Exceptions to General Verification Requirements (Continued)

310.01.02 DEVELOPMENT OF EQUITY VALUE

Develop the equity value of a resource (liquid or nonliquid) when an individual alleges a debt against it and the difference between equity and CMV could mean the difference between eligibility and ineligibility. Verify, at a minimum, the outstanding principal balance (payoff), the rate of interest and the schedule and amount of payments (to permit the projection of increases in equity). Obtain a copy of the agreement or note that establishes the debt. If this does not provide all the information needed, use other records of the individual, the creditor or both.

310.01.03 FREQUENCY OF VERIFICATION REQUIREMENTS

At a minimum, resources owned by a client are verified at the time of application and at each regular review scheduled annually. However, circumstances may warrant re-verification of resource(s) at shorter intervals.

The following describes situations which mandate re-verification of resources at shorter intervals than annually, but it is not an all-inclusive list. Any reported changes in resources or discovery of changes in resources may warrant verification or re-verification.

Resources within $100 of Applicable Limit

Individuals/couples determined eligible for Medicaid who own countable resources valued within $100 of the applicable limit **must have resources renewed/verified every six months,** rather than annually. The purpose of the 6-month special review will be to verify the value of countable resources in order to determine if the individual/couple remains eligible based on resources. A tickler must be utilized to control the timing of the required special review of cases with countable resources close to the resource limit.

Frequency Of Verification Requirements (Continued)

Cases With VA Income That is Not Countable

Client cases, especially long term care cases that receive excess income that is not countable as income must be monitored closely for excess resources. The amount of the monthly income that is not counted will determine the frequency review/re-verification is deemed necessary.

Long Term Care Recipients in Medicare Beds

Individuals who are placed in Medicare-certified nursing facilities are not required to pay any of their income toward the cost of their care which means that income may be allowed to accumulate and result in excess resources during the first 100 days of possible Medicare coverage. This means it is necessary to re-verify resources during the period of Medicare coverage to check for possible excess resources.