL SECURITY NUMBER

When an applicant has not been enumerated, two methods may be used to obtain an SSN. The methods are:

- **Application Filed at the Social Security Office:** The applicant/beneficiary completes a Form SS-5, Application for Social Security Card, and mails or takes the original SS-5 with required documentation to the SSA office. The applicant/beneficiary then provides an official receipt from SSA to meet the requirement of applying for a SSN. A copy of the receipt must be filed in the case record.

- **Enumeration at Birth:** A parent gives permission on the birth certificate registration form for the Bureau of Vital Statistics to provide a child's birth information to SSA to assign a Social Security Number to the child.

When a Medicaid application is filed for a newborn, not deemed eligible, the parent must either provide the child's Social Security Number or provide verification that an application has been filed through the enumeration at birth process or directly with SSA.

Enumeration can be verified by the newborn's birth certificate which verifies enumeration at birth or by a document from SSA such as the **SSA-2853, A Message from Social Security**, or **SSA-5028, Application for a Social Security Number**, which confirms the SS-5 was filed. When these verification methods are used, the SSN must be provided at the next annual review for the FCC programs. For ABD, a tickler must be set for 90 days, at which time the specialist will contact the applicant regarding receipt of the SSN.

102.06.05 VERIFICATION OF THE SSN

When the applicant provides a document with the SSN or provides the number verbally, the Medicaid Specialist must verify it through SVES. A "V" validation code will appear on the SVES response to indicate the SSN has been verified. If the number originally submitted to SVES is not verified, the specialist will obtain the correct information and re-submit the SVES inquiry. If discrepancies exist, such as an applicant/beneficiary has more than one SSN or has the same SSN as another individual, the client must be referred to the SSA office for resolution.

102.07 CATEGORICAL ELIGIBILITY

Eligibility for the Medicaid program is limited to certain groups of individuals authorized by Congress. When authorizing a group, Congress also establishes specific requirements which must be met to qualify as a member of that group. Each designated group is assigned a category of assistance. The requirements which must be met to fit into a group or category are known as categorical requirements.

The Division of Medicaid is responsible for the following categories of assistance:

- Aged,
- Blind,
- Disabled,
- Children under age 19,
- Pregnant women,
- Families with dependent children.

Aged

An individual categorically eligible as aged must be 65 years of age or older. According to SSI policy, a given age is attained on the first moment of the day preceding the anniversary of the individual's birth.

Example: A person born on January 1, 1943, is considered to be age 65 as of December 31, 2007, and meets the definition of an aged individual in the month of December 2007. A person born January 2, 1942, meets the definition of an aged individual in January 2008.

Blindness and Disability

To be categorically eligible for Medicaid as blind or disabled, the individual must, at a minimum, meet the Supplemental Security Income (SSI) definition of blindness or disability. The Disability Determination Service (DDS) makes all decisions relating to disability and blindness for the Division of Medicaid and the Social Security Administration (SSA).

Children under Age 19

The Families, Children and CHIP (FCC) programs serve children in specific age groups. Children have continuous eligibility for a 12-month certification period unless an "early-out" termination reason is met.

Pregnant Women

A pregnant woman of any age is categorically eligible. A pregnant woman's eligibility includes a 2-month post partum period following the month of delivery, miscarriage or other termination of pregnancy. Pregnancy and due date must be verified by a healthcare professional.

Families with Dependent Children

Low-income families with children under age 18 are categorically eligible for Medicaid. This includes intact 2-parent families, families in which the children are deprived of one or both parents, and qualified pregnant women.

A qualified pregnant woman has no children in the home. She is assessed for eligibility as if her unborn child were born. In this instance, the unborn is her "qualifying child." If there is a spouse, the spouse's eligibility for family coverage cannot be assessed until the child is born; however, his needs and income are included for his spouse's eligibility.

102.08 GENERAL ELIGIBILITY REQUIREMENTS

The eligibility requirements common to both ABD and FCC are discussed in this section. When the requirement also has a program-specific application, it is discussed separately with ABD discussed first, then FCC.

Basic Eligibility Requirements

An eligible individual must be in one of the categories of assistance discussed in 102.07; and,

- A citizen of the United States or a qualified alien (102.04 and 102.05); and,
- A resident of Mississippi (102.03); and in addition,
- Have income and resources, when applicable, within specified program limits; and,
- File an application.

Reasons for Ineligibility

Notwithstanding the above, an individual is not eligible in any program if the person:

(1) Fails to apply for any and all other benefits for which he may be eligible; (102.08.04)

(2) Fails to assign rights to any third party medical support or cooperate with Medicaid in obtaining third party payments; (102.08.05) or

(3) Is a resident of a public institution.(102.11)

Additional Factors Causing Ineligibility

- A person who refuses to accept vocational rehabilitation services is ineligible in the ABD programs.
- A resident of a long term care facility is ineligible in the FCC programs.

Eligible Individuals

❖ **Aged, Blind and Disabled Programs**

The eligible ABD adult or child is one who meets all basic program requirements. An eligible spouse is a person who (1) meets all of the basic program requirements, (2) is the husband or wife of an eligible individual and (3) lives with the eligible individual. This includes a man and woman who hold themselves out as husband and wife. The individual and spouse must each apply and meet all of the basic program requirements to establish eligibility as a couple.

Eligible Individuals

❖ **Families, Children and CHIP Programs**

Children under age 19, pregnant women of any age and parents or needy caretakers, within the specified degree of relationship, are eligible individuals for the FCC programs if they apply and meet program requirements.

For family coverage in the Medical Assistance Program (85), the married couple must live together, have a qualifying child, apply and meet all of the basic program requirements. Couples in "holding-out" situations are unrelated adults for FCC purposes.

However, if the unmarried couple has a common child, the adults' eligibility is established in the same way as a married couple with a qualifying child, i.e., both legal parents must live with the child, both apply and meet all basic program requirements.

102.08.01 VERIFICATION OF AGE

The age of an individual must be verified in the following situations:

- The applicant is an adult or child applying for benefits which are based on age;
- There are ineligible children in an ABD deeming household;
- A disabled or blind applicant under age 21 applies for ABD and any of the following conditions exist:
    - Deeming
    - Student earned income exclusion
    - Support from absent parent exclusion

Examples of acceptable sources of age verification are:

- Birth certificate or other birth records
  (Must be established during the first 5 years of life and certified by the custodian of the record. This could include a statement signed by the midwife or physician who was in attendance at the birth and who attests to the date of birth.)
- Social Security records
- BENDEX System
- SDX Listing
- Religious records
  Family Bible or other family record – must examine the entire publication
  Baptismal or confirmation certificate
- Hospital, school or physician/clinic records
- State or Federal Census records established near date of birth
- Marriage record which shows age or date of birth
- Insurance policy which shows age or date of birth
- Passport
- Employment records
- Military records
- Child's birth certificate which shows parent's age

Records which might be available to those born in foreign countries include the documents listed above and the following:

- Foreign passport
- Immigration record established upon arrival in the U. S.
- Naturalization papers
- Alien registration card

102.08.02 MARITAL RELATIONSHIPS

❖ **Aged, Blind and Disabled Programs**

Definition of a Marital Relationship

A marital relationship is one in which members of the opposite sex are:

- Married under State law;
- Married under common law, provided the couple began holding out prior to April 1, 1956;
- Married for Title II purposes, meaning one member of the couple is entitled to spouse's benefits on the record of the other;
- Living in the same household in a 'holding out" relationship as man and wife.
    - A man and woman who live in the same household are married for SSI/Medicaid purposes if they hold themselves out to the community in which they live as husband and wife.
    - It is possible for a couple to live together and not be "holding out" as man and wife, depending on economic and social circumstances. The only way to make a determination of marital status is for the Specialist to examine how the couple holds themselves out to the community.

      If the couple is determined to be living separately and apart, each is treated as an individual. However, when evidence does not support that a couple is living separately and apart, couple rules and deeming applies.
    - When a couple lives together, but denies "holding out", the Specialist must obtain as many items of evidence as possible to make a determination as to the couple's relationship and living arrangement.

      Such evidence may include mortgages, leases rent receipts, property deeds, bank accounts, tax returns, credit cards, information from other government programs (SSA, public housing, food stamps, etc.), and statements from friends, relatives and neighbors.

❖ **Aged, Blind and Disabled Programs**

Termination of a Martial Relationship

For ABD programs, the marital relationship no longer exists as of the date that:

- Either individual dies;
- A final decree of divorce or annulment is issued for the marriage;
    - If a divorced couple resumes living together, the specialist must develop whether they have a holding-out relationship.
- Either individual begins living with another person as their spouse;
- The couple is determined not to be married for Title II purposes if that was the basis for considering the couple married;
- The couple begins living in separate households.
    - When a married couple claims to be living apart, the Specialist must obtain as many items of evidence as possible to make a determination as to the couple's relationship and living arrangement.

      Such evidence may include mortgages, leases rent receipts, property deeds, bank accounts, tax returns, credit cards, information from other government programs (SSA, public housing, food stamps, etc)., and statements from friends, relatives and neighbors.
    - If the Specialist determines the couple is living apart, each person is treated as an individual.
    - A man and woman who are still legally married and resume living together after having lived apart is a married couple, regardless of the reason for having resumed living together.

❖ Aged, Blind and Disabled Programs

Verification of a Marital Relationship

A marital relationship is presumed for an ABD couple unless the client states otherwise and provides the types of evidence listed above which indicate the relationship does not exist or has terminated.

Changes in Marital Status

A man and woman are married for a month if they meet any of the criteria for a marital relationship within the month. When a change occurs and an individual marries, resumes living with a spouse, enters a "holding out" relationship, etc., use couple budgeting beginning the month of the marriage. An increase in benefits can be effective immediately if policy otherwise allows it. Adverse action rules apply when ineligibility or a decrease in benefits results for a recipient.

Termination of marriage is effective the month after the month of a death, divorce, annulment or separation.

NOTE: For the spousal impoverishment allocation, the couple must be legally married under state law or in a common-law marriage which began prior to April 1, 1956. The spousal impoverishment allocation is not applicable to couples in "holding-out" situations which began on or after April 1, 1956.

102.08.02A MARITAL RELATIONSHIPS

❖ **Families, Children and CHIP Programs**

Definition of a Marital Relationship

A marital relationship is one in which members of the opposite sex are:

- Married under State law;
- Married under common law prior to April 1, 1956 as recognized by MS.

Couples in "holding out" situations are unrelated individuals for FCC purposes. However, when the couple has a child, the applicant child and both legal parents are included in the budget group. Consequently, each adult can impact the eligibility of the other when an application is filed for family coverage in the Medical Assistance Program.

Example: Sally Jones and Ben Johnson are an unmarried couple. They are the legal parents of one minor child, Brittany Johnson. Sally is not pregnant, but she needs Medicaid for herself and Brittany. An application for Medical Assistance/85 is filed for the parents and the child. Based on SFU requirements, both parents and the child must be included in the application. Ben earns $2700 per month so his income exceeds the 85 gross income limit for a family of 3. In this example, Brittany is the only qualifying child. Based on Ben's income, Brittany is not deprived. Ben is ineligible and Sally is also ineligible even though there is no marital relationship. Brittany will be assessed for placement in another Medicaid program or CHIP.

Termination of a Martial Relationship

The marital relationship no longer exists for FCC purposes as of the date that:

- Either individual dies;
- A final decree of divorce or annulment is issued for the marriage;
    - If a divorced couple resumes living together, the adults are unrelated; however, if they are the legal parents of the applicant children, both adults are included in the Assistance Unit (AU) or Standard Filing Unit (SFU) together.
- The married couple begins living in separate households.

❖ **Families, Children and CHIP Programs**

Termination of a Martial Relationship (Continued)

- A legally married man and woman who resume living together after having lived apart are treated as a married couple, regardless of the reason for having resumed living together.

NOTE: Legal parents must be included in the AU or SFU with their children.

Verification of a Marital Relationship

Marital status is verified by client statement or self-declaration. Refer to 102.01.01 when determining if information is considered questionable and requires additional verification.

Changes in Marital Relationship - Applications

Marriage or termination of marriage, including separation, is effective the month the event occurs. In application situations, individuals must be in the home at least one day of the month to be included in that month.

Example: A household applies May 27. At the interview on June 5, the head of household reports her spouse and the father of the children returned to the home on May 30. The spouse is considered part of the household effective May 1. If the spouse had moved back in the home on June 3, he would be included in the household effective June 1.

However, when a head of household reports prior to the eligibility determination that a person moved out, that person is not considered part of the household in the month the change occurred.

Example: A household applies on July 30th and is interviewed August 8th. During the interview, the head of household reports that her husband and the father of the children abandoned the family on August 3rd and she does not expect him to return. The spouse would not be included in the household effective August 1.

- **Families, Children and CHIP Programs**

Changes in Marital Relationship – Active Cases

A change in marital status must be reported by adult recipients eligible in the Medical Assistance Program. When an adult becomes ineligible due to a change in marital status, eligibility is terminated after allowing 10-day (plus 2 days mailing time) notice of the adverse action. Any changes resulting for the children will be handled at review.

102.08.03 DEFINITION OF A CHILD

❖ **Aged, Blind and Disabled Programs**

In the ABD programs, a child is defined as someone who is neither married nor head of a household and is either:

- Under age 18; or
- Under age 22 and a student regularly attending school or college or training that is designed to prepare him for a paying job.

Verification

A child's age must be verified. For a list of acceptable verifications, refer to 102.08.01. If the document used to verify a child's age does not also verify the parent/child relationship, self-declaration of relationship is permissible.

As indicated above, someone who is married cannot meet the definition of a child for ABD Medicaid purposes; however, he may meet the definition of an "eligible individual" as discussed in 102.08.

Termination of Child Status

Status as a child ends:

- Effective with the month the child becomes age 18 or age 22, if a student, or
- The month he last meets the definition of a child.

Developing ABD Student Status

No development of student status is necessary for a child under age 18 who does not expect to earn over $65 in any month. However, school attendance must be explored whenever an applicant or recipient between the ages of 18 and 22 alleges being a student.

An individual meets the definition of a child for purposes of allocation and budgeting if he is under age 22 and regularly attending school, college or training designed to prepare him for a paying job. Obtain the following information to develop student status:

❖ Aged, Blind and Disabled Programs

Developing ABD Student Status (Continued)

- Name and address of school or institution furnishing the training;
- Name of the person to contact for verification, if necessary; and
- Information on the course or courses of study dates of enrollment, number of hours of attendance, and other activities of the child.
- Verify enrollment by examining a student record such as an ID card, tuition receipt or contact with the school.

Regular attendance means the individual takes one or more courses of study and attends classes:

- In a college or university for at least 8 hours a week under a semester or quarter system; or
- In grades 7 – 12 for at least 12 hours a week; or
- In a course of training to prepare him for a paying job for at least 15 hours a week if the course involves shop practice or 12 hours a week if it does not involve shop practice.

  NOTE: This kind of training includes antipoverty programs, such as Job Corps and government-supported courses in self-improvement.

- For less than the time indicated above for reasons beyond the student's control, such as illness, if the circumstances justify the reduced credit load or attendance.

  Example of school attendance less than required hours: A paraplegic is forced to limit vocational school attendance to one day a week due to the unavailability of transportation. Although the student is enrolled for attendance of less than 12 hours a week, he qualifies as regularly attending school because lack of transportation is a circumstance beyond his control.

- Student status is also granted to homebound students who have to stay home due to a disability.

- Student status is granted if the child studies courses given by a school (grades 7 – 12), college, university or government agency and a home visitor or tutor directs the study or training.

A child remains a student when classes end if he attends classes regularly prior to school vacation and intends to return when school reopens.

102.08.03A DEFINITION OF A CHILD

❖ **Families, Children and CHIP Programs**

To be categorically eligible as a child in the FCC programs, the individual must be under the age of 19. Age must be verified. For a list of the acceptable verification methods, refer to 102.08.01.

An individual's status as a child ends effective the month after he turns age 19.

Emancipated Children

Most children are dependents of their parents or have another adult caretaker. However, some children may be emancipated. An emancipated minor is authorized to act on his own behalf. Though not a dependent child, the emancipated minor under age 19 is a categorically eligible child for FCC programs. Emancipation may occur the following ways:

- **Court-Ordered Emancipation**

  In certain situations, a court may grant an order of emancipation or relief of minority to remove a minor child from the parents' supervision and financial responsibility and allow the minor child to live independently and act on his own behalf.

- **Marriage**

  When a minor child marries, he in effect emancipates himself. If the minor lives with a spouse, he is not considered a dependent of his parents. However, if the minor lives with his parents apart from the spouse, he returns to dependent child status for FCC purposes.

- **Living Independently**

  There may be instances in which parents relinquish supervision and financial responsibility for a child. When a child is living independently, he is an emancipated minor.

Minor Parents

An unmarried parent under age 19 who resides in the home with his children and his parents (the children's grandparents) is a dependent child of his parents for purposes of determining the minor's own eligibility. The minor's children are dependent children of the minor parent for determining their eligibility.

❖ **Families, Children and CHIP Programs**

Minor Heads of Household

There are instances in which it is permissible for a child to be the head of household. Children living independently, including those in group homes, orphanages and other situations in which parents have relinquished or abandoned custody, often have individuals filing on their behalf, such as a social worker, administrator or foster parent; however, it is also permissible for the child to file the application when he is capable of doing so.

In addition, a child living with parents can be the head of household, i.e., the person filing the application, under certain circumstances:

- A married minor living with a spouse can file an application as head of household, independent of parents;
- A pregnant pre-teen or teen can file an application as a pregnant woman, independent of parents;
- A minor parent can file an application for his/her children as head of household. However, a minor parent must have his own eligibility determined with his parents.

102.08.04 UTILZATION OF OTHER BENEFITS –GENERAL

As a condition of eligibility, an ABD or FCC applicant or recipient must take all necessary steps to obtain all benefits to which they are entitled when the benefit(s) is one of the following types:

Medicare - Medicare-entitled individuals must enroll in the program.

Unemployment Benefits - Unemployment insurance provides income to those who have been laid off or are unemployed due to no fault of their own and are able to work and are available for work. Potential eligibles should be referred for these benefits.

Worker's Compensation Benefits - If a client alleges either injury on the job or has what may be a work-related impairment, refer for these benefits.

Social Security Retirement, Survivors and Disability Insurance Benefits, Including Early Retirement At Age 62 - Any client who is not already receiving Social Security benefits or Railroad Retirement benefits at time of application must be referred to apply for either retirement benefits, including early retirement, disability benefits if under age 65 or survivor's benefits, if a widow(er) or disabled child of a deceased parent.

Retirement or Disability Benefits Including Veterans' Pensions And Compensation - Explore the possibility of entitlement to VA benefits if a client is a veteran, the child or spouse of a veteran, a widow(er) or previous spouse of a veteran or the parent of a veteran who died from service-connected causes.

When a client is determined to be ineligible for VA benefits at home, the case must be documented that a referral to VA will be needed if the client subsequently enters a nursing facility. Use DOM-312, Notice of Potential Eligibility for VA Benefits, to notify the client of the requirement to file and follow through with an application.

NOTE: VA Aid and Attendance is not a required benefit under this provision.

Annuity Or Pension Such As Private Employer Pensions, Civil Service Pensions, Union Pensions, Railroad Retirement Annuities And Pensions, Municipal, County Or State Retirement Benefits - Explore entitlement for private sector benefits if the client or former/deceased spouse worked for a private sector employer with a pension plan and if not already receiving or has not received a pension based on that employment.

Annuity or Pension (Continued)

- Explore entitlement for benefits if the client or former/deceased spouse (or deceased parent if the client is a child) is not already receiving or has not received a pension based on such employment and was employed in one of the following:

    - Federal Civilian Employment for a minimum of five years;
    - Federal Uniformed Service (Military) for a minimum of twenty years;
    - State or Local Government employment.

Benefits Exempt from Utilization Provision

The client is not required to apply for the following types of benefits:

- Temporary Assistance for Needy Families (TANF)
- General Public Assistance, including SSI
- Bureau of Indian Affairs General Assistance
- Victim's Compensation payments
- Other Federal, state, local or private programs with payments based on need
- Earned Income Tax Credits

Exempt Individuals

This provision applies only to eligible individuals (applicants or recipients). It does not apply to non-applicants or ineligibles. This includes the ineligible spouse or community spouse in ABD and non-applicant or ineligible parents or caretaker relatives of children; however, the responsible adult is required to file on behalf of children potentially eligible for other benefits as a condition of the child's eligibility.

Exception to the Utilization Provision

An individual is not required to accept another benefit if the resulting payment would be a reduction in current benefits payable to the individual. This does not include a reduction in Medicaid benefits.

Good Cause for Failure to Comply with Provision

The agency must require clients to take all steps necessary to apply for other benefits to which they are entitled, unless good cause can be shown for not doing so. A denial or dismissal of a claim for other benefits due to failure to submit required verification does not satisfy this requirement.

Good cause for not applying for other benefits may be found to exist if the individual does not apply due to:

- Illness and there is no authorized representative to apply on the client's behalf; or
- The individual previously applied and was denied and the reason for the denial has not changed; or,
- The individual was unaware of the availability of a benefit and the agency did not advise him of its availability.

If good cause does not exist for failure to comply with this requirement, eligibility will be denied or terminated as discussed later in this section.

Applying the Provision

The utilization of other benefits provision is applicable at the time of application and for the duration of eligibility. The individual potentially eligible for the types of benefits listed above or the responsible person, if the client is a child, must take steps to apply for the benefits. If eligible, the individual must accept the payment regardless of the impact the additional income will have on Medicaid eligibility.

Client and Regional Office Responsibilities

It is the client's responsibility to supply information regarding the possibility of other benefits. In addition the client must file for these benefits when informed by the regional office of potential eligibility and then follow through with all actions needed to obtain an eligibility decision. The case must be documented with actions taken and the award decision.

Client and Regional Office Responsibilities (Continued)

The Regional Office has the following responsibilities:

- Determining that the benefit is the type of benefit that must be pursued;
- Determining the likelihood of possible eligibility for the benefit;
- Providing the written notice of the actions the client must take in regard to the benefit;
- Referring the client to the proper agency; and
- Assisting the individual, as necessary, to comply with the requirement to file for the benefit and follow through to an eligibility determination.

Determination of Potential Eligibility

The Regional Office may become aware of potential eligibility for other benefits from:

- Responses to questions on the application;
- Interview discussion;
- Inquiries from other agencies;
- Staff knowledge of government and private pension plans and disability programs.

If staff determines an application for other benefits would not be beneficial, i.e., proof exists of a prior denial and there has been no change in circumstances, the individual should not be required to apply for the benefit. The case record must be documented with the reason for a decision not to require the client to file for the benefit.

If there is doubt about potential eligibility in a given case, the specialist must contact the agency or organization involved to determine if the client is potentially eligible. If the Specialist cannot determine that the client is not potentially eligible, the client must be notified of the requirement to apply for the benefit.

Notification Requirements

The client must be furnished with written request notice explaining the responsibility to apply for the potential benefit within 30 days of the notice for ABD and within 15 days of the notice for FCC.

The DOM-307, Request for Information, will be used to inform the individual of the following:

- The type of benefit the client appears to be eligible for;
- The agency or organization where an application should be filed:
- That the client has 30 days (or 15 for FCC) from the date of the notice in which to file an application for the potential benefit; and
- Proof that that application has been filed must be provided to the Regional Office within the 30-day (or 15-day) timeframe.

Agreement to Comply

An agreement to comply does not negate any prior action to deny or terminate benefits. The effective month of eligibility is the month in which the individual takes the steps necessary to obtain benefits from the other agency.

Other Issues

- A client may be eligible for more than one type of benefit. All potential sources of benefits must be identified.
- The election of a lower benefit when the individual has an option between a high and low benefit will result in denial or loss of eligibility.
- When a client has a choice regarding payment as a lump sum or an annuity, the annuity must be selected. A one-time total withdrawal of pension plan funds in this situation does not comply with the statutory requirements that mandate application for the annuity or pension, i.e., money payment at some regular interval.
- Recommend conversion of lump-sum applications in appropriate situations to focus on maximizing the use of the other benefits to provide ongoing support.

102.08.04A UTILIZATION OF OTHER BENEFITS

❖ Aged, Blind and Disabled Programs

If the ABD client has not provided the verification that the application has been filed or proof of ineligibility within the 30 days, the DOM-309 will be issued allowing 10 additional days (plus 2 days mail time) to provide the information. If the client still has not provided either evidence that an application has been filed or proof that the client is not eligible, the specialist will contact the agency in question to attempt to determine whether an application has been filed and the usual processing time involved for the application in question.

Action When Application Has Been Filed

If the application for other benefits has been filed, eligibility for Medicaid can continue or a Medicaid application may be approved while the application for other benefits is in process. A tickler will be set for the end of the usual processing time for the other benefits so the specialist can contact the individual or the other agency to determine the final decision.

The regional office much keep a control in this manner to make a determination at any point in time that the individual has taken all appropriate steps in pursuing the claim for other benefits.

Action When Final Decision is Reached

When the regional office is notified of the final decision, the record must be documented with the outcome of the application. A copy of the decision letter or other verification must be filed in the case record. If the specialist contacted the other agency to determine the final decision, the case should be documented appropriately.

The specialist will then determine the effect of the decision on the individual's Medicaid eligibility. If the individual was approved for the other benefit, the payment must be included in the budget and the client notified of the resulting effect on Medicaid eligibility.

❖ **Aged, Blind and Disabled Programs**

Failure to Comply without Good Cause

If the ABD individual has failed without good cause to take all steps to obtain the other benefits, the specialist will take action to deny or terminate benefits until the requirement is fulfilled. An agreement to comply does not negate any prior action to deny or terminate benefits.

The effective month of eligibility is the month in which the individual takes the steps necessary to obtain benefits from the other agency or provides proof of ineligibility for the benefit.

102.08.04B UTILIZATION OF OTHER BENEFITS

❖ Families, Children and CHIP Programs

If the FCC client or responsible person has not provided either evidence that an application has been filed or proof of ineligibility within the 15-day request period, the Specialist will contact the agency in question to determine if an application has been filed and the usual processing time for the application. This information must be documented in the record.

Action When Application Has Been Filed

If the application for other benefits has been filed, coverage can be approved for the individual, if otherwise eligible. If the case involves an adult(s) receiving family coverage in the 85 program, a tickler will be set for the end of the usual processing time for the application for other benefits for the Specialist to contact the Head of Household or agency to obtain the final decision. If the decision is still pending, the RO must continue to maintain controls until a final decision is made and to ensure the client is taking all necessary steps to pursue the claim.

Action When Final Decision is Reached

When the final decision has been reached, the Regional Office must obtain documentation/verification for the case record. The Specialist will review the case to determine the effect the decision has on the 85 adult's eligibility. If the benefit was approved, the payment must be included in the budget and the client notified of changes in the adult's eligibility, if any.

Since children have 12 months continuous eligibility regardless of income changes, a child's eligibility will not be impacted by approval for other benefits until review.

Failure to Comply Without Good Cause

When the application for other benefits has not been filed and good cause does not exist, the FCC adult or child who was potentially eligible for the other benefits cannot be approved for Medicaid. However, any other eligible children included in the application can be placed in an appropriate program. If the 85 program is involved, one ineligible parent or sibling will cause the children and parents/caretaker relative to be ineligible due to Standard Filing Unit requirements. Therefore, any eligible children must be placed in an appropriate FPL program.

102.08.05 ASSIGNMENT OF THIRD PARTY RIGHTS – GENERAL

Federal law requires that all Medicaid applicants and recipients must, as a condition of eligibility, cooperate with the Medicaid Agency in identifying, to the extent they are able, potentially liable insurers and other third parties who may be liable to pay for care and services covered by Medicaid. Cooperation includes repaying any monies to the Medicaid Agency received from a third party source to the extent that Medicaid has paid for the covered service.

By accepting Medicaid each applicant/recipient is deemed to have made an assignment to the Medicaid Program of his rights to medical support or any third party benefits, including hospitalization, accident, medical or health benefits owed to the individual, as well as rights to such benefits owed by any third party to the children or any other person for whom the applicant/recipient has legal authority to execute such an assignment.

Requirements

As a condition of eligibility each applicant/recipient must:

- Assign to the state his individual rights to medical support and other third party payments, and such rights of any other eligible individuals for whom he has legal authority;
- Cooperate in establishing paternity and obtaining medical support or payments, when applicable, and
- Cooperate in identifying and providing information to obtain third party payments.

Automatic Assignment Of Third Party Rights

Although assignment of third party rights is automatic, the applicant/recipient must be informed of the requirement. The ABD and FCC application forms contain the mandatory assignment of rights statement in the section of the form requiring the signature of the applicant, recipient, head of household or designated representative. When an interview is completed, an explanation must be provided to the individual who is assigning rights to third party payments for medical care as a condition of eligibility for Medicaid. The individual's signature on the application form at initial application and each redetermination of eligibility acknowledges the automatic assignment of all third party rights.

Failure to Cooperate With Third Party Assignment

The Third Party Liability (TPL) Unit has the responsibility for determining if an individual has failed, without good cause, to cooperate with assignment of third party rights. If the TPL Unit determines there was good cause for failure to cooperate, the individual will be exempted from the cooperation requirement. However, a determination of failure to assign rights or lack of cooperation in obtaining third party payments, without good cause, will result in denial or termination of Medicaid benefits after affording the right to appeal.

If the TPL Unit determines an individual has failed, without good cause, to cooperate with third party assignment, Enrollment will be notified. In turn, the appropriate Regional Office will be notified of the action needed to deny or terminate eligibility.

Advance notice must be issued to terminate eligibility; however, the individual has the right to a hearing. All appeals regarding failure to cooperate with the TPL Unit must be handled through a state hearing request.

When benefits are terminated due to failure to cooperate with TPL, the Regional Office will be notified of the period of ineligibility. If the cooperation issue is resolved with TPL, the Regional Office will be notified of the action necessary to restore eligibility.

❖ **Families, Children and CHIP Programs**

102.08.05A CHIP AND OTHER INSURANCE COVERAGE

There is no requirement for assignment of third party rights in the Children's Health Insurance Program because the program is for uninsured children only. Children who are covered by creditable third party insurance at application are not eligible for CHIP. This is true regardless of who pay the health insurance premiums.

Termination of third party insurance must be verified when the application indicates insurance coverage will terminate within the 30-day application processing period or terminated within the six months prior to the application. As indicated above, a child covered by insurance at the time of application is not eligible; however, when insurance coverage will terminate within the 30-day application processing period, do not deny an otherwise CHIP-eligible child. If all other factors of eligibility will be met, hold the application and take action to approve the child after the insurance coverage has ended.

Example: An application is filed on February 2nd for an otherwise CHIP-eligible child whose verified insurance termination date is February 15th. Action can be taken to approve CHIP after insurance coverage has ended, beginning February 16th. Action is must taken within the 30-day timeframe; therefore, the effective date for CHIP eligibility will be either March 1st or April 1st, depending on the authorization date.

When a child's eligibility changes from Medicaid to CHIP, there should be no break in coverage. However, there will always be a break in coverage between termination of third party insurance and the CHIP start date. The specialist must make a good-faith effort to approve a CHIP-eligible child for the earliest possible effective date. Notwithstanding, all FCC applications must be processed within 30 days.

Creditable insurance coverage is full health insurance. Children covered only by the following types of insurance may qualify for CHIP: accident insurance, disability income insurance, liability insurance, supplemental policies for liability insurance, worker's compensation, automobile medical payment insurance, credit-only insurance, coverage for onsite medical clinics or limited-scope dental or vision or long term care insurance.

102.08.06 CHILD SUPPORT REQUIRMENTS - GENERAL

State child support (IV-D) agencies are required to provide all appropriate child support services available under IV-D of the Social Security Act to families with an absent parent who receive Medicaid benefits and who have assigned rights for medical support to the State. State IV-D agencies are required to petition for medical support when health insurance is available to the absent parent at a reasonable cost.

In order for the IV-D agency to provide the services required by law, the Division of Medicaid must refer the following children to the Mississippi Department of Human Services (MDHS), Child Support Enforcement Office:

- Disabled children in an ABD program with an absent parent; and
- Children in the Medical Assistance Program (85) with an absent parent.

There are additional IV-D requirements in FCC as discussed in 102.08.06B.

102.08.06A CHILD SUPPORT REQUIREMENTS

- ❖ **Aged, Blind and Disabled Programs**

The specialist will complete a manual referral using Form DOM-TPL-410, Absent Parent Referral, and forward to Child Support Enforcement within the Mississippi Department of Human Services (MDHS) for disabled children in an ABD program who have an absent parent. Non-cooperation with child support enforcement does not impact a disabled child's eligibility.

102.08.06B CHILD SUPPORT REQUIREMENTS

- ❖ **Families, Children and CHIP Programs**

The specialist will provide applicants with information about child support services available through the Office of Child Support Enforcement within MDHS to establish paternity and/or seek or enforce financial and medical support orders for minor children. Cooperation with child support activities is a requirement for the eligibility of adults in the Medical Assistance program. Cooperation is not required for the FPL programs; however, the HOH can volunteer for the child support services for children in the FPL Medicaid programs, but voluntary services are not available not for CHIP recipients.

❖ Families, Children and CHIP Programs

Voluntary Referrals

Referral to and cooperation with Child Support Enforcement is not a requirement for the FPL Medicaid categories or CHIP. However, the parent or responsible adult can voluntarily request child support services for children receiving Medicaid in the FPL programs (87, 88, 91). Voluntary referrals will be made through MEDSX/METSS child support interface.

As indicated previously, voluntary referrals cannot be made for CHIP children. The parent of the CHIP child must file an application for child support services with MDHS for the child.

Child Support Requirement for Medical Assistance Program

Referral to and cooperation with child support is required as a condition of the 85 adult's eligibility if the deprivation reason for at least one child included in the Standard Filing Unit is continued absence. The 85 parent or caretaker relative must cooperate with child support requirements and assist the state by cooperating with enforcement of existing court orders or in obtaining at least medical support from the absent parent. A referral will be made whether or not there is an existing court order and regardless of whether child support is being paid by the absent parent.

Cooperation

Cooperation includes providing information about the absent parent, including name, SSN, current or last known address, current or last known place of employment, as well as helping to locate the absent parent and in establishing paternity or medical support.

Non-Cooperation and Good Cause Responsibilities

At time of application, if the 85 parent or caretaker relative refuses to cooperate with child support, the specialist will deny the adult and test the children for eligibility in an FPL program. After a referral has been made, MDHS child support staff determines satisfactory cooperation, good cause for failure to cooperate and satisfactory cooperation after a period of non-compliance.

- **Families, Children and CHIP Programs**

Handling Non-Compliance

When the Medicaid specialist is notified by child support of failure to cooperate, the 85 adult's eligibility will be terminated allowing adverse action notice. The child support sanction can only be removed when the adult has complied fully with child support requirements and the Office of Child Support Enforcement has notified DOM of the compliance.

The requirement to cooperate as a condition of eligibility impacts the eligibility of an adult receiving Medicaid in the 85 program only. The eligibility of children is not impacted by the adult's sanction.

Lack of cooperation by the parent or responsible adult who voluntarily requested a child support referral for children in the FPL Medicaid programs does not result in any adverse action.

102.09 ABD NON-FINANCIAL REQUIREMENTS

The non-financial requirements which pertain only to the Aged, Blind and Disabled programs are discussed in this section.

102.09.01 DEFNITIONS

Definition of Adult Disability

The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

This means the adult is unable to do his previous work or any other substantial gainful activity which exists in the national economy. The adult's residual functional capacity, age, education and work experience are considered in the disability determination process.

Definition of Childhood Disability

An individual under the age of 18 is considered disabled under SSI policy if that child has a medically determinable physical or mental disability, which results in marked and severe functional limitation, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of at least 12 months.

No individual under the age of 18 who engages in substantial gainful activity may be considered disabled.

Definition of Blindness

Statutory blindness is central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which has a limitation in the field of vision so that the widest diameter of the visual field subtends an angle no greater than 20 degrees is considered to have a central visual acuity of 20/200 or less. An individual's ability to work will not affect eligibility based on blindness.

NOTE: Throughout the remainder of this section, the term "disability" also refers to blindness.

❖ **Aged, Blind and Disabled Programs**

102.09.02 DISABILITY DETERMINATION PROCESS

In Mississippi, an application for SSI is also an application for Medicaid. This does not mean a separate Medicaid application cannot be filed by an SSI applicant; however, the regional office is not required to obtain a separate Medicaid disability determination for any months of potential SSI eligibility, starting on the effective filing date of the SSI application. The applicant is required to wait until SSA makes the SSI eligibility determination.

Independent Disability Determinations

However, the regional office will make an independent disability determination when a separate Medicaid application has been filed under one of the following circumstances:

- The individual has not applied for SSI or has applied and been denied for a reason other than disability.
- An individual applies separately for both SSI and Medicaid and SSI fails to make a decision within 90 days. In this instance, DDS must provide Medicaid with a decision prior to the SSI decision.
    - When DDS approves Medicaid disability prior to an SSI decision, a tickler must be set to check on the final SSI decision. If the SSI decision is a disability denial, the case must be closed for Medicaid purposes and the case referred to state office along with all medical information in the case record for routing to DDS for a final decision.
- An individual applies for Medicaid and alleges a disabling condition that is different from, or in addition to, that considered by SSA.
- An individual meets all 3 of the criteria below:

    (1) Applies for Medicaid more than 12 months after SSA last made a final determination that the individual was not disabled; **and**
    (2) The individual alleges his condition has deteriorated since that final decision; **and**
    (3) The individual has not reapplied for SSI.

❖ **Aged, Blind and Disabled Programs**

Independent Disability Determinations (Continued)

If the above conditions do not exist and the individual is potentially eligible for SSI, he must be advised to file or re-file for SSI benefits. This does not mean a separate Medicaid application cannot be filed; however, Medicaid eligibility decision will be tied to the SSI decision.

Example: An individual applied for SSI and was denied due to disability in June 2008. In October 2008, the individual files for Medicaid only but alleges no change in his physical condition since his SSI application was denied. In this case, the SSI disability denial controls the Medicaid decision. The individual must be denied Medicaid eligibility based on the previous SSI denial and referred to SSA to reapply for SSI.

Requesting Reconsideration

Under SSA rules, an individual may request reconsideration within 60 days of receipt of the notice denying SSI disability. If the individual does not appeal the decision within 60 days, he may still request reopening of the determination within 1 year for any reason and within 2 years for good cause, such as new or material evidence.

Therefore, if an individual alleges deterioration of the condition on which the previous disability denial was based, he can submit this to SSA for reconsideration or reopening within 12 months of the most recent final SSI determination.

102.09.03 EXCEPTIONS TO OBTAINING DDS DISABILITY APPROVALS

There may be instances when DDS has already determined disability using SSI criteria for the same period of time to be covered by a Medicaid application. If so, a separate Medicaid determination is not needed. However, if the disability onset date, as established by SSA, does not include all months of requested Medicaid eligibility, a separate DDS decision is required.

Situations Which Do Not Require a Separate Disability Determination

In the following situations a separate blindness/disability determination for Medicaid is not needed. The Specialist can consider the applicant/beneficiary to be blind/disabled and complete the eligibility determination process.

❖ Aged, Blind and Disabled Programs

Situations Which Do Not Require a Separate Disability Determination (Continued)

- **Applicant Receives Title II Disability –** The Medicaid applicant receives Title II disability benefits on an ongoing basis based on his own disability and the disability onset date is verified to include all months to be covered by the Medicaid application, i.e., the month of application and any retroactive months. Receipt of Title II disability must be re-verified at each redetermination.

- **Disability Decision Overturned by Administrative Law Judge (ALJ) Order -** An Administrative Law Judge (ALJ) reverses a disability denial and establishes disability with a disability onset date which covers all months of the Medicaid application.
  If the Medicaid applicant is otherwise eligible, eligibility can be established as of the date of the onset of disability as established by the ALJ order, but no earlier than:

  - The Medicaid application date; or
  - Three months before the Medicaid application date if retroactive benefits are an issue.

  Example: An ALJ order reversed a disability decision and established disability effective February 2008. The application for Medicaid is filed on July 2, 2008. If the Medicaid applicant met all other requirements and requested retroactive benefits, eligibility could be established effective April 1, 2008.

- **Deceased Applicants** - A verified death date establishes disability if a disability, due to any illness or accident which resulted in death, existed in all months for which Medicaid eligibility was requested.

  Example: A traumatic onset of disability occurred on September 14, 2008, due to an accident. On October 12, 2008, individual dies as a result of injuries sustained in the accident. The application for Medicaid is filed on November 3, 2008. Under this exception, Medicaid eligibility can only be established starting September, the month of the accident, forward.

- **Disabled Adult Children –** Disability has previously been established by SSA for an applicant who is over age 18, entitled to Medicare and receiving Title II benefits as a child (C1-C9 beneficiary). The disability onset date must be determined.

❖ **Aged, Blind and Disabled Programs**

102.09.04 OBTAINING DDS DISABILITY DECISIONS

If there is no indication that any of the above exceptions apply, the Medicaid Specialist will use the following procedures to obtain a DDS decision when an applicant applies for Medicaid on the basis of disability or blindness.

Procedures for DDS Forms Completion

- Complete Form DOM-323, Disability or Blindness Report. This form is used to record the applicant's condition and medical background based on the applicant's responses and worker observations. If the applicant has medical records from the providers listed on the 323 in his possession, submit the medical records with the 323.
- If the applicant is a child, complete Form DOM-323A, Disabled Child Questionnaire, in addition to the DOM-323. The 323A is used for children age 18 or under to record medical and educational information based on the parent/representative's responses.
- If the applicant is currently employed, include detailed information regarding work hours, income, name and type of employer, etc., on the DOM-323. Also indicate whether the applicant has been examined by a physician within the last 3 months. If so, specify the physician.
- If the applicant has a communication problem due to language, speech or hearing difficulties which would make it hard for DDS to contact the applicant, complete Form DOM-324, Vocational Report, as a supplement to the DOM-323.
- The applicant must sign a DOM-301A, Authorization to Release Medical Information, for the number of providers identified on the DOM-323. In addition, the applicant must sign, but not date, two additional "Authorization to Release Medical Information" forms.
    - Signatures on blank releases are required so that DDS will have sufficient releases for providers indicated on the DOM-323 and other providers they feel it necessary to contact without having to delay the process to get additional releases. Medicaid Specialists must explain this reasoning to applicants.
    - If an applicant refuses to sign blank forms, have the applicant complete the provider's name and sign the form. Explain that there could be a delay in the process if the applicant has to be contacted for any additional releases that may be needed.

❖ **Aged, Blind and Disabled Programs**

OBTAINING DDS DISABILITY DECISIONS

Procedures for DDS Forms Completion (Continued)

- Signatures required on the DOM-301A, Authorization to Release Medical Information:
  - The applicant or an individual who has the legal authority to act on behalf of the applicant, such as a parent, power of attorney, agency or individual holding custody, or conservatorship, must sign the release.
  - When someone other than the applicant signs the release, the individual must sign his name (not the name of the applicant) and indicate his relationship to the applicant.
  - If the applicant is unable to sign the release and the designated representative signs in the applicant's place, the authorized representative must state why the applicant is unable to sign his name, e.g., "patient unconscious", "patient senile", etc.
  - If a representative signs the DOM-301A, attach a copy of the DOM-302 Designated Representative Statement". If the DOM-302 is signed as self-designation, there must be an explanation of why the applicant did not sign the 302 before medical information is released.
  - If the release is signed with an "X", two witnesses must also sign.

- Complete Form DOM-325, Disability Determination and Transmittal. This form serves as the transmittal form for submitting DOM-323, DOM-323A and DOM-324, if applicable, medical releases and prior medical information from the case record.
  - If the individual is applying under the Working Disabled coverage group, this should be clearly indicated in "Remarks".
  - If the applicant is a child, put the parent or representative's name on the DOM-325 in the same space with the case name.
  - For example, enter Jane Doe (parent) for Janie Doe.

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Submission to DDS

Include all material discussed above in a file folder labeled with the client's name, Social Security Number and case number: **Jane Doe**
425-45-9999
300-74-8855

Mail the folder to DDS as follows: **Disability Determination Service**
P O Box 1271
Jackson, MS 39205

Timeframes

For initial DDS submissions and re-submissions, set a ticker for 75 days. If a disability decision is not received within 75 days or if any problem occurs pertaining to the medical decision the regional bureau director should be notified to contact DDS. The DDS toll free telephone number is: (800) 962-2230. The local DDS telephone number is (601) 853-5100.

Procedures for Receiving DDS Decisions and Reevaluations

- DDS will return the medical information file and a disability or blindness decision to the regional office. The decision will be recorded on the lower portion of the DOM-325. Any 325 that does not have physician's signature should have a physician's rating referenced in the "Remarks" section.
- DDS will attach this cross-referenced documentation to the 325. Each regional office will ensure DDS sends all relevant material for a decision.
- When an approved DOM-325 is received, the need for a re-examination and date is indicated in section 15. If no re-examination is needed, the DOM-325 is valid indefinitely or until the recipient is determined "no longer disabled". If a re-examination date is given, the DOM-325 is valid until that re-examination date. The valid DOM-325 can be used for reapplications when the Medicaid closure reason was not loss of disability.
- A case must not be sent in for reevaluation prior to the date specified on the DOM-325 in section 15. However, the worker must set a tickler for a date prior to the due date to ensure the medical information is resubmitted following the above procedures for submission to DDS on the specified due date.

❖ **Aged, Blind and Disabled Programs**

Procedures for Receiving DDS Decisions and Reevaluations (Continued)

- Upon receipt of the decision from DDS, the regional office will take appropriate action on the case and notify the recipient of the decision.

- When an SSI individual is medically approved for the retroactive period, but denied SSI benefits ongoing on a medical denial, the case should be referred to the Bureau Director, Deputy, responsible for the region to be re-submitted to DDS for an explanation of the action taken.

❖ **Aged, Blind and Disabled Programs**

102.09.05 TEMPORARY SSI CLOSURES

Cases that are SSI-eligible but terminate once per quarter and are reinstated by SSI after one or two months of ineligibility are referred to as "ping-pong" cases. The usual cause of the temporary SSI closure is earned income in a 5-week month.

The individual whose SSI is temporarily terminated can apply for Medicaid coverage during the missing SSI months by filing an application with the regional office. The procedures below should be followed when processing "ping-pong' cases.

Procedures for Handling "Ping-Pong" Cases:

- At initial application, handle the case according to ongoing policy. Obtain a DDS decision and verify all other required information. Advise the client or representative to contact the regional office each time the SSI terminates.

- The initial application form is valid for the first 12 months. When SSI terminates again, update the initial application form. An interview is not required but the form must be dated and signed each time.

  Use the initial DDS decision (and 260DC if applicable) unless a re-examination is specified.

- When the initial application is 12 months old, complete a redetermination. The redetermination form is valid for another 12-month period and may be updated as discussed above each time SSI terminates within the year.

❖ **Aged, Blind and Disabled Programs**

102.09.06 ESTATE RECOVERY REQUIREMENTS

The Division of Medicaid is required to seek recovery of payments for nursing facility services and Home and Community-Based Services (HCBS) as well as related hospital and prescription drug services from the estates of deceased Medicaid recipients who were fifty-five (55) or older when Medicaid benefits were received.

The estate recovery provision applies to all Medicaid recipients in a nursing facility as of July 1, 1994, and all Medicaid recipients who entered the Home and Community-Based Waiver (HCBS) Program on or after July 1, 2001, who:

- Are age 55 or older at time of death;
- Own real or personal property at time of death that can be considered an estate.

NOTE: Individuals who entered the HCBS Waiver Program prior to July 1, 2001, are "grandfathered in" and will not have their case referred to estate recovery unless the individual is discharged from the program and readmitted after July 1, 2001. In which case, "grandfathered" status is lost and the individual will be referred to estate recovery as a new HCBS client subject to the provision.

Estate Property

Estate property includes any real or personal property owned by the recipient in its entirety or by shared ownership. Ownership of life estate interests or ownership of property that has been transferred into a trust is not subject to estate recovery.

Real property includes the home and any other real property, including ownership of mineral rights and/or timber rights. Personal property includes ownership of any cash reserves, stocks, bonds, automobiles, RVs, mobile homes or any other type of property with value known to be owned by the recipient in full or in part.

Exceptions to the Estate Recovery Provision

Estate recovery rules to not apply to a deceased recipient if at the time of death the recipient has a:

- Legal surviving spouse, or
- A surviving dependent child under the age of 21 or

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Exceptions to the Estate Recovery Provision (Continued)

- A dependent blind or disabled child of any age. The blind or disabled individual must be dependent on the Medicaid recipient for a home or income, such as a disabled child drawing benefits from the parent's record.

Assets and Resources Exempt from Estate Recovery

The following assets and resources of American Indians and Alaska natives are exempt from estate recovery:

- Interest in and income derived from Tribal land and other resources currently held in trust status and judgment funds from the Indian Claims commission and the U. S. Claims Court;

- Ownership interest in trust or non-trust property, including real property and improvements located on a reservation;

- Reservation payments to special populations.

Estate Recovery Referrals to Third Party Liability (TPL)

TPL has established a $5000 liquid asset threshold for use in determining whether a case record is to be referred to TPL for estate recovery purposes. The $5000 threshold is set so that the client will have sufficient funds for burial.

When calculating the $5000 threshold, do not include burial or insurance or life estate property. Life insurance will be referred only when the estate is the beneficiary. Joint bank accounts, annuities and promissory notes will not be referred to TPL.

Procedures for Referral or Estate Recovery Cases

- If a client owned real property (regardless of CMV) or personal property totaling more than $5000, the case record is to be referred to TPL via DOM-TPL-411.

❖ **Aged, Blind and Disabled Programs**

Procedures for Referral or Estate Recovery Cases (Continued)

- If the client owned no real property and the total value of all personal property (liquid assets) is $5000 or less, complete DOM-TPL-412, and send the form only to TPL.

  This will let TPL know the client is deceased but the case record is not being referred to TPL because total assets are below the established threshold.

- If a client owned an annuity purchased on or after February 8, 2006, the case is to be referred to TPL via DOM-TPL-411.

102.10 FCC NON-FINANCIAL REQUIREMENTS

The non-financial requirements which pertain only to the Families, Children and CHIP program are discussed in this section.

102.10.01 DEPRIVATION

Deprivation is an eligibility factor for children eligible in the Medical Assistance (85) program. These children must be deprived of the support of one or both of their parents for one of the following reasons:

- Death
- Continued absence from the home
- Physical or mental incapacity (2-parent families only)
- Unemployment or Underemployment (2-parent families only)

A condition of deprivation is not applicable to children who qualify on financial need for the FPL Medicaid programs (87, 88, and 91) or CHIP.

Adoption

Deprivation is established for the 85 child in relation to the child's legal and/or natural parents. The biological parent of a child who has been legally adopted is no longer a legally responsible parent. When a child has been legally adopted, deprivation is determined only in regard to the adoptive parents. Deprivation due to continued absence is always met in a single parent adoption.

Legally Responsible Parents

The following are legally responsible parents:

- The child's mother
- The child's legal father
- The adoptive parent who has been legally granted a final decree of adoption.

❖ Families, Children and CHIP Programs

Legal Father

For the deprivation determination in the 85 program and for budgeting in all FCC programs, a child's legal father is one of the following:

- A man whose name appears on the child's birth certificate is the legal father unless a court has determined otherwise;
- A man who has been declared to be the child's father by a court order;
- A man who has acknowledged paternity of the child in an Admission of Paternity if there is no legal father either on the birth certificate or in a court order;
- A man who married the child's mother subsequent to the birth and publicly acknowledges that he is the father of the child when there is no legal father listed on the child's birth certificate and a paternity order has not been issued establishing a different person as the father .

Deprivation Based on Death

A child is considered deprived if either or both of his parents are deceased.

Deprivation Based on Continued Absence of a Parent

Continued absence exists when a parent does not live in the home with the child as the result of divorce, legal separation, desertion, incarceration, long term hospitalization, institutional care, court-ordered removal of the child from the home or because paternity has not been established. Deprivation is also established if the parent is convicted of an offense and sentenced to perform unpaid public work or community service during working hours and is allowed by the court to live at home. However, deprivation does not exist when a parent lives at an address separate and apart from the child, and:

- The parent is out of the home solely to seek or accept employment or
- The parent is out of the home solely due to active duty in the uniformed service of the United States.

Accept the declaration of the applicant/recipient regarding continued absence unless it is questionable.

❖ **Families, Children and CHIP Programs**

Deprivation Based on Incapacity

A child who lives with biological, legal or adoptive parents is deprived of parental support or care if one or both parents receive Social Security Disability or SSI.

Deprivation Based on Under/Unemployment

A child who lives with both of his biological, legal or adoptive parents is deprived of parental support or care if the combined family income is equal to or below the 85 program gross and net income limits for the appropriate family size.

102.10.02 TEMPORARY ABSENCE FROM THE HOME

The temporary absence of the parent, other adult caretaker or the child from the home does not affect the eligibility determination, provided the absent member does not establish a home elsewhere and the reasons for the absence is temporary. In addition, the adult must retain legal responsibility for the child during the absence. The case must be documented with the reason for separation, the approximate duration and plan for the child or adult to return to the home.

The following situations are considered temporary absences:

- Either the adult or child is temporarily out of the home receiving care or treatment in a medical facility, such as a hospital, a maternity home or drug treatment facility.
- Either the adult or child is out of the home for a visit. For example, a child spending a summer vacation with his non-custodial parent, who lives in MS or out-of- state.
- Either the adult or child is out of the home to attend school or training. For example, the child is in Job Corps or the parent is attending college.
- The adult works away from home and retains responsibility for the child, even though day-to-day care is delegated to someone else.
- The child is in a juvenile facility that is not a state institution and the qualified relative retains legal responsibility for the child even though the facility has physical custody;
-
- The child is in a Psychiatric Residential Treatment Facility (PRTF).
- Absence due to fulfilling military obligation is considered temporary absence; in this instance, a legal parent who is away from home on military duty is considered part of the budget group unless there is abandonment of the family. Benefits will not be authorized for the person away on military duty.

Any family member who is residing elsewhere permanently cannot be considered temporarily absent.

102.10.03 RELATIONSHIP

102.10.03A FPL Programs

The responsible adult may be a relative or a non-relative for children eligible in the FPL Medicaid programs and CHIP. Self-declaration is used to verify the relationship of the parent or responsible adult for children for 87, 88, 91 and 99.

102.10.03B Medical Assistance Program

To meet the requirement of relationship for the Medical Assistance program (85), a child must live in the home with a legal or biological parent or one of the following relatives within the specified degree of relationship:

- Grandfather or grandmother (extends to great, great-great and great-great-great)
- A grandparent-in-law is within the required degree. The relationship of grandparent-in-law occurs when one of the child's grandparents remarries. For instance, if the child's paternal grandmother dies and his paternal grandfather marries again, this second wife of the child's grandfather becomes the child's grandmother-in-law.
    - A step-grandparent is not within the degree of relationship. A step-grandparent is the parent of the child's stepmother or stepfather.
- Brother or sister (including half brother and half sister)
- Uncle or aunt (extends to great and great-great)
- First cousin, including first cousin once removed (child of a first cousin)
- Nephew or niece (extends to great and great-great)
- Stepfather or stepmother or
- Stepbrother or stepsister

Determining Relationship After Marriage Ends

Relationship extends to the legal spouse of the above listed relatives even after the marriage is terminated by death or divorce. The relationship requirement is met when the child lives with any of the above named relatives. Legal custody is not a factor in determining relationship.

❖ **Families, Children and CHIP Programs**

Medical Assistance Program (Continued)

Adoption

Legal adoption terminates all prior relationships except that the biological parent remains a qualified relative to the child for eligibility in the Medical Assistance (85) program. A natural or biological parent whose child has returned to the parent's home after being legally adopted by another individual is within the degree of relationship. In such instances the natural parent is not legally responsible for the child and the adoptive parents must be reported as absent parents to the Division of Child Support.

> Example: The maternal grandmother adopts her grandchild. The biological mother returns to live in the home. The biological mother is not within the degree of relationship because the legal mother (the grandmother) is living in the home.
>
> Example: The maternal grandmother adopts her grandchild and the child later returns to live with the biological mother. In this case, the biological mother is within the degree of relationship because the legal mother is not living in the home. The adoptive mother (grandmother) is the absent legal parent for child support purposes.

Verifying Relationship

Relationship for the Medical Assistance program must be verified by documents. While parents may provide the child's birth certificate or other legal documents to prove relationship, another relative will need to provide additional documents to show the relationship to the child's parent and to the child.

If the needy caretaker relative wishes to be included for Medicaid eligibility, it will be the relative's responsibility to provide adequate documents to verify the relationship to the qualifying children.

102.11 RESIDENTS OF AN INSTITUTION

Residence in an institution can affect an applicant's or recipient's eligibility for any ABD or FCC program. An individual is not eligible when:

- The individual is an inmate; and
- The facility in which the individual is residing is a public institution.

Age and Institutionalization

- Individuals under age 22 may receive Medicaid while in an institution for mental diseases if they are receiving psychiatric services and are otherwise eligible for Medicaid.
- Individual between the ages of 22 and 65 are not eligible to receive any Medicaid benefits while residing in an institution for mental diseases.
- Individuals age 65 or older may not receive Medicaid benefits while in an institution unless they reside in a long term care facility.

Inmate Eligibility

Inmate status is interrupted when an individual is admitted as an inpatient to a medical institution; therefore, an inmate may be eligible for Medicaid only while an inpatient in a medical facility (hospital, nursing facility, juvenile psychiatric facility or intermediate care facility).

When determining inmate eligibility, consider all groups of Medicaid coverage, including children, pregnant women and aged, blind or disabled. Inmates must meet all non-financial and financial eligibility factors of the program for which they are being considered.

NOTE: If an inmate does not meet citizenship requirements, but qualifies for Emergency Service, the inmate is eligible for emergency inpatient services only.

102.11.01 INSTITUTIONS

An institution is an establishment that provides food, shelter and some treatment or services to four or more person unrelated to the proprietor.

Public Institutions

A **public** institution is an institution which is the responsibility of a government unit or over which a governmental unit exercises administrative control including:

- A penal institution or correctional facility is a facility under the control and jurisdiction of the governmental agency in charge of the penal system or a facility in which convicted criminals can be incarcerated, such as a hospital for the criminally insane. This includes state prisons which operate their own hospitals; state mental hospitals and privately-owned prisons under contract to a correctional facility.
- An institution for mental diseases (IMD) is a hospital, nursing facility or other institution of more than 16 beds which is primarily engaged in providing diagnosis and treatment or care, including medical attention, nursing and convalescent care and related services, to persons with mental diseases.
- Intermediate Care Facility for the Mentally Retarded provides active treatment for individuals with mental retardation.

NOTE: A VA nursing facility falls under the definition of a public institution.

Medical Institutions

A **medical** institution is not considered a public institution. Residents may receive Medicaid benefits if otherwise eligible. A medical institution is one that:

- Is organized to provide medical care, including nursing and convalescence care;
- Has the necessary professional personnel, equipment and facilities to manage the medical, nursing and other health needs of patients on a continuing basis in accordance with accepted standards;
- Is authorized under state law to provide medical care; and
- Is staffed by professional personnel who provide professional medical and nursing services.

102.11.02 INMATE STATUS

An individual is an inmate if serving time for a criminal offense or is confined involuntarily in a state or federal prison, jail, detention facility or other penal facility.

An individual who voluntarily resides in a public institution is not considered an inmate. Likewise, an individual who voluntarily resides in a public education or vocational training institution for purposes of securing education or vocational training or is voluntarily residing in a public institution for a temporary period while other living arrangements appropriate to meet his needs are being made is not considered an inmate.

NOTE: There is no difference between juveniles and adults when applying this policy.

Individuals Ineligible for Medicaid Due to Inmate Status

There are a variety of alternatives to traditional incarceration. An individual is considered an inmate of a penal institution as long a penal authorities remain responsible for providing (or arranging for provision of) food and shelter to the individual. An individual is considered an inmate regardless of use of an alternative method of incarceration. In addition, inmate status continues during period of authorized or unauthorized absence from the penal facility. Inmate status is not terminated until the individual is paroled or otherwise unconditionally and permanently released.

Situations in which Medicaid is not available due inmate status:

- Inmates who are sent to work on farms on a seasonal basis;
- Inmates involuntarily residing at a wilderness or boot camp under governmental control; **NOTE:** If such a facility is privately owned and/or operated, residents may receive Medicaid, if they are otherwise eligible based on home living arrangements.
- Individuals who are on home or work release for a temporary period of time or who have to report to the facility for incarceration at night or on weekends;
- Individuals in correctional or holding facilities, who have been arrested or detained involuntarily and are awaiting trial or disposition of charges, or who are held under court order as material witnesses or juveniles;

Individuals Ineligible for Medicaid Due to Inmate Status (Continued)

- Inmates involuntarily residing in half-way houses under governmental control;
- Inmates receiving care on the premises of a prison, jail, detention center or other penal setting;
- Inmates receiving outpatient care;
- Escaped prisoners.

Non-Inmate Status - Individuals Potentially Eligible for Medicaid

Admittance as an inpatient in a hospital, nursing facility, juvenile psychiatric facility or intermediate care facility interrupts inmate status. Explore Medicaid eligibility in an appropriate program for these individuals. If otherwise eligible, the individual can be approved for Medicaid.

NOTE: This does not include medical facilities on the grounds of or under the control of a penal facility.

Situations in which Medicaid is potentially available if all factors of eligibility are otherwise met:

- Infants living with the inmate in the public institution;
- Paroled individuals; Individuals in violation of the terms of their parole remain potentially eligible for Medicaid even though SSI or Social Security Disability benefits have been terminated due to fugitive status. These individuals can qualify or continue to qualify for Medicaid unless or until they are under the direct control of the penal system, at which time, they fall under the "inmate" policy discussed previously.
- Individuals on probation; Individuals in violation of the terms of their probation remain potentially eligible for Medicaid even though SSI or Social Security Disability benefits have been terminated due to fugitive status. These individuals can qualify or continue to qualify for Medicaid unless or until they are under the direct control of the penal system, at which time, they fall under the "inmate" policy discussed previously.

Non-Inmate Status - Individuals Potentially Eligible for Medicaid (Continued)

- Individuals on house arrest or home release when not required to report to the public institution for overnight stay;

- Individuals voluntarily living in a detention center, jail or penal facility after their case has been adjudicated and other living arrangements are being made;

- Inmates who become inpatients at a medical facility, i.e., acute care hospital, nursing facility, juvenile psychiatric facility or intermediate care facility. The individuals may be approved for the period of their inpatient care, if otherwise eligible.

Public Educational or Vocational Training Institutions

Children attending these facilities to obtain an education or vocational training may receive Medicaid if they are eligible in their home living arrangement. Schools for the deaf or blind are examples of such facilities.

Special Considerations

- The inmate cannot be considered a sole applicant until they have been separated from other household members for 30 days. When determined Medicaid-eligible as a member of the community, the inmate is eligible for full Medicaid services.

- The inmate can be considered as the sole member of the budget group for the month in which the 31st day falls. When determined eligible as an inmate and as the sole member of the budget group, the inmate is eligible only for inpatient services.

- If the inmate is receiving Social Security Retirement, Disability or Survivors benefits, and convicted of a crime and confined to the correctional institution for more than 30 continuous days, Social Security will suspend benefits.

  Similarly, Social Security must suspend benefits to individuals receiving Supplemental Security Income (SSI) payments when the person is incarcerated for at least one full calendar month. These suspended payments are disregarded as income.

End of Inmate Status

Inmate status is not terminated until the individual is paroled, otherwise unconditionally and permanently released. Inmate status ends when the individual is no longer residing in a penal institution and is released from the penal system due to:

- End of sentence;
- Pardon;
- Probation or parole;
- Unconditional release.

Parole is the conditional release of an offender from prison before he or she has served the full sentence of the court; thereby, allowing the offender to serve a portion of the sentence in the community under supervision. Parole differs from probation in that most probationers have never been in prison for a felony conviction. The sentencing judge in such cases orders probation instead of a prison term.

Parole is distinguishable from the pardon process in that any convicted felon, including those that are not eligible for parole, may apply for pardon, restoration of citizenship rights or commutation (reduction) of sentence.

102.11.03 VERIFICATION OF INMATE STATUS

Verification sources for inmate status may include:

- State Department of Corrections
- Local prison/mental health authorities;
- Court documents;
- Court clerk for court which sentenced the individual;
- A representative of the prosecutor’s or State’s Attorney’s office;
- Discharge arrangements and agreements between the individual and the penal/judicial authority.

102.11.04 INMATE APPLICATION PROCESS

The Mississippi Department of Corrections forwards the applications of inmates who have had inpatient treatment in a medical facility to the Division of Medicaid. Inmate applications are processed by state office staff.