TABLE OF CONTENTS

SECTION D - NONFINANCIAL ELIGIBILITY FACTORS

TABLE OF CONTENTS - Cont'd

Subsections

NONFINANCIAL ELIGIBILITY FACTORS
BASIC POLICY

A. INTRODUCTION

Title XIX of the Social Security Act specifies who is eligible to receive Medicaid benefits. Eligibility for Medicaid is determined using both SSI and Medicaid policy, as specified in federal law and federal regulations.

Basic non-financial requirements under SSI and Medicaid policy are explained in this section and are outlined below.

B. POLICY PRINCIPLES

Basic eligibility requirements are:

- an eligible individual must be either aged (65 or over) or blind or disabled; and,
- a citizen of the United States or an alien lawfully admitted for permanent residence in the U. S. or an alien permanently residing in the U. S. under color of law; and,
- a resident of Mississippi; and,
- have income and resources within specified limits; and,
- file an application.

1. Definition of Eligible Individual

A person who meets all of the basic requirements shown above. This includes a person who meets the definition of a "child."

2. Definition of Eligible Spouse

A person who meets all of the basic requirements shown above and is the husband or wife of an eligible individual with whom he or she lives (including a man/woman who hold themselves out as husband/wife).

An individual and spouse must each file an application and meet all of the criteria shown above to establish eligibility as an eligible couple.

NONFINANCIAL ELIGIBILITY FACTORS
BASIC POLICY

3. Eligibility Exceptions

Despite meeting all of the above criteria, an individual is not eligible for Medicaid if the person:

- fails to apply for any and all other benefits for which he/she may be eligible.
- is a resident of a public institution.
- refuses to accept vocational rehabilitation services.
- fails to assign rights to any third party medical support or cooperate with Medicaid in obtaining third party payments.

NONFINANCIAL ELIGIBILITY FACTORS
MARITAL & PARENT/CHILD RELATIONSHIPS

A. MARITAL RELATIONSHIPS

Whether a man and woman are married for SSI/Medicaid purposes governs whether:

- couple budgeting rules apply; or
- spousal or parental deeming applies.

In addition, someone who is married cannot be considered a child.

1. Marital Criteria

For SSI/Medicaid purposes, a marital relationship is one in which members of the opposite sex are:

- married under State law (common law marriage is recognized in Mississippi if the couple began holding out prior to April 1, 1956); or,
- married for title II purposes; or,
- living in the same household and holding themselves out to the community as husband/wife.

2. When a Martial Relationship Ends

A man and woman are no longer considered married as of the date that:

- either dies;
- a final decree of divorce or annulment is issued;
- either begins living with another as that person's spouse;
- they are determined not to be married for title II purposes if this was the basis for considering the couple married;
- they begin living in separate households.

NONFINANCIAL ELIGIBILITY FACTORS
MARITAL & PARENT/CHILD RELATIONSHIPS

3. Evidence of Marriage or Termination of Marriage (Including Living Apart

A marital relationship must be documented with proof that the marriage exists or has been terminated. Photocopy marriage records or SSA records showing entitlement on a spouse's record or divorce or separation papers for the case record.

If a married couple claims to be living apart, obtain as many items of evidence as possible to make a determination as to the couple's relationships and living arrangement. Evidence such as:

- mortgages, leases, rent receipts, property deeds, bank accounts, tax returns, credit cards, etc.

- information from other government programs (SSA, Food Stamps, public housing, etc.)

- statements from relatives, friends or neighbors.

If a couple is determined to be living apart, each is treated as an individual. If evidence does not substantiate that a couple lives apart, then couple rules/deeming may apply.

NONFINANCIAL ELIGIBILITY FACTORS
MARITAL & PARENT/CHILD RELATIONSHIPS

C. HOLDING -OUT RELATIONSHIPS

A man and a woman who live in the same household are married for SSI/Medicaid purposes if they hold themselves out as husband and wife to the community in which they live.

If a couple lives together but denies "holding out," obtain as many of the following items of evidence as possible to make a determination of the couple's status:

- mortgages, leases, property deeds, bank accounts, insurance policies, passports, tax returns, credit cards;

- information from other government programs, such as SSA, Food Stamps, public housing, etc.

- statements from relatives, friends or neighbors.

It is possible for a couple to live together and not be "holding out" as man/wife depending on their circumstances (economic/social), but the only way to make a determination of marital status is to examine how the couple holds themselves out to the community. If the couple is determined to be living apart, each is treated as an individual. If evidence does not substantiate that a couple lives apart, then couple rules and deeming applies.

Note: A man and woman who are still legally married and resume living together after having lived apart are a married couple, regardless of the reason for having resumed living together. If a divorced couple resume living together, develop whether they are "holding out."

NONFINANCIAL ELIGIBILITY FACTORS
MARITAL & PARENT/CHILD RELATIONSHIPS

D. INDIVIDUAL IS A CHILD

A child is defined as someone who is neither married nor head of a household and:

- Under age 18; or

- Under age 21 and a student regularly attending school or college or training that is designed to prepare him/her for a paying job.

An individual who does not meet the definition of a child (e.g., age 17 but married) may meet the definition of an eligible individual.

1. Definition of Parent

A natural or adoptive parent or stepparent who lives in the same household as the child.

- The stepparent must be the present husband or wife (including a holding out relationship) of the natural or adoptive parent living in the same household as the child.

- A person is not the stepparent if the natural or adoptive parent has died, been divorced from the stepparent, or had the marriage annulled.

2. Child Status Ends

Do not consider an individual a child effective with the month the child becomes age 18 or age 21 if a student or the month he/she last meets the definition of a child.

3. Evidence of Child Status

Obtain proof of age or marital status, if married, for the child. Use the birth or baptismal record to verify proof of age and the parent/child relationship.

NONFINANCIAL ELIGIBILITY FACTORS
MARITAL & PARENT/CHILD RELATIONSHIPS

E. STUDENT CHILD

A student child is someone who is under age 21 and regularly attends school of college or training designed to prepare him/her for a paying job.

1. Student Requirements

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

- In a college or university for a 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/her 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. This kind of training includes anti-poverty programs, such as the Job Corps and government-supported course in self-improvement; or

- 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:** 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.

NONFINANCIAL ELIGIBILITY FACTORS
MARITAL & PARENT/CHILD RELATIONSHIPS

2. Vacation

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

3. Evidence of School Attendance

Develop school attendance whenever an applicant/recipient between ages 18-21 alleges being a student. This individual may meet the definition of a child if he/she qualifies as a student. No development is necessary for a child under age 18 who does not expect to earn over $65 in any month.

Obtain the following information:

- Name and address of the 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, other activities of the child.
- Verify enrollment by examining a student record such as an ID card, tuition receipt or contact with the school.

NONFINANCIAL ELIGIBILITY FACTORS
AGE

A. DEFINITION

To be considered "aged" an individual must be age 65 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. For example, an individual born January 1, 1929 is considered to be age 65 as of December 31, 1993, and could file an application as an aged individual as an aged individual in the month of 12/93.

B. VERIFICATION

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

- an applicant applies for benefits based on age.
- a disabled or blind applicant under age 21 applies and any of the following conditions exists:
  a. deeming.
  b. student earned income exclusion.
  c. support from absent parent exclusion.
- there are ineligible children in a deeming household.

1. Acceptable Evidence

Acceptable evidence for establishing age consists of the following:

- The original birth record. This is a birth certificate or hospital birth record established during the first 5 years of life and certified by the custodian of record. This could include a statement signed by the physician or midwife who was in attendance at the birth who attests to the date of birth.
- Social Security records when application has been made for a Social Security number.
- School records.

- Church records.
- Family Bible or other family record. (Must examine the entire publication)
- State or Federal census records established near date of birth.
- Insurance policy which shows age or date or birth.
- Marriage record which shows age or date of birth.
- Passport.
- Employment records.
- Military records.
- Child's birth certificate which shows age of parent.

2. Evidence For Those Born In Foreign Countries

Records which might be available to those born in foreign countries are those listed above plus the following:

- A foreign passport.
- An immigration record established upon arrival in the U.S.
- Naturalization papers.
- An alien registration card.

NONFINANCIAL ELIGIBILITY FACTORS
BLINDNESS AND DISABILITY

A. BACKGROUND

Under the provisions of sections 1902(a)(10) and 1905(a) of the Social Security Act, individuals who meet certain income and resource requirements and other general eligibility requirements and who are disabled, as defined under the Social Security Act, are eligible for Medicaid. The law requires that the SSI definition of disability set forth in section 1614 of the Social Security Act must be satisfied, at a minimum, in order for an individual to be eligible for Medicaid based upon disability.

B. DEFINITION OF DISABILITY (20 CFR 416.905)

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 an individual unable to do his/her previous work or any other substantial gainful activity which exists in the national economy. In making this determination, an individual's residual functional capacity, age, education and work experience are considered.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) changed the definition of childhood disability to specify:

1. An individual under the age of 18 shall be considered to be disabled under SSI 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, and

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

In addition to the new definition of disability for children, the law mandates two changes to current evaluation criteria in SSA/SSI regulations:

1. The discontinuation of individualized functional assessment (IFA) for children, and

2. The elimination of maladaptive behavior in the domain of personal/behavioral function in determining whether a child is disabled.

The new definition applies to all applications filed on or after August 22, 1996 (and to applicants whose claims were not finally adjudicated as of that date) and to all redeterminations of childhood disability.

C. 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: Blindness alone precludes eligibility under the Poverty Level Aged and Disabled coverage group. An individual must be determined "disabled," as described above, in order to qualify for coverage under the poverty level group. (Blindness does not meet the medical criteria for disability under the PLAD coverage group.)

NONFINANCIAL ELIGIBILITY FACTORS
BLINDNESS AND DISABILITY

D. DISABILITY DETERMINATIONS IN 1634 STATES

Under contract with the Medicaid State Agency and the Social Security Administration, the Disability Determination Service (DDS) makes all decisions relating to disability or blindness.

In cases in which a State has a section 1634 agreement with SSA (as does Mississippi) and an individual files an application only with SSA for SSI, the Medicaid Agency is not required to make a Medicaid disability determination for the period starting on the effective filing date of the SSI application. This is because an application for SSI is also an application for Medicaid in such States. An applicant is required to wait until SSA makes an SSI eligibility determination.

Note: This does not mean that a separate MAO application cannot be filed. This means that Medicaid is not required to make a separate disability decision for any months of potential SSI eligibility.

1. Circumstances Which Warrant A Separate Medicaid Application

The circumstances under which the State Medicaid Agency is required to make an independent determination of disability by way of a separate MAO application are as follows:

a. An individual has not applied for SSI or has applied for SSI and been denied for a reason other than disability.

b. An individual applies both to SSI and to Medicaid and SSI fails to make a disability decision within 90 days. In such an instance DDS must provide Medicaid with a decision prior to the SSI decision.

Note: If DDS provides a Medicaid approval 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.

c. An individual applies for Medicaid and alleges a disabling condition that is different from or in addition to that considered by SSA.

d. An individual applies for Medicaid more than 12 months after SSA last made a final determination that the individual was not disabled and the individual alleges his/her condition has deteriorated since that final decision and the individual has not reapplied for SSI.

2. Circumstances Which Warrant a Referral to SSA

If the above conditions do not exist and the individual is potentially eligible for SSI, he/she must be advised to file or refile with SSA for SSI benefits; however, this does not mean an MAO application cannot be filed. For example: An individual applied for SSI and was denied due to disability in October, 1989. In March, 1990, the individual applies 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 and the individual must be denied eligibility based on the previous SSI denial and referred to SSA to refile for SSI.

In addition, any allegation of a deterioration of the condition for which SSA made a determination that is filed less than 12 months after the most recent final SSI determination must be submitted to SSA for reconsideration or reopening. Under SSA rules, an individual may request a reconsideration within 60 days of receipt of the notice denying SSI disability. If the individual does not appeal the decision within 60 days, he/she 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.

3. Disability Questionnaire (for PLAD applicants)

An individual who wishes to file an MAO application must be allowed to do so. However, a separate DDS decision is not required if an SSI medical decision has been rendered within the previous 12 months or is currently pending with SSA.

NONFINANCIAL ELIGIBILITY FACTORS
BLINDNESS AND DISABILITY

In order to assist a worker in deciding whether a DDS decision is required, a Poverty Level Disability Questionnaire and instructions have been developed for this purpose. It is designed to be used for an applicant with no income or income below the SSI FBR appropriate for the individual to determine if a previous SSI medical denial exists. The Questionnaire is not necessary for someone who currently receives title II disability benefits.

NONFINANCIAL ELIGIBILITY FACTORS
BLINDNESS AND DISABILITY

E. EXCEPTIONS TO OBTAINING DDS DISABILITY APPROVALS

A separate Medicaid determination of disability is not require in certain instances where DDS has already determined determined disability using SSI criteria for the same period of time to be covered by a MAO application. If the date disability began, as established by SSA, does not include all months of requested Medicaid eligibility, a separate DDS decision is required. The exceptions are as follows:

1. Applicant Receives Title II Disability

If an applicant receives title II disability benefits (for a disability other than blindness for PLAD applicants) on an ongoing basis based on his/her own disability and the date disability began is verified to include all months to be covered by the Medicaid application, i.e., the month of application and any retroactive month(s), then a separate DDS decision for Medicaid is not required. The "Date Disability Began" will appear on the applicant's TPQ response from SSA. The receipt of title II disability must be reverified at each redetermination.

2. ALJ Reversal

If you have evidence of an ALJ (Administrative Law Judge) reversal that establishes disability (other than blindness for a PLAD applicant) and the date of onset of disability, this evidence can be used provided the onset of disability encompasses all months of the Medicaid eligibility request.

3. Deceased Applicants

A verified death date is sufficient to establish disability for a deceased applicant provided the disability which resulted in death existed in all months that Medicaid eligibility is requested. For example, if a traumatic onset of disability such as an accident occurred which resulted in death, eligibility could only be established under this exception for the month of the accident forward.

4. Disabled Adult Child(ren)

If an applicant is: over 18, entitled to Medicare, and receives title II benefits as a C1-C9 beneficiary, then no separate DDS decision is required as disability has previously been established by SSA.

NONFINANCIAL ELIGIBILITY FACTORS
BLINDNESS AND DISABILITY

F. OBTAINING DDS DISABILITY DECISIONS

When an applicant under age 65 applies for Medicaid on the basis of disability or blindness and a DDS decision is required, follow the procedure outlined below:

1. Complete the Appropriate Forms

The worker will complete, with the applicant's assistance, Form DOM-323, Disability or Blindness Report. This form is completed based on the applicant's responses and worker observations. If the applicant is a child, Form DOM-323A must also be completed.

Note: If applicant is currently employed, DDS needs detailed information regarding work hours, income, name and type of employer, etc. included on DOM-323. Also include whether applicant has been examined by a physician within the last 3 months and specify the physician.

Form DOM-324, Vocational Report, will be completed by the worker only if the applicant has a communication problem due to language, speech or hearing difficulties which would make it difficult for DDS to contact the applicant.

The applicant must sign the appropriate number of Form DOM-301A, Authorization to Release Medical Information, based on the number of medical sources identified on DOM-323 plus 2 additional signed forms. (Note: Leave the "Date" space blank.) DDS will use the signed forms to obtain necessary medical information from each provider. If the applicant is a child, the parent or representative must sign the 301A Forms. Note: If the applicant is unable to sign DOM-301A and the designated representative signs in the applicant's place, the authorized representative must state why the applicant is unable to sign his/her name, e.g., "patient unconscious," "Patient senile," etc. If a representative signs DOM-301A, attach a copy of DOM-302 Designated Representative Statement. If DOM-302 is signed as a self-designation, there must be an explanation as to why applicant did not sign the 302 before medical information is released.

NONFINANCIAL ELIGIBILITY FACTORS
BLINDNESS AND DISABILITY

Complete Form DOM-325, Disability Determination and Transmittal. This form serves as the transmittal form for submitting DOM-323, DOM-324, if applicable, and prior medical information from the case record. Note: if the applicant is applying under the Poverty Level coverage group, indicate this in the "Remarks" section of DOM-325 to alert DDS to the fact that a disability other than blindness must exist.

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.

2. Submit a File Folder to DDS and Set a Tickler

Include all material cited in item 1 in a file folder labeled with the client's name, Social Security number and case number. For example:

Brown, Samuel T. 425-76-8320

104-24-3467

Mail the folder to DDS. The mailing address is:

Disability Determination Service
P. O. Box 1271
Jackson, MS 39205

At the time the Regional Office submits the medical information folder to DDS for a disability decision, whether it is an initial submission or a resubmission, the worker will set a tickler for 75 days. If the Regional Office has not received a disability decision within 75 days or if any problem occurs pertaining to the medical decision, the Supervisor should mail a copy of the DOM-325 to the State Office. The State Office will in turn contact DDS.

NONFINANCIAL ELIGIBILITY FACTORS
BLINDNESS AND DISABILITY

3. Receipt of the DDS Decision 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 DOM-325. Any 325 that does not have a 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 make sure DDS sends all relevant material for a decision. When Disability Determination Services sends an approved DOM-325, the need for a re-exam and date is indicated. If no re-exam is needed, the DOM-325 is valid indefinitely or until the recipient is determined "no longer disabled". If a re-exam date is given, the DOM-325 is valid until that re-exam date. The valid DOM-325 can be used for reapplications when the closure was due to a reason other than disability. Note: Do not send a case in for reevaluation prior to the date specified by DDS in item 15 on DOM-325. The worker must set a tickler for a date prior to the due date to ensure the medical information is resubmitted following the procedure outlined above on the specified due date.

Upon receipt of the decision from DDS, the Regional Office will initiate appropriate action on the case and notify the applicant of the decision regarding his eligibility.

Note: SSI retro approvals for the retroactive period yet denied ongoing SSI benefits due to a medical denial must be submitted to the State Office for review. The case will be resubmitted to DDS for an explanation.

4. DDS Telephone Numbers

The DDS toll free # is 1-800-962-2230.
The local DDS # is 853-5100.

5. SSI Temporary Closures

Cases that are SSI eligible but terminate up to once per quarter (usually due to earned income in a 5-week month) and are then reinstated as SSI are referred to as "ping-pong" cases. The individual can apply for MAO coverage during these missing SSI months by filing a separate MAO application. If a DDS decision is required in these types of cases, the initial DDS decision remains valid during the intervening SSI months of eligibility unless a re-exam is specified by DDS.

NONFINANCIAL ELIGIBILITY FACTORS

STATE RESIDENCE

A. STATE RESIDENCE REQUIREMENTS (42 CFR 435.403)

An eligible individual must be a resident of the State of Mississippi. A resident is someone who is:

- voluntarily living in Mississippi with the intention to remain permanently or for an indefinite period; or
- living in Mississippi having entered with a job commitment or for the purpose of seeking employment (whether or not currently employed).

1. Intent to Reside

Residence is based on the concept of intent to reside. An individual must be capable of indicating intent. An individual would be considered incapable of stating intent if the individual:

- Has an IQ of 49 or less or has a mental age of 7 or less 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 person licensed by the State in the field of mental retardation.

2. Exceptions

To determine whether an applicant is a resident of Mississippi or whether a recipient continues to be a resident of Mississippi, apply one of the rules listed below based on the client's age and living arrangement. The exception to the rules listed below are as follows:

- An individual who is receiving a state supplementary payment (optional or mandatory) is considered a resident of the state making the payment.
- For individuals of any age who are receiving Federal payments for foster care under title IV-E and individuals with respect to whom there is an adoption assistance agreement in effect under title IV-E, the state of residence is the state where the individual is living.

NONFINANCIAL ELIGIBILITY FACTORS
STATE RESIDENCE

3. Individuals Under Age 21

For any individual who is emancipated from his/her parents or who is married and capable of stating intent, the state of residence is the state where the individual is living with the intention to remain permanently or for an indefinite period.

For any individual in a private living arrangement whose Medicaid eligibility is based on blindness or disability, the state of residence is the state in which the individual is living.

For any institutionalized individual who is neither married nor emancipated, the state of residence is:

a. The parent's state of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent); or,

b. The current state of residence of the parent who files the application if the individual is institutionalized in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian who files the application is used); or,

c. The state of residence of the individual or party who files an application is used if the individual has been abandoned by his/her parent(s), does not have a legal guardian and is institutionalized in that state.

4. **Individuals Age 21 and Over - In a Private Living Arrangement**

For any individual in this category the state of residence is the state where the individual is living with the intention to remain permanently or for an indefinite period or the state where the individual is living which the individual entered with a job commitment or seeking employment (whether or not currently employed).

If the individual in this category is incapable of stating intent, the state of residence is the state where the individual is living.

NONFINANCIAL ELIGIBILITY FACTORS
STATE RESIDENCE

5. Individuals Age 21 and Over - In Institutions

For an institutionalized individual who became incapable of indicating intent before age 21, the state of residence is:

a. That of the parent applying for Medicaid on the individual's behalf (if the parents reside in separate states). If a legal guardian has been appointed, the state of residence of the guardian is used; or,

b. The parent's state of residence at the time of placement (or if a legal guardian has been appointed, the state of residence of the guardian is used); or,

c. The current state of residence of the parent who files the application if the individual is institutionalized in that state (or if a legal guardian has been appointed, the state of residence of the guardian is used); or,

d. The state of residence of the individual or party who files an application is used if the individual has been abandoned by his/her parent(s), does not have a legal guardian and is institutionalized in that state.

For any institutionalized individual who became incapable of indicating intent at or after age 21, the state of residence is the state in which the individual is physically present, except where another states makes a placement. A state agency that arranges for an individual to be placed in an institution located in another state is recognized as acting on behalf of the state in making a placement. The state arranging or actually making the placement is considered as the individual's state of residence.

For any other institutionalized individual, the state of residence is the state where the individual is living with the intention to remain there permanently or for an indefinite period.

NONFINANCIAL ELIGIBILITY FACTORS
STATE RESIDENCE

B. DURATIONAL REQUIREMENTS PROHIBITED

Medicaid eligibility may not be denied because an individual has not resided in Mississippi for a specified period or because the individual did not establish residence in Mississippi before entering an institution. An individual determined to be a resident of Mississippi as set forth in one of the residency rules established above must have eligibility determined as a Mississippi resident.

1. Temporary Absence

A resident of Mississippi does not lose residency due to temporary absence from the State. Medicaid eligibility may not be denied or terminated because of an individual's temporary absence from the State if the person intends to return when the purpose of the absence has been accomplished, unless another state has determined that the individual is a resident there for purposes of Medicaid.

A Medicaid recipient is responsible for reporting his absence from Mississippi and for giving information as to his purpose, plans, dates of departure, and return.

For the recipient who does not notify the agency of his departure, an attempt will be made to determine the address in the other state so that information can be secured from the recipient regarding whether his absence is temporary in nature, its purpose, and date of return.

No limit is placed on the length of an out-of-state visit, but the recipient's eligibility must be reviewed every three (3) months to determine the recipient's intent of residence and necessary action taken on the case as a result of the eligibility determination.

The recipient who leaves the State with no declared intent to return is determined to have given up his Mississippi residency and his case is closed after advance notice. (If a recipient's whereabouts are unknown, advance notice is not required as specified in Section C, "Exceptions to Advance Notice.")

NONFINANCIAL ELIGIBILITY FACTORS
STATE RESIDENCE

2. Homeless Eligibility

The Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509) specified that states are prohibited from posing any residence requirements which excludes from Medicaid any qualified individual who resides in the State, regardless of whether the residence is maintained permanently or at a fixed address. In other words, a "homeless" individual or one who frequently moves from one address to another can qualify for Medicaid if otherwise eligible.

In addition, Medicaid cards must be made available to individuals with no fixed home or mailing address. This can be accomplished by having the card mailed to a specific shelter or similar facility or to the Regional Medicaid Office or county Human Services Office. Whatever method works best for the Medicaid recipient and is agreeable to the agency or group receiving the card is permissible. The recipient should be advised of the time and place that the card will be available.

C. DISPUTED RESIDENCY

Where two or more states cannot resolve which state is the state of residence, the state where the individual is physically located is the state of residence.

NONFINANCIAL ELIGIBILITY FACTORS
UTILIZATION OF OTHER BENEFITS

A. REQUIREMENT TO APPLY (42 CFR 435.603)

As a condition of eligibility, an applicant or recipient must take all necessary steps to obtain any annuities, pensions, retirement and disability benefits to which they are entitled, as explained below:

1. Other Program Benefits

An individual must apply for another benefit if the other benefit is classified as:

- an annuity or pension, such as private employer pensions, Civil Service pensions, union pensions, Railroad Retirement annuities and pensions, municipal, county or State retirement benefits;

- Social Security retirement, survivors and disability insurance benefits, early retirement at age 62;

- retirement or disability benefits, including veterans' pensions and compensation (VA Aid & Attendance benefits are not a required benefit under this provision);

- Worker's Compensation payments;

- Unemployment Insurance benefits.

An individual potentially eligible for the types of benefits listed above must take all appropriate steps to apply for the benefit(s), and if eligible, accept payment regardless of the impact acceptance will have on Medicaid eligibility. The exception to this rule is that an individual is not required to accept another benefit if the resulting payment would be a reduction in current benefits payable (excluding Medicaid benefits). Election of a lower benefit when the individual has an option between a high or low benefit will result in denial or less of eligibility.

NONFINANCIAL ELIGIBILITY FACTORS
UTILIZATION OF OTHER BENEFITS

2. Exempt Other Program Benefits

Types of other benefits exempt from the filing requirements are:

- Aid to Families With Dependent Children (AFDC),
- General Public Assistance
- Bureau of Indian Affairs General Assistance,
- Victims' Compensation payments,
- Other Federal, State, local or private programs which make payments based on need,
- Earned Income Tax Credits.

3. Applying the Provision

The utilization of other benefits requirement is applicable at the time of application as well as throughout the time a client receives Medicaid. Applicants, recipients, and the Medicaid agency assume responsibilities in connection with this provision of the law. It is the client's responsibility to supply information about possible eligibility for some other benefit, to file for such benefits when informed by the Medicaid Regional Office of potential eligibility for these benefits, and pursue such benefits. It is the Regional Office's responsibility to judge the likelihood of such eligibility and inform the client in writing of the possible eligibility for other benefits. The client's pursuit of other benefits to award or denial must be documented in the case record.

4. Ineligible and Community Spouses Exempt

The requirement to apply for other benefits applies only to the eligible individual (applicant or recipient). It does not apply to an ineligible spouse or a community spouse (who is ineligible).

NONFINANCIAL ELIGIBILITY FACTORS
UTILIZATION OF OTHER BENEFITS

5. Lump Sum or Annuity

When a client can choose payment of an "other benefit" as a lump sum or an annuity, advise him/her that he/she must choose the annuity. 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)

With the focus on maximizing the use of other benefits to provide ongoing benefits, recommend conversion of lump-sum applications in appropriate situations.

NONFINANCIAL ELIGIBILITY FACTORS
UTILIZATION OF OTHER BENEFITS

B. DETERMINATION OF POTENTIAL ELIGIBILITY FOR OTHER BENEFITS

The Regional Office has the responsibility for determining the likelihood of potential eligibility for other benefits, providing the written notice and referral to the proper agency, and assisting the individual, as necessary, in complying with the requirements that he or she file for certain other benefits. Awareness of potential eligibility for other benefits is elicited from:

- Responses to lead questions on DOM-300/DOM-300A
- Information received from the initial interview;
- Inquiries with other agencies; and,
- Knowledge of governmental and private pension plans and disability programs.

If the Regional Office determines that an application for other benefits would not be beneficial, e.g., proof exists of a prior denial and there has been no change in circumstances, do not require the individual to apply for such benefits. The case record must be documented with the reason for the decision not to refer a client to file for other benefits.

If there is doubt about the possibility of eligibility in a given case, the worker should try to resolve the matter by means of a telephone call or written inquiry to the agency or organization involved. If the issue of potential eligibility is still uncertain, notify the individual of the potential eligibility as outlined below.

1. General

A client may be eligible for more than one type of benefit so care must be taken to identify all potential sources of benefits.

NONFINANCIAL ELIGIBILITY FACTORS
UTILIZATION OF OTHER BENEFITS

2. Social Security/ Railroad Retirement Benefits

Any client who is not already receiving Social Security or Railroad Retirement benefits at the 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). The case record must be documented as to why no benefits are payable if none are awarded.

3. Workers' Compensation Payments

If a client alleges either injury on the job or has what may be may be a work-related impairment, refer the client to apply for such benefits.

4. Veterans' Benefits

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.

5. Private Sector

Explore entitlement for benefits if the client or former/deceased spouse worked for a private employer with a pension plan and is not already receiving or has not received a pension based on that employment.

6. Public Sector

Explore entitlement for benefits if the client or former/deceased spouse (or deceased parent if 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:

a. Federal Civilian Employment for a minimum of 5 years,

b. Federal Uniformed Service (Military) for a minimum of 20 years,

c. State or Local Government Employment.

NONFINANCIAL ELIGIBILITY FACTORS
UTILIZATION OF OTHER BENEFITS

C. NOTIFICATION REQUIREMENTS

Upon a determination of potential eligibility for another benefit, the worker must furnish the individual a dated written notice explaining the individual's responsibility to apply within 30 days of the notice. DOM-307, Request for Information, will be used to inform the individual of the following:

- The type of benefit for which he/she may be eligible;
- The organization or agency where the application is filed;
- That the individual has 30 days from the date shown on the DOM-307 in which to file application for the potential benefit; and,
- That the individual must provide evidence to the Regional Office that application has been filed.

List the information specified above on DOM-307 and set a tickler for 30 days at which time the client will be contact by use of DOM-309, Second Request for Information, if the client has not already provided evidence within the 30 days that application has been filed. The DOM-309 allows an additional 10 days for the client to provide evidence. If the client has no evidence to present which documents application has been filed, the worker will contact the agency in question to determine whether an application has been filed and the usual processing time involved for the application in question.

NONFINANCIAL ELIGIBILITY FACTORS
UTILIZATION OF OTHER BENEFITS

If application for other benefit(s) is filed within the allowable 30 days, eligibility for Medicaid will continue or an application may be approved while the application is in process for the other benefits. A tickler will be set for the end of the usual processing time for the application for the other benefit(s) so that the worker can contact the individual and/or agency to determine the final decision. The Regional Office must keep a control in this fashion to make a determination at any point in time as to whether the individual has taken all appropriate steps in prosecuting his/her claim for other benefits.

As soon as the Regional Office is notified of the final decision, the case record must be documented with the decision. The individual should receive written notice explaining the decision which should be obtained and photocopied for the case record. If the worker contacts the agency to determine the final decision, document the case record accordingly. Appropriate action will then be taken by the worker to determine the effect the decision has on Medicaid eligibility. If approved for the other benefit, the payment must be included in the budgeting procedure and the client notified of the resulting effect on Medicaid eligibility.

NONFINANCIAL ELIGIBILITY FACTORS
UTILIZATION OF OTHER BENEFITS

D. FAILURE TO COMPLY AND GOOD CAUSE

The agency must require clients to take all necessary and appropriate steps to obtain "other" benefits, unless good cause can be shown for not doing so. A denial or dismissal of the claim for other benefits because of the failure of the individual to submit requested verification does not satisfy the fulfillment of the requirement to apply.

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

1. illness (and there is no authorized representative to apply in the client's behalf); or,

2. the individual previously applied and was denied and the reason for the denial has not changed; or,

3. the individual was unaware of the availability of a benefit and the agency did not advise him/her of its availability.

If good cause does not exist for the failure on the individual's part to take all appropriate steps to obtain an "other" benefit, the worker will take action to deny or terminate Medicaid benefits until such time as the requirement is fulfilled. Agreement to comply with the requirement does not negate any prior action to deny or terminate benefits. The effective month of establishing eligibility is the month in which the individual takes the steps necessary to obtain benefits from the other agency.

NONFINANCIAL ELIGIBILITY FACTORS
ASSIGNMENT OF RIGHTS

A. ASSIGNMENT OF RIGHTS (AOR) REQUIREMENT (42 CFR 435.604)

Applicants and recipients of Medicaid must, as a condition of eligibility, assign to the Medicaid Agency their rights to medical support or other payments for medical care and cooperate with Medicaid in obtaining third party payments. The Statutory requirement for this provision is in the Deficit Reduction Act of 1984 (P. L. 98-369) mandating assignment of rights to payments for medical support and other medical care owed to recipients. Failure to assign rights or cooperate with Medicaid in obtaining third party payments will result in denial or termination of Medicaid benefits after the appropriate advance notice affording the applicant or recipient the right to appeal.

Application and Redetermination Forms contain the mandatory assignment of rights statement in the section of the form requiring the signature of the applicant, recipient or designated representative. An explanation must be provided to applicants or their representatives at the time of the initial interview that by their signature on the DOM-300 Form they are assigning their rights to third party payments for medical care as a condition of eligibility for Medicaid. This requirement must be reaffirmed by the appropriate signature on the DOM-300A Form at each redetermination of eligibility. In addition, Form-TPL 406, Medical Insurance Form must be completed by the applicant/recipient or representative before an application for eligibility or redetermination of eligibility can be approved.

1. Failure to Cooperate

Section 9503(e) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P. L. 99-272) added a new requirement to the assignment of rights provision regarding cooperation. 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 also 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. The

cooperation aspect of the assignment of rights provision is handled by the Third Party Liability (TPL) Unit of the State Medicaid Agency.

An individual who refuses to cooperate under this provision must be found ineligible for Medicaid. The individual will remain ineligible for future Medicaid benefits until full restitution has been made to the Medicaid Agency. If the TPL Unit determines that there was good cause for failure to cooperate, the applicant/recipient will be excused from the cooperation requirement.

2. Notification Process

The TPL Unit will notify the Eligibility Division of any any instances of failure to cooperate. The Eligibility Division will notify the appropriate Regional Office of the appropriate action necessary to deny or terminate eligibility. Advance notice must be issued to terminate eligibility and the recipient has the right to a hearing as per ongoing policy. However, all appeals regarding failure to cooperate with the TPL Unit must be handled via a State Hearing request. A Hearing Officer from the Eligibility Division will open and conclude the hearing, but the worker handling the case in the Third Party Unit will be present to discuss the issue regarding cooperation.

The Regional Office will be notified of the length of time ineligibility will exist when a case is to be terminated for failure to cooperate. When and if the cooperation issue is resolved, the Regional Office will be notified of the action necessary to restore eligibility.

NONFINANCIAL ELIGIBILITY FACTORS
ASSIGNMENT OF RIGHTS

B. REFERRAL OF ABSENT PARENT INFORMATION

Section 9142 of the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) contains a requirement that State Child Support (IV-D) Agencies provide all appropriate child support services available under IV-D of the Social Security Act to families (with an absent parent) who receives Medicaid benefits and who has 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 Medicaid recipients who are disabled children in absent parent situations to the Child Support Enforcement Office at the county office of the Department of Human Services located in the county where the child lives. The referral is to be made in writing via Form DOM-TPL-410, Absent Parent Referral.

NONFINANCIAL ELIGIBILITY FACTORS
ESTATE RECOVERY

A. ESTATE RECOVERY REQUIREMENT

Effective July 1, 1994, the Division of Medicaid will begin to seek recovery of payments for nursing facility services and related hospital and prescription drug services from the estate of a deceased Medicaid recipient who was fifty-five (55) years of age or older when Medicaid benefits were received. Estate recovery was mandated by the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66) and is now State law located in the Mississippi Code, Section 43-13-317.

Estate recovery applies to all Medicaid recipients in a nursing facility as of July 1, 1994, who:

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

1. 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 previously been transferred into a trust is <u>not</u> 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, RV's, mobile homes or any other type of property with value known to be owned by the recipient in full or in part.

2. Exceptions to Estate Recovery

Estate recovery rules do <u>not</u> apply to a deceased recipient if at the time of death the recipient had a:

a. Legal surviving spouse, or,

b. A surviving dependent child under the age of 21; or,

c. 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.

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 judgement 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.

- Reparation payments to special populations

3. HCBS Waiver Applicants/ Recipients

Under federal and state law, the Division of Medicaid is required to seek recovery of payments for home and community-based services, related hospital services, and prescription drug services from the estates of deceased Medicaid beneficiaries who were 55 years of age or older when these benefits were received. Effective July 1, 2001, estate recovery applies to persons applying for a HCBS Waiver Program. Any person who entered the HCBS Waiver Program prior to July 1, 2001, will not have their case referred to estate recovery. Those individuals will be "grandfathered"; however, if the individual is discharged from the program and is readmitted after July 1, 2001, the "grandfathered" status is lost. The case will be referred to estate recovery as a new HCBS client

NONFINANCIAL ELIGIBILITY FACTORS
ESTATE RECOVERY

B. REFERRAL TO TPL

TPL has established a $5000 liquid assets 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 beneficiary is the estate. Joint bank accounts, annuities, and promissory notes will not be referred to TPL. If a client has countable assets that exceed the $5000 limit, the case must be referred to TPL via Form DOM-TPL-411. If total countable assets is $5000or less, do not refer the case to TPL but complete Form DOM-TPL-412.

Refer cases subject to Estate Recovery as follows:

1. 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, Estate Recovery Form.

2. If a client owned no real property and the total value of all personal property (liquid assets) is $5000 or less, complete DOM-TPL-412, Non-Referral Estate Recovery Form, and send the form only to TPL. This will let TPL know that the client is deceased but the case record is not being referred to TPL because total assets are below the established threshold.