Medicaid for the Elderly and People with Disabilities Handbook

Chapter A, General Information and MEPD Groups

A-1000, General Information

Body

Revision 20-2, Effective June 1, 2020

Medicaid is a jointly funded federal and state program that provides health coverage to certain groups of low-income people. It provides medical care and supportive services to people who qualify for Medicaid under one of the programs in this chapter. Services include doctor visits, vendor drugs, nursing facility services, and long-term care. While the federal government establishes general guidelines for the program, each state determines Medicaid eligibility. To participate in Medicaid, states are required to cover certain mandatory groups of people and may choose to cover other optional groups.

HHSC Medicaid for the Elderly and People with Disabilities (MEPD) staff determine eligibility under one of the MEPD programs in this chapter for people who are aged, blind, or have a disability.

Related Policy

Mandatory Coverage Groups, A-2000
Optional Coverage Groups, A-3000
Other Service-Related Programs, A-4000
Type Programs (TP) and Type Assistance, A-7000

A-1100, Texas Administrative Code Rules

Body

Revision 11-2; Effective June 1, 2011

§358.107. Coverage Groups.

(a) General. This section describes the groups of people who are categorically eligible for a Medicaid-funded program for the elderly and people with disabilities (MEPD) under the Texas State Plan for Medical Assistance.

(b) Mandatory coverage groups. In accordance with 42 CFR Part 435, Subpart B, the Texas Health and Human Services Commission (HHSC) determines eligibility for MEPD for a person who falls into at least one of the following mandatory coverage groups:

(1) Supplemental Security Income (SSI) eligible. In accordance with 42 CFR §435.120, this mandatory coverage group covers a person who is aged, blind, or disabled and is receiving SSI or deemed to be receiving SSI. The Social Security Administration (SSA) determines eligibility for SSI under Title XVI of the Social Security Act. If SSA determines that a person is eligible for SSI, HHSC accepts SSA's determination as an automatic determination of eligibility for Medicaid.

(2) Coverage for certain aliens. In accordance with 42 CFR §435.139, an alien, as defined in 42 CFR §435.406, is provided services necessary for the treatment of an emergency medical condition, as defined in 42 CFR

§440.255.

(3) Disabled adult child. In accordance with §1634(c) of the Social Security Act (42 U.S.C. §1383c), this mandatory coverage group covers a person who:

(A) is at least 18 years of age;

(B) became disabled before 22 years of age;

(C) is denied SSI because of receipt of or an increase in Retirement, Survivors, and Disability Insurance (RSDI) disabled children's benefits received on or after July 1, 1987, and any subsequent increase; and

(D) meets current SSI criteria, excluding the RSDI benefit described in subparagraph (C) of this paragraph.

(4) Historical 1972 income disregard. In accordance with 42 CFR §435.134, this mandatory coverage group covers a person who:

(A) was receiving both public assistance and Social Security benefits in August 1972; and

(B) meets current SSI eligibility criteria, excluding from income the October 1972 cost-of-living adjustment (COLA) increase in Social Security benefits but not excluding subsequent COLA increases in Social Security benefits.

(5) Title II COLA disregard (Pickle). In accordance with 42 CFR §435.135(a) - (b), this mandatory coverage group covers a person who:

(A) has been denied SSI for any reason since April 1977; and

(B) meets current SSI eligibility criteria, excluding from countable income any Social Security COLA increases received after the person last received both SSI and Social Security benefits in the same month.

(6) Disabled widow's or widower's COLA disregard. In accordance with 42 CFR §435.137, this mandatory coverage group covers a person who:

(A) is 50 to 60 years of age;

(B) is ineligible for Medicare;

(C) was denied SSI due to an increase in a disabled widow's or widower's and surviving divorced spouse's RSDI; and

(D) meets SSI eligibility criteria, excluding from countable income the RSDI benefit and any subsequent COLA increases in RSDI.

(7) Early age widow's or widower's COLA disregard. In accordance with 42 CFR §435.138, this mandatory coverage group covers a disabled person who was denied SSI due to early receipt of Social Security widow's or widower's benefits and:

(A) is at least 60 years of age;

(B) is not eligible for Medicare; and

(C) meets current SSI eligibility criteria, excluding from countable income the RSDI benefit and any subsequent COLA increases in RSDI.

(8) SSI denied children. In accordance with §1902(a)(10)(A)(i)(II) of the Social Security Act (42 U.S.C. §1396a(a)(10)(A)(i)(II)), this mandatory coverage group covers a person who:

(A) is under 18 years of age;

(B) was receiving SSI on August 22, 1996;

(C) was subsequently denied SSI because of the change in disability criteria implemented by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193); and

(D) meets SSI eligibility criteria, including the disability criteria in effect before August 22, 1996.

(c) Optional coverage groups. In accordance with 42 CFR Part 435, Subpart C, HHSC determines Medicaid eligibility for MEPD for a person who falls into an optional coverage group described in this subsection. Although federal regulations may allow other optional coverage groups, HHSC does not provide benefits to a member of an optional coverage group unless the group is included in the Texas State Plan for Medical Assistance.

(1) Institutional. In accordance with 42 CFR §435.211, this optional coverage group covers a person who would be eligible for SSI, as specified in 42 CFR §435.230, if the person were not in an institutional setting.

(2) Institutional special income limit. In accordance with 42 CFR §435.236, this optional coverage group covers a person who has lived in an institutional setting for at least 30 consecutive days, as described in §358.433 of this chapter (relating to Special Income Limit), and is eligible under the special income limit.

(3) §1915(c) waiver program. In accordance with 42 CFR §435.217, this optional coverage group covers a person who would be eligible for Medicaid if institutionalized, but is living in the community and receiving services under a §1915(c) waiver program.

(d) Other. In accordance with the Texas State Plan for Medical Assistance, HHSC determines Medicaid eligibility for MEPD for a person who meets the criteria for one of the following services:

(1) Primary home care services. This is a person who needs primary home care services and meets the criteria established in §1929(b)(2)(B) of the Social Security Act (42 U.S.C. §1396t(b)(2)(B)) but is not otherwise eligible for Medicaid.

(2) Program of All-Inclusive Care for the Elderly (PACE). In accordance with 42 CFR Part 460, this is a person who is enrolled in a PACE program under a PACE program agreement.

(3) Susan Walker v. Bayer Corporation services. A person who has received payments from the class action settlement of Susan Walker v. Bayer Corporation may be eligible for Medicaid as a result of excluding from countable resources the payments from the settlement.

(e) Retroactive coverage. In accordance with 42 CFR §435.914, HHSC may determine eligibility for retroactive coverage:

(1) for up to three months before the date of application for:

(A) an applicant;

(B) a person who has been denied SSI;

(C) a deceased person, if a representative for the deceased person requests that HHSC determine eligibility for retroactive coverage; and

(D) a person eligible under the SSI-denied-children coverage group in subsection (b)(8) of this section; and

(2) for up to two months before the month in which an SSI recipient's Medicaid coverage automatically begins.

(f) Medicare Savings Program. In accordance with 42 U.S.C. §1396a(a)(10)(E) for this mandatory coverage group, HHSC may determine eligibility for a person who meets the criteria in Chapter 359 of this title (relating to Medicare Savings Program) for a Medicare Savings Program, which uses Medicaid funds to help the person pay for all or some of the person's out-of-pocket Medicare expenses, such as premiums, deductibles, or coinsurance.

(g) Medicaid Buy-In Program. In accordance with §1902(a)(10)A)(ii)(XIII) of the Social Security Act (42 U.S.C. §1396a(a)(10)(A)(ii)(XIII)) for this optional coverage group, HHSC may determine eligibility for a person with a disability who is working and earning income and meets the criteria established in Chapter 360 of this title (relating to Medicaid Buy-In Program).

(h) Medicaid Buy-In for Children. In accordance with §1902(cc) of the Social Security Act (42 U.S.C. §1396a(cc)) for this optional coverage group, HHSC may determine eligibility for a child with a disability who meets the criteria established in Chapter 361 of this title (relating to Medicaid Buy-In for Children Program).

A-2000, Mandatory Coverage Groups

Body

Revision 19-4; Effective December 1, 2019

HHSC determines eligibility for MEPD for a person who falls into at least one of the following mandatory coverage groups:

A-2100, Supplemental Security Income

Body

Revision 19-4; Effective December 1, 2019

The Social Security Administration (SSA) administers the SSI program. In Texas, persons found eligible for SSI cash payment are automatically eligible for Medicaid. SSA notifies the state through an automated interface called the State Data Exchange System (SDX). Once received, the person is certified for Medicaid and sent a Your Texas Benefits Medicaid card.

SSI appears as type of assistance ME-SSI (TP 13) in TIERS.

Related Policy

SSI Applications, B-7100
MEPD Eligibility Pending a Decision of SSI Application, B-7300
Interstate Requests for Assistance, D-3610
SSI Recipient Visiting in Texas, D-3660
Co-Payment for SSI Cases, H-6000

A-2200, Emergency Medicaid Coverage for Aliens

Body

Revision 12-3; Effective September 1, 2012

Certain aliens with an emergency medical condition who meet all SSI criteria, except citizenship, may be eligible for Medicaid coverage for the medical emergency. Coverage is for the duration of the emergency period. It is not considered as a "prior" medical, though prior months may be covered.

Automated System Program Identifier

TIERS – ME-A and D Emergency

A-2300, RSDI Cost of Living Adjustment Increase

Body

Revision 09-4; Effective December 1, 2009

Medicaid eligibility for the aged, blind and disabled is directly related to receipt of SSI in most states. Loss of SSI payments can result in loss of Medicaid coverage. To preserve Medicaid coverage for certain groups of persons who lose SSI payments, Congress enacted special Medicaid continuation provisions. Persons denied SSI due to certain increases in Social Security benefits may continue to be eligible for Medicaid coverage. SSA informs HHSC through automated files to help locate potential eligible persons who may apply for continued Medicaid.

A-2310 Disabled Adult Children (DAC)

Revision 11-4; Effective December 1, 2011

This applies to persons denied SSI after July 1, 1987, and who meet SSI eligibility criteria when qualifying RSDI disabled adult children's benefits are excluded from countable income (OBRA 1986). These persons were denied SSI benefits because of an increase in or receipt of RSDI disabled children's benefits. These persons may continue to be eligible for Medicaid if they:

- are at least 18;
- become disabled before they are 22;
- are denied SSI benefits because of entitlement to or an increase in RSDI disabled children's benefits received on or after July 1, 1987, and any subsequent increase; and
- meet current SSI criteria, excluding the children's benefit specified above.

Automated System Program Identifier

TIERS – ME-Disabled Adult Child

Note: Based on SSA information, adult disabled child benefits generally end if the person gets married. There are exceptions such as marriage to another adult disabled child. This is an SSA requirement and not part of MEPD policy.

A-2320 Historical 1972 Income Disregard

Revision 11-4; Effective December 1, 2011

This applies to persons who were receiving both public assistance and Social Security benefits in August 1972. These persons must meet current SSI or MEPD eligibility criteria, with the exclusion from income of the amount of the October 1972, 20% Social Security cost of living adjustment (COLA) increase.

Automated System Program Identifier

TIERS – ME-Pickle

A-2330 Pickle

Revision 11-4; Effective December 1, 2011

This applies to persons denied SSI cash benefits for any reason since April 1977. They must meet all current SSI eligibility criteria, with the exclusion of any Social Security COLA increases received since they were eligible for and entitled to both SSI and Social Security benefits in the same month. The earliest COLA increase that can be excluded is the increase received in July 1977. There are two files received from SSA for Title II COLA denials. The 503 file identifies "Pickle" potentials and is received late November of each year. The Lynch vs. Rank file is usually received mid-December.

Automated System Program Identifier

TIERS – ME-Pickle

A-2340 Widow(er)s

Revision 11-4; Effective December 1, 2011

This applies to persons age 60 to 65 who are ineligible for Medicare and who are denied SSI due to excess widow/widower's RSDI benefits. They must meet SSI eligibility criteria, with the exclusion of their RSDI benefit and any subsequent COLA increases from countable income (OBRA 1987).

Automated System Program Identifier

TIERS – ME-Early Age Widow(er)

This applies to persons age 50 to 60 who are ineligible for Medicare and who are denied SSI due to excess disabled widow/widower's and surviving divorced spouse's RSDI benefits. They must meet SSI eligibility criteria, with the exclusion of their RSDI benefit and any subsequent COLA increases from countable income (OBRA 1990).

Historically this also applies to persons denied SSI due to a recomputation of their Social Security disabled widows/widowers benefits for January 1984. They must meet SSI eligibility criteria, with the exclusion of the recomputation increase and any subsequent Social Security COLA increases from countable income. Persons had to have filed an application before July 1, 1998, to be eligible under this program. Enrollment for this program ended June 30, 1998 (OBRA 1985).

Automated System Program Identifier

TIERS – ME-Disabled Widow(er)

A-2350 Reserved for Future Use

Revision 19-4; Effective December 1, 2019

A-3000, Optional Coverage Groups

Body

Revision 18-1; Effective March 1, 2018

HHSC also determines Medicaid eligibility for MEPD for persons who fall into an optional coverage group. Although federal regulations may allow other optional coverage groups, HHSC only provides benefits to a member of an optional coverage group if the group is included in the Texas Medicaid State Plan.

A-3100, SSI Denied Due to Entry into a Long-Term Care Facility

Body

Revision 09-4; Effective December 1, 2009

This optional coverage group covers a person who would be eligible for SSI, if the person were not in an institutional setting.

A-3200, Special Income Limit

Body

Revision 16-1; Effective March 1, 2016

The special income limit applies to persons who will reside in a Medicaid-approved long-term care facility or who apply for certain Home and Community-Based Services (HCBS) waiver programs. Countable income must be equal to or less than the special income limit established by HHSC (see Appendix XXXI, Budget Reference Chart). A person must live in one or more Medicaid-certified long-term facilities at least 30 consecutive days to be eligible under the special income limit. The following are included in this group:

- Persons of any age in Medicaid-certified nursing facilities who meet medical necessity
- Persons of any age in Medicaid-certified sections of state supported living centers and private facilities for persons with intellectual disabilities
- Persons age 65 and over in Medicaid-approved sections of state hospitals (institutions for mental diseases)
- Persons applying for certain HCBS waiver programs who are not already Medicaid eligible under another coverage group covered by the waiver and who meet the waiver eligibility criteria.

Automated System Program Identifier
TIERS – ME-Nursing Facility; ME-State School; ME-Non-State Group Home; ME-State Group Home; ME-State Hospital; ME-Waivers

A-3300, Home and Community-Based Services Waiver Programs

Body

Revision 16-1; Effective March 1, 2016

Home and Community-Based Services (HCBS) waiver programs may have limited enrollment and are an alternative to institutionalization. A person can enroll in only one HCBS waiver at a time, but may be on the interest list for multiple HCBS waivers. Persons applying for certain HCBS waiver programs who are not already Medicaid eligible under another coverage group covered by the waiver and who meet the waiver eligibility criteria may be Medicaid eligible using the special income limit.

For additional information about HCBS waiver programs, including interest lists, go to http://hhs.texas.gov/services/disability/intellectual-or-developmental-disabilities-idd-long-term-care.

Descriptions for some of the Home and Community-Based Services waiver programs follow in this section.

A-3310 Community Living Assistance and Support Services (CLASS)

Revision 16-1; Effective March 1, 2016

A person may be eligible for services through CLASS if the person:

- is residing in the community;
- is age 65 or older or, if less than 65, receives a Social Security Administration (SSA), Supplemental Security Income (SSI), or Railroad Retirement (RR) disability benefit or has a disability determination by HHSC, which is required;
- has an ICF/IID Level of Care (LOC) VIII;
- has an approved plan of care or service plan;
- has a service begin date no later than 30 days from certification; and
- is eligible for Medicaid using the special income limit.

Automated System Program Identifier

TIERS – ME-Waivers

A-3320 Deaf Blind with Multiple Disabilities (DBMD)

Revision 16-1; Effective March 1, 2016

A person may be eligible for services through DBMD if the person:

- is residing in the community;
- is 65 or older or, if less than 65, receives a Social Security Administration (SSA), Supplemental Security Income (SSI), or Railroad Retirement (RR) disability benefit or has a disability determination by HHSC, which is required;
- has an ICF/IID Level of Care (LOC) VIII;
- has an approved plan of care or service plan;
- has a service begin date no later than 30 days from certification; and
- is eligible for Medicaid using the special income limit.

Automated System Program Identifier

TIERS – ME-Waivers

A-3330 Home and Community-based Services (HCS)

Revision 16-1; Effective March 1, 2016

A person may be eligible for services through HCS if the person:

- is residing in the community;
- is age 65 or older or, if less than 65, receives a Social Security Administration (SSA), Supplemental Security Income (SSI), or Railroad Retirement (RR) disability benefit or has a disability determination by HHSC, which is required;
- has an ICF/IID Level of Care (LOC) VIII;
- has an approved plan of care or service plan;
- has a service begin date no later than 30 days from certification; and
- is eligible for Medicaid using the special income limit.

Automated System Program Identifier

TIERS – ME-Waivers

A-3340 Youth Empowerment Services (YES)

Revision 16-1; Effective March 1, 2016

A person may be eligible for services through YES if the person:

- is residing in the community;
- is at least age 3, but less than age 19;
- receives a Social Security Administration (SSA), Supplemental Security Income (SSI), or Railroad Retirement (RR) disability benefit or has a disability determination by HHSC, which is required;
- meets clinical level of care criteria;
- has an approved individual plan of care (IPC);
- has a service begin date no later than 30 days from certification; and
- is eligible for Medicaid using the special income limit.

Note: This program is administered by the Department of State Health Services. For additional information, go to www.dshs.state.tx.us/mhsa/yes(link is external).

Automated System Program Identifier

TIERS – ME-Waivers

A-3350 Medically Dependent Children Program (MDCP)

Revision 16-1; Effective March 1, 2016

A person may be eligible for services through MDCP if the person:

- is residing in the community;
- is less than age 21;
- receives a Social Security Administration (SSA), Supplemental Security Income (SSI), or Railroad Retirement (RR) disability benefit or has a disability determination by HHSC, which is required;
- has an MN;
- has an approved plan of care or service plan;
- has a service begin date no later than 30 days from certification; and

- is eligible for Medicaid using the special income limit.

Automated System Program Identifier

TIERS – ME-Waivers

A-3360 Reserved for Future Use

Revision 16-1; Effective March 1, 2016

A-3370 Texas Home Living (TxHmL)

Revision 18-1; Effective March 1, 2018

A person may be eligible for services through TxHmL if the person:

- is residing in the community;
- has an ICF/IID Level of Care (LOC) VIII;
- has an approved plan of care or service plan; and
- is currently a Medicaid recipient.

Eligibility is not determined using the special income limit.

Automated System Program Identifier

TIERS shows this as ME-Pickle, ME-Disabled Adult Child, etc. HHSC puts the person on TxHmL.

A-3380 STAR+PLUS Waiver (SPW)

Revision 16-1; Effective March 1, 2016

The SPW provides for the managed care delivery of home and community-based Medicaid services in addition to all other services provided through STAR+PLUS.

A-3400, Medicaid Buy-In for Children

Body

Revision 16-1; Effective March 1, 2016

This program covers children with disabilities up to the age of 19 with family income up to 300 percent of the federal poverty level. A family may have to pay a monthly premium as a condition of eligibility. The MBIC program began Jan. 1, 2011. For more information, see Chapter N, Medicaid Buy-In for Children.

Automated System Program Identifier

TIERS – ME-MBIC
TA 88

A-3500, Medicaid Buy-In

Body

Revision 16-1; Effective March 1, 2016

Texans with disabilities who work can apply for health insurance benefits even if their income exceeds traditional Medicaid limits. A person may have to pay a monthly premium as a condition of eligibility. For more information on the Medicaid Buy-In Program, see Chapter M, Medicaid Buy-In Program.

Automated System Program Identifier

TIERS – ME-MBI
TA 87

A-4000, Other Service-Related Programs

Body

Revision 20-4; Effective December 1, 2020

HHSC also determines Medicaid eligibility for MEPD for a person who meets the criteria for one of the following services.

A-4100, Community Attendant Services

Body

Revision 11-4; Effective December 1, 2011

Those who may be eligible for CAS services are persons who are not eligible under a Medicaid program and have a functional need for Medicaid Primary Home Care (PHC) services. The intent of the program is to delay or prevent the need for institutional care; therefore, countable income must be equal to or less than HHSC's special income limit. Eligible persons do not receive regular Medicaid benefits; they receive only PHC services. The program has its statutory basis in §1929(b) of the Social Security Act. This program historically was called Waiver Five and later 1929(b).

Automated System Program Identifier

TIERS – ME-Community Attendant and CC-CCAD-Community Attendant

A-4200, Program of All-Inclusive Care for the Elderly

Body

Revision 20-4; Effective December 1, 2020

The PACE program serves the frail elderly and features a comprehensive service delivery system and integrated Medicare and Medicaid financing. Those who may be eligible for PACE services are people 55 years and older,

with chronic medical problems and functional impairments who meet criteria for MN and are eligible for Medicaid (see §1905(a)(26) of the Social Security Act (enacted in Section 4802 of the Balanced Budget Act of 1997)).

Automated System Program Identifier

TIERS – ME-Waivers

A-4300, Retroactive Coverage

Body

A-4310 General

Revision 12-4; Effective December 1, 2012

In addition to the creation of the SSI program, Public Law 92-603 extended Medicaid benefits to cover the three-month time period before the month an application is filed with the Social Security Administration for SSI, if unpaid or reimbursable medical bills are incurred during the prior months.

Medicaid coverage also is extended to cover the three-month time period before the month an application is filed with MEPD for an ongoing MEPD program. For example, if an individual applies for ME – Nursing Facility, the eligibility specialist explores three months prior coverage.

People are potentially eligible for coverage in the prior months, regardless of their eligibility for the month of application and ongoing is approved or denied.

Note: This provision does not provide prior coverage for an application for which no MEPD program is available.

For specific program coverage, see Section G-7100, Prior Coverage for SSI Applicants, Section G-7200, Prior Coverage for Medical Assistance Only (MAO) Applicants, Section G-7210, Prior Coverage for Deceased Applicants, and Section G-7300, Prior Coverage for Aliens.

A-4320 Two Months Prior

Revision 11-4; Effective December 1, 2011

Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Section 3502.4, changed policy for retroactive Medicaid coverage for persons found eligible for SSI. Effective July 1997, HHSC automatically adds Medicaid coverage for the month prior to the first month of SSI cash payment due (20 CFR §416.501). The person may apply with HHSC for coverage for the two preceding months if there are unpaid or reimbursable medical bills and the person meets all Medicaid eligibility requirements in those months.

Automated System Program Identifier

TIERS – ME-SSI Prior

A-4330 Deceased Individuals

Revision 12-4; Effective December 1, 2012

Medicaid coverage is extended to a deceased person, if a bona fide agent files an application with MEPD on behalf of a deceased person. The three-month time period is the three months prior to the month the application is received by MEPD.

A-5000, Texas Medicaid Hospice Program

Body

Revision 18-1; Effective March 1, 2018

Persons eligible for full Medicaid benefits may elect to participate in the Texas Medicaid Hospice Program if they have a medical prognosis of six months or less to live. In order to enroll in the Texas Medicaid Hospice Program, the person or authorized representative signs and dates Form 3071, Individual Election/Cancellation/Update. This election remains in effect until another Form 3071 is completed canceling hospice election. Recipients electing hospice waive their rights to other Medicaid services related to treatment of the terminal illness(es). They do not waive their rights to Medicaid services that are not related to treatment of the terminal illness(es). Hospice services may be received at home, in a hospital or in a Medicaid-contracted long-term care facility.

A-5100, Hospice in the Community

Body

Revision 11-4; Effective December 1, 2011

Persons residing in a community-based living arrangement, such as their home or a hospital, may elect to participate in the Texas Medicaid Hospice Program if they are eligible for full Medicaid benefits. This means that they qualify as an SSI recipient (ME-Temp Manual SSI or ME-SSI) or an MEPD recipient in the community (certified under ME-Pickle, ME-Disabled Adult Child or ME-Early Aged Widow(er)).

Persons whose only eligibility is MC-SLMB, MC-QMB and MC-QDWI may not participate in the Texas Medicaid Hospice Program because they receive only limited Medicaid coverage. However, they may be entitled to receive Medicare hospice services.

For a list of programs, see the TIERS Policy and Procedures Guide, Section A-6, Type Program Lists in the Texas Integrated Eligibility Redesign System (TIERS) in the Texas Works Handbook.

A-5200, Hospice in a Long-Term Care Facility

Body

Revision 18-1; Effective March 1, 2018

A Medicaid recipient may elect to receive hospice services in a Medicaid-certified nursing facility (NF) or intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID). In order to receive Medicaid hospice services, the person must meet all eligibility criteria for MEPD in a long-term care facility, including confinement in one or more Medicaid-certified long-term care facilities for 30 consecutive days. Form 3071, Individual Election/Cancellation/Update, substitutes for the medical necessity determination when hospice is elected.

The hospice provider informs the eligibility specialist of the possibility of hospice election by a recipient. When the recipient (or authorized representative) signs and dates Form 3071, the hospice provider contacts the eligibility specialist, providing the effective date that the recipient is starting/electing hospice services. The

hospice provider follows up this contact by sending Form 3071 to the contractor for Medicaid claims, with a copy to the eligibility specialist.

For Medicaid hospice residents in long-term care facilities, the hospice provider is responsible for collecting the applied income, and the nursing facility manages the patient trust fund. The hospice provider is responsible for completing Form 3071 in the event of any change in the hospice provider, cancellation of the hospice election, and death. There is normally no need for the eligibility specialist to take any action in response to any of these changes. The automated system receives this information through interfacing with the Service Authorization System Online (SASO) and communication with HHSC. If the eligibility worker becomes aware of the death of the recipient, manual denial of the case should be taken.

A-6000, Persons in Institutions for Mental Diseases

Body

Revision 12-3; Effective September 1, 2012

Coverage for persons age 65 and older in IMDs is part of the Medicaid program. These persons must meet all eligibility criteria for institutional care. The medical necessity determination is met by a letter from the institution stating that in-patient care is necessary. The personal needs allowance is $60 for a person and $120 for a couple. There is no protected earned income allowance.

For TIERS, persons in IMDs (ME-State Hospital or ME-Non-State Group Home) receive a Your Texas Benefits Medicaid card. Although these cases are Title XIX community-based ICF/IID facilities and state hospitals, the co-payment is calculated as appropriate for institutional cases.

A-7000, Type Programs and Type Assistance

Body

Revision 19-4; Effective December 1, 2019

Staff can access the Type Programs (TP) and Type Assistance (TA) chart that lists and describes all the types of assistance and program types in the Texas Works Handbook (TWH), C-1150 , Type Programs (TP) and Type Assistance (TA).

The chart lists all Texas Works (TW), Texas Department of Family Protective Services (DFPS), and Medicaid for the Elderly and People with Disabilities (MEPD) programs.

A-8000, Medicare Savings Programs

A-8100, Qualified Medicare Beneficiary

Body

Revision 11-4; Effective December 1, 2011

QMBs are entitled to Medicare Part A (either with or without payment of premiums) with income usually counted according to the SSI rules at or below the federal poverty guidelines. States determine QMB eligibility, and Medicaid pays all Medicare-related expenses for QMBs (premiums, deductibles and coinsurance). Many SSI beneficiaries meet the QMB eligibility factors. Persons may be eligible under both a Medicaid or

Community Attendant Services program and the QMB program (Public Law 100-360). For more information on the QMB program, see Section Q-2000, Qualified Medicare Beneficiaries (QMB) – MC-QMB.

Automated System Program Identifier
TIERS – MC-QMB

A-8200, Specified Low-Income Medicare Beneficiaries

Body

Revision 13-4; Effective December 1, 2013

Persons eligible for this program do not receive regular Medicaid benefits. Medicaid will pay the Medicare Part B premiums for SLMB. The person must be entitled to enroll in Medicare Part A and must meet all of the eligibility requirements for QMB status, except for income less than 120 percent of the federal poverty level. Persons may be eligible under both a Medicaid or Community Attendant Services program and the SLMB program (see Section 4501(b) of the OBRA, 1990). For more information on the SLMB program, see Section Q-3000, Specified Low-Income Medicare Beneficiaries (SLMB) – MC-SLMB.

Automated System Program Identifier
TIERS – MC-SLMB

Note: For TIERS, the following programs cannot be dually eligible for SLMB: ME-Pickle; ME-SSI Prior; ME-Temp Manual SSI; ME-SSI; ME-Disabled Adult Child (DAC); MC-SLMB; MC-QMB; and ME-A and D Emergency. Even though ME-Pickle and ME-DAC recipients may meet SLMB eligibility requirements, the Medicare Part B premium is already paid by the state of Texas based on their prior SSI eligibility and the continuation of that Medicaid coverage. The only requirement to test for SLMB is if the Pickle or DAC eligibility will be denied.

A-8300, Qualifying Individuals

Body

Revision 14-2; Effective June 1, 2014

Persons eligible for this program do not receive regular Medicaid benefits. QIs must meet the eligibility criteria for the Qualified Medicare Beneficiary (QMB) Program, except the income limits are higher. Medicaid will pay the Medicare Part B premiums for QIs. These persons must be entitled to be enrolled in Medicare Part A and have countable income of at least 120 percent but less than 135 percent of the current federal poverty level. Eligibility is determined for each calendar year.**QI recipients cannot be certified under any other Medicaid-funded program and receive QI benefits simultaneously** (Public Law 105-33, Balanced Budget Act of 1997). For more information on the QI program, see Section Q-5000, Qualifying Individuals (QIs).

Automated System Program Identifier

TIERS – MC-QI-1

Note: Even though ME-Pickle and ME-Disabled Adult Child (DAC) recipients may meet QI-1 eligibility requirements, the Medicare Part B premium is already paid by the state of Texas through the Pickle or DAC Medicaid program eligibility. The only requirement to test for QI-1 is if the Pickle or DAC eligibility will be denied.

A-8400, Qualified Disabled Working Individuals

Body

Revision 14-2; Effective June 1, 2014

Persons eligible for this program do not receive regular Medicaid benefits and must be disabled working individuals entitled to Medicare Part A (hospital coverage). Medicaid will pay the Medicare Part A premiums for QDWIs. These persons must be entitled to enroll in Medicare Part A, not otherwise certified under any other Medicaid-funded program, have countable income of no more than 200% of the federal poverty guidelines, have countable resources of no more than twice the SSI resource limit and be referred by SSA (Public Law 101-239, OBRA 1989). For more information on the QDWI program, see Section Q-6000, Qualified Disabled and Working Individuals (QDWI) – MC-QDWI.

Automated System Program Identifier

TIERS – MC-QDWI

A-9000, Medicaid-Medicare Relationship

Body

Revision 18-1; Effective March 1, 2018

Medicare beneficiaries who have low incomes and limited resources may also receive help from the Medicaid program. For persons who are eligible for full Medicaid coverage, Medicare health coverage is supplemented by services that are available under the Medicaid program, according to eligibility category. For persons enrolled in both programs, any services that are covered by Medicare are paid for by the Medicare program before any payments are made by the Medicaid program, since Medicaid is always the "payer of last resort." Certain other Medicare beneficiaries may receive help with Medicare premium and cost-sharing payments through the Medicaid program.

A-9100, Medicare Benefits

Body

Revision 18-1; Effective March 1, 2018

Medicare is a federal program under Title XVIII of the Social Security Act and is administered by the Social Security Administration (SSA). Medicare provides health care benefits for individuals age 65 or older, under age 65 with certain disabilities, and any age with permanent kidney failure (called end-stage renal disease).

Those younger than 65 will receive Medicare after getting Social Security disability benefits for at least two years.

There are exceptions to the two-year waiting period, including:

- a chronic renal disease that requires a kidney transplant or maintenance dialysis (SSA determines if an individual with a chronic renal disease diagnosis meets the requirements for the exception to the waiting period); or
- Lou Gehrig's disease (amyotrophic lateral sclerosis).

Medicare is available to an individual who has paid into the Medicare trust account through payroll taxes sometimes called the Federal Income Contributions Act (FICA). Most employers are required to withhold FICA taxes, but there are some exceptions. Federal government employees have been eligible to participate in Social Security only since 1984. As a result, some older employees have opted to remain with the former Civil Service

Retirement System. Some state and local government employee retirement plans also are not covered by Social Security.

If an individual receives Medicare, they are either:

- 65 years old or older; or
- determined disabled by SSA.

Medicare is divided into four parts:

- Medicare Part A (Hospital Insurance) – Helps pay for inpatient care in a hospital, skilled nursing facility or hospice, and for home health care if certain conditions are met. Most people do not have to pay a monthly premium for Medicare Part A because they or a spouse paid Medicare taxes while working in the U.S. If the Part A premium is not automatically free, an individual still may be able to enroll and pay a premium.
- Medicare Part B (Medical Insurance) – Helps pay for medically necessary doctors' services and other outpatient care. It also pays for some preventive services (like flu shots), and some services that keep certain illnesses from getting worse. Most individuals pay the standard monthly Medicare Part B premium.
- Medicare Part C (Medicare Advantage Plans) – Individuals must be enrolled in both Part A and Part B. These plans are available through Medicare-approved private insurance companies. The plans cover all of the Part A and Part B services and, in most cases, include Part D Prescription Drug Coverage as well. Some plans offer additional services, such as vision, hearing, dental, and health and wellness programs. Individuals pay a monthly premium and co-payments that are usually lower than the coinsurance and deductibles under the original Medicare. Actual costs and benefits vary by plan.
- Medicare Part D (Medicare Prescription Drug Coverage) provides prescription drug coverage. Individuals can add Part D by joining a Medicare Prescription Drug Plan (PDP). Individuals must pay a deductible and usually pay coinsurance each time services are received. The PDPs are available through private insurance companies approved by Medicare. Costs and benefits vary by plan.

Premiums

In most cases, the Part B and Part D premiums are deducted from the Social Security or Railroad Retirement check. The recipient is responsible for calendar-year deductibles and co-pay liabilities for both Parts A and B.

The Part C premium is handled by the private company that offers the benefit as a Medicare Advantage Plan. The Medicare Advantage Plan has its own benefits and coverage that differs from the traditional Medicare benefits. Medicare pays a fixed amount every month to the companies offering Medicare Advantage Plans. These companies must follow rules set by Medicare. However, each Medicare Advantage Plan can charge different out-of-pocket costs and have different rules for how one gets services.

Extra help for Part D (Medicare Prescription Drug Coverage) is available for people with Medicare who have limited income and resources. If eligible for extra help, Medicare will pay for almost all prescription drug costs. Extra help provides a subsidy based on the amount of income and resources an individual has.

Full Subsidy Benefits from Extra Help:

- Full premium assistance up to the premium subsidy amount
- Nominal cost sharing up to out-of-pocket threshold
- No coverage gap

Other Low Income Subsidy Benefits from Extra Help:

- Sliding scale premium assistance
- Reduced deductible

- Reduced coinsurance
- No coverage gap

Individuals who have Medicare and Medicaid or who are eligible for the Medicare Savings Program (MSP) do not need to apply for extra help through the SSA.

Individuals can apply for **extra help** or get more information about **extra help** subsidy by calling Social Security at 800-772-1213 (TTY 800-325-0778) or visiting www.socialsecurity.gov.

A-9200, Medicare Buy-In

Body

Revision 11-4; Effective December 1, 2011

To ensure that Medicaid recipients who are entitled to Medicare receive maximum health care protection, the state pays for certain recipients' Medicare Part B premiums. This process is called buy-in. For those persons who have dual entitlement, Medicare becomes the payer of first resort, with Medicaid paying deductibles and co-insurance for Medicaid-covered services.

If recipients in ME-Nursing Facility, ME-State School, ME-Waivers and ME-Community Attendant are not eligible for QMB or SLMB, they are not eligible for buy-in.

A-9210 Eligibility Requirements for Medicare Buy-In

Revision 11-4; Effective December 1, 2011

Recipients are eligible for buy-in if they are:

- 65 or older and U.S. citizens;
- 65 or older and lawfully admitted aliens who have lived in the U.S. five consecutive years;
- under 65 and have received or been eligible to receive Social Security or Railroad Retirement disability benefits for 24 consecutive months; or
- under 65 and qualify for Medicare Part A because of chronic renal disease.

If recipients in ME-Nursing Facility, ME-State School, ME-Waivers and ME-Community Attendant are not eligible for QMB or SLMB, they are not eligible for buy-in.

A-9220 Time Frames for Medicare Buy-In Enrollment

Revision 13-4; Effective December 1, 2013

Persons who have Medicare Part B coverage at the time they are certified for Medicaid are enrolled as follows:

- SSI and Temporary Assistance for Needy Families (TANF) recipients are enrolled for buy-in effective the first month they receive a cash payment.
- ME-Pickle recipients who are RSDI pass-on recipients are enrolled in continuous buy-in.

  Example: The recipient was denied SSI on Dec. 31 due to a cost of living increase. The recipient applied

for ME-Pickle in February and was certified eligible on March 5. Medical effective date is Jan. 1. Medicare Part B buy-in is effective Jan. 1. The recipient will be reimbursed by SSA for any premiums withheld from the recipient's RSDI check.

- ME-Disabled Adult Child (DAC) recipients who are RSDI pass-on recipients are enrolled in continuous buy-in.

  Example: The recipient was denied SSI on Dec. 31 due to a cost of living increase. The recipient applied for ME-DAC in March and was certified eligible on April 10. Medical effective date is Jan. 1. Medicare Part B buy-in is effective Jan. 1. The recipient will be reimbursed by SSA for any premiums withheld from the recipient's RSDI check.

- ME-Nursing Facility, ME-State School, ME-Waivers, ME-Non-State Group Home and ME-State Group Home recipients who are QMB-eligible, whose certification was accomplished as a program transfer, and whose certification has no break in Medicaid coverage are eligible for continuous buy-in.

  Example: The MQMB recipient has SSI and RSDI income and enters a nursing facility in January. SSI is denied effective Feb. 28. The recipient qualifies for QMB and Medicaid. The medical effective date for MQMB is March 1. The recipient is entitled to continued Medicare buy-in and is reimbursed for any premium withheld from the RSDI check.

- Recipients who are denied in error and are recertified have continuous enrollment for buy-in. This is true except for those recipients in ME-Nursing Facility who are not eligible for QMB benefits.

  Example: The MQMB recipient is enrolled in Medicaid, ME-Nursing Facility. During the first year's review process, the recipient was denied due to excess resources effective Jan. 31. During a subsequent application in March, the eligibility specialist discovers the recipient should not have been denied in January and grants a medical effective date of Feb. 1, reopening the case. The recipient is entitled to continued Medicare buy-in and is reimbursed for any premium withheld from the RSDI check.

- ME-Nursing Facility recipients who are also QMB-eligible are enrolled for buy-in effective the month of their eligibility for QMB benefits.

  Example: The recipient is certified for ME-Nursing Facility and is also eligible for MQMB. Certification is Jan. 15, and the MQMB effective date is Feb. 1. Medicare buy-in is effective Feb. 1. The recipient will be reimbursed by SSA for any premiums withheld after the effective date of buy-in.

- Recipients eligible for QMB who do not have Medicare Part B coverage at the time of Medicaid certification are enrolled in buy-in when they meet Medicare criteria. These recipients remain on the buy-in rolls while they are eligible for Medicare, Medicaid and QMB benefits.

When a recipient is enrolled in buy-in, SSA stops charging for Part B premiums. Usually this occurs the month after SSA has acknowledged receiving the recipient's name as an addition to the buy-in rolls. If premiums have been withheld from the monthly benefit, the recipient's check should reflect an upward adjustment by the third month after the month of certification.

Address questions about the buy-in status of a recipient who has been certified for at least three months to:

CCC_Data_Integrity_Program@hhsc.state.tx.us

Chapter B, Applications and Redeterminations

B-1000, Applications and Redeterminations

Body

Revision 09-4; Effective December 1, 2009

This chapter contains processes for applications and redeterminations for all MEPD coverage groups.

See Chapter A, General Information and MEPD Groups, for descriptions.

B-1100, Texas Administrative Code Rules

Body

Revision 09-4; Effective December 1, 2009

§358.505. Application Process Overview.

(a) The Texas Health and Human Services Commission (HHSC) gives anyone the opportunity to apply for a Medicaid-funded program for the elderly and people with disabilities (MEPD), in accordance with 42 CFR §435.906. A person can apply for MEPD by submitting:

(1) an application for assistance to HHSC; or

(2) an application for Supplemental Security Income (SSI) to the Social Security Administration.

(b) Under the application submittal process described in subsection (a)(1) of this section, a person must follow the requirements in §358.515 of this subchapter (relating to Application Requirements) to obtain an eligibility determination from HHSC.

(c) In accordance with 42 CFR §435.120 and §435.909(b)(1), an application for SSI as described in subsection (a)(2) of this section serves as an application for MEPD. A person receiving or deemed to be receiving SSI derives eligibility for MEPD from the person's SSI eligibility and does not require an eligibility determination from HHSC.

§358.510. Authorized Representative.

In accordance with 42 CFR §435.908, an authorized representative may accompany, assist, and represent an applicant or recipient in the application or eligibility redetermination process.

§358.515. Application Requirements.

(a) To apply for a Medicaid-funded program for the elderly and people with disabilities (MEPD) under the application submittal process described in §358.505(a)(1) and (b) of this subchapter (relating to Application Process Overview), and in accordance with 42 CFR §435.907, an applicant, authorized representative, or someone acting responsibly for the applicant (if the applicant is incompetent or incapacitated) must:

(1) use the application prescribed by the Texas Health and Human Services Commission (HHSC) and complete it according to HHSC instructions:

(A) in writing, using a paper application obtained via telephone, Internet request, or other means;

(B) online, using the application process available over the Internet;

(C) over the telephone, through the State's toll-free telephone number; or

(D) in person, by visiting an HHSC benefits office;

(2) provide all requested information according to HHSC instructions; and

(3) sign the application for assistance under penalty of perjury.

(b) If someone helps an applicant or authorized representative complete the application for assistance, the name of the person completing the form must appear as requested on the application.

(c) If HHSC sends an applicant or authorized representative a request for missing information or verification documents, or both, the applicant or authorized representative must provide the requested information to HHSC by the due date given in the request, or eligibility may be denied.

§358.520. Date of Application.

(a) The date of application is the date on which:

(1)the Texas Health and Human Services Commission receives an application for assistance in accordance with subsection (c) of this section; or

(2) an application for Supplemental Security Income is filed with the Social Security Administration.

(b) If an application for assistance is received after the close of business, the date of application is the next working day.

(c) For purposes of determining the date of application for an application for assistance received under subsection (a)(1) of this section:

(1) an application received via fax or mail must contain, at a minimum, the applicant's name, address, and valid signature; and

(2) an application received via telephone or the Internet:

(A) must contain, at a minimum, the applicant's name and address; and

(B) the applicant must provide a valid signature within 45 days after the date of application.

§358.525. Previously Completed Application for Assistance.

An application for assistance remains valid for 90 days after a date of denial, if the Texas Health and Human Services Commission denies eligibility. An applicant may use his or her previously completed application to reapply during the 90-day period, in accordance with HHSC instructions.

§358.530. Eligibility Determination.

(a) Time frame for determination. After an applicant or authorized representative provides all information and verification documents requested, the Texas Health and Human Services Commission (HHSC) makes an eligibility determination within the following time frames, in accordance with 42 CFR §435.911:

(1) by the 90th day after the date of application if the applicant is applying on the basis of a disability;

(2) by the 45th day after the date of application for all other applicants; or

(3) beyond the time frames established in paragraphs (1) and (2) of this subsection under unusual circumstances, such as those set forth in 42 CFR §435.911.

(b) Basis for determination. HHSC decides whether an applicant meets the eligibility criteria for a Medicaid-funded program for the elderly and people with disabilities based on:

(1) a complete, signed, and dated application for assistance;

(2) information obtained from an interview, if an interview occurred; and

(3) required verification documents.

§358.545. Eligibility Redetermination.

(a) In accordance with 42 CFR §435.916, the Texas Health and Human Services Commission (HHSC) redetermines a person's eligibility for a Medicaid-funded program for the elderly and people with disabilities (MEPD):

(1) at least every 12 months;

(2) after HHSC receives information about a change in the person's circumstances, such as living arrangement, income, or resources, that may affect MEPD eligibility; and

(3) at the appropriate time based on an anticipated change in the person's circumstances.

(b) If the result of an eligibility redetermination causes an adverse action, HHSC:

(1) gives timely and adequate notice of the proposed action to terminate, discontinue, or suspend MEPD eligibility;

(2) gives timely and adequate notice to reduce or discontinue MEPD services; and

(3) informs the person of the right to request a hearing to appeal the adverse action in accordance with 42 CFR Part 431, Subpart E and HHSC's fair hearing rules in Chapter 357 of this title (relating to Hearings).

B-2000, Responsibilities of an Eligibility Specialist

B-2100, Reporting Abuse and Neglect

Body

Revision 09-4; Effective December 1, 2009

HHSC staff are mandated to report abuse or neglect that threatens the health or welfare of a child or an elderly or disabled adult. Staff must report instances of:

- physical or mental injury;
- sexual abuse;
- exploitation; and
- neglect.

Report such instances to the Department of Family and Protective Services. The toll-free number to report abuse is 800-252-5400.

For reports of domestic violence, abuse or neglect of adults, inform the person or his or her authorized representative of the report unless you believe informing them would place the person at risk of serious harm.

B-2200, Conflict of Interest

Body

Revision 09-4; Effective December 1, 2009

An eligibility specialist has an obligation to avoid even the appearance of impropriety or conflict of interest when determining Medicaid eligibility. The eligibility specialist must not work on or review an ongoing case nor assist an applicant or recipient to receive benefits if the applicant or recipient is a relative (by blood or marriage), roommate, dating companion, supervisor or someone under the specialist's supervision. The specialist may not determine their eligibility for Medicaid. The specialist may provide anyone with an application for Medicaid and may inform anyone how and where to apply. The specialist may help anyone gather documents to verify eligibility and need for Medicaid, but must not take any other role in determining eligibility.

The specialist must consult with the supervisor if the applicant or recipient is a friend or acquaintance. Generally, the specialist should not work on cases or applications involving these individuals, but the degree and nature of the relationship should be taken into account.

B-2300, Eligibility Determination

Body

Revision 09-4; Effective December 1, 2009

Verify all eligibility factors according to the verification and documentation requirements for each factor.

Document all factors of eligibility in the case record to substantiate the decisions made on all applications and redeterminations before certifying, recertifying, denying or taking any other action on a person's eligibility and/or co-payment.

B-2400, Documentation Standards

Body

Revision 11-4; Effective December 1, 2011

Documentation standards are contained in this handbook. Specific documentation and verification standards can be found in Appendix XVI, Documentation and Verification Guide. Appendix XVI provides documentation expectations and suggested sources for obtaining information that have proven to result in quality, accurate cases.

When supervisor approval is suggested, written or documented, verbal contact is acceptable. Requirements for documenting telephone contacts are contained in Appendix XVI.

Documentation standards include the date and name/signature of the MEPD eligibility specialist on all recording documents and case actions.

See Section B-8440, Streamlining Methods.

B-2500, Explaining Policy vs. Giving Advice

Body

Revision 09-4; Effective December 1, 2009

Explaining policy is appropriate. The law requires that Medicaid rules, policies and procedures be freely available to the public. The rules governing MEPD are contained in the Texas Administrative Code (TAC), Title 1, Part 15, Chapters 358, 359 and 360. This handbook also contains the MEPD rules, as well as policies, procedures and examples. Both the TAC and MEPD Handbook are available online. MEPD eligibility specialists act properly in explaining the rule or policy that applies to an applicant's or recipient's situation, and in referencing the applicable rule or handbook sections.

Giving advice is contrary to HHSC policy. Giving advice includes suggesting options for how to become eligible or how to avoid Medicaid estate recovery, as well as expressing any opinion of what is preferable or more advantageous to the applicant or recipient. Giving advice is contrary to HHSC policy because it:

- usually constitutes the unauthorized practice of law (which can subject the eligibility specialist to legal penalties);
- encroaches on the contractual relationship that may exist between the applicant or recipient and attorney or financial advisor; and
- can subject the eligibility specialist to personal liability for giving advice that is incorrect or that fails to take into account issues other than eligibility (attorneys and financial planners take into account other issues, such as tax laws, in giving estate planning advice relating to Medicaid eligibility).

The approach taken by MEPD eligibility specialists should be to explain policy but not to make recommendations. If an MEPD eligibility specialist is asked for advice, an appropriate response would be to provide the policy that applies to the situation, and to otherwise decline the request. The MEPD eligibility specialist should explain that agency policy prohibits giving advice, and may suggest that the applicant or recipient seek the assistance of an attorney or other estate planning professional of their own choosing.

Excess Income

See Appendix XVI, Documentation and Verification Guide, and Appendix XXXVI, Qualified Income Trusts (QITs) and Medicaid for the Elderly and People with Disabilities (MEPD).

If an applicant is income ineligible in an institutional living arrangement, Appendix XXXVI may be shared with applicants and their representatives to assist them in understanding the purpose of and requirements for a QIT.

To prevent allegations that MEPD staff are engaging in the unauthorized practice of law, the following instructions are provided. Use the instructions on the chart regarding the appropriate actions to take and the actions to avoid.

MEPD Staff

May	May Not
Provide applicants or their representatives with a copy of Appendix XXXVI for informational purposes only.	Tell applicants or their representatives that they need a QIT.
Provide applicants or their representatives with applicable policy and procedures.	Recommend specific actions applicants or their representatives should take to become eligible for Medicaid.

May	May Not
Refer applicants or their representatives to the following allowable referral list: • local legal aid office, • local Area Agency on Aging, • National Academy of Elder Law Attorneys, • local bar association or lawyer referral service, • Advocacy Inc., or • State Bar of Texas for a list of attorneys who practice elder law in the area.	Tell applicants or their representatives whether or not they must have an attorney to establish a QIT. Recommend that an applicant or representative consult with a specific attorney or organization. (See allowable referral list.)
Speak with their supervisor or regional services attorney about any questions they have regarding the use of Appendix XXXVI.	Recommend that an applicant or representative call an HHSC attorney for legal advice.

Excess Resources

See Appendix XVI, Documentation and Verification Guide.

If excess resources can be designated as burial funds, allow the individual the opportunity to do so. See Section F-4227, Burial Funds.

If a person is determined ineligible because of excess funds in a joint account, allow an opportunity to disprove the presumed ownership of all or part of the funds. The person also must be allowed to disprove ownership of joint accounts that currently do not affect eligibility but may in the future. See Section F-4121, Joint Bank Accounts.

B-2600, Medicaid Estate Recovery Program Notification Requirements

Body

Revision 18-1; Effective March 1, 2018

Medicaid Estate Recovery Program (MERP) is not part of the eligibility determination process for Medicaid.

MERP recovers from a Medicaid recipient's estate the cost of Medicaid assistance paid for an individual who:

1) was age 55 or older at the time Medicaid services were received; and
2) initially applied for certain types of long-term care (LTC) services on or after March 1, 2005.

Individuals whose estate may be subject to MERP recovery include:

- an applicant for a Medicaid program that covers these LTC services; or
- a recipient who requests a change to a Medicaid program that covers these LTC services.

Individuals applying for or receiving these LTC services must be informed about MERP.

A signed Form 8001, Medicaid Estate Recovery Program Receipt Acknowledgement, or documentation the Form 8001 was provided, must be in the case record of each applicant whose estate is subject to MERP recovery.

B-2610 Types of MEPD Groups Subject to MERP

Revision 18-1; Effective March 1, 2018

On March 1, 2005, Texas implemented MERP in compliance with federal Medicaid and state laws. The program is managed by HHSC. Under this program, the state may file a claim against the estate of a deceased Medicaid recipient who: 1) was age 55 or older when Medicaid services were received; and 2) first applied for certain long-term care services and supports on or after March 1, 2005. The most complete, current and accurate source of information regarding MERP is the HHS website: Medicaid Estate Recovery Program. MERP Claims include the cost of Medicaid assistance paid for the following services:

- nursing facilities;
- intermediate care facilities for individuals with an intellectual disability or related conditions (ICF/IID), which include state supported living centers;
- Home and Community-Based Services waiver programs. See Chapter O, Waiver Programs, Demonstration Projects and All-Inclusive Care;
- Community Attendant Services; and
- related hospital and prescription drug services.

Notes:

- A person who is placed on an interest list for a Home and Community-Based Services waiver program is not considered to be an applicant.
- As of Jan. 1, 2010, states are prohibited from recovering the value of Medicare cost-sharing paid under Medicare savings programs as a result of the Medicare Improvements for Patients and Providers Act (MIPPA) signed into law on July 15, 2008.

B-2620 HHSC MERP Notification Requirements

Revision 18-1; Effective March 1, 2018

HHSC staff must inform anyone requesting Medicaid assistance for long-term services and supports that may be subject to MERP recovery. Complete the following to document this requirement:

- Form 8001, Medicaid Estate Recovery Program Receipt Acknowledgement, is mailed with all Form H1200 application requests received on or after March 1, 2005.
- Ensure the signed MERP Receipt Acknowledgement (Form 8001) is imaged in the case record.
- Include the MERP documentation with SSI monitoring requirements outlined in Section B-7100, SSI Monitoring.
- Record information (name, address, telephone number) of any of the following individuals representing the applicant:
  - guardian of the person or guardian of the estate of the applicant;
  - agent under a durable power of attorney or a medical power of attorney; or
  - if none of the above individuals are known, family members acting on behalf of the applicant.
- If a signed MERP Receipt Acknowledgement form is not returned by the applicant/recipient, send Form 8001 and document in case comments that the MERP information was sent to inform the recipient about MERP and the potential for estate recovery. Include in the documentation the date the form was sent to the recipient.

If a Form H1746-A, MEPD Referral Cover Sheet, has a mark in the box "MERP shared," do not send MERP notifications to the individual. The agency making the referral has shared MERP information with the individual.

The MERP notification requirement applies to any individual, age 55 or older, who is applying for Medicaid assistance for long-term care services and supports that are subject to MERP on or after March 1, 2005, either through an application or program transfer. Individuals transferring to long-term care services and supports subject to MERP must have documentation of Form 8001 in the case record. If there is no documentation in the case record, send Form 8001 and follow documentation guidelines outlined in this section.

Example: Mr. Andy Allen applied for a Medicare Savings Program (MSP) before Nov. 1, 2004, and was certified, but did not receive Form 8001 since Mr. Allen was on an MSP before March 1, 2005. Mr. Allen entered a nursing facility this month and requested a program transfer. Based on Section B-7450, Medicaid Certified Person Enters Nursing Facility or Home and Community-Based Services Waiver Program, the program transfer is complete, and Form 8001 is sent to Mr. Allen. Staff document in case comments the date the Form H8001 was mailed.

B-3000, Applications

B-3100, Application Process

Body

Revision 20-2; Effective June 1, 2020

For Medicaid for the Elderly and People with Disabilities (MEPD), the application for assistance is based on one of the following versions of Form H1200:

- Form H1200, *Application for Assistance — Your Texas Benefits*, for all MEPD programs;
- Form H1200-EZ, *Application for Assistance — Aged and Disabled*, for Medicare Savings Programs (MSP) programs;
- Form H1200-PFS, *Medicaid Application for Assistance (for Residents of State Facilities) Property and Financial Statement*, for state supported living centers, state hospitals, and state centers;
- Form H1200-MBI, *Application for Benefits — Medicaid Buy-In*, for the MBI program only; or
- Form H1200-MBIC, *Application for Benefits — Medicaid Buy-In for Children (MBIC)*, for the MBIC program only.

If requested, give the applicant a receipt (Form H1800, Receipt for Application/Medicaid Report/Verification/Report of Change) to verify they provided an application. An applicant may request Form H1800 by fax or mail. Mail the receipt to the applicant's listed address.

Related Policy

Date of Application, B-4000
Previous Completed Application, B-5000
Notices and Forms, M-9000
Notices and Forms, N-9000

B-3200, Application Requirements

Body

Revision 09-4; Effective December 1, 2009

Federal law requires that anyone who wishes to apply for a Medicaid program be allowed to file an application without delay, regardless of the person's ultimate eligibility for assistance.

An application form must be mailed within two working days from the receipt of the request for an application.

Use an application form to test eligibility for all Medicaid programs for which a person meets the criteria. A separate application form is not required for each of the different Medicaid programs for the elderly and persons with disabilities.

Consider the application complete with a name, address and signature.

B-3210 Who May Complete an Application for Assistance

Revision 16-3; Effective September 1, 2016

An individual who may complete or sign an application for an applicant may possibly not be on the list of individuals to whom the Texas Health and Human Services Commission (HHSC) can release the applicant's individually identifiable health information. See Section C-5000, Personal Representatives, for individuals who may receive or authorize the release of an applicant's individually identifiable health information under Health Insurance Portability and Accountability Act (HIPAA) privacy regulations.

An authorized representative may accompany, assist and represent an applicant or recipient in the application or eligibility redetermination process.

Anyone may assist the applicant, guardian, power of attorney or authorized representative in completing an application form. If someone helps complete the application for assistance, the name of the individual completing the form must appear as requested on the application.

See Section B-3220, Who May Sign an Application for Assistance, to determine who may sign an application for assistance form. The requirements for signing a redetermination form are the same as the requirements for signing an application.

See Section C-1100, Responsibility of Applying.

Most applicants in an institutional setting such as a nursing facility are signed into the facility by someone else. An application and information from the applicant and/or the individual(s) having knowledge of the applicant's fina al circumstances are required.

B-3220 Who May Sign an Application for Assistance

Revision 16-3; Effective September 1, 2016

An individual who may complete or sign an application for an applicant may not be on the list of people to whom HHSC can release the applicant's individually identifiable health information. See Section C-5000, Personal Representatives, for individuals who may receive or authorize the release of an applicant's individually identifiable health information under HIPAA privacy regulations.

An applicant, authorized representative or someone acting responsibly for the applicant (if the applicant is incompetent or incapacitated) may sign an application for assistance. **The application for assistance must be signed under penalty of perjury.**

If an applicant has a guardian, the guardian must:

- sign the application for assistance;
- obtain a copy of the guardianship papers; and
- work with the guardian in the eligibility process.

If an application is signed by someone other than the applicant or the applicant's guardian, power of attorney, family member, or a friend who is knowledgeable of the applicant's finances, the individual must provide a Form H1003, Appointment of an Authorized Representative, signed by the applicant, or evidence of:

- authority to complete and sign an application on behalf of an applicant;
- the individual's relationship to the applicant; and
- responsibility for the applicant's care.

If an applicant makes an "X" on the signature line for applicant/recipient, a witness must sign on the witness signature line.

B-3221 Valid Signatures

Revision 19-1; Effective March 1, 2019

All applications and renewals must be signed under the penalty of perjury statement.

Valid signatures include only the following:

- a traditional written signature;
- a faxed written signature;
- an electronic signature submitted through YourTexasBenefits.com; and
- a telephonic signature submitted by calling 2-1-1.

YourTexasBenefits.com

An applicant may apply for all MEPD programs through YourTexasBenefits.com. Applications submitted online through YourTexasBenefits.com by an applicant or AR are considered electronically signed. A "traditional" written signature is not required before an applicant can be certified.

Calling 2-1-1

An applicant may apply for Medicaid by calling 2-1-1. An applicant or AR may complete and sign an application over the phone by:

- providing their information over the phone to a customer care representative (CCR); and
- signing the application telephonically by stating their name and agreeing to the penalty of perjury statement read by the CCR.

The CCR enters and submits the information provided by the applicant or AR through YourTexasBenefits.com.

Unsigned Applications

An application or renewal form received without a signature below the penalty of perjury statement is considered invalid.

If the agency receives an application without a signature and does not accept the application by giving the application an established file date, then the application is considered invalid. Staff must return the application with a letter and a self-addressed return envelope explaining that the application must be signed before the agency can establish a file date.

If the agency receives and accepts an application without a signature and the application is given an established file date in error, the date the application is received is considered a valid file date. Staff must send Form H1020, Request for Information or Action, along with the signature page requesting a signature. If the applicant fails to provide a signed application by the final due date, staff must deny the application for failure to provide information.

Related Policy

Processing Deadlines, B-6400
Who May Sign an Application for Assistance, B-3220

B-3230 Receipt of Duplicate or Identical Applications

Revision 20-3; Effective September 1, 2020

Duplicate Application

An application filed after another application has already been filed is a duplicate application if it:

- does not include a request for a new program (i.e.: a type of program not requested on the initial application or a type of program not currently received by the applicant); and
- is not needed for a redetermination of the active program(s).

Example: An application is received on January 2 and a second application for the same program is received on January 5. The second application is considered a duplicate application.

If a duplicate application is received while the first application is being processed:

- treat the duplicate application as a report of change; and
- assign to the eligibility staff currently processing the case.

If a duplicate application is received after the first application has been processed, review the application to ensure the person is not applying for a different type of program and that a redetermination is not due. If a new program is not being requested:

- consider the duplicate application as a report of change; and
- assign as a change indicating "duplicate application."

If the person is applying for a new program, the application is not a duplicate application. Process the application as a new request for assistance.

Identical Application

An identical application is an exact copy of an application previously submitted by an applicant.

Example: An application is received by fax on January 2 and an exact copy of the same application (with the same signature and date of the previously submitted application) is received by mail on January 5. The second application is considered an identical application.

Required Action on Identical Application Received

If an identical application is received, write "Identical Application" on the front page of the application and route for imaging. The identical application will be imaged and added to the electronic case record. No other action is needed.

B-3300, Authorized Representative

Body

Revision 21-1; Effective March 1, 2021

An authorized representative (AR) is a person who is familiar with the applicant and knowledgeable of the applicant's financial affairs.

An applicant, person receiving benefits, head of household (HOH), or someone with legal authority to act on their behalf (e.g., legal guardian or power of attorney) may designate a person or organization as an AR.

When applying for benefits, an AR must be verified using one of the following:

- applicant's or recipient's signature on one of the following HHSC applications for benefits containing the AR designation:
  - Form H1200, Application for Assistance — Your Texas Benefits;
  - Form H1200-MBI, Application for Benefits — Medicaid Buy-In;
  - Form H1200-MBIC, Application for Benefits — Medicaid Buy-In for Children; or
  - Form H1206, Health Care Benefits Renewal;
- applicant's signature on a Marketplace application for health care benefits that is transferred to HHSC and contains the AR designation;
- legal documentation that the AR has authority to act on behalf of the applicant or recipient under state law (e.g., legal guardianship or power of attorney);
- letter designating AR authority and containing the applicant's or recipient's signature, in addition to the name, address and signature of the AR;
- completed Form H1003, Appointment of an Authorized Representative;
- applicant's or recipient's electronic signature designating the AR on an application, renewal or reported change submitted through YourTexasBenefits.com; or
- applicant's or recipient's telephonic signature submitted by calling 2-1-1.

If a person or organization submits an application on behalf of an applicant and indicates they wish to be the AR but the application is not signed by the applicant, send correspondence to both the unverified AR and the applicant to request the verification.

- Send the following to the applicant:
  - Form H1020, Request for Information or Action, listing the missing information needed before eligibility can be determined.
  - Form H1003, to capture the AR designation and the signatures of the applicant and the AR.
- Send the following to the unverified AR:
  - Form H1004, Cover Letter: Authorized Representative Not Verified, explaining what is needed to verify the AR.

- Form H1003, to capture the AR designation and the signatures of the applicant and the AR.

For the AR to be verified, either the AR or the applicant must return the completed Form H1003 within 10 days (or 39 days from the file date). All missing information listed on the Form H1020 must also be returned timely. If the AR verification is not received by the due date, do not designate an AR.

The AR designation is effective from the date the AR is verified until:

- the applicant or recipient notifies HHSC that the AR is no longer authorized to act on their behalf;
- the AR notifies HHSC that they no longer wish to act as the AR for the applicant or recipient;

  Note: The AR will not be able to do this during the redetermination process if the AR is the person completing and signing the redetermination.

- there is a change in the legal authority (i.e., legal guardianship or power of attorney) on which the AR's designation is based; or
- the applicant or recipient designates a new AR to act on their behalf. If there is an existing AR designated on a case, the person or organization most recently designated as the AR will replace the existing AR on the case.

Requests to end the designation of an AR must include the signature of the applicant, the recipient or the AR as appropriate.

Note: An AR is not automatically a personal representative.

An AR is designated at the case level to have access to all benefit information for that case. A verified AR may:

- sign an application on behalf of an applicant;
- complete and submit a renewal form;
- receive copies of notices or renewal forms in the preferred language selected on the application, and other communications from HHSC;
- designate a health plan; and
- act on behalf of the applicant or the recipient in all other matters with HHSC.

The applicant, recipient or AR may also request that the AR receive the recipient's Medicaid ID card and enrollment-related agency correspondence.

Mailing Address for AR

When processing the application, obtain the AR's complete mailing address if not included on the application form. Record the AR's address on the TIERS Data Collection page, **Household – Authorized Representative**. If the applicant cannot provide a complete mailing address for the AR, do not pend the case. Record the applicant's mailing address as the AR's address in TIERS.

When an applicant or recipient and their designated AR have the same mailing address, correspondence will be sent only to the AR.

When an applicant or recipient has a legal guardian, correspondence will be sent only to the guardian, even if the applicant or recipient and the guardian have different mailing addresses.

Applicants, recipients or ARs who have chosen to receive eligibility correspondence electronically will continue to receive correspondence electronically.

Related Policy

Who May Complete an Application for Assistance, B-3210
Who May Sign an Application for Assistance, B-3220
Prior Coverage for Deceased Applicants, G-7210

B-3400, General Procedures

Body

Revision 21-4; Effective December 1, 2021

If an applicant or authorized representative (AR) contacts HHSC to initiate an application and appears to be eligible for SSI, refer the person or AR to the Social Security Administration (SSA). If the person or AR wishes to file an application with HHSC, provide the appropriate cover letter, application for assistance and Form H0025, HHSC Application for Voter Registration.

Explain that eligibility is determined based on:

- a completed, signed and dated application for assistance;
- information obtained from the completed form, the applicant and AR, tape matches and interviews if needed; and
- required verification documents.

When determining eligibility for a person in an institutional setting using the special income limit, the eligibility determination cannot be disposed in the system of record until the person has resided in an institutional setting for at least 30 consecutive days. The person must also have an approved level of care (LOC) for an intermediate care facility for persons with intellectual disabilities (ICF/IID) or an approved medical necessity (MN) with a nursing facility LOC.

Do not approve medical assistance for a person in an institutional setting unless the person has been in a Medicaid facility for at least 30 days and has an approved LOC or MN determination.

Related Policy

Institutional Living Arrangement, B-6300
Voter Registration, C-7000
Assessment and SPRA, J-4000

B-4000, Date of Application

Body

Revision 20-2; Effective June 1, 2020

The file date of an application is the date the Texas Health and Human Services Commission (HHSC) receives an application form containing the applicant's name, address and appropriate signature. This is day zero in the application process.

For electronically filed applications, the file date is the date the applicant clicks the "Submit Application" button in YourTexasBenefits.com.

For applications received after the close of business or on days when HHSC is closed, including weekends and holidays, the file date is the next business day.

If an application is denied in error, the original file date of the application must be protected no matter how old the application for assistance.

Within 10 calendar days from receipt of an application, send Form H1236, Notification of Receipt of Application, to the nursing facility or ICF/IID where a person resides or intends to reside. If requested, provide the applicant a receipt (Form H1800, Receipt for Application/Medicaid Report/Verification/Report of Change) to verify an application was received. An applicant may request Form H1800 by fax or mail. Mail the receipt to the applicant's listed address.

Related Policy

Previously Completed Application, B-5000
Application Due Dates, B-6410

B-5000, Previously Completed Application

Body

Revision 20-4; Effective December 1, 2020

A previously completed application for assistance is valid for 90 days. It may be used to reopen the application or renewal in the following situations.

Failure to Provide Requested Information

- An application is denied for failure to provide information and all requested information is provided within 90 days of the date of denial.
- A renewal is denied for failure to provide information and all requested information is provided after the date of denial but within 90 days of the last day of the last benefit month.

Reopen and re-evaluate eligibility using the information provided and the previously submitted application or renewal form. A written request to reopen is not required.

The date all the information and verification that was originally requested is provided is the new file date. If additional information is needed to make an accurate eligibility determination based on the new file date, request the needed information following regular policy and process.

Failure to Provide Verification of Level of Care (LOC) or Medical Necessity (MN)

If an application is denied for failure to provide verification of LOC or MN and all other eligibility criteria are met:

- Reopen and re-evaluate eligibility using the previously submitted application if verification of LOC or MN is received within 90 days of the date of denial. A written request to reopen is not required. The date the verification is received is the new file date.
- If additional information is needed to make an accurate eligibility determination based on the new file date, request the needed information following regular policy and processes.

Application or Renewal Denied for Reasons Other Than Failure to Provide Information

If an application or renewal is denied for a reason other than failure to provide information and the person requests to reapply:

- Obtain a written, dated and signed statement of request to reapply from the person or authorized representative to establish the file date.
- The previously completed application for assistance is valid for 90 days from the date of denial.
- The previously completed renewal form is valid for 90 days from the last day of the last benefit month.
- Verification must be updated if circumstances have changed.

Application or Renewals Denied in Error

- If an application is denied in error, the original file date of the application must be used regardless of the age of the application.
- If a renewal is denied in error, the receipt date of the renewal packet must be used regardless of the age.
- If the application or renewal denial is determined to be agency error, do not require a new application or statement to reapply from the person or authorized representative to reopen the application if supervisory approval is obtained.

Applications Received from Other HHSC Areas

Applications for assistance may be received by other areas within HHSC, including Community Care Service Eligibility (CCSE) staff or waiver staff. Regardless of the signature date, the applications must be forwarded to Medicaid eligibility staff for an eligibility determination. Staff must contact the applicant or authorized representative to obtain current information.

Example: CCSE staff refer a person receiving Family Care to MEPD for a financial eligibility determination for Community Attendant Services (CAS). The application was signed and dated two months prior. MEPD staff must contact the person to obtain current income and resource information.

Related Policy

Date of Application, B-4000
Processing Deadlines, B-6400

B-6000, Eligibility Determination

B-6100, Face-to-Face and Telephone Interviews

Body
Revision 10-3; Effective September 1, 2010

As a result of the initiative to integrate application and eligibility determination processes, a face-to-face interview or a telephone interview is not required in determining eligibility for Medicaid programs within this handbook.

At the request of the person or the person's authorized representative, conduct a face-to-face interview or an interview by telephone based on the request. Form H1246, Medicaid Eligibility Interview Guide, is optional for staff to use to record information during the interview.

Information to consider for the case documentation:

- Whether a face-to-face or telephone interview was conducted.

- Date of the interview and name of the person interviewed (applicant or authorized representative).
- Relationship of the authorized representative to the applicant.
- Reason, if an interview was requested but not conducted.

Interviews are not required for Medicaid applicants or recipients. If an appointment is scheduled and the person does not keep the appointment, do not deny based on the missed appointment.

B-6200, Financial Management

Body
Revision 10-3; Effective September 1, 2010

If a person does not report a bank account, trust fund or similar account on Form H1200, Application for Assistance – Your Texas Benefits, or other application for assistance, ask the person or the authorized representative to explain how the person's financial affairs are handled. This includes determining who:

- cashes the checks and where;
- pays the bills and how; and
- keeps the money and how the funds are kept.

If the person reveals previously unreported liquid resources, request verification to determine the value, ownership and accessibility according to the requirements for the resource involved.

Sources for verifying financial management are as follows:

- Statements from the applicant and the person who handles the applicant's funds.
- Statement from a knowledgeable third party (for example, an administrator or bookkeeper in the facility usually knows who receives the applicant's benefit payments and pays the bills).

Use Appendix XVI, Documentation and Verification Guide, for sources of needed verifications.

Include the following information in the case record documentation:

- Where checks are cashed and how bills are paid.
- Who handles the person's checks, pays the person's bills and maintains the person's money.
- How much money, if any, the person or anyone else keeps.
- How much has accumulated.
- Source of information.

Note: If the person's bank account is dormant, financial management must be verified and documented. For applications, explore financial management if there has been no activity in a reported account during the month of application and the month before.

B-6300, Institutional Living Arrangement

Body
Revision 19-2; Effective June 1, 2019

Determine the first day a person's eligibility can be established under the special income limit. Form 3618, Resident Transaction Notice; Form 3619, Medicare/SNF Patient Transaction Notice; and Form H0090-I, Notice of Admission, Departure, Readmission or Death of an Applicant/Recipient of Supplemental Security Income and/or Assistance Only in a State Institution, provide adequate verification of dates of admission to a Medicaid

facility. In absence of the above-listed forms, eligibility staff may contact the administrator, bookkeeper or office manager for the date of admission.

Eligibility under the special income limit cannot be processed or disposed until the applicant has resided in an institutional setting for at least 30 consecutive days.

The 30-day requirement begins with confinement to one or more Medicaid-certified facilities (Medicare-SNF, NF or ICF/IID) for at least 30 consecutive days. The date of admittance to an institution is day zero.

Example 1: Mr. Smith entered the nursing facility on March 27. He stayed there for 30 consecutive days – not going home, to the hospital or to another nursing facility. The earliest staff can certify the case is the 31st day, which is April 27.

Example 2: Mr. Lopez entered the hospital on Feb. 10 and entered the nursing facility on Feb. 19. He stayed there for 30 consecutive days – not going home, to the hospital or to another nursing facility. The start of the 30 consecutive days started on Feb. 19, **not** Feb. 10. The earliest staff can certify the case is the 31st day, which is March 22.

Example 3: Mr. Johnson entered the nursing facility on March 1. He went to the hospital on March 5. He returned to the nursing facility on March 10. The 30 consecutive days started on March 1 and was **not** interrupted by the hospital stay. The earliest staff can certify the case is the 31st day, which is April 1.

Example 4: Mr. Brown entered the nursing facility on May 10. The 31st day is June 10. He went home on June 1. He did not stay the required 30 consecutive days. Staff cannot certify the case.

Example 5: Mr. Leo entered the nursing facility on April 20. The 31st day is May 21. He died on May 10. He did not stay the required 30 consecutive days, however, staff can certify the case if the person meets all other eligibility requirements.

Example 6: Mr. Smith entered the hospital on Feb. 15 and then went directly to the nursing home on March 10. His wife continues to live in their home in the community. The 30 consecutive days starts on March 10, **not** Feb. 15. The earliest staff can certify the case is the 31st day, which is April 10th.

Note: The hospital stay in February is the start date for the continuous period in an institution for the spousal resource assessment – which is different than the 30-consecutive day's requirement.

See Chapter J, Spousal Impoverishment, regarding the resource assessment and spousal protected resource amount (SPRA). When determining the 30 consecutive day requirement, consider both the days in a medical facility and the days in the Home and Community-Based Services waiver setting.

Use the special income limit for the month of entry to a Medicaid-certified long-term care facility (Medicare-SNF, NF or ICF/IID) if it is anticipated that the person will remain in a Medicaid-certified facility for at least 30 consecutive days. When eligibility is based on the special income limit, finalization of the person's eligibility cannot be processed or disposed until the 30 consecutive days in an institutional setting have been met. See MEPD Due Date Chart job aid on The LOOP, to determine the 31st day.

It may be necessary to verify the living arrangement for prior months by contacting the applicant or authorized representative to ensure the appropriate income limit is used for determining eligibility for prior months. It may also be necessary to contact the facility, the Home and Community-Based Services waiver provider or the hospital, if an applicant has been discharged to a hospital, to ensure that the 30 consecutive day requirement is met.

The case record must include the following verification and documentation :

- Date the applicant entered the Medicaid facility.
- Date the applicant met the 30 consecutive day requirement (or date of death).

- Source of verification.

See Appendix XXX, Medical Effective Dates (MEDs). Use the information under the Institutional Based area to determine the appropriate income limit for the month of application and the prior months.

The 30 consecutive day requirement does not apply to a regular Medicaid recipient who:

- is eligible for SSI; or
- was eligible for SSI and continues regular Medicaid eligibility through one of the cost of living adjustment (COLA) disregard programs.

The COLA disregard programs are:

- ME-Pickle
- ME-Disabled Adult Child
- ME-Disabled Widow(er)
- ME-Early Aged Widow(er)

Related Policy

Medical Effective Dates (MEDs), Appendix XXX
Medicaid Certified Person Enters Nursing Facility or Home and Community-Based Services Waiver Program, B-7450
Institutional Eligibility Budget Types, G-6000
Prior Coverage, G-7000

B-6400, Processing Deadlines

Body
Revision 10-3; Effective September 1, 2010

Make and document an eligibility decision on an application as soon as all required verification is received.

Time frame for eligibility determination:

- Make an eligibility decision within 45 days on applications from applicants 65 years or older.
- Make a decision within 45 days on applications from applicants under age 65 who have had disability established based on the Social Security Administration criteria for RSDI Title II or SSI Title XVI disability.
- Make a decision within 90 days on applications from applicants who must have disability established by the HHSC Disability Determination Unit.

References:

- See Section B-4000, Date of Application, for clarification of date of application and complete application.
- See Section R-3100, Establish Processing Deadlines, for automation procedures to follow when applications cannot be completed within the normal 45/90-day limit and for requirements to request a delay in certification.
- See Section D-2100, When a Medical Determination Is Not Required, and Section D-2200, When a Medical Determination Is Required, for further information regarding a medical determination for applicants under age 65.

B-6410 Application Due Dates

Revision 20-2; Effective June 1, 2020

Applications must be processed in a timely manner. For timeliness and processing purposes:

- The timeliness count begins the date the completed and signed application for assistance is received by HHSC.
- The file date of an application is day zero for application processing.

If a person applies for multiple programs and all requested information is provided for one program and not the other(s), make an eligibility determination for the program in which all the information has been received. Continue to allow for the opportunity to provide the remaining missing information for the other program(s) until the final due date.

Reminders:

- The date of application is established when HHSC receives the completed and signed application form.
- For applications submitted after the close of business for the day, or on days when HHSC is closed (including weekends and holidays), the date of application is the following business day.
- If an application is denied in error, the original date of application must be protected no matter how old the original date on the application for assistance. A new application processing date must be established.

Related Policy

Date of Application, B-4000
Previously Completed Application, B-5000

B-6420 Missing Information Due Dates

Revision 14-1; Effective March 1, 2014

Applications

Use Form H1020, Request for Information or Action, to request missing information or verifications. The final due date for missing information for applications on Form H1020 is the:

- 39th day from the date of application, or
- 84th day from the date of application for a person who needs a disability determination.

Do not send a second request for missing information. Take appropriate case action based on the original request for missing information.

Delay in Certification

When there is an approved delay in certification, the 39th and 84th days are extended 90 days.

Always send notification to the applicant/authorized representative and nursing facility, using Form H1020 and Form H1247, Notice of Delay in Certification.

Use Form H1020 to indicate the needed information and the re-established due dates during the delay in certification. See Section B-6510, Failure to Furnish Missing Information.

Re-established due dates are based on the reason for the delay in certification and reasonable MEPD specialist judgment. For example, if the delay is due to the 30-day consecutive requirement not being met, the re-established due date would not automatically need to be the full 90-day extension. However, if the delay is due to the facility pending certification, the full 90-day extension may be necessary. When unsure of the re-established due dates based on the reason for the delay in certification, consult the supervisor to determine the re-established pending period. Do not send a second request for missing information during the re-established due dates based on the delay in certification. Take appropriate case action based on the Form H1247 and Form H1020 used to notify the applicant of the delay in certification and the needed verification.

Redeterminations

Use Form H1020 to request missing information or verifications. The due date for missing information or verifications for redeterminations should be 10 days from the date on Form H1020.

B-6500, Denials

Body
Revision 11-4; Effective December 1, 2011

Before a person is denied for any reason during application, eligibility for QMB/SLMB must also be tested.

Examples:

- An applicant for nursing facility coverage also must be tested for QMB coverage. If the applicant is ineligible for nursing facility coverage but eligible for QMB, certify the applicant for QMB. Indicate on the notice that the applicant is ineligible for nursing facility coverage but eligible for QMB coverage.
- When an MQMB recipient dually eligible for nursing facility coverage leaves the nursing facility to live at home, test for continuing QMB coverage in the new living arrangement.
- When a Community Attendant Services (CAS) recipient who is also QMB-eligible no longer has physician's orders and is ineligible for CAS, do not deny the QMB coverage unless a change in the recipient’s circumstances also results in ineligibility for QMB.

B-6510 Failure to Provide Missing Information

Revision 20-4; Effective December 1, 2020

Applications

For applications, initiate the written request for verification within 30 calendar days from the date the application is received by the Texas Health and Human Services Commission (HHSC).

If more information or verification is required to complete an application, the applicant or the applicant’s authorized representative (AR) is allowed at least 10 days to provide the information or verification. The final due date must be a workday.

Send Form H1020, Request for Information or Action, to request the needed verification. The Form H1020 provides:

- the information or verification needed;
- the date the information or verification is due; and
- the final decision date.

Note: The final decision date is the date the application may be denied if the required information or verification is not received.

The day Form H1020 is sent is considered day zero of the pending period.

Deny the application if the requested information is not received by close of business on the final decision date provided on the H1020.

If the required information is requested more than 30 days after the file date, allow at least 10 days to provide the required verification. Do not deny the application for the missing information before close of business on the 10th day.

Do not send a second request for missing information for applications.

Delay in Certification

Delay in certification procedures may be necessary if the applicant or the AR is attempting to obtain the information but cannot meet the deadline.

Note: If Asset Verification System (AVS) information impacts eligibility, pend the case and send Form H1020. Allow at least 10 days to provide verification of the new information. Delay in certification procedures may be necessary if the missing information due date is after the application due date.

Redeterminations

All information and verification needed to make an eligibility redetermination decision must be provided.

Send Form H1020, Request for Information or Action, to request the needed verification. The Form H1020 provides:

- what is required;
- the date the verification is due; and
- the date the renewal could be denied if the verification is not received.

The day Form H1020 is sent is considered day zero of the pending period.

Allow at least 10 days to provide the requested verification. The system-generated due date is 10 days from the date of the H1020.

Do not send a second request for previously requested information for redeterminations.

If all previously requested information is returned and new information that impacts eligibility is discovered before disposition, send a new Form H1020 and allow at least 10 days to provide verification of the new information.

Deny the redetermination if the information or verification is not provided by the close of business on the final decision date indicated on the H1020.

Do not deny the redetermination for missing information before close of business on the 10th day.

Related Policy

Date of Application, B-4000
Missing Information Due Dates, B-6420
Establish Processing Deadlines, R-3100
Consideration of AVS Information, R-3744

B-7000, Special Application Procedures

B-7100, SSI Applications

Body

Revision 11-1; Effective March 1, 2011

The Social Security Administration (SSA) determines Medicaid eligibility for all persons who apply for SSI cash benefits. When SSA makes a determination on an application for SSI cash benefits (either approved or denied), HHSC is notified by means of the SSA/State Data Exchange System (SDX).

SSA is responsible for redetermination of SSI Medicaid eligibility. See Section H-6000, Co-Payment for SSI Cases, for other special handling of SSI eligible individuals.

B-7110 Continuous Medicaid Coverage After SSI Denial for Income

Revision 20-3; Effective September 1, 2020

Certain SSI recipients are eligible for temporary Medicaid following the loss of SSI due to excess income. Medicaid eligibility is automatically extended for a short time for the following SSI recipients:

- children under 18 years old who receive waiver services; and
- people who receive an increase in Social Security Disabled Adult Children (DAC) benefits or Early Aged or Disabled Widow(er)'s benefits, who have no other income.

Recipients must return the Form H1200 and be determined eligible to continue to receive Medicaid after the short-term extended period ends.

Recipients who do not return a Form H1200 will be denied Medicaid at the end of the extended period. If SSA reinstates the recipient's SSI benefits, SSI Medicaid will be reinstated. Medicaid coverage will not be extended again at subsequent SSI denials or suspensions for the following 12 months.

Correspondence

Send the following correspondence when Medicaid is extended after the loss of SSI:

- Form H1296, Notice of SSI Medicaid Ending – to notify the person that SSI Medicaid is ending due to the loss of SSI benefits.
- Form TF0001, Notice of Case Action – to inform the person of the extended Medicaid period and that they must complete and return the Form H1200 by the due date in order to receive Medicaid after the extended period; and
- Form H1200, Application for Assistance - Your Texas Benefits.

If Form H1200 is received, determine ongoing eligibility for the appropriate type of Medicaid. Expedite processing applications received before the extended Medicaid coverage ends. Expedited applications must be

processed within 10 workdays from the date of application.

Children Receiving Waiver Services

Children who receive services through one of the following waiver programs are eligible to receive temporary ME-Waiver Medicaid for one month following the loss of SSI due to excess income:

- Medically Dependent Children Program (MDCP);
- Community Living Assistance and Support Services (CLASS);
- Home and Community-based Services (HCS);
- Youth Empowerment Services (YES); or
- Deaf Blind with Multiple Disabilities (DBMD).

Ongoing Eligibility

If Form H1200 is received, determine ongoing eligibility for ME-Waiver Medicaid. If eligible, ME-Waiver Medicaid will remain active through the end of the month of the child's 18th birthday. If the child is determined not eligible under any other Medicaid type of assistance, Medicaid is denied at the end of the one-month extended period.

- Applications submitted by the child or their parent or authorized representative do not require an associated Form H1746-A, MEPD Referral Cover Sheet.
- Applications submitted by program providers, including Managed Care Organizations (MCOs), Local Intellectual & Developmental Disability Authorities (LIDDAs) and Local Authorities (LAs), on behalf of a child receiving extended ME-Waiver Medicaid must include an associated Form H1746-A.

SSI Eligibility

If SSI benefits are reinstated while the child is active ME-Waiver Medicaid, SSI Medicaid will be suppressed, and ME-Waiver Medicaid will remain active. This is to avoid future gaps in coverage.

If SSI benefits are active when the child turns 18, ME-Waiver Medicaid will terminate and SSI Medicaid will be reinstated.

If SSI benefits are not active when the child turns 18, ME-Waiver Medicaid will remain active and will follow the regular renewal process.

Recipients of DAC or Widow/Widower Benefits

SSI recipients denied due to an increase in or receipt of RSDI disabled adult children's benefits or widow/widower's benefits, who do not receive income other than RSDI, are eligible to receive temporary Medicaid for two months following the loss of SSI.

- People receiving Social Security DAC benefits are eligible for ME-DAC Medicaid. (**Note:** People receiving SSI and QMB will receive ME-DAC and MC-QMB.)
- People receiving Social Security Early Aged or Disabled Widow/Widower's benefits are eligible for ME-Disabled Widow(er) or ME-Early Aged Widow(er) Medicaid.

If Form H1200 is received, determine ongoing eligibility for the appropriate type of Medicaid, ME-DAC, ME-Disabled Widow(er) or ME-Early Aged Widow(er). If the recipient is determined not eligible, Medicaid will be denied at the end of the two-month extended period.

Related Policy

Supplemental Security Income (SSI), A-2100
Disabled Adult Children (DAC), A-2310
Pickle, A-2330
Widow(er)s, A-2340
SSI Applications, B-7100
When Deeming Procedures Are Not Used, E-7200

B-7200, SSI Cash Benefits Denied Due to Entry into a Medicaid Facility

Body

Revision 12-3; Effective September 1, 2012

When an SSI recipient enters a Medicaid facility and the SSI cash benefit will be denied because the income is greater than the reduced federal benefit rate, and:

- If contacted by the recipient/authorized representative (AR), inform the recipient/AR to notify SSA of the entry to the Medicaid facility. Send Form H1200, Application for Assistance – Your Texas Benefits, to the recipient/AR to complete and return to HHSC.
- If contacted by the Medicaid facility, inform the facility to notify SSA of the entry to the Medicaid facility. Obtain the AR's information, including mailing address, and send Form H1200 to the AR to complete and return to HHSC.

TIERS is notified by the State Data Exchange (SDX) system when SSI cash benefits have been denied because of income that is greater than the reduced SSI federal benefit rate. Once the SDX denial notice is received by TIERS, the SSI Medicaid will be denied by the system.

There is no overlay option in TIERS. Certification for MEPD benefits cannot occur until the SSI is denied. This may require delay in certification, closing and re-opening applications until the SSI is denied.

When SSI has been denied and an MEPD application has not been filed, and:

- If contacted by the recipient/AR, send Form H1200 to the recipient/AR to complete and return to HHSC.
- If contacted by the Medicaid facility, obtain the AR's information, including mailing address. Send Form H1200 to the AR to complete and return to HHSC.

Reference: See Section B-7210, Ensuring Continuous Medicaid Coverage.

After receipt of Form H1200, determine the recipient's financial eligibility for MEPD using the special income limit beginning with the first month after SSI denial. Also determine whether the recipient has an approved medical necessity or level of care and meets all other eligibility requirements. If the recipient has been denied a medical necessity or level of care but remains in the Medicaid facility (Medicare-SNF, NF or ICF/IID), or if the recipient does not remain in a Medicaid facility (Medicare-SNF, NF or ICF/IID) for 30 consecutive days, deny the MEPD application and refer the recipient back to SSI for reinstatement of full SSI benefits. If the recipient will not be reinstated for full SSI benefits, test eligibility for other Medicaid-funded programs, such as QMB, ME-Pickle, etc.

Notes:

- If the MEPD application is not returned, the eligibility specialist contacts the recipient/authorized representative to attempt to obtain information to determine continued Medicaid eligibility. The eligibility specialist uses Form H1200 as a recording document, if necessary.

- Follow the procedures for SSI to MEPD transfer, unless continued SSI eligibility occurs under temporary provisions. If that situation occurs, do not process an institutional Medicaid application unless the SSI benefits are denied and the recipient is still in the facility.

Reference: See Chapter H, Co-Payment, for exceptions to reduced SSI payment standard.

B-7210 Ensuring Continuous Medicaid Coverage

Revision 13-4; Effective December 1, 2013

When a recipient is eligible for institutional Medicaid coverage, the medical effective date (MED) is the day after the date of SSI denial, when the SSI denial is due to entry into an institution. This ensures continuous Medicaid coverage.

Note: To ensure continuous Medicaid coverage for SSI recipients who enter institutions, the coverage may be more than three months from the application file date. For example, SSI was denied March 31, 2013. The individual applied for ME-Nursing Facility on Sept. 10, 2013. The MED can go back to April 1, 2013, which is more than three months prior.

B-7300, MEPD Eligibility Pending a Decision of SSI Application

Body

Revision 19-4; Effective December 1, 2019

Persons who have applied for SSI, whose SSI application has been delayed longer than 90 days, may be certified under the appropriate MEPD program pending the SSI eligibility decision.

Person(s) must meet all non-financial and financial MEPD criteria to be eligible including:

- establishing disability, if applicable;
- pursuing all other benefits; and
- meeting the 30 consecutive days of institutionalization, if applicable.

Consider the age of the person to determine if a disability determination is needed.

The state office Disability Determination Unit (DDU) needs a disability determination if the person is younger than 65. DDU cannot make a disability determination decision unless 90 days have passed since the SSI date of application and SSA's disability decision is still pending. If SSA finds the person is not disabled after DDU has established a disability, DDU is required to follow SSA's decision and eligibility must be denied. Staff must set a special review for the fifth month to monitor the final SSA decision on disability.

Once an MEPD eligibility recipient becomes eligible for SSI, SSA will report the SSI eligibility to HHSC via the SDX system. Once the SDX information is received, TIERS will automatically deny MEPD coverage and activate the SSI coverage. This is not an adverse action because the person does not lose benefits.

The above should be used only in situations where the processing of a SSI application has been delayed. Staff must verify and document that an SSI application has been filed.

Note: If the person is age 65 or older, no disability determination is needed. Verify that the person has filed an application for SSI.

Related Policy

SSI Applications, B-7100
Special Reviews, B-8430
Supplemental Security Income (SSI) Applicants and Retroactive Coverage, D-2500
Application for Other Benefits Requirement, D-6300
Other Benefits Subject to Application Requirement, D-6310
Other Benefits Exempt from Application Requirement, D-6320
Supplemental Security Income (SSI), D-6340

B-7400, Application for Institutional Care

Body

Revision 12-3; Effective September 1, 2012

HHSC is responsible for processing Medicaid applications for certain residents of Medicaid facilities (Medicare SNF, NF, ICF/IID and institutions for mental diseases (IMD)). To qualify for medical assistance for institutional care, a person must:

- meet the 30-consecutive-day stay requirement (for verification and documentation requirements, see Appendix XVI, Documentation and Verification Guide);
- meet financial criteria; and
- have an approved level of care or medical necessity determination.

Reference: Section B-6300, Institutional Living Arrangement.

HHSC processes:

- initial applications from persons whose income is equal to or in excess of the reduced SSI federal benefit rate; and
- reapplications for Medicaid from persons who will be or have been denied SSI on the basis of excess income because the SSI federal benefit rate has been reduced after entry into a Medicaid facility.

B-7410 Persons Under Age 22

Revision 09-4; Effective December 1, 2009

State law (Chapter 242, Health and Safety Code) requires that community resource coordination groups (CRCG) be notified when a recipient under age 22 with a developmental disability enters an institutional setting. HHSC must notify the CRCG in the county of residence of the recipient's parent or guardian within three days of the recipient's admission.

The name and telephone number of the appropriate CRCG can be obtained by calling the CRCG state office at 1-866-772-2724. A CRCG list is available on the Internet at: /services/service-coordination/community-resources-...

Documentation of the notification to the CRCG should be filed in the case record.

B-7420 Level of Care/Medical Necessity

Revision 20-4; Effective December 1, 2020

To be eligible for Medicaid in an institutional setting, a person must have an approved level of care (LOC) for an intermediate care facility for persons with intellectual disabilities (ICF/IID) or an approved medical necessity (MN) with a nursing facility LOC. Texas Medicaid & Healthcare Partnership (TMHP), the state Medicaid claims administrator, is responsible for determining MN for recipients in Medicaid certified facilities.

Do not approve a person for medical assistance for institutional care unless the person has been in a Medicaid facility for at least 30 days and has an approved LOC or MN determination.

For applicants residing in a Medicare skilled nursing facility, the Medicare determination of need for care is acceptable as verification of a valid MN determination. Form 3071, Recipient Election/Cancellation/Discharge Notice, substitutes for the MN determination when hospice is elected as referenced in A-5200, Hospice in a Long-Term Care Facility.

Use the previous LOC or MN determination if:

- a person is being reinstated for assistance (a case that was denied in error or a request for a program transfer from SSI to MEPD institutional care); and
- vendor payments were made to the Medicaid facility up to the date of denial based on the previous LOC or MN determination.

Program Support Unit (PSU) staff are responsible for providing verification of an approved LOC or MN determination for a person applying for a Home and Community Based Services (HCBS) waiver program.

An approved MN determination for HCBS waiver eligibility is valid to complete a program transfer from an HCBS waiver Medicaid program to the appropriate institutional care program.

A permanent MN determination remains valid at reapplication if a denied Medicaid recipient is discharged from a Medicaid facility for not more than 30 days.

If the LOC or MN determination is still pending prior to certification and the person meets all other eligibility criteria, place the application on delay pending the approved LOC or MN. If verification of the LOC or MN is not received before the end of the delay period, deny the application for no LOC or MN. If the LOC or MN determination is denied, deny the application.

Reopen the application if verification of an approved LOC or MN is received within 90 days of the date of denial following policy in B-5000, Previously Completed Application.

Related Policy

Previously Completed Application, B-5000
Establish Processing Deadlines, R-3100
Documentation and Verification Guide, Appendix XVI

B-7430 Reserved for Future Use

Revision 20-4; Effective December 1, 2020

B-7431 Denial of Level of Care/Medical Necessity Determination

Revision 13-4; Effective December 1, 2013

If a level of care/medical necessity determination is denied for an MEPD recipient, initiate denial procedures immediately.

A recipient may continue to be Medicaid-eligible as long as the recipient meets all eligibility criteria and:

- has a diagnosis of mental illness, intellectual disabilities or a related condition;
- no longer meets the medical necessity criteria; and
- has lived in a nursing facility for 30 months before the date medical necessity is denied and chooses to remain in the facility.

If the recipient has not been in the facility for 30 months, regular Medicaid denial procedures apply.

If an MEPD recipient in a private Medicaid facility is denied solely because of no level of care/medical necessity determination, refer the person to SSA if available income is less than the SSI full federal benefit rate. Refer SSI recipients who are denied a level of care/medical necessity determination to SSA for rebudgeting to the full federal benefit rate.

B-7440 Alternate Care Services

Revision 21-3; Effective September 1, 2021

Information about all available long-term services and supports must be provided to long term care recipients, their authorized representatives (ARs) and at least one family member of the recipient, if possible. This allows them to make an informed decision about service options.

Form H1204, Long Term Care Options, provides information on available long-term services and supports. It is included with the TF0001, Notice of Case Action, for all MEPD certifications, except for recipients residing in state supported living centers, state hospitals and state centers.

If an applicant, recipient, AR or family member(s) has questions about available long-term care services, refer them to 2-1-1 for current information.

Form H1746-A, MEPD Referral Cover Sheet, includes an "LTSS Information Shared" checkbox. Referring agencies will select the box to indicate that Form H1204 has been shared with the person.

B-7450 Medicaid Certified Person Enters Nursing Facility or Home and Community-Based Services Waiver Program

Revision 21-4; Effective December 1, 2021

Eligibility Systems and Payment Systems

Service Authorization System Online (SASO) identifies the recipient as Service Group 1 and allows vendor payment when:

- an active recipient with coverage Code R (either Long Term Care or Texas Works) enters a nursing facility; and
- has a valid medical necessity and facility admission.

The system also automatically assigns a Code 60 (authorization for unlimited medications), which allows all medications to be paid through the vendor drug benefit.

If the nursing facility stay is temporary and the recipient returns home before being transferred to institutional Medicaid, no action is required. Retroactive coverage code changes are not needed.

Texas Works Medicaid to MEPD

If a Texas Works Medicaid recipient enters a facility for a long-term stay, TIERS receives the nursing facility admission information from the DADS webservice interface. TIERS automatically denies the Texas Works Eligibility Determination Group (EDG) and creates a pending ME-Nursing Facility EDG. An H1200 Application for Assistance - Your Texas Benefits must be received before testing for ME-Nursing Facility Medicaid. Disposition of both EDGs must be coordinated. There is no need for retroactive coverage code changes. Vendor payment and medications are authorized through SASO.

If a facility notifies HHSC that an active Texas Work Medicaid recipient has entered the facility, once an application is received, process as any other application and coordinate with Texas Works.

Community to Nursing Facility or Home and Community-Based Services Waiver Eligibility Considerations

Review case information for factors that may impact eligibility and co-payment when an active Medicaid (MEPD or Texas Works) or Medicare Savings Program recipient enters a facility for a long-term stay or is applying for waiver services. Impactful information includes transfer of assets and a large home equity. Also consider notification requirements about annuities, estate recovery and long-term care options.

Related Policy

Medicaid Coverage Issues Related to Nursing Facility Costs, H-7300
Medicare Skilled Nursing Facilities, R-1210
Notices, R-1300

B-8000, Redeterminations

B-8100, Certificates of Insurance Coverage

Body
Revision 09-4; Effective December 1, 2009

The certificate of insurance coverage is proof of a Medicaid recipient's most recent period of Medicaid coverage. The Department of State Health Services sends the certificate, a requirement of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, to denied recipients. HIPAA mandates that prior health insurance coverage must be counted toward reducing or eliminating any applicable pre-existing condition exclusion period when a person enrolls in a new health insurance plan. Former Medicaid recipients may request a certificate within 24 months after their Medicaid is denied by calling 1-800-723-4789.

B-8200, Redetermination Cycles

Body
Revision 15-4; Effective December 1, 2015

A recipient's eligibility is redetermined:

- when necessary because of previously obtained information indicating an anticipated change;
- within 10 workdays after receipt of a report indicating changes that may affect eligibility or co-payment, including program transfers;
- within 30 workdays after receipt of a report indicating changes that affect neither eligibility nor co-payment;
- at periodic intervals not to exceed 12 months; and
- at least every six months, if income is averaged or an incurred medical expense is budgeted. The person's income is verified and documented and past co-payment is reconciled.

For more information on redeterminations, see Section B-8430, Special Reviews, and Section B-8440, Streamlined Redetermination (Passive Redetermination).

Note: For couple cases, including cases with spouses who may be certified under different type programs, redeterminations should be synchronized to minimize the redetermination process for the recipients and the workload for the eligibility specialist. A complete redetermination of each person's eligibility must be completed at least once every 12 months.

It is a recommended practice to review community-based cases at least every three months if the recipient's countable resources are within $100 of the resources limit.

Monitor eligibility at least every three months if the person's:

- countable resources are within $100 of the resources limit, or
- total countable income is within $10 of the income limit.

The following information must be included in the case record documentation:

- Whether a special review is needed
- Date special review will be conducted
- Method of monitoring for special review

Clearly document:

- specific information regarding the reason a special review is set,
- which person is affected, and
- the eligibility area(s) subject to the review.

Example: If someone has a private pension and the pension amount is anticipated to increase in the future, a special review must be set for the anticipated change. The eligibility area will be income. Documentation must specify pension information that will need to be verified at the special review, including:

- date on which the anticipated change is to occur,
- type of pension,
- source of pension, and
- frequency of payment of pension that will need to be verified at the special review.

Use Form H1020, Request for Information or Action, and Form H1020-A, Sources of Proof, to request information from the person or authorized representative. When requesting missing information on a redetermination, allow 10 calendar days from the date the notice is mailed for the individual to provide the information. Do not deny the case for failure to furnish information before the due date listed on Form H1020.

Note: Monitor special reviews for resource or income elements through entry of the special review due date in the applicable TIERS screen.

Data Broker is not required on redeterminations, including the streamlined versions.

B-8300, Who May Sign a Redetermination Form

Body
Revision 12-4; Effective December 1, 2012

Note: A person who may complete or sign a redetermination form for a recipient may possibly not be on the list of people to whom HHSC can release the recipient's individually identifiable health information. See Section C-5000, Personal Representatives, for persons who may receive or authorize the release of a recipient's individually identifiable health information under HIPAA privacy regulations.

See Section B-3220, Who May Sign an Application for Assistance, to determine who may sign a redetermination form. The requirements for signing a redetermination form are the same as the requirements for signing an application.

Note: A signature is not needed when the redetermination is passive or simplified. See Section B-8440, Streamlined Redetermination (Passive Redetermination).

B-8400, Procedures for Redetermining Eligibility

Body

Revision 21-4; Effective December 1, 2021

Administrative Renewal Process

The administrative renewal process is used for all MEPD types of assistance (TOAs) that require an annual redetermination. The system initiates an administrative renewal and requires no staff action. During the administrative renewal process, the system uses information from the existing case record and electronic data sources. This determines if the recipient remains eligible for Medicaid benefits. The electronic data is requested the weekend before cutoff in the ninth month of the recipient's certification period.

During the administrative renewal process, the system checks for the required verification by program. If there is enough information to verify that the recipient remains eligible, the administrative renewal process may be completed without any staff action.

The administrative renewal process uses electronic data to automatically:

- assess the verification required by program type;
- determine the eligibility outcome; and
- send the renewal correspondence to the recipient, the authorized representative (AR) or both.

Note: This automated process does not change the verification requirements for renewals.

If more verification is required, the system automatically generates and mails a renewal packet to the recipient, AR or both. The renewal packet and all required verification must be returned within 30 days to complete the redetermination.

When a renewal of eligibility is due for a recipient, the automated system sends one of the following cover letters and application forms:

- Form H1200, Application for Assistance – Your Texas Benefits;
- Form H1200-A, Medical Assistance Only (MAO) Recertification;
- Form H1200-EZ, Application for Assistance – Aged and Disabled;
- Form H1200-MBIC-R, Application for Benefits;
- Form H1200-PFS, Medical Application for Assistance;
- Form H1200-SR, MEPD Streamlined Redetermination;
- Form H1206, Health-Care Benefits Renewal;
- Form H1211, It's Time to Renew Your Health-Care Benefits Cover Letter; or
- Form H1233-MBIC, Redetermination Cover Letter.

The cover letter informs the recipient, AR or both, that it is time to renew benefits. It instructs them to complete the renewal form and return it along with any required verification documents within 30 days. If the recipient does not return the renewal form and required verification, the system automatically denies the eligibility determination group (EDG) at cut-off in the 12th month for failure to provide the requested information.

Note: Recipients are **not** required to return Form H1200-SR. The renewal cover letter advises the recipient that if the information on Form H1200-SR is correct and has not changed, they do not need to return the renewal form.

Asset Verification System (AVS) **must** be run at every renewal if staff are renewing an MEPD-type program that requires an AVS report.

Note: Form H0025, HHSC Application for Voter Registration, is also sent to the recipient, AR or both. Staff document any actions taken about voter registration in the Agency Use Only section of any of the H1200 series. If the recipient contacts the office declining to complete Form H0025, mail Form H1350, Opportunity to Register to Vote, to the recipient. Form H1350 records the recipient's decision about registering to vote.

Related Policy

Who May Complete an Application for Assistance, B-3210
Who May Sign an Application for Assistance, B-3220
Redetermination Cycles, B-8200
Streamlined Redetermination (Passive Redetermination), B-8440
Voter Registration, C-7000
Asset Verification System (AVS), R-3740

B-8410 Financial Management

Revision 09-4; Effective December 1, 2009

For redeterminations, explore financial management if there has been no activity in the person's bank account, other than interest credited, since the last redetermination.

If a person does not report a bank account, trust fund or similar account on the application for assistance, ask the person or the authorized representative to explain how the person's financial affairs are handled. This includes determining who cashes his checks and where, who pays his bills and how, and who keeps his money and how the funds are kept.

If the person reveals previously unreported liquid resources, determine the value, ownership and accessibility according to the requirements for the resource involved.

Sources for verifying financial management are as follows:

- Statements from the recipient and the person who handles the recipient's funds.
- Statement from a knowledgeable third party (for example, an administrator or bookkeeper in facility usually knows who receives the recipient's benefit payments and pays the bills).

Include the following information in the case record documentation:

- Where checks are cashed and how bills are paid.
- Who handles the person's checks, pays the person's bills and maintains the person's money.
- How much money, if any, the person or anyone else keeps.
- How much has accumulated.
- Source of information.

B-8420 Notification of Changes as a Result of Redetermination

Revision 11-4; Effective December 1, 2011

On receipt of the completed, signed and dated H1200 series form, redetermine eligibility for MEPD. A review may result in no changes being made or one of the following situations:

- **Decrease of co-payment**

  If a review results in a decrease in a recipient's co-payment, dispose of the case action and send Form TF0001, Notice of Case Action, to notify the recipient, and Form TF0001P, Provider Notice, to notify the facility. To correct co-payment for a previous period of time, complete Form H1259, Correction of Applied Income.
- **Increase of co-payment**

  If a review results in an increase in the recipient's co-payment, dispose the case action and send Form TF0001 to the recipient and Form TF0001P to the facility. If the recipient does not indicate a desire to appeal by the end of the 12-day notification period, the increased co-payment remains.
- **Denial of benefits**

  If a review results in a denial of benefits, send Form TF0001 to advise the recipient and Form TF0001P to notify the facility (if applicable). If the recipient does not indicate a desire to appeal by the end of the 12-day notification period, the benefits remain denied.

Note: Complete Form H1259 manually for notification if co-payment involves averaged income (raised or lowered) or incurred medical expenses. If all amounts are lower in the reconciliation shown on Form H1259, then adverse action is not required. In the above situations, ensure that if Form TF0001 and/or Form TF0001P is not sent automatically, a manual Form TF0001 and/or Form TF0001P is sent.

If there is no change in eligibility or co-payment, there is no mandate to send a notification to the recipient.

B-8430 Special Reviews

Revision 10-1; Effective March 1, 2010

A special review occurs between the annual review cycles to evaluate one or more eligibility elements without completing the annual review. The annual review (redetermination) packet is not required for a special review.

The need for a special review is based on policy, a reported change or the eligibility specialist's judgment.

Examples of when special reviews are needed for follow-up:

- On the person's action for applying for potential benefits. An initial 30-calendar day special review is required to evaluate if the person made application after the person has been notified to do so. This may occur before the application is completed. Another special review will be needed to follow up to see if the recipient continues to be eligible.
- When variable income and/or incurred medical expenses are averaged and projected. Special reviews are required at least every six months unless documentation substantiates an exception.
- Within a 90-day time frame when the total countable income is within $10 of the income limit.
- Within a 90-day time frame when the total countable resources are within $100 of the resource limit.
- When any change is anticipated to occur.

For special reviews, document clearly the detailed reason(s) for the special review. Documentation must include:

- specific information regarding the reason a special review is set;
- the name of the individual who is affected; and
- the eligibility area(s) subject to the review.

Include this information on correspondence sent to the person to request information concerning the special review. No redetermination packet is required.

For example, if someone has a private pension and the pension amount is anticipated to increase in the future, set a special review for the anticipated change. The eligibility area will be income. Documentation must specify pension information that will need to be verified at the special review. Include the:

- date on which the anticipated change is to occur;
- type of pension;
- source of pension; and
- frequency of payment of pension that will need to be verified at the special review.

Form H1020, Request for Information or Action, and Form H1020-A, Sources of Proof, are used to request information from the person or authorized representative. Include the due date on Form H1020 or H1020-A. If the recipient calls with questions, follow Appendix XVI, Documentation and Verification Guide, for acceptable verification sources.

Example:

George Black called this morning saying he received a letter requesting verification that he had applied for Veterans Affairs (VA) benefits. He stated that he had applied and was told that it would take at least six months to hear anything.

Document what Mr. Black said. Recipient declaration is acceptable verification that he has applied for additional benefits. Be sure to tell Mr. Black to call and report if he hears anything about his eligibility from the VA.

B-8440 Streamlined Redetermination (Passive Redetermination)

Revision 19-2; Effective June 1, 2019

For certain stable community-based cases, a redetermination may be completed without requiring a renewal form. The passive redetermination is completed based on information available in the case record or other information available through electronic data sources.

Community-based cases are considered stable and eligible for a passive redetermination if they have no more than:

- one bank account;
- excluded burial funds;
- excluded resources;
- income requiring no more than annual verification; and
- variable income not more than $4.99.

For community-based cases that meet the criteria for a passive redetermination, the Form H1200-SR, Streamlined Redetermination for Medicaid for the Elderly and People with Disabilities, is sent. If there are no changes in income or resources to report, a completed renewal form is not required and eligibility is automatically renewed based on existing case information.

If the recipient returns the Form H1200-SR, process the redetermination following regular redetermination policy and procedures.

At least one annual redetermination must be completed using a regular application or redetermination form (Form H1200, Form H1200-A or Form H1200-EZ) before a case may be considered for the passive renewal process.

The streamlined redetermination process only applies to the following Types of Assistances (TOA's):

- TP-14-ME-CAS - Community Attendant Services
- TP-23-MC-SLMB - Specified Low-Income Medicare Beneficiaries
- TP-24-MC-QMB - Qualified Medicare Beneficiaries
- TP-25-MC-QDWI - Qualified Disabled and Working Individuals
- TP-26-MC-QI-1 - Qualifying Individuals.

AVS applicable TOAs are not eligible for a passive redetermination.

Related Policy

Procedures for Redetermining Eligibility, B-8400
Asset Verification System (AVS), R-3740

B-8450 Special Reviews when Facility Contract Closure or Cancellation Occurs

Revision 21-3; Effective September 1, 2021

When a facility's Medicaid contract is terminated, the facility notifies the recipient and provides them with the option to move to a Medicaid covered facility.

If the Medicaid recipient continues to live in an uncontracted facility, deny Medicaid eligibility and send Form TF0001, Notice of Case Action, to the recipient and or authorized representative (AR) and TF0001P, Provider

Notice of Case Action, to the facility. The person will then be responsible for the full vendor payment for that facility.

If the recipient relocates to a Medicaid contracted facility, process a change of address, verify the person continues to meet all Medicaid eligibility criteria and send out a new TF0001 to the recipient and or AR and TF0001P to the new facility.

Related Policy

Institutional Living Arrangements, B-6300
Redetermination Cycles, B-8200
Notices, R-1300

B-8460 Changes and Program Transfers

Revision 21-4; Effective December 1, 2021

Changes

Changes are situations that may affect a person's eligibility, continued eligibility or co-payment amount.

An applicant, recipient or authorized representative must report changes within ten days of the event, including the following:

- Change of address;
- Change in living arrangements;
- Change in income;
- Change in resources; and
- Change in marital status.

To ensure the most accurate information is on file, staff must act on reported changes:

- Within ten workdays for changes that may affect eligibility or co-payment; or
- Within 30 workdays for changes that do not affect eligibility or co-payment.

Program Transfers

A program transfer occurs when a Medicaid or MSP recipient is determined eligible for another type of Medicaid due to a change in circumstances.

Example: A CAS recipient enters a nursing facility or requests waiver services.

A request for a program transfer to a new program or a request to add another type of Medicaid is considered a change. Process the change within ten workdays of receiving the request.

Redetermine eligibility and verify all required eligibility criteria for the new program, including the 30-day consecutive stay, transfer of assets, substantial home equity and spousal impoverishment, if applicable. Request AVS prior to disposing eligibility. If more information is needed, send Form H1020, Request for Information or Action. The due date for missing information or verifications should be 10 days from the date on Form H1020.

If an active recipient reports a spouse, process the change within 10 workdays. Request verification for the new person and redetermine eligibility as appropriate for a couple or companion case.

Related Policy

Medicaid Certified Person Enters Nursing Facility or Home and Community-Based Services Waiver Program, B-7450
Redetermination Cycles, B-8200
Responsibility to Provide Information and Report Changes, C-8000

B-9000, Denials

B-9100, Reserved for Future Use

Body

Revision 21-3; Effective September 1, 2021

B-9200, Medical Necessity/Level of Care Determination at Redetermination

Body

Revision 09-4; Effective December 1, 2009

When reviewing an MEPD case, verify medical necessity/level of care determination if:

- the recipient's medical necessity or level of care determination has been denied, or
- the recipient has relocated to a different facility and no medical necessity/level of care determination has been received.

If the medical necessity/level of care determination has been denied, do not sustain the review.

Reference: See Section B-7431, Denial of Level of Care/Medical Necessity Determination, for procedures when medical necessity/level of care is denied.

B-9300, Date of Death Denials and Verification Sources

Body

Revision 19-3; Effective September 1, 2019

Date of Death Matches

HHSC matches recipients on active TIERS Eligibility Determination Groups (EDGs) with records from the Social Security Administration (SSA), Texas Bureau of Vital Statistics (BVS), the Centers for Medicaid and Medicare Services (CMS), and DADS Webservices to identify deceased persons and automatically remove them from active EDGs. If unable to process the death data automatically, TIERS creates tasks for staff to perform more research to determine the validity of the computer match. TIERS will attempt to update the Date of Death (DOD) information for all active and inactive person(s).

Death Verification Sources

Take action to clear any discrepancies when DOD data is received on an active or inactive person within TIERS and the system is unable to automatically dispose the case. When the system cannot dispose the case, a series of alerts are created for staff to explore and request additional verification of the death data.

Primary source of verification of death is the Bureau of Vital Statistics (BVS).

If BVS is not available, verify the date of death using two of the following sources:

- Social Security Administration (SSA);
- statement from guardian or other authorized representative;
- copy of death certificate;
- statement from a doctor;
- newspaper death notice (obituary);
- statement from a relative or household member;
- statement from funeral director; or
- records from hospital or other institution where the person died.

Note: If BVS is received but the date of death does not match previously reported information, accept BVS as verification and dispose the case. No additional verification is needed because BVS is considered the primary verification source.

Example: DOD data received from an SSA interface shows a DOD of 01/15/2019 but, the same person had a DOD of 01/13/2019 listed in TIERS. Alert 812, *Verify Discrepancy in Date of Death for Individual* is created for additional action. Staff verify the DOD by contacting the nursing home where the person was residing prior to death and also locate the person's obituary online. Staff enter the DOD based on the additional information and clear the alert

For detailed processing instructions, staff may review the Eligibility Services State Processes document and the Change and Alert Guide.

Related Policy

Social Security Administration Deceased Individual Report, R-4110

Chapter C, Rights and Responsibilities

C-1000, Texas Administrative Code Rules

Body

Revision 10-2; Effective June 1, 2010

§358.601. Rights.

An applicant or recipient has the right to:

(1) be treated fairly and equally regardless of race, color, religion, national origin, gender, political beliefs, or disability;

(2) have information collected for determining his or her eligibility to be treated as confidential;

(3) request a review of an action;

(4) have his or her eligibility tested for other programs before HHSC denies eligibility;

(5) review all information that contributed to an eligibility decision; and

(6) request a fair hearing to appeal an action by HHSC.

§358.602. Disclosure of Official Records and Information.

The Texas Health and Human Services Commission follows 20 CFR §§401-403 concerning disclosure of information about a person, both with and without the person's consent; the maintenance of records; and the general guidelines in deciding whether to make a disclosure.

§358.603. Release of Medical Information.

A person requesting assistance on the basis of disability must complete a medical information release form.

§358.604. Responsibility To Provide Information and Report Changes.

(a) An applicant or recipient must provide the Texas Health and Human Services Commission (HHSC) the necessary documentation and information to determine eligibility for Medicaid.

(b) An applicant or recipient must report to HHSC certain events that affect benefits in accordance with 20 CFR Subpart G.

§358.605. Fraud Referral and Restitution.

(a) The Texas Health and Human Services Commission (HHSC) follows 42 CFR §§455.13-455.16 for issues governing fraud referral and restitution.

(b) HHSC evaluates a person's willful withholding of information for fraud, including:

(1) willful misstatements, oral or written, made by the person or the person's authorized representative in response to oral or written questions from HHSC concerning the person's income, resources, or other circumstances that may affect the amounts of benefits, including understatements or omission of information about income and resources; and

(2) willful failure by the person or the person's authorized representative to report changes in income, resources, or other circumstances that may affect the amount of benefits, if HHSC has clearly notified the person or the person's authorized representative of the person's obligation to report these changes.

C-1100, Responsibility of Applying

Body

Revision 10-2; Effective June 1, 2010

Federal law requires that anyone who wishes to apply for Medicaid be allowed to file an application, regardless of the person's ultimate eligibility for services. See Chapter B, Applications and Redeterminations, for more information.

In addition to meeting other requirements, a person must file an application to become eligible to receive benefits. An authorized representative may accompany, assist and represent an applicant or recipient in the application or eligibility redetermination process.

Someone who is Supplemental Security Income (SSI) eligible automatically receives Medicaid and does not have to file a separate application unless coverage for unpaid or reimbursable bills during prior months to the SSI application is requested. See Section A-4300, Retroactive Coverage.

To apply for an MEPD program, an application for assistance must be received that is:

- HHSC approved for MEPD Medicaid,
- completed according to HHSC instructions, and
- signed and dated under penalty of perjury by the applicant and/or authorized representative or someone acting responsibly for the applicant (if the applicant is incompetent or incapacitated).

An applicant or authorized representative must also provide all requested information according to HHSC instructions. See Section C-8000, Responsibility to Provide Information and Report Changes.

If someone helps an applicant or authorized representative complete the application for assistance, the name of the person completing the form must appear as requested on the application.

Filing an application will:

- permit HHSC to make a formal determination whether or not a person is eligible to receive Medicaid; and
- give a person the right to appeal if there is a disagreement with the determination.

C-2000, Confidential Nature of the Case Record

Body

Revision 21-3; Effective September 1, 2021

Information that is collected in determining initial or continuing eligibility is confidential. The restriction on disclosing information is limited to information about applicants and recipients. HHSC may disclose general information, including financial or statistical reports; information about policies, procedures or methods of determining eligibility; and any other information that is not about or does not specifically identify an applicant or recipient.

An applicant or recipient may review all information in the case record and in HHSC handbooks that contributed to the eligibility decision.

C-2100, Correcting Information

Body

Revision 09-4; Effective December 1, 2009

Applicants/recipients have a right to correct any information that HHSC has about the applicant/recipient and any other individual on the applicant's/recipient's case.

A request for correction must be in writing and must:

- identify the individual asking for the correction;
- identify the disputed information about the individual;

- state why the information is wrong;
- include any proof that shows the information is wrong;
- state what correction is requested; and
- include a return address, telephone number or email address at which HHSC can contact the individual.

If HHSC agrees to change individually identifiable health information, the corrected information is added to the case record, but the incorrect information remains in the file with a note that the information was amended per the applicant's/recipient's request.

Notify the applicant/recipient in writing within 60 days (using current HHSC letterhead) that the information is corrected or will not be corrected and the reason. Inform the applicant/recipient if HHSC needs to extend the 60-day period by an additional 30 days to complete the correction process or obtain additional information.

If HHSC makes a correction to individually identifiable health information, ask the applicant/recipient for permission before sharing with third parties. HHSC will make a reasonable effort to share the correct information with persons who received the incorrect information from HHSC if they may have relied or could rely on it to the disadvantage of the applicant/recipient. Follow regional procedures to contact HHSC's privacy officer for a record of disclosures.

Note: Do not follow procedures above if the accuracy of information provided by a applicant/recipient is determined by another review process, such as:

- a fair hearing;
- a civil rights hearing; or
- another appeal process.

The decision in that review process is the decision on the request to correct information.

C-2200, Establishing Identity for Contact

Body

Revision 09-4; Effective December 1, 2009

Keep all information HHSC has about an applicant/recipient or any individual on the applicant's/recipient's case confidential. Confidential information includes, but is not limited to, individually identifiable health information.

Before discussing or releasing information about an applicant/recipient or any individual on the applicant's/recipient's case, take steps to be reasonably sure the individual receiving the confidential information is either the applicant/recipient or an individual the applicant/recipient authorized to receive confidential information (for example, an attorney or personal representative).

C-2210 Telephone Contact

Revision 11-4; Effective December 1, 2011

Establish the identity of an individual who identifies himself/herself as an applicant/recipient using his/her knowledge of the applicant's/recipient's:

- Social Security number;
- date of birth;
- other identifying information; or

- call back to the individual.

Establish the identity of a personal representative by using the individual's knowledge of the applicant's/recipient's:

- Social Security number;
- date of birth;
- other identifying information;
- call back to the individual; or
- the knowledge of the same information about the applicant's/recipient's representative.

Establish the identity of attorneys or legal representatives by asking the individual to provide Form H1003, Appointment of an Authorized Representative, completed and signed by the applicant/recipient.

Establish the identity of legislators or their staff by following regional procedures.

C-2220 In-Person Contact

Revision 12-3; Effective September 1, 2012

Establish the identity of the individual who presents himself/herself as an applicant/recipient or applicant's/recipient's representative at an HHSC office by:

- driver's license;
- date of birth;
- Social Security number; or
- other identifying information.

Establish the identity of other HHSC staff, federal agency staff, researchers or contractors by:

- employee badge; or
- government-issued identification card with a photograph.

Identify the need for other HHSC staff, federal staff, research staff or contractors to access confidential information through:

- official correspondence or telephone call from state office or regional offices, or
- contact with regional attorney.

Contact appropriate regional or state office staff when federal agency staff, contractors, researchers or other HHSC staff, etc., come to the office without prior notification or adequate identification and request permission to access HHSC records.

Note: Contractors cannot have access to IRS Federal Tax Information (FTI).

C-2230 Verification and Documentation

Revision 12-3; Effective September 1, 2012

If disclosing individually identifiable health information, document how you verified the identity of the person if contact is outside the interview.

Verify the identity of the person who contacts you with a request to disclose individually identifiable health information using sources such as:

- valid driver's license or Department of Public Safety ID card;
- birth certificate;
- hospital or birth record;
- adoption papers or records;
- work or school ID card;
- voter registration card;
- wage stubs; and
- U.S. passport.

As a condition for receiving federal taxpayer returns and return information from the IRS, HHSC is required pursuant to IRC 6103(p)(4) to establish and maintain, to the satisfaction of the IRS, safeguards designed to prevent unauthorized access, disclosure, and use of all returns and return information and to maintain the confidentiality of that information. The IRS security requirements for safeguarding IRS FTI are outlined in Publication 1075, Tax Information Security Guidelines for Federal, State and Local Agencies, Safeguards for Protecting Federal Tax Returns and Return Information.

MEPD Income Eligibility and Verification System (IEVS) specialists must independently verify the income and resource information from any of the data matches to ensure continuous financial eligibility for the MEPD programs.

For all case actions regarding the clearance of the IEVS match of IRS FTI, MEPD staff must not enter any IRS FTI into TIERS (including comments). Documentation on the TIERS income/resource screen is limited to the approved language indicated in the centralized process available on the Social Services Intranet on the Medicaid Eligibility for the Elderly and People with Disabilities home page at hhs.texas.gov/laws-regulations/handbooks/medicaid-elderly-people-disabilities-handbook.

C-2240 Alternate Means of Communication

Revision 09-4; Effective December 1, 2009

HHSC must accommodate an applicant's/recipient's reasonable request to receive communications by alternative means or at alternate locations.

The applicant/recipient must specify in writing the alternate mailing address or means of contact and include a statement that using the home mailing address or normal means of contact could endanger the applicant/recipient.

C-2300, Custody of Records

Body

Revision 21-3; Effective September 1, 2021

Records must be safeguarded. Use reasonable diligence to protect and preserve records and to prevent disclosure of the information they contain except as provided by HHS regulations.

"Reasonable diligence" for employees responsible for records includes keeping records:

- in a locked office when the building is closed;
- properly filed during office hours;
- always in the office except when authorized to remove or transfer them; and
- electronic file information as referenced in HHS Computer Usage and Information Security training.

Reporting Unauthorized Inspection or Disclosure of Internal Revenue Service (IRS) Federal Tax Information (FTI)

Upon discovery of an actual or possible compromise of an unauthorized inspection or disclosure of IRS FTI including breaches and security incidents, the person making the observation or receiving the information must contact the HHS IRS Coordinator immediately at 512-706-7158. They must also email the HHS Privacy Office Mailbox. If you are unable to personally reach the HHS IRS Coordinator by phone, send a secure email to the HHS IRS Coordinator Mailbox.

The HHS IRS Coordinator will report the incident by contacting the office of the appropriate Special Agent-in-Charge, Treasury Inspector General for Tax Administration (TIGTA) and the IRS Office of Safeguards as directed in Section 10.2 of Publication 1075.

Reporting Unauthorized Inspection or Disclosure of Social Security Administration (SSA) Provided Information

Staff who become aware of an incident of unauthorized access to, or disclosure of, restricted verified SSA information or confidential information must contact the HHS Privacy Office Mailbox immediately.

The HHS Privacy Office will report the incident by contacting the Chief Information Security Office (CISO).

If a person is responsible for a security breach or an employee's employment is terminated, the user's access to all information resources is removed. Supervisors must follow agency procedures for removing access for employees, contractors, vendors or trainees.

C-2400, Safeguarding Federal Income Data

Body

Revision 21-3; Effective September 1, 2021

In addition to the measures for custody of records, use the following to safeguard tape match data obtained through the Income Eligibility and Verification System (IEVS) module within the Automated System of Office of Inspector General (ASOIG) application:

- Use IEVS data only for the purpose of determining eligibility for MEPD, Medicare Savings Program (MSP), Medical Assistance, Temporary Assistance for Needy Families (TANF) and Supplemental Nutrition Assistance Program (SNAP) benefits.
- Verify IEVS tax data before taking adverse case actions.
- Review the Annual Safeguards Federal Tax Information Training and the following three laws that explain criminal and civil penalties for unauthorized disclosure of tax data once a year:
    - Section 7213 – Unauthorized Disclosure of Returns or Return Information, a criminal felony punishable upon conviction by a fine as much as $5,000 or imprisonment for as long as 5 years, or both, together with the cost of prosecution.
    - Section 7213A – Unauthorized Inspection of Returns or Return Information, a criminal misdemeanor punishable upon conviction by a fine of as much as $1,000 or imprisonment for as

long as 1 year, or both, together with the cost of prosecution.
- Section 7431 – Civil Damages for Unauthorized Disclosure of Returns and Return Information, permits a taxpayer to sue for civil damages if a person knowingly or negligently discloses tax return information and upon conviction, a notification to the taxpayer.

Related Policy

Custody of Records, C-2300
System Generated IEVS Worksheet Legends of IRS Tax Data, Appendix XVII
IRS Tax Code, Sections 7213, 7213A and 7431, Appendix XVIII

C-2500, Disposal of Records

Body

Revision 21-3; Effective September 1, 2021

To dispose of documents with an applicant or recipient's information, follow procedures for destruction of confidential data according to Texas Health and Human Services records management policies.

The approved method of destruction of IRS FTI is shredding. The IRS requires the following safeguards:

- HHS staff must perform the destruction of IRS FTI at an HHS facility.
- Destruction of IRS FTI must be documented on Form H1861, Federal Tax Information Record Keeping and Destruction Log.
- IRS FTI documents should be inserted into the shredder so the lines of print are perpendicular to the cutting line to render the document undisclosable.
- IRS FTI documents should be shredded to 1 mm x 5 mm (0.04 in. x 0.2 in.) in size (or smaller).

C-2600, Procedure for Preventing Disclosures of Information

Body

Revision 12-3; Effective September 1, 2012

1. If information about an applicant/recipient is requested but cannot be released, inform the inquiring person or agency that federal and state laws and HHSC regulations require that the information being requested remain confidential. Refer the questioner to Title 42 of the United States Code, Section 1396a(a)(7); 42 CFR Sections 431.300-431.307; and Texas Human Resource Code, Sections 12.003 and 21.012. For individually identified health information, refer the requestor to 45 CFR sections 164.102-164.534. For tax information obtained through IEVS, also refer the requestor to the Internal Revenue Service (IRS) Code, Sections 7213, 7213A and 7431. Title 26 US Code Section 6103 is the confidentiality statue that prohibits disclosure of FTI. For human services agencies, it is IRC 6103(1)(7).

   Reference: See Appendix XVIII, IRS Tax Code, Sections 7213, 7213A and 7431.

2. If subpoenaed to appear in court with an applicant's/recipient's record, notify the supervisor immediately. Give the supervisor all the facts about the case and the date and time of the court hearing. The supervisor should contact the lawyer who is requesting the record and determine whether the requested information is confidential. If a problem exists, the supervisor should inform the regional attorney about all relevant facts. Usually, the subpoenaed employee must take the record and appear in court as directed by the summons. When requested to disclose information from the record, ask the judge to be excused from

disclosing the information because of the statutory prohibitions stated previously in this section. Abide by the ruling of the judge.

3. If subpoenaed to appear in court, and no time is allowed to follow the steps specified in this section, take the record and appear in court as directed by the summons. When requested to disclose the information from the record, follow the procedure described in Step 2.

For individually identifiable health information, refer the requestor to 45 CFR Sections 164.102-164.534.

C-3000, When and What Information May Be Disclosed

Body

Revision 21-4; Effective December 1, 2021

Notes:

Staff must make reasonable efforts to limit the use or disclosure of individually identifiable health information to determine eligibility and operate the program. Disclosure of medical information from HHSC records must be minimal to achieve the requested disclosure. For example, If a person authorizes release of income verification, including disability income, do not release related case medical information unless specifically authorized by the person.

Case information may be released to Medicaid providers to help in providing services and filing claims for payment.

Only release case information, such as personal information or addresses, to a person who has written permission from the applicant or recipient to get the information.

You must have the applicant's or recipient's consent to respond to inquiries from their relatives or friends requesting addresses or personal information. Inform the applicant or recipient of any inquiries. Allow the applicant or recipient to decide if they wish to share the information before providing the information to the inquiring party.

The applicant or recipient authorizes the release of information by completing and signing:

- Form H1003, Appointment of an Authorized Representative;
- Form H1826, Case Information Release; or
- A document containing all following information:
  - the case name and case number, or full name, including middle initial, and either their date of birth or Social Security number;
  - a description of the information to be released. If a general release is authorized, provide the information that can be disclosed to the person. Withhold confidential information from the case record, such as names of people who disclosed information about the household without the household's knowledge, and the nature of pending criminal prosecution;
  - a statement specifically authorizing HHSC to release the information;
  - the name of the person or entity to whom the information will be released;
  - the purpose of the release;
  - an event that triggers an expiration of the authorization, or an expiration date of the release;
  - a statement about whether refusal to sign the release affects eligibility for or delivery of services;
  - a statement describing the person's right to revoke the authorization to release information;
  - the date the document is signed; and
  - the signature of the person or Authorized Representative (AR).

If the case information released includes individually identifiable health information, the document must clearly indicate the applicant or recipient understands any information released may not be private and may be released again by the person receiving the information.

When information is requested from the case records of a deceased person, protect the privacy of the deceased person. Follow policy to determine who can act for the deceased person about individually identifiable health information.

Do not include Form H1826 or other information release authorization documents in application packets.

The HHSC Office of the Chief Counsel handles questions about the release of information under the Open Records Act. Refer all questions and issues encountered by people concerning release of information to the Open Records Division, Office of the General Counsel.

Follow Confidential Nature of Medical Information – HIPPA policy for restrictions on the release of a person's protected health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations.

Related Policy

Confidential Nature of Medical Information, C-4000
Deceased Individuals, C- 5300
Prior Coverage for Deceased Applicants, G-7210

C-4000, Confidential Nature of Medical Information

Body

Revision 15-2; Effective June 1, 2015

Applicants/recipients requesting assistance on the basis of disability must complete a medical information release form.

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that sets additional standards to protect the confidentiality of individually identifiable health information. Individually identifiable health information is information that identifies or could be used to identify an individual and that relates to the:

- past, present or future physical or mental health or condition of the individual;
- provision of health care to the individual; or
- past, present or future payment for the provision of health care to the individual.

C-4100, Privacy Notice

Body

Revision 21-4; Effective December 1, 2021

HIPAA requires HHSC to provide a notice of privacy practices that explains:

- the person’s privacy rights;

- the duties of HHSC to protect the person's health information; and
- how HHSC may use or disclose the person's health information without an authorization. For example, HHSC may share health information with the person's providers to:
  - arrange for services; or
  - with other government entities to report suspected abuse or neglect.

Provide Form 0401, Notice of Privacy Practices (English), or Form 0401S, Aviso de Normas Sobre la Privacidad (Spanish), as appropriate, to each household with a person enrolled in a medical program.

Provide Form 0401 or Form 0401S with Form TF0001, Notice of Case Action, to each household enrolled in a medical program:

- at initial certification; or
- at recertification after a break in services of more than 180 days.

Form 0403, Explanation to Health Information Privacy Rights, provides a reminder of privacy practices and where to locate Form 0401.

Provide Form 0403 with Form TF0001 to each head of household:

- at each recertification;
- after a break in services of at least 30 days but not more than 180 days; or
- when a new person is added to a case.

C-4200, Applicant/Recipient Authorization

Body

Revision 11-4; Effective December 1, 2011

The applicant/recipient may authorize the release of his or her health information from HHSC records by using a valid authorization form. Form H1003, Appointment of an Authorized Representative, includes all the authorization elements required by HIPAA privacy regulations. See Section C-3000, When and What Information May Be Disclosed, for the elements necessary for a valid authorization.

C-4300, Minimum Necessary

Body

Revision 09-4; Effective December 1, 2009

Reasonable efforts must be made to limit the use, request or disclosure of individually identifiable health information to the minimum necessary to determine eligibility and operate the program. The disclosure of individual medical information from HHSC records must be limited to the minimum necessary to accomplish the requested disclosure. For example, if an applicant/recipient authorizes release of income verification, including disability income, do not release related case medical information unless specifically authorized by the applicant/recipient.

C-5000, Personal Representatives

Body

Revision 09-4; Effective December 1, 2009

Only an applicant's/recipient's personal representative can exercise the applicant's/recipient's rights with respect to individually identifiable health information. Therefore, only a applicant's/recipient's personal representative may authorize the use or disclosure of individually identifiable health information or obtain individually identifiable health information on behalf of an applicant/recipient. **Exception:** HHSC is not required to disclose the information to the personal representative if the applicant/recipient is subjected to domestic violence, abuse or neglect by the personal representative. Consult the regional attorney if you believe that health information should not be released to the personal representative.

Note: A responsible party is not automatically a personal representative.

C-5100, Adults and Emancipated Minors

Body

Revision 09-4; Effective December 1, 2009

If the applicant/recipient is an adult or emancipated minor, including married minors, the applicant/recipient's personal representative is a person who has the authority to make health care decisions about the applicant/recipient and includes a:

- person the applicant/recipient has appointed under a medical power of attorney, a durable power of attorney with the authority to make health care decisions, or a power of attorney with the authority to make health care decisions;
- court-appointed guardian for the applicant/recipient; or
- person designated by law to make health care decisions when the applicant/recipient is in a hospital or nursing home and is incapacitated or mentally or physically incapable of communication. Follow regional procedures to contact the regional attorney for approval.

C-5200, Unemancipated Minors

Body

Revision 09-4; Effective December 1, 2009

A parent is the personal representative for a minor child except when:

- the minor child can consent to medical treatment by himself or herself. Under these circumstances, do not disclose to a parent information about the medical treatment to which the minor child can consent. A minor child can consent to medical treatment by himself or herself when the:
  - minor is on active duty with the U.S. military;
  - minor is age 16 or older, lives separately from the parents and manages his own financial affairs;
  - consent involves diagnosis and treatment of a disease that must be reported to a local health officer or the Texas Department of State Health Services (DSHS);
  - minor is unmarried and pregnant and the treatment (other than abortion) relates to the pregnancy;
  - minor is age 16 years or older and the consent involves examination and treatment for drug or chemical addiction, dependency or use at a treatment facility licensed by DSHS;
  - consent involves examination and treatment for drug or chemical addiction, dependency or use by a physician or counselor at a location other than a treatment facility licensed by DSHS;
  - minor is unmarried, is the parent of a child, has actual custody of the child and consents to treatment for the child; or
  - consent involves suicide prevention or sexual, physical or emotional abuse; and
- a court is making health care decisions for the minor child or has given the authority to make health care decisions for the minor child to an adult other than a parent or to the minor child. Under these

circumstances, do not disclose to a parent information about the health care decisions not made by the parent.

C-5300, Deceased Individuals

Body

Revision 09-4; Effective December 1, 2009

The personal representative for a deceased applicant/recipient is an executor, administrator or other person with authority to act on behalf of the applicant/recipient or the applicant's/recipient's estate. These individuals include:

- an executor, including an independent executor;
- an administrator, including a temporary administrator;
- a surviving spouse;
- a child;
- a parent; and
- an heir.

Consult the regional attorney if you have questions about whether a particular person is the personal representative of an applicant or recipient.

C-6000, Fraud and Fair Hearings

C-6100, Appeals

Body

Revision 13-2; Effective June 1, 2013

If an individual is dissatisfied with HHSC's decision concerning his eligibility for any MEPD program, including Medicaid Savings Programs, the individual has the right to appeal through the appeal process established by HHSC. In certain circumstances, the individual is entitled to receive continued benefits or services until a hearing decision is issued. Whether an individual is entitled to continued assistance is based on requirements set forth in appropriate state or federal law or regulation of the affected program. See the Fair and Fraud Hearings Handbook.

Individuals whose medical assistance is denied because of an SSA decision should file an appeal with the appropriate SSA office.

Note: If an individual submits an application during the time the continued benefits are being processed, the application must be processed as normal. See Chapters B-2300, Eligibility Determination, B-3200, Application Process, and B-6400, Processing Deadlines.

C-6110 Program Representation at Fair Hearings

Revision 18-4; Effective December 1, 2018

If an applicant or recipient requests a fair hearing, the burden of proof to uphold HHSC's decision rests with HHSC. The hearing officer is a neutral party and is restricted by law from presenting HHSC's case.

Form H4800, Fair Hearing Request Summary, provides a space for the names of HHSC's representative and supervisor. The supervisor is responsible for ensuring that either the HHSC representative participates in the hearing or that a back-up person is assigned. Additionally, the supervisor should ensure that the designated representative is sufficiently prepared and knowledgeable of the case to represent HHSC during the fair hearing process.

The hearing officer has the responsibility of setting the date and time of the hearing. In those program areas where Form H4800 may be completed by someone other than agency staff (contracted case management, HHSC representatives, etc.), it is important that the hearing officer be given the name(s) of those people who are to be notified of the date and time of the hearing. If there is not sufficient space on Form H4800 to provide this information, list the name(s) on Form H4800-A, Fair Hearing Request Summary (Addendum), Item 3, "Additional Information."

In those program areas where Form H4800 is completed by HHSC staff but someone other than, or in addition to, HHSC staff will appear (Attorney General's Office staff, Workforce Commission staff, home health nurses, nursing facility staff, etc.), the person completing Form H4800 is responsible for providing the hearing officer with the name(s) of those people who are to be notified of the date and time of the hearing. If there is not sufficient space on Form H4800 to provide this information, list the name(s) on Form H4800-A, Item 3, " Additional Information."

C-6200, Applicant/Recipient and Provider Fraud Detection and Referral

Body

Revision 11-4; Effective December 1, 2011

Applicants/recipients receiving MEPD programs are perceived by HHSC as essentially honest and entitled to the same protection under the law as all other individuals. When potential fraud is indicated, the allegations must be investigated.

HHSC also endorses the concept that people who provide services are essentially honest and are entitled to the same protection under the law as all other individuals. However, if there is an indication of potential fraud, the allegations must be investigated.

The Office of Inspector General (OIG) investigates waste, abuse and fraud in all health and human services programs in Texas. Any state employee or private citizen may report waste, abuse and fraud to the OIG.

HHSC staff, concerned citizens, providers (for example, doctors, dentists, counselors, etc.), Medicaid applicants/recipients and others can help prevent cases of waste, abuse and fraud by notifying OIG.

If applicant/recipient or provider waste, abuse or fraud is suspected in the Medicaid system, complete the OIG's online complaint form, which is available at: https://oig.hhsc.state.tx.us/wafrep/.

If access to the Internet is not available, contact the fraud hotline at 800-436-6184 or mail the complaint to:

Texas Health and Human Services Commission
Office of Inspector General
Mail Code 1361
P.O. Box 85200
Austin, TX 78708-5200

C-7000, Voter Registration

Body

Revision 21-4; Effective December 1, 2021

HHSC must offer applicants and recipients an opportunity to register to vote at application, redetermination and any time the person has a change of address.

Form H0025, HHSC Application for Voter Registration, is included with each application and redetermination packet. Additionally, the Form H0025 is provided when a person reports a change of address. System-generated application and redetermination packets contain Form H0025.

If the person indicates they do not wish to register to vote, mail Form H1350, Opportunity to Register to Vote. Document that the person declined in the Texas Integrated Eligibility Redesign System (TIERS), **Voter Registration Information** section of the person **Demographics — Citizen** page. If the person returns Form H1350, sign and mark the Client Declined box in the Agency Use Only: Voter Registration Status section of Form H1350 and send the form for imaging.

Who Can Register to Vote

To register to vote, a person must be:

- a U.S. citizen; and
- at least 17 years and 10 months.

The opportunity to register to vote is not required if a person does not meet these two requirements.

Staff Requirements for Voter Registration

Staff must tell the person:

- HHSC offers the same help and services when aiding the person with voter registration activities as when helping them with agency forms. This can happen whether HHSC provides the service in the office, outside of the office or at the person's home.
- The decision to register or to decline to register to vote does not affect eligibility or benefit amount. HHSC will keep all voter registration information confidential and only use it for voter registration purposes.
- The person may decide to seek help from staff to fill out the voter registration application form. The person may also fill out the application form in private.
- The person may return the completed application form to:
  - the Secretary of State (SOS), by mail using the postage-paid, self-addressed application form;
  - the local voter registrar, by mail or in person; or
  - the advisor.
- The person may ask more voter registration questions or file a voter registration complaint by contacting the Elections Division of the Secretary of State, P.O. Box 12060, Austin, TX 78711, 800-252-8683.

Staff must not:

- influence a person’s political preference or party registration;
- display any political preference or party affiliation;
- make any statement to discourage the person from registering to vote;
- make any statement to a person or take any action to make the person believe that a decision to register or not to register has any bearing on the availability of services or benefits; or

- pend the EDG or delay or deny benefits if the person fails or refuses to complete the voter registration information on any form, or fails to return Form H0025 or Form H1350.

Documentation

Document all actions taken to provide the person with an opportunity to register to vote at application, redetermination, and change of physical address in TIERS in the Voter Registration Information section of the person's **Demographics — Citizen** page.

C-8000, Responsibility to Provide Information and Report Changes

Body

Revision 10-2; Effective June 1, 2010

Providing Information

When a person applies for Medicaid, HHSC will ask for documents and any other information needed to make sure all the requirements for Medicaid are met. HHSC will ask for information about income, resources and other eligibility requirements.

As a requirement of Medicaid, a person must provide HHSC MEPD staff with the necessary documentation and information to determine eligibility for Medicaid.

If HHSC sends an applicant or authorized representative a request for missing information or verification documents, or both, the applicant or authorized representative must provide the requested information to HHSC by the due date given in the request, or eligibility may be denied.

See Section B-6510, Failure to Furnish Missing Information.

Reporting Changes

Report to HHSC MEPD staff certain events that affect Medicaid eligibility and co-payment.

HHSC requires that the applicant/recipient or authorized representative must report certain events because they may affect eligibility or continued eligibility or the amount of the co-payment in the cost of care. See Chapter H, Co-Payment.

Who, What, When and How of Reporting Changes

Who must make reports? The person(s) responsible for making required reports to HHSC include an:

- eligible individual;
- eligible spouse;
- eligible child; or
- applicant awaiting a final determination upon an application.

Additional:

- If the applicant/recipient has an authorized representative and has not been legally adjudged incompetent, either the applicant/recipient or the authorized representative must make the required reports.

- If the recipient's co-payment is impacted by either the community spouse or a dependent family member, the recipient, authorized representative, community spouse or dependent family member is responsible for making required reports to HHSC.
- If the applicant/recipient has an authorized representative (legal guardian) and has been legally adjudged incompetent, the authorized representative (legal guardian) is responsible for making required reports to HHSC.

What must be reported?

Although not all inclusive, events that must be reported are:

- Change of address — Report any change in mailing address and any change in the address where the person (or spouse/dependent family member) lives.
- Change in living arrangements — Report any change in the make-up of the household; that is, any person who comes to live in the household and any person who moves out of the household.
- Change in income — Report any increase or decrease in income, and any increase or decrease in the income of:
  - the ineligible spouse who lives with the recipient;
  - the community spouse or dependent family member;
  - the parent, if the recipient is an eligible child and the parent lives with the eligible child; or
  - an ineligible child who lives with the eligible child.
- Change in resources — Report any resources received or parted with by the:
  - applicant/recipient;
  - ineligible spouse who lives with the recipient;
  - community spouse or dependent family member; or
  - parent, if the recipient is an eligible child and the parent lives with the eligible child.
- Eligibility for other benefits — Report eligibility for benefits. Responsibility to apply for any other benefits for which a person may be eligible is required. See Section D-6000, Social Security Number (SSN) and Application for Other Benefits.
- Certain deaths — If the person is an eligible individual, the individual or the individual's authorized representative must report the death of:
  - the eligible spouse;
  - the ineligible spouse who was living with the individual; and
  - any other person who was living with the individual including a parent of an eligible child.

  Additionally, if the recipient's co-payment is impacted by either the community spouse or a dependent family member, the recipient, authorized representative, community spouse or dependent family member is responsible for making required reports to HHSC.
- Change in marital status — Report the marriage, divorce or annulment of a marriage of the:
  - eligible individual;
  - parent who lives with the eligible child; or
  - spouse or dependent family member.

    Additionally, report the marriage of an ineligible child who lives with an eligible individual.
- Medical improvements — If eligible for Medicaid because of disability or blindness, report any medical condition improvement.
- A termination of residence in the U.S. — Report leaving the U.S. voluntarily with the intention of abandoning residence in the U.S. or leaving the U.S. involuntarily.
- Leaving the U.S. temporarily — Report leaving the U.S. for 30 or more consecutive days or for a full calendar month (without the intention of abandoning residence in the U.S.).

Include in the Reports

When reporting changes either in writing or verbally, include the following:

- applicant or recipient's name and Social Security number;
- event and the date it happened; and
- reporter's name.

Reports are due to HHSC when:

- an event happens, the report is due within 10 days of the event.
- HHSC requests a report and provides a due date.

C-9000, Interpreter and Translation Services

C-9100, Requirement for Interpreter and Translation Services

Body

Revision 13-3; Effective September 1, 2013

All Programs

HHSC is required to provide interpreter services and written translated materials to applicants and recipients who are Limited English Proficient (LEP). HHSC also is required to provide an effective method to communicate with applicants and recipients who indicate they are deaf or hearing impaired. Applicants and recipients indicate on Form H1200, Application for Assistance – Your Texas Benefits, or during an interview that they need interpreter services. For more information on procedures, refer to the Eligibility Operations Procedures Manual.

C-9200, Availability of Translated Written Material

Body

Revision 19-3; Effective September 1, 2019

All Programs

Staff must inform applicants and recipients about the availability of written or verbal translation services for written materials HHSC sends to them at application and redetermination.

When staff verbally communicate with Limited English Proficient (LEP) applicants or recipients at the time of application, redetermination and change actions, staff must ensure that applicants or recipients understand the eligibility action (Form H1020, Request for Information or Action, and Form TF0001, Notice of Case Action) being taken and the requirements for the application process (including the request for any missing information).

Note: This requirement is not applicable when staff process the case action without talking with the applicants or recipients.

The Vietnamese Translation Interpreter Form is automatically attached to applicable eligibility notices when Vietnamese is selected as the primary household language.

Chapter D, Non-Financial

D-1000, Aged, Blind or Disabled

D-1100, Related Texas Administrative Code Rules

Body

Revision 09-4; Effective December 1, 2009

§358.211. Aged, Blind, or Disabled.

(a) To be eligible for a Medicaid-funded program for the elderly and people with disabilities (MEPD), a person must be aged, blind, or disabled, according to the following criteria:

(1) Aged. A person must be 65 years of age or older to be considered aged, in accordance with 42 U.S.C. §1382c(a)(1)(A).

(2) Blind.

(A) To be considered blind for eligibility purposes, a person must meet the criteria in 42 U.S.C. §1382c(a)(2).

(B) There is no minimum age requirement for a person who is blind.

(C) A person must have a medical determination of blindness before the Texas Health and Human Services Commission (HHSC) can determine eligibility.

(3) Disabled.

(A) To be considered disabled for eligibility purposes, a person must meet the criteria in 42 U.S.C. §1382c(a)(3).

(B) There is no minimum age requirement for a person who is disabled, unless the person lives in an institution for mental diseases as described in §358.213 of this subchapter (relating to Resident of an Institution for Mental Diseases).

(C) A person must have a medical determination of a disability before HHSC can determine eligibility.

(b) A person under 65 years of age who has applied for Supplemental Security Income, and subsequently applies for retroactive coverage, must have a medical determination of blindness or a disability effective during any month of coverage that the person was under 65 years of age.

D-1200, Age

Body

Revision 09-4; Effective December 1, 2009

In determining age for aged, blind, or disabled individuals, the age is reached the day before the anniversary of birth. This affects the month a disability determination is required for persons born on the first day of the month. **Example:** The person turns 65 on Jan. 1, and is eligible for Medicare Dec. 1, before the person's 65th birthday in January. If the person meets all other eligibility criteria, the person can be certified for benefits for December without a disability decision.

Determine a person's age by the person's statement on the application. Compare the reported information with Social Security Administration records using systems in place to exchange or request data. Other acceptable

evidence includes such readily available sources as:

- insurance policies;
- family Bible;
- marriage record;
- child's birth certificate;
- hospital admission record;
- driver's license;
- hunting license;
- fishing license; or
- voter registration card.

D-1210 Definition of a Child

Revision 09-4; Effective December 1, 2009

A child is neither married nor a head of a household and is either:

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

Child status ceases effective with the month after the month of attainment of age 22 (age 18, if not a student) or the month after the month the person last meets the definition of child.

SSI policy defines full-time student as an individual attending at least:

- 12 hours per week if in high school or under;
- 12 hours per week if in a technical or vocational school (shop practice is not included in the course);
- 15 hours per week if in a technical or vocational school (shop practice is included in the course); or
- eight hours per week per semester if in a college or university.

A student is deemed to be in regular school attendance during normal vacation periods if he attends regularly during the month immediately following the vacation period. A person may be considered a full-time student without attending the required number of hours per week, if the person is disabled and physically unable to attend full-time, has difficulty obtaining transportation or is taking all that is needed to complete the person's education.

The age requirements involved in identifying a child apply only to a person who is otherwise eligible. A blind or disabled applicant who meets these age requirements, however, can become eligible for Medicaid, even though the person does not meet the definition of a child.

D-1300, Blindness

Body

Revision 09-4; Effective December 1, 2009

In determining blindness for aged, blind or disabled individuals, blindness is met if a person is considered “legally blind” as defined by the Social Security Administration. Based on a medical determination of blindness, a person is considered blind if the visual acuity in the person's better eye is 20/200 or less with corrective lenses, or if the person has tunnel vision that limits the field of vision to 20 degrees or less.

D-1400, Disability

Body

Revision 09-4; Effective December 1, 2009

In determining disability for aged, blind or disabled individuals, disability is met if the person is considered disabled as defined by the Social Security Administration. Based on a medical determination of disability, a person is considered disabled if the person is unable to engage in any substantial, gainful activity because of a medically determinable physical or mental impairment that can be expected to result in death or has continued or can be expected to continue for at least 12 months. A child who is not engaged in substantial, gainful activity is considered disabled if the child suffers from any medically determinable physical or mental impairment of comparable severity to that which would preclude an adult from engaging in substantial, gainful activity.

Note: A person who lives in an institution for mental diseases (IMD) must be 65 years of age or older to be eligible for an MEPD program. Do not establish a medical determination for blindness or disability for a person who lives in an IMD who is less than 65 years old.

D-2000, Determining Blindness or Disability

D-2100, When a Medical Determination Is Not Required

Body

Revision 12-4; Effective December 1, 2012

Receipt of Medicare is an indication that the person is either:

- age 65 or older; or
- has been determined blind or disabled based on the Social Security Administration (SSA) criteria for RSDI Title II or SSI Title XVI disability.

A medical determination **is not required** to establish blindness or disability if the person has Medicare. The receipt of the Medicare is satisfactory verification that the person has been determined to meet the SSA's criteria for aged, blind or disabled. This includes a person determined blind or disabled by SSA in the 24-month period before receiving Medicare. Upon verification of the receipt of a disability benefit, a medical determination **is not required** to establish blindness or disability if a person is currently receiving disability benefits from:

- SSI;
- RSDI; or
- Railroad Retirement.

For an eligibility determination during the retroactive coverage months, a medical determination **is not required** to establish blindness or disability during that retroactive coverage period if a person:

- has unpaid or reimbursable covered Medicaid expenses during the retroactive coverage months prior to the application;
- has a date of onset for RSDI Title II blindness or disability based on SSA query records; and
- the date of onset for the RSDI Title II blindness or disability covers the retroactive coverage months prior to the application.

Note: Do not use the Title XVI "Dsblty Onset Date" on the SSI Entitlement screen as the basis to establish blindness or disability for:

- retroactive coverage;
- current coverage; or
- future coverage.

A medical determination **is not required** to establish blindness or disability if a person:

- applies with HHSC for SSI-related medical assistance only (MAO);
- is under age 65; and
- lost SSI for reasons other than a decision that the disability or blindness has stopped.

D-2200, When a Medical Determination Is Required

Body

Revision 16-4; Effective December 1, 2016

When an individual does not have Medicare or is not receiving a disability benefit from SSI, RSDI, or Railroad Retirement (See E-4200, Railroad Retirement Benefits), a medical determination, including date of onset, of either disability or blindness **is required.** The date of onset can affect the start date of Medicaid.

The following must not be used to establish disability for MEPD programs:

- a Civil Service disability determination;
- a medical certification an individual submits to an Achieving a Better Life Experience (ABLE) program or to the Internal Revenue Service as proof of meeting ABLE program requirements.

An individuals under age 65 who lives in an institutional setting and who would, except for income, be eligible for SSI if they lived outside the facility, must meet the SSA's definition of disability or blindness. These individuals may or may not have applied for SSI cash benefits.

If a medical decision for determining blindness or disability is required, request a decision from the Disability Determination Unit (DDU). See Section D-2300, Requesting a Decision from the Disability Determination Unit (DDU).

Do **not** request a decision from the DDU in the following circumstances.

If an individual …	then …
resides in a state supported living center or the Rio Grande State Center,	the staff at these facilities, and not HHSC staff, is responsible for ensuring the completion of the forms for a disability determination.

If an individual …	then …
requests an eligibility determination during a retroactive period and the individual: • has unpaid or reimbursable covered Medicaid expenses during the retroactive coverage months prior to the application; • has a date of onset for RSDI Title II blindness or disability based on SSA query records; and • the date of onset for the RSDI Title II blindness or disability does not cover any of the retroactive coverage months prior to the application,	the DDU cannot establish an earlier date of onset for RSDI Title II blindness or disability because federal regulations prevent a state's disability determination to conflict with the RSDI Title II date of onset.

A medical determination of disability or blindness **is required** when RSDI Title II blindness or disability is not established and an individual is:

- under age 65;
- either under or over age 65 and applying for the Medicaid Buy-In (MBI) program; or
- either under or over age 65 and presumed to be a child with a disability to meet exception to transfer penalty.

To determine whether RSDI Title II blindness or disability is established, query the SSA records available.

Do not use the SSI Title XVI "Dsblty Onset Date" as the basis to establish blindness or disability.

D-2300, Requesting a Decision from the Disability Determination Unit

Body

Revision 14-4; Effective December 1, 2014

When a medical decision for determining blindness or disability is necessary, a decision must be requested from DDU. Complete and submit these forms for imaging, along with the medical records, to the Texas Health and Human Services Commission, P.O. Box 149027, Austin, TX 78714-9971:

- Form H3034, Disability Determination Socio-Economic Report
- Form H3035, Medical Information Release/Disability Determination

In addition to these forms, submit the following when available:

- Minimum Data Set information (physician's signature page)
- Medical treatment records for a waiver applicant
- Medical records for an applicant for primary home care services through Community Attendant Services (CAS)

DDU may request more complete medical documentation.

On receipt of Form H3034, Form H3035 or other medical records, DDU uses this information to determine whether the person meets SSA's definition of disability or blindness and makes the final decision about disability

or blindness.

DDU will consider the date of onset for the retroactive period, if needed. Specify the retroactive months needed on Form H3034. DDU's date of onset, however, cannot precede the RSDI Title II disability onset date indicated on the SSA query.

D-2400, Disability Determination Unit Request Required

Body

Revision 11-4; Effective December 1, 2011

When the application is for a person who is younger than age 65 and has never had a disability determination, an override for the application due date default of 45 days is needed. The application due date will be 90 days from the file date. Follow the steps in the system procedure instructions for this override.

Sometimes an application cannot be certified within 90 days because a disability determination is pending past the initial 90 days. In these cases, send Form H1247, Notice of Delay in Certification, to the applicant and the facility administrator, if applicable.

Applications for which delay-in-certification procedures have been followed are excluded from the delinquent count in timeliness reports. These applications are excluded for 180 days (90 days + 90-day extension); however, if the application is still pending on the 181st day, it will be counted as delinquent. Applications that cannot be certified within the normal 90-day limit, plus the 90-day extension, must be denied. A new application will be necessary to reconsider eligibility.

D-2500, Supplemental Security Income Applicants and Retroactive Coverage

Body

Revision 14-4; Effective December 1, 2014

An applicant for Social Security disability benefits is evaluated for both SSI Title XVI and RSDI Title II disability eligibility. HHSC determines Medicaid eligibility for retroactive coverage for up to:

- three months before the date of SSI application for a person who has been denied SSI; or
- two months before the month in which an SSI recipient's Medicaid coverage automatically begins.

In these cases, the medical records; Form H3034, Disability Determination Socio-Economic Report; and Form H3035, Medical Information Release/Disability Determination, should be imaged in the Texas Integrated Eligibility Redesign System (TIERS). DDU uses this information to make the final decision (disability or blindness) for the retroactive coverage months. DDU enters the disability determination in case comments and in the Disability Determination — DDU page in TIERS, which indicates the decision, including the date of onset of the disability or blindness.

Federal regulations prevent a state's disability determination to conflict with the RSDI Title II date of onset, and DDU cannot establish an earlier date of onset for RSDI Title II blindness or disability. As a result, deny an application based on the person not meeting blind (Not Blind) or disabled (Not Disabled) criteria when a person applies for Medicaid and the person:

- has unpaid or reimbursable covered Medicaid expenses during the retroactive coverage months prior to the application;

- has a date of onset for RSDI Title II blindness or disability based on Social Security Administration (SSA) query records; and
- the date of onset for RSDI Title II blindness or disability does not cover any of the retroactive coverage months prior to the application.

Note: Do not use the SSI Title XVI "Dsblty Onset Date" on the SSI Entitlement screen as the basis to establish blindness or disability for retroactive coverage.

Federal regulations prohibit a state from making a disability decision that conflicts with an SSA decision. DDU cannot make an independent decision until all appeals to SSA regarding the date of disability onset for both RSDI Title II and SSI Title XVI are settled.

Request medical records covering the period for which eligibility is being tested when:

- there is no date of onset for RSDI Title II disability; or
- 90 days have elapsed since the SSI/RSDI file date and SSA has not completed a disability determination.

Submit the following items for imaging to the Texas Health and Human Services Commission, P.O. Box 149027, Austin, TX 78714-9971:

- Medical records
- Form H3034
- Form H3035

Occasionally, Form 4116, Authorization for Expenditures, is required to provide payment to medical providers for submitting medical records. If Form 4116 is required, submit this form for imaging with the medical records, Form H3034 and Form H3035.

D-2600, Disability Determination Unit Decision

Body

Revision 13-2; Effective June 1, 2013

DDU will enter the disability determination in TIERS case comments and in the Disability Determination – DDU page. This determination will include notification about the decision, including the date of onset of the disability or blindness and if the individual is permanently excused from any further medical review.

- Do not make a final eligibility decision until DDU has completed the Disability Determination – DDU page in TIERS and documented the decision in case comments.
- Medicaid cannot begin and the medical effective date cannot precede or be earlier than the first day of the month in which the onset of the disability or blindness occurred.
- Medicaid begin and end date for ME – A&D Emergency is date-specific. Medicaid does not occur in full month increments for this program.
- Before certifying a person under age 65 for Medicaid, the eligibility specialist must review case comments and the Disability Determination – DDU page to see if the individual has had a previous disability determination and/or is permanently excused. If documentation does not indicate that the individual is permanently excused, the eligibility specialist may contact DDU. The specialist must document in case comments concerning any previous disability determination decision.

D-2700, Use of Decision on the Disability Determination – DDU Page in TIERS

Body

Revision 13-2; Effective June 1, 2013

Some applicants for Medicaid in an institutional setting are former recipients of Medicaid.

If a person was certified for Medicaid in an institutional setting based on the medical decision for either disability or blindness reflected in TIERS case comments and documented on the Disability Determination – DDU page, continue to use the existing record to reinstate the Medicaid in an institutional setting, unless case comments indicates a review of the disability or blindness is needed.

In addition, if TIERS case comments and the Disability Determination – DDU page indicates the applicant is permanently excused from further medical review, staff can continue to use this decision for future ME-A and D-Emergency requests or applications.

Do not use the existing Disability Determination – DDU page to process an application in any other situations, except those mentioned above.

D-2800, Disability Determination at Time of Review

Body

Revision 09-4; Effective December 1, 2009

At each periodic review, determine whether the decision about disability or blindness is current. Unless Form H3035, Medical Information Release/Disability Determination, indicates that the applicant is permanently excused from further medical review, complete a new Form H3034, Disability Determination Socio-Economic Report, and Form H3035 before the date of review indicated on Form H3035.

D-3000, Residence

D-3100, Related Texas Administrative Code Rules

Body

Revision 09-4; Effective December 1, 2009

§358.207. Residence.

To be eligible for a Medicaid-funded program for the elderly and people with disabilities, a person must be a resident of the United States (U.S.) and the state of Texas.

(1) U.S. residence. The Texas Health and Human Services Commission (HHSC) follows 20 CFR §416.1603 in determining a person's U.S. residence.

(A) The U.S. residence requirement does not apply to:

(i) a child who is a citizen and is living with a parent who is a member of the U.S. Armed Forces assigned to permanent duty ashore outside the U.S.; or

(ii) to certain persons temporarily abroad for study.

(B) Once eligible for benefits, a person must maintain a presence in the U.S. in accordance with 42 U.S.C. §1382(f)(1). If a person has been outside the U.S. for 30 consecutive days, the person is not eligible for benefits until the person has been in the U.S. for 30 consecutive days.

(2) Texas residence. HHSC follows 42 CFR §435.403 in determining a person's state residence.

§358.215. Inmates of Public Institutions.

An inmate of a public institution, including a jail, prison, reformatory, or other correctional or holding facility, as defined in 42 CFR §435.1009 and §435.1010, is not eligible for Medicaid payment for Medicaid-covered services received while residing in the public institution.

§358.213. Resident of an Institution for Mental Diseases.

A person who lives in an institution for mental diseases must be 65 years of age or older to be eligible for a Medicaid-funded program for the elderly and people with disabilities.

D-3200, Eligibility

Body

Revision 09-4; Effective December 1, 2009

To be eligible for Medicaid, a person must be a resident of the U.S.

To be eligible for an MEPD program under Texas Medicaid, a person must be a resident of the state of Texas. The person must have established residence in Texas and must intend to remain in Texas.

Consider a person a resident of the U.S. and Texas if the person has:

- established an actual dwelling place within the geographical limits of the U.S. and Texas; and
- the intent to continue to live in the U.S. and Texas.

Accept the person's statement on the application or redetermination form regarding Texas residency.

Further evidence of Texas residency is required only if Texas residency is questionable. A person can prove residency by providing document(s) that indicate a Texas address. For example, sources of evidence could be from the following:

- Property, income or other tax forms or receipts
- Utility bills, leases or rent payment records

D-3300, Maintaining Presence in the U.S.

Body

Revision 18-1; Effective March 1, 2018

A Medicaid recipient is not eligible for Medicaid for any month during all of which the person is outside of the U.S. If a person is outside of the U.S. for 30 or more days in a row, they are not considered to be back in the U.S. until they are back for 30 days in a row. A person may again be eligible for Medicaid in the month in which the 30 days end if they continue to meet all other eligibility requirements.

Note: The U.S. is considered the 50 States, the District of Columbia and the Northern Mariana Islands.

The period of absence begins with the day after the person's departure from the U.S. The period of absence ends for eligibility purposes:

- the day before the person's return to the U.S., if the time outside the U.S. is **less than 30 consecutive days**; or
- 30 consecutive days after return to the U.S., including a person newly arrived in the U.S. (that is, for the very first time), if the time outside the U.S. is **30 consecutive days or more**.

Develop continuous presence in the U.S. if there is reason to believe the person has been outside the U.S. for 30 consecutive days or a full month.

If otherwise eligible, a person whose eligibility has been denied because of absence from the U.S. can be recertified effective with the day:

- following the 30th day of continuous presence in the U.S. after the person's return, if the time outside the U.S. was 30 consecutive days or more; or
- the person returned to the U.S., if the time outside the U.S. was a full calendar month, but less than 30 consecutive days (calendar month of February only).

D-3310 Exceptions to U.S. Presence

Revision 09-4; Effective December 1, 2009

The U.S. residence requirement does not apply to:

- a child who is a citizen and is living with a parent who is a member of the U.S. Armed Forces assigned to permanent duty ashore outside the U.S.; or
- to certain persons temporarily abroad for study.

D-3400, Change of Address

Body

Revision 12-3; Effective September 1, 2012

When a recipient moves, the recipient is required to report this change within 10 days to HHSC. A permanent change of address or residence is important for the following reasons:

- It is very important to receive and maintain current address and residence information on the recipient's record to ensure proper receipt of Medicaid. Processing a change of address (COA) or residence request promptly will help alleviate any problems affecting the recipient's Medicaid eligibility.
- A COA or residence request may indicate that a change in circumstances has occurred which may affect continuing Medicaid eligibility. For example, there may be changes in living arrangements, marital status, in-kind support and maintenance, and resources (for example, home ownership).

When a recipient wishes to visit another address within the state for more than a month, the recipient is required to report this change within 10 days to HHSC. If this COA is temporary, a temporary COA does not impact eligibility if the visit is for no longer than three months.

See Section F-3121, Intent to Return Policy.

D-3500, Intent to Remain in Texas

Body

Revision 09-4; Effective December 1, 2009

To be eligible for Texas Medicaid, a person must be a resident of the state of Texas; that is, the person must have established residence in Texas and must intend to remain in Texas.

D-3510 Intent to Return

Revision 11-4; Effective December 1, 2011

A visit to another state does not terminate Texas residence if the person intends to return when the purpose of the visit is completed.

If a Texas resident visits out of the state (but remains in the United States) with subsequent returns or expressions of intent to return, the person's Texas residence is not interrupted. A recipient is responsible for requesting a temporary change of address because of an absence from the state. The recipient is also responsible for informing HHSC about the purpose, plans, date of departure and date of planned return.

If the recipient does not contact HHSC before departure, but HHSC learns about the recipient's absence from some other source, treat this information as a reported change. Attempt to get the recipient's out-of-state address. After receiving the out-of-state address, contact the recipient to determine whether the absence from the state is temporary, why the recipient left and when the recipient plans to return to Texas.

The length of out-of-state visits is not limited. Review the recipient's situation every three months to determine where the recipient intends to live permanently.

If the recipient's absence from the state is temporary and an annual review is scheduled, mail the redetermination packet directly to the recipient at the out-of-state address. If the nature of the recipient's visit is questionable, additionally request the recipient to:

- restate the purpose of the absence; and
- indicate the recipient's official permanent residence.

Review the recipient's response on the redetermination packet as to residency and intent to remain a Texas resident. Redetermine eligibility based on the recipient's usual living arrangement unless the recipient no longer indicates Texas residency with the intent to remain a Texas resident.

Reference: Chapter F, Resources, for treatment of a home and out-of-state property.

D-3520 No Intent to Return

Revision 09-4; Effective December 1, 2009

A recipient leaving the state with no declared intent to return, and without any evidence that would indicate plans to return, is considered to have moved from the state and Medicaid is denied immediately. If the recipient

subsequently returns to the state and declares the intent to remain, Medicaid may be resumed if the recipient meets all other eligibility requirements.

D-3600, Interstate Issues

Body

D-3610 Interstate Requests for Assistance

Revision 09-4; Effective December 1, 2009

If a recipient is eligible for Medicaid in another state and receives Medicaid in that state, the person is not eligible for Medicaid from the state of Texas.

If a person is placed in an institution located in Texas by an agency of another state, the person remains a resident of the state that made the placement.

D-3620 Out-of-State Medicaid and Texas Medicaid Recipients

Revision 09-4; Effective December 1, 2009

Under certain conditions, HHSC makes vendor payment to out-of-state providers on behalf of Texas Medicaid recipients. An out-of-state provider must be contracted with Texas as a Medicaid provider in its own state to provide care or services to Medicaid recipients and the recipients must be eligible for Texas Medicaid for the time involved. No payment commitment can be made until all necessary forms have been completed.

An out-of-state provider can contact Texas' contracted Medicaid claims administrator, currently the Texas Medicaid and Healthcare Partnership (TMHP). TMHP's website for the Texas Medicaid Program is www.tmhp.com.

The provider should furnish as much information as possible about the recipient, including the recipient's full name, Texas Medicaid number, Social Security number, date of birth, date of admission and date of discharge.

Note: If the person receives SSI and intends to live in the other state, inform the person to notify the Social Security Administration immediately about the move.

D-3630 Texas Applicant Outside the State of Texas

Revision 09-4; Effective December 1, 2009

If a person from Texas wishes to apply for Medicaid while outside the state, the person should contact the other state's Medicaid agency. The other state's Medicaid agency determines whether:

- the person plans to live or visit in that state; and
- that state's Medicaid is available to the person.

If the other state's Medicaid agency determines that the person is not eligible for that state's Medicaid, the other state's Medicaid agency contacts HHSC.

HHSC sends the person an application to apply for Texas Medicaid.

When the completed application is returned, use the person's Texas address as the residence address and the out-of-state address as the mailing address. Consider the person as a resident of Texas for the month of application and for the retroactive coverage period if appropriate.

After eligibility is determined, a copy of the decision is sent to the other state's Medicaid agency.

D-3640 Applicant from Another State

Revision 09-4; Effective December 1, 2009

A person from another state may ask to apply for Medicaid in Texas. Although the opportunity to apply for Medicaid cannot be denied to another, ask the following questions to assist the person in determining whether an application in Texas is appropriate:

- Is the person visiting or does the person intend to live in Texas?
- Is the person receiving Medicaid from another state?
- Does the person want to receive Medicaid from Texas or from the other state?
- Has the person declared intent to live in Texas with the full knowledge that if the person is eligible for Medicaid in Texas, the person is not eligible to receive Medicaid from the other state?
- Is the person aware that if the person declares the intent to live in Texas and is certified for Medicaid in Texas, HHSC notifies the other state?

In some instances, a person might tentatively declare intent to live in Texas but is found to be ineligible for Medicaid in Texas. Be careful to avoid action that might jeopardize a person's continued eligibility for Medicaid from another state. Although a person might at first declare intent to live in Texas, the person might decide to continue receiving Medicaid from the other state (if the person learns of ineligibility for Medicaid in Texas). Consequently, the person might revoke the declaration of intent to live in Texas and keep the person's residence in the other state.

D-3650 Out-of-State Recipient Visiting Texas

Revision 09-4; Effective December 1, 2009

If a recipient who receives a money grant (TANF, general assistance, state supplementary payments to SSI) or Medicaid, including Medicare Savings Program benefits, from another state and applies for Medicaid in Texas, determine whether:

- the recipient intends to continue receiving the money grant or Medicaid from the other state; and
- Medicaid benefits are available to the recipient from that state.

Declaration to continue living in the other state — If the recipient declares the intent to continue living in the other state, the recipient is not eligible for Medicaid in Texas. Contact the out-of-state Medicaid agency to determine which services are covered and how providers file claims. Have the recipient inform any Texas Medicaid provider to send any claim to the out-of-state Medicaid agency in the recipient's state of residence.

Declaration to live in Texas — If a recipient who receives a money grant from another state (TANF, general assistance, state supplementary payments to SSI) makes a declaration of intent to live in Texas, this declaration

does not automatically establish eligibility. Determine eligibility according to the requirements of the Texas Medicaid Program.

Impact on the medical effective date — If the intent to live in Texas is made by the recipient and the recipient meets Texas MEPD requirements, contact the out-of-state Medicaid agency of the recipient's former state of residence to determine the last day Medicaid claims will be paid by that state. The denial effective date is the last day for which the recipient 's former state of residence will pay Medicaid claims. This is not necessarily the denial effective date on the former state's computer system. The medical effective date for the recipient in Texas is no earlier than the day following the date the recipient 's former state of residence will pay Medicaid claims.

D-3660 SSI Recipient Visiting in Texas

Revision 16-3; Effective September 1, 2016

If an out-of-state SSI recipient indicates an intent to live in Texas, refer the recipient to a Social Security Administration (SSA) office. SSA makes the SSI residence determination. SSA will modify the SSI file indicating the new address. The change in the SSI file will trigger a change in the new address for the Medicaid file.

If the SSI recipient indicates a need for medical care during the month of the move to Texas, give the recipient Form H1300, Declaration of Texas Residency, and refer the recipient to an SSA office for verification of SSI status. SSA accepts Form H1300 via fax.

When the completed Form H1300 is returned, process under ME – Nursing Facility, to begin Medicaid coverage in Texas effective the day after the last date claims will be paid in the former state. Once the application has been disposed, Form H1027-A, Medicaid Eligibility Verification, covering the recipient's residence in Texas can be issued, if needed.

Example: An SSI recipient moves to Texas on Aug. 10 and needs medical care. After receipt of confirmation of SSI status for the month of August and verification from the former state that it will pay no Medicaid claims after Aug. 9, the eligibility specialist processes the application using ME – Nursing Facility for 8/10/YYYY through 8/31/YYYY and issues Form H1027 for those dates, if needed.

Note: Remember that Medicaid coverage in Texas may begin no earlier than the day after the last date claims will be paid by the former state.

If the request for coverage of medical care received in the month of the recipient's move to Texas is made during a subsequent month (or received in the month of the move, but the application is not disposed until the following month), the procedure is the same as above except that the application is processed using ME-SSI Prior for the month of move to Texas. In this instance, the medical effective date would be the first day of the month of move and the denial date would be the last day of that month. Do not issue Form H1027 for a past month. Instead, inform the recipient that Your Texas Benefits Medicaid ID card will be sent so that receipt is within seven to 14 days. The recipient must notify all providers of the added coverage for purposes of timely claims filing.

Example: An SSI recipient moves to Texas on May 24 and receives medical care on May 26. On June 15, the recipient requests assistance for that expense. After receipt of confirmation of SSI status for the month of May and verification from the former state that it will pay no Medicaid claims after May 23, the eligibility specialist processes the application using ME-SSI Prior for 5/1/YYYY through 5/31/YYYY. Inform the recipient that Your Texas Benefits Medicaid ID card will be sent so that receipt is within seven to 14 days, which the recipient must then use to notify provider(s) of Medicaid eligibility.

TIERS Procedures

Process as a manual SSI during the month of move. The medical effective date will be the first of the month.

Note: Even though the medical effective date precedes the actual date the recipient moves into the state, Texas medical claims would not have been incurred prior to the move date.

D-3700, Special Situations

Body

Revision 09-4; Effective December 1, 2009

In the following situations, the state in which the person resides is influenced by several factors.

- **Under age 21 and not in an institutional setting.** A person under age 21 who is not residing in an institutional setting is a Texas resident if the person is:
  - living in Texas more than temporarily;
  - living in another state when Texas has legal custody of the person; or
  - living in Texas, meets the blindness or disability criteria, and is MEPD eligible.
- **Under age 21 and in an institutional setting.**
  - If the parent(s) or legal guardian lives outside of Texas, the residence of an institutionalized person under age 21 is the state in which the parent or legal guardian states the institutionalized person is present, and intends to stay.
  - If the parents have abandoned the person and no legal guardian has been appointed, the person's residence is the state in which the institution is, if the authorized representative acting on behalf of the person in making an application for MEPD lives in that same state.
  - If the person is married, the person's residence is the institution's state.
- **Age 21 or over and in an institutional setting.**
  - The residence of an institutionalized person age 21 or over is the state in which the person is residing with the intent to remain.
  - If the person is incapable of indicating intent, the person's residence is determined in the same way as the residence of an institutionalized person under age 21.

Interstate institutional setting issue — If a person, regardless of his/her age, is placed in an institution located in Texas by an agency of another state, the person remains a resident of the state that made the placement.

Reminder: A person who lives in an institution for mental diseases must be age 65 or older to be eligible for an MEPD program.

D-3800, People Confined in a Public Institution

Body

Revision 21-4; Effective December 1, 2021

A person confined in a public institution, including a jail, prison, reformatory or other correctional or holding facility, is not eligible for Medicaid.

Permanent Release

A person who enters a Medicaid certified long-term care facility, skilled nursing facility, nursing facility or intermediate care facility for people with an intellectual disability or related condition after a permanent release from a correctional facility is not considered to be in a public institution.

Related Policy

People Confined in a County Jail in Texas, D-3810

D-3810 People Confined in a County Jail in Texas

Revision 21-4; Effective December 1, 2021

When a Texas county jail reports a Medicaid recipient is confined for more than 30 days, suspend or terminate benefits.

If notified of the person's confinement from a source other than a county jail in Texas, terminate the person's Medicaid.

Suspension

Suspend Medicaid within two business days of receiving a report of confinement from a county jail for the following types of assistance (TOAs):

- TA 10, ME – Waivers
- TA 88, ME – Medicaid Buy-In for Children
- TP 03, ME – Pickle
- TP 14, ME – Community Attendant Services
- TP 18, ME – Disabled Adult Child
- TP 21, ME – Disabled Widow(er)
- TP 22, ME – Early Aged Widow(er)
- TP 23, MC – SLMB
- TP 24, MC – QMB
- TP 26, MC – QI-1

The suspension is effective the day after receiving the date the report of confinement.

Provide a new reasonable opportunity period to submit documentation of citizenship or alien status if a person's original reasonable opportunity period expires during the suspension period. The new reasonable opportunity period is the earlier of:

- 95 days from the date the reinstatement is disposed; or
- the last day of their current certification period.

Keep the original reasonable opportunity period if the person's Medicaid coverage is reinstated before the reasonable opportunity period end date.

The TF0001, Notice of Case Action, generated at reinstatement will include the reasonable opportunity information to remind the person to submit documentation of citizenship or alien status.

Note: For couple cases, suspend Medicaid for the incarcerated person only. The spouse may continue to receive benefits, if eligible.

Reinstatement

Reinstate Medicaid that was suspended due to incarceration in a county jail within two business days of receiving notification from any source that a person has been released from a Texas county jail. To reinstate Medicaid:

- Perform individual inquiry to determine if the person has suspended Medicaid.
- If Medicaid is suspended, perform a County Jail Release - Search to determine if:
  - the person's Medicaid was suspended due to confinement; and
  - there are months remaining in their original certification period.
- If yes, create a Process a County Jail Confinement/Release task for all active cases where the person was included before suspension and enter the release information into TIERS on the **County Jail Release - Details** page.

Medicaid coverage is reinstated effective the date of the person's release from the county jail for the remaining months of the original certification period. Form TF0001 is generated to notify the person of the reinstatement.

Consider the report of release as a change report for all other types of assistance. Determine if the person needs to be added to the other types of assistance.

If the person's health care coverage terminated at confinement or the original certification period has ended, the person is not eligible for reinstatement. Send a Medicaid application to the person's last known address.

Termination

Terminate Medicaid within two business days of receiving a report of confinement for the following TOAs:

- TA 12, ME – State Group Home
- TP 10, ME – State Supported Living Center
- TP 15, ME – Non-State Group Home
- TP 16, ME – State Hospital
- TP 17, ME – Nursing Facility
- TP 25, MC – QDWI
- TP 87, ME – Medicaid Buy In

Medicaid is terminated effective the day after HHSC receives the notification.

Related Policy

People confined in a Public Institution, D-3800
Reasonable Opportunity to Provide Verification of Alien Immigration Status, D-8841

D-4000, Fiduciary Agents and Living Arrangement

D-4100, Fiduciary Agents

Body

Revision 09-4; Effective December 1, 2009

§358.327. Transactions Involving Agents.

(a) An action by a fiduciary agent is the same as an action by the person for whom the fiduciary agent acts.

(1) An asset held by a fiduciary agent for another person is not a countable asset to the fiduciary agent.

(2) An asset held by a fiduciary agent for another person is a countable asset to the person for whom the fiduciary agent acts, unless otherwise excludable.

(b) A person's resources are available if the resources are being managed by a legal guardian, representative payee, power of attorney, or fiduciary agent. If, however, a court denies a guardian or fiduciary agent access to the person's resources, the resources are not considered available to the person.

(1) If a person's guardianship papers do not show that a legal guardian is prohibited access, and if the court has not subsequently ruled a prohibition, the resources are considered available.

(2) A guardian's routine need to petition the court for permission to dispose of a person's resources is not a prohibition.

(3) When the court rules on a petition to dispose of a person's resources, resources are considered available only to the extent to which the court has made the resources available for the person's benefit.

D-4120 Transactions Involving Agents

Revision 15-4; Effective December 1, 2015

Agents act on the person's behalf to sign applications and redetermination packets. When a guardianship exists, only that person can act on the person's behalf to sign applications and redetermination forms.

Guardian of the estate. Under Section 1151.101 and 1151.151 of the Texas Estates Code, it is the duty of the guardian of the estate to take care of and manage the estate as a prudent person would manage the person's own property. The guardian of the estate collects all debts, rentals or claims due to the ward, enforces all obligations in favor of the ward, and brings and defends suits by or against the ward. Only the guardian of the estate can deal with resources.

Guardian of the person. Under Section 1151.051 of the Texas Estates Code, the guardian of the person has the:

- right to have physical possession of the ward;
- right to establish the ward's legal domicile;
- duty of care, control and protection of the ward;
- duty to provide the ward with clothing, food, medical care and shelter; and
- power to consent to medical, psychiatric and surgical treatment other than the in-patient psychiatric commitment of the ward.

For HHSC purposes, the guardian of the person can sign documents, represent the person at hearings, and deal with small amounts of money. The guardian of the person is like other authorized representatives in that they have the authority to protect the interests of the ward.

Under Section 1151.004 of the Texas Estates Code, a court may appoint the same person to be both guardian of the estate and guardian of the person. If there are two guardians, one of the estate and one of the person, then the eligibility specialist must examine the court orders establishing the guardianships to decide which is the most appropriate to represent the person with HHSC.

A person's resources are available to him if they are being managed by a legal guardian, representative payee, power of attorney or fiduciary agent. If, however, a court denies a guardian or agent access to the resources, HHSC does not consider the resources available to the person.

If a person's guardianship papers do not show that the legal guardian is prohibited access, and if a court has not subsequently ruled a prohibition, the person's resources are considered available. A guardian's routine need to petition the court for permission to dispose of a person's resources is not a prohibition. When the court rules on a petition to dispose of a person's resources, resources are considered available only to the extent to which the court has made them available for the person's benefit.

If a legal guardian exists, obtain a copy of the guardianship or power of attorney document. Identify a fiduciary relationship by the way in which a resource is styled. A bank account established in two names connected by "for" or "by" indicates a fiduciary relationship. Another indication is an account established in two names with the designation of "representative payee" next to one of the names, or an account with the designation "special."

D-4121 Examples

Revision 15-4; Effective December 1, 2015

- A person has resources valued at $1,300, which are being managed by his son. The son claims that as the power-of-attorney, he is the only one who has access to the funds.

  Because a power-of-attorney is given voluntarily, and management of the resources is with the person's consent and for his benefit, this person's resources are available to him.
- Another person's parents used their own funds to purchase a certificate of deposit (CD) for him. The CD was issued as "Person's Name, by Parents' Names, Joint Representative Payees."

  The CD is an available resource to this person, because the designation indicates that the parents are acting in a fiduciary capacity in controlling funds belonging to him, regardless of the fact that the parents paid the purchase price.
- A third person recently left the hospital and entered a long-term care facility. She is in a coma, and there are no known living relatives or friends. After the person had a stroke, her landlady looked through the person's papers and found a $600 term life insurance policy and a checkbook showing a balance of $3,840.65. The eligibility specialist verified the bank balance.

  Although court action to appoint a guardian would be necessary to allow disposal of the person's excess funds, the resources are available to her. Until a court judges the person to be incompetent and unable to handle her affairs, the eligibility specialist cannot assume that the court will prohibit an appointed guardian from disposing of any of the funds in the checking account. This person is ineligible because of excess resources.

D-4200, Living Arrangements

Body

Revision 09-4; Effective December 1, 2009

Whether or not a person is married or has children has some bearing on the treatment of income and resources in determining Medicaid eligibility, both in a community setting or an institutional setting.

If the living arrangement is in a community setting, deeming of income and resources affects the budget.

When the living arrangement is in an institutional setting, spousal impoverishment and dependant allowances may have a bearing on the budget. This chapter focuses on the community setting. Chapter J covers spousal impoverishment policy for institutional settings.

D-4210 Deeming

Revision 09-4; Effective December 1, 2009

When neither a person's spouse nor child is in an institutional setting, deeming from spouse-to-spouse or parent-to-child applies in household situations. Only those residing in the household are considered part of the household for deeming purposes.

Exceptions to deeming:

- A person is in an institutional setting, including receiving services through a Home and Community-Based Services waiver program.
- Spouse-to-spouse and parent-to-child deeming do not apply in situations where a family does not have a residence. For example, if a family lives in a car because they cannot afford shelter, neither spouse-to-spouse nor parent-to-child deeming would apply.
- A person is not a member of the household if he/she is absent from home for a period that is not a temporary absence (for example, confinement in a public institution). Consider absences due to active duty military assignments as temporary.
- If a child is born in an institution (for example, a hospital), the child is not a member of the household until the month after the month the child goes home.
- Deeming does not apply when either an eligible person or an ineligible spouse is in an institutional setting, even when sharing a room.

Deeming does apply in noninstitutional care situations (for example, adult foster care), if the eligible person is living with an ineligible spouse.

D-4211 Spouse

Revision 15-4; Effective December 1, 2015

For Medicaid purposes, whether two people are married governs whether:

- couple computation rules apply;
- spousal or parental deeming applies; and/or
- spousal impoverishment rules apply.

Note: Someone who is married cannot be a child for Medicaid purposes.

Accept a person's allegation that he or she is married unless:

- the person would otherwise be considered a child for Medicaid purposes;
- there is evidence to the contrary; or
- the allegation could be self-serving.

Normally, for Medicaid purposes, two people are married as of the first moment of the month. If a marital relationship ends by death, divorce or annulment in the same month it began, treat the marriage as if it had never existed. Otherwise, the termination of marriage is effective the month after the month of death, divorce or annulment.

In Texas, there are three ways to terminate a marriage:

- **Void marriages** — A determination that the marriage could not have existed because of one of the following legal impediments: the parties married within a prohibited degree of consanguinity (for example, nephew or niece), or at least one party has a previous marriage that has not been resolved. Void marriages do not require a lawsuit, and the marriage may be declared void in a collateral action (for example, contest of will). A legal marriage between parties never existed.
- **Annulments** — Also called voidable marriages. Grounds for annulment include, but are not limited to, marrying under the influence of drugs/alcohol, at least one party being incapacitated or the marriage being coerced. Annulments require court action, but under common law, an annulment is retroactive to the date of marriage.
- **Divorce** — Requires court action, and the marriage is dissolved effective the date of the divorce decree.

Persons with void marriages or who have obtained a court annulment of their marriages are treated as though they were always individuals. In the instance of a divorce, persons are considered married through the end of the calendar month in which the divorce is issued.

For spouse-to-spouse deeming purposes, consider the following in the budget:

- the eligible individual; and
- the spouse; or
- any of the couple's children (or children of either member of the couple).

D-4212 Child

Revision 09-4; Effective December 1, 2009

A child is someone who is neither married nor the head of a household, and is:

- under age 18; or
- under age 22 and a student.

Eligible child for deeming purposes. For deeming purposes, an eligible child is a natural or adopted child under age 18 who lives in a household with one or both parents, is not married and is eligible for Medicaid.

Deeming to such an eligible child no longer applies beginning the month following the month the child attains age 18.

A person attains a particular age on the day preceding the anniversary of his/her birth. Deeming applies in the month of attainment of age 18 regardless of whether an application filed that month is filed before or after the day of attainment.

Ineligible child for deeming purposes. For deeming purposes, an ineligible child must:

- be either a natural or adopted child of:
  - an eligible person or the eligible person's spouse; or
  - an ineligible parent or the ineligible parent's spouse;
- live in the same household with an eligible person;
- not be married; and
- be either:
  - under age 18; or
  - under age 22 and a student.

Verification and Documentation Guidelines

- Verify an eligible child's date of birth and document the file. Accept the allegation of an ineligible child's age, absent evidence to the contrary.
- Accept a person's statement that a parent-child relationship exists.
- If a child under age 18 alleges to have no earnings, accept the allegation of student status. If an **eligible or ineligible** child under age 18 (or a student child age 18 to 22) alleges student status and earnings, verify school attendance and document.
- Document an eligible child's income and verify when necessary following general income rules for an eligible person.
- If any ineligible children in the household have income, and the ineligible spouse or parent has income that is subject to deeming, verify and document the ineligible child's income. However, if the alleged income exceeds the amount of the ineligible child allocation (that is, no ineligible child allocation applies for that ineligible child), document the allegation, but do not verify the income unless the income would be subject to the student child earned income exclusion. Accept an allegation when any ineligible child living in the household has no income.

D-4213 Parent

Revision 09-4; Effective December 1, 2009

A parent whose income and resources are subject to deeming is one who lives in the same household with an eligible child and is:

- a natural or adoptive parent of the child; or
- the spouse of the natural or adoptive parent (“stepparent”) who lives in the same household as the natural or adoptive parent.

Deeming applies from a parent to a child when they live together in the same household, except in a Home and Community-Based Services waiver situation. Deem a parent's income and resources to an eligible child beginning the month:

- after the month the child comes home to live with the parent(s) (for example, the month following the month the child comes home from the hospital);
- of birth if a child is born in the parent's home;
- after the month of adoption (the month of adoption is the month the adoption becomes final); or
- after the month of a parent’s marriage (that is, when a natural or adoptive parent marries) or the month after the month a parent begins living in a “holding out” relationship.

Generally, the same deeming rules that apply to a parent also apply to the spouse of a parent (a stepparent).

Exceptions: Do not deem the income or resources of a stepparent living with an eligible child if the natural or adoptive parent:

- is deceased;
- is divorced from the stepparent; or
- has permanently left the household.

Treat any absence by a natural or adoptive parent as permanent unless it is considered a temporary absence, such as military duty.

For parent-to-child deeming purposes, consider the following in the budget:

- the eligible child;

- the eligible child's parent(s); and
- other children of the parents.

Note: A person whose parental rights have been terminated due to adoption no longer meets the definition of "parent" for Medicaid purposes. This remains true even if the adopted child later lives in the same household with the former parent.

Refer cases involving adopted Native American children who return to the household of a former parent to your regional attorney. The parent-child relationship in these cases is governed by tribal law and likely requires further legal interpretation.

D-5000, Citizenship and Identity

Body

Revision 21-3; Effective September 1, 2021

All U.S. citizens and nationals are entitled to apply for and receive Medicaid if they provide documentation of their citizenship and identity and meet all other eligibility requirements.

D-5100, Texas Administrative Code Rules

Body

Revision 09-4; Effective December 1, 2009

§358.203. Citizenship and Qualified Alien Status.

(a) In accordance with 42 CFR §435.406, to be eligible for a Medicaid-funded program for the elderly and people with disabilities (MEPD), a person must be:

(1) a citizen or national of the United States (U.S.);

(2) an alien who entered the U.S. before August 22, 1996, who has lived in the U.S. continuously since entry, and who meets the definition of a qualified alien at 8 U.S.C. §1641; or

(3) an alien who entered the U.S. on or after August 22, 1996, who has lived in the U.S. continuously since entry, and who meets the definition of a qualified alien at 8 U.S.C. §1641 with the eligibility limitations in 8 U.S.C. §1612 and §1613.

(b) A person must provide proof of eligibility under subsection (a) of this section that establishes both identity and citizenship or alien status, unless the person:

(1) receives Supplemental Security Income (SSI) or has ever received SSI and was not denied due to citizenship;

(2) is entitled to or enrolled in any part of Medicare, as determined by the Social Security Administration (SSA); or

(3) is entitled to federal disability benefits based on SSA disability criteria.

D-5200, Citizenship

Body

Revision 09-4; Effective December 1, 2009

An individual may become a U.S. citizen by birth or naturalization.

For Medicaid eligibility purposes, a person meets the citizenship requirement if he/she:

- was born in one of the 50 states, the District of Columbia, Puerto Rico, Guam, Virgin Islands of the U.S., American Samoa, Swains Island or the Northern Mariana Islands;
- was born to a U.S. citizen living abroad; or
- is a naturalized U.S. citizen.

The Immigration and Nationality Act of 1952 provides that a child of unknown parentage found in the U.S. while the child is under five years old is a citizen of the U.S. unless it is shown (before the child is 21) that the child was not born in the U.S.

Note: While all U.S. citizens are U.S. nationals, persons born in American Samoa or Swains Island are technically considered non-citizen U.S. nationals. For purposes of Medicaid eligibility, "citizenship" includes these non-citizen nationals when discussed in this section. A person born in the Independent State of Samoa (formerly known as Western Samoa) is **not** a U.S. national and therefore is **not** included in the discussion of citizenship in this section.

D-5210 Child Citizenship Act of 2000

Revision 13-4; Effective December 1, 2013

The Child Citizenship Act (CCA) of 2000 amended the Immigration and Nationality Act to provide derivative citizenship to certain foreign-born children of U.S. citizens. This applies to individuals who were under age 18 on Feb. 27, 2001, and anyone born since that date. Children included in the provisions of the CCA are:

- adopted children meeting the two-year custody requirement,
- orphans with a full and final adoption abroad or adoption finalized in the U.S.,
- biological or legitimated children, **or**
- certain children born out of wedlock to a mother who naturalizes.

The CCA provides that foreign-born children who meet the conditions below automatically acquire U.S. citizenship on the date the conditions are met. They are not required to apply for a certificate of naturalization or citizenship to prove U.S. citizenship. These conditions are that the child:

- has at least one parent who is a U.S. citizen (whether by birth or naturalization);
- is under age 18;
- has entered the U.S. as a legal immigrant;
- if adopted, has completed a full and final adoption; **and**
- lives in the legal and physical custody of the U.S. citizen parent in the U.S.

Adopted children automatically become U.S. citizens if they meet all of the above conditions and were:

- **adopted under the age of 16** and have been in the legal custody of and resided with the adopting parent or parents for at least two years;
- **adopted while under the age of 18**, have been in the legal custody of and resided with the adopting parent or parents for at least two years, and are siblings of another adopted child under age 16;
- **orphans adopted while under the age of 16** who have had their adoption and immigration status approved by U.S. Citizenship and Immigration Services (USCIS) (need not have lived with the adoptive parents for two years); or

- **orphans adopted under the age of 18** who have had their adoption and immigration status approved by USCIS and are siblings of another adopted child under age 16 (need not have lived with the adoptive parents for two years).

USCIS, under the Department of Homeland Security, is the federal agency formerly known as the Immigration and Naturalization Service (INS) that is responsible for citizenship and lawful immigration to the U.S.

D-5220 Compact of Free Association (COFA) Citizens

Revision 21-3; Effective September 1, 2021

The Compacts of Free Association (COFA) are agreements between the United States and three independent states:

- Republic of the Marshall Islands (RMI);
- Federated States of Micronesia (FSM); and
- Republic of Palau (PAL).

Under these agreements, COFA citizens have a special status with the U.S. which allows them to enter the country, work and acquire a Social Security number without obtaining an acceptable immigration status.

COFA citizens are considered qualified non-citizens and are exempt from the five-year waiting period and the seven-year limited period. They are eligible for full Medicaid if they meet all other eligibility requirements.

Acceptable verification of immigration status for COFA citizens includes:

- I-94 or I-766 with the following Class of Admission (COA) Codes:
  - CFA/RMI – Citizen of Republic of the Marshall Islands (RMI) due to the Compact of Free Association
  - CFA/FSM – Citizen of the Federated States of Micronesia (FSM)
  - CFA/PAL – Citizen of the Republic of Palau
- I-766 Employment Authorization Document (EAD) with the following Category Code:
  - A-08 Citizen of the Marshall Islands, Micronesia or Palau admitted as a nonimmigrant
- An unexpired passport with annotations “CFA/RMI,” “CFA/FSM” or “CFA/PAL.”

Related Policy

Qualified Aliens Not Subject to a Waiting Period or Limited Period, D-8320

D-5300, Acceptable Documentation of Citizenship and Identity

Body

Revision 13-2; Effective June 1, 2013

A person applying for or receiving Medicaid and declaring to be a U.S. citizen or national must provide evidence of citizenship. Documentation must establish both citizenship and identity.

The following primary evidence documents are acceptable as proof of both citizenship and identity:

- U.S. passport
- Certificate of Naturalization (N-550 or N-570)

- Certificate of U.S. Citizenship (N-560 or N-561)

If a person does not provide one of these primary evidence documents that establish both U.S. citizenship and identity, the person must provide one document that establishes:

- U.S. citizenship; and
- identity.

Levels of evidence of citizenship are documents that establish citizenship based on reliability of evidence. See Appendix V, Levels of Evidence of Citizenship and Acceptable Evidence of Identity Reference Guide. Begin with the second level and continue through the levels to explore the most reliable source of documentation of citizenship available. If a document from the second level is not used, include in the case record the reason why a more reliable source of documentation of citizenship is not available.

Example: If a hospital record of birth is used to document citizenship (third level), include in the case record a reason why a source from the second level is not used – "None of the second level of evidence of citizenship documents are available."

Note: When using the levels of evidence of citizenship, the same document cannot be the source to verify both citizenship and identity.

Example: If a person provides a birth certificate to verify citizenship, the person must provide a document other than a birth certificate to verify identity.

Note: Affidavits are to be used only as a last resort if the person is unable to provide any other documentary evidence of citizenship.

Criteria for acceptable affidavits:

- The person applying for or receiving Medicaid or the person's authorized representative must provide an affidavit explaining why documentary evidence does not exist or cannot be readily obtained.
- Two adults, regardless of the blood relationship to the person, must each complete an affidavit.
- The two adults must attest that they have proof of their own citizenship and identity. These adults are not required to submit proof of citizenship and identity.
- The two adults must provide any available information explaining why documentary evidence establishing the person's claim of citizenship does not exist or cannot be readily obtained.
- Affidavits must be signed under penalty of perjury.

Form H1097, Affidavit for Citizenship/Identity, incorporates the required criteria.

Documentation of citizenship and identity is a one-time activity. Once documentation of citizenship is established and documented in the case record, do not request again even after a break in eligibility. The documentation must be available and the case information must not be purged.

If the individual has a Social Security number (SSN), use Social Security Administration (SSA) records to verify citizenship by submitting a citizenship verification request via Wire Third-Party Query (WTPY). If the WPTY response indicates that citizenship is verified, no additional action is required. If the WTPY response indicates that citizenship is not verified and the individual is not exempt from providing verification of citizenship, allow the individual a WTPY Citizenship Resolution Period using policy in D-5320, Using Wire Third-Party Query (WTPY) to Verify Citizenship.

If the individual has applied for an SSN but has not been issued one and:

- additional information is required to determine eligibility, request the additional information and verification of citizenship. Allow the individual 10 days to provide proof; or

- no other information is required to determine eligibility, allow the individual a period of reasonable opportunity to provide the verification using policy in D-5500, Reasonable Opportunity. If a reasonable opportunity period has been provided, citizenship must be verified before certifying for Medicaid.

After allowing reasonable opportunity or a WTPY Citizenship Verification Resolution Period, if the applicant or recipient refuses or fails to provide proof, deny the individual until proof is provided.

If all applicants or recipients in the household refuse or fail to provide proof of citizenship, deny the Eligibility Determination Group (EDG).

Note: If a person declares U.S. citizenship but cannot provide documentation, do not certify the person for ME-A and D-Emergency.

D-5310 Exceptions to Documentation of Citizenship and Identity Requirement

Revision 13-1; Effective March 1, 2013

The following individuals are not required to provide evidence of identity and citizenship when they claim to be U.S. citizens or U.S. nationals **and** are:

- **active SSI recipients.**
- **denied SSI recipients.** If the State Data Exchange (SDX) contains the needed information to verify U.S. citizenship. Use SDX as a valid documentation source of both citizenship and identity when the denial is for any reason other than citizenship. SDX action code N13 is the denial code for citizenship.
- **determined to be entitled to or enrolled in Medicare Part A or B.** This includes persons determined disabled for Social Security benefits who are in the 24-month period before receiving Medicare.
- **receiving Social Security Disability Insurance (SSDI) benefits based on their own disability**.
- **in foster care and assisted under Title IV-B of the Social Security Act, and are beneficiaries of foster care maintenance or adoption assistance payments under Title IV-E of the Social Security Act.**

Note: Neither the ineligible spouse of a person applying for Medicaid nor a parent applying for a child are required to provide evidence of citizenship and identity.

D-5320 Using Wire Third-Party Query (WTPY) to Verify Citizenship

Revision 13-2; Effective June 1, 2013

If an applicant has an SSN, use WTPY to verify citizenship. WTPY will return a response indicating that citizenship is verified or not verified for the individual.

If the WTPY response comes back with Codes A or C indicating citizenship is verified, take no further action unless the response also comes back with an indication of death (Code C). If this occurs, treat the death information as a change.

If the WTPY response is returned with any other code indicating that citizenship is not verified and the individual is not exempt from providing verification (see D-5310, Exceptions to Documentation of Citizenship and Identity Requirement), take the following actions:

- Review the information entered into the WTPY request with the information provided by the applicant/recipient. If a typographical error is found, submit a new WTPY request with the correct information.
- If no typographical errors are found, contact the applicant/recipient by phone to ensure the information provided is accurate. If new information is provided, submit another WTPY request with the correct information. **Note:** Update the case record with the correct information.
- If unable to verify citizenship via WTPY, certify the individual. Allow a WTPY Citizenship Verification Resolution Period to give the individual additional time to provide verification of citizenship using sources found in D-5300, Acceptable Documentation of Citizenship and Identity. The WTPY Citizenship Verification Resolution Period begins with the date the TF0001, Notice of Case Action, is generated.
- Generate Form TF0001 to inform the individual of the WTPY Citizenship Verification Resolution Period. TF0001 informs the individual citizenship verification is needed and lists the names of each individual who must provide citizenship verification and the due date.

The day after the WTPY Citizenship Verification Resolution Period expires, TIERS will generate an alert that will create a task. Deny the individual if he/she has not provided citizenship verification.

Applicants requesting three months prior Medicaid coverage must provide citizenship verification before prior coverage can be provided.

If the applicant was denied and later reapplies:

- Do not allow another WTPY Citizenship Verification Resolution Period to clear discrepancy. This includes situations in which an individual only received a portion of the WTPY Citizenship Verification Resolution Period. **Examples:** The individual moved out of state before the end of the 95-day period or an individual was added to an existing case and the case has a review due before the end of the 95-day period.
- Allow a WTPY Citizenship Verification Resolution Period to provide verification of citizenship if the individual never received the WTPY Citizenship Verification Resolution Period.
- Do not allow a WTPY Citizenship Verification Resolution Period for individuals who already received reasonable opportunity to provide proof of citizenship.

D-5400, Notification

Body

Revision 09-4; Effective December 1, 2009

Notify a person applying for Medicaid about the requirement to provide proof of citizenship and identity. A person receiving Medicaid must also be notified at their next annual redetermination, if proof of citizenship and identity is not already in the case record.

Use Appendix XV, Notification to Provide Proof of Citizenship and Identity, to provide information about the requirement and some of the common acceptable sources of documentation of citizenship and identity.

Add a copy of Appendix XV to each application and redetermination packet. If documentation is already in the case record (for example, SOLQ/WTPY showing Medicare entitlement or enrollment), do not add a copy of Appendix XV to the application or redetermination packet.

D-5500, Reasonable Opportunity to Provide

Body

Revision 09-4; Effective December 1, 2009

Inform an applicant or recipient of the reasonable opportunity to provide documentation of citizenship and identity. The reasonable opportunity to provide is different for applicants and recipients. Case action will be different if the person indicates that acceptable documentation does not exist, as opposed to refusing to furnish the documentation.

D-5510 Initial Request at Time of Application

Revision 14-4; Effective December 1, 2014

Allow an applicant a reasonable opportunity to provide documentation. If the person makes a good faith effort to provide documentation of citizenship and is unable to locate or does not provide the documentation by the application due date, but meets all other eligibility criteria, do not deny the application based on the lack of documentation of citizenship. If the applicant meets all other eligibility factors except for verification of citizenship, do not delay certifying the application. Form TF0001, Notice of Case Action, instructs the applicant to submit documentation of citizenship within 95 days for each of the individuals listed on the form.

If the person refuses to provide documentation of citizenship within the 95 days, deny the application based on failure to furnish.

D-5520 Initial Request at Time of Redetermination

Revision 09-4; Effective December 1, 2009

Reminder: Because Medicare is one of the eligibility criterion for Medicare Savings Programs (MSP), documentation of citizenship is not required for MSP.

If proof of citizenship and identity is not in the case record at the time of redetermination, allow the Medicaid recipient a reasonable opportunity to provide documentation. If the person is making a good faith effort to provide documentation of citizenship and identity and is unable to locate or does not provide the documentation, do not deny eligibility based on the lack of documentation for citizenship or identity at this complete redetermination. Send a notice to the person upon completion of the redetermination informing the person that documentation must be provided by the next complete redetermination in order to continue receiving benefits.

If the person refuses to provide documentation of citizenship and identity, deny based on failure to furnish.

If a Medicaid recipient is denied for failing to provide proof of documentation of citizenship after a reasonable opportunity to provide is given, and the person later reapplies, consider the person as a new applicant when allowing a reasonable opportunity to provide documentation of citizenship and identity.

D-5600, Providing Assistance

Body

Revision 09-4; Effective December 1, 2009

If a person is unable to provide documentary evidence of citizenship and identity in a timely manner because of incapacity of mind or body or the lack of an authorized representative to assist, assist the person in obtaining documentary evidence of citizenship and identity by referring the person to appropriate entities.

The following is a nonexclusive list of entities that may be able to provide assistance:

- Department of Family and Protective Services, Adult Protective Services
- Legal Aid
- Social Security Administration
- 2-1-1

Dialing 2-1-1 will connect persons with community-based organizations that may be able to help.

For persons born out of state, some sources to obtain a birth certificate are:

- birthcertificate.com;
- vitalchek.com; and
- usbirthcertificate.net or its toll free number, 1-888-736-2692.

When assisting a person in providing documentary evidence of citizenship and identity, request available documents, regardless of the level of evidence. Ensure the case record comments address the situation.

D-6000, Social Security Number and Application for Other Benefits

Body

Revision 19-4; Effective December 1, 2019

HHSC requires an applicant to provide his/her Social Security number (SSN). An exception to this requirement is for treatment of an emergency medical condition.

HHSC requires an applicant to apply for and obtain, if eligible, all other benefits to which he/she may be entitled, with some exceptions.

D-6100, Texas Administrative Code Rules

Body

Revision 09-4; Effective December 1, 2009

§358.209. Social Security Number.

In accordance with 42 CFR §435.910, a person must give his or her social security number to the Texas Health and Human Services Commission as a condition of eligibility, except as provided in §358.205(c) of this subchapter (relating to Alien Status for Treatment of an Emergency Medical Condition).

§358.205. Alien Status for Treatment of an Emergency Medical Condition.

(c) An undocumented non-qualifying alien applying for Medicaid for the treatment of an emergency medical condition is exempt from providing proof of alien status or providing a Social Security number as described in 42 CFR §435.406(b).

§358.217. Application for Other Benefits.

To be eligible for a Medicaid-funded program for the elderly and people with disabilities, a person must apply for and obtain, if eligible, all other benefits to which the person may be entitled, in accordance with 42 U.S.C. §1382(e)(2).

D-6200, SSN Requirement

Body

Revision 14-2; Effective June 1, 2014

As a condition of eligibility, a person must furnish HHSC with his/her Social Security number (SSN). If the person is married, the person must also provide his/her spouse's SSN.

State office uses two tape exchanges with the Social Security Administration (SSA) to verify the person's SSN.

Sources for verification of an SSN are:

- SOLQ or WTPY;
- Social Security card; and
- verification of a Medicare number with suffix A, J1, M, S or T.

The applicant should be given a reasonable opportunity to provide an SSN.

D-6210 When a Person Does Not Have an SSN

Revision 11-4; Effective December 1, 2011

Explain to the person the necessity and the procedure for obtaining a Social Security number (SSN) if the person does not have one. Document the explanation in the case record.

Give the person or authorized representative notice that an SSN must be obtained by the first redetermination. This notice can be on the eligibility letter or on Form H1020, Request for Information or Action. The person must apply for and secure an SSN by the redetermination date.

Complete Form H1106, Enumeration Referral, which is found in the Texas Works (TW) Handbook. Upon receipt of Form H1106, the Social Security Administration (SSA) processes an SSN application.

If necessary, give SSA-5, Application for a Social Security Number, to the person and assist the person in completing the SSA-5. Inform the person to forward the SSA-5 to SSA with proof of his/her age, identity and citizenship (or lawful admission to the U.S.).

Grant eligibility at application, if otherwise eligible, pending receipt of an SSN. Tell the person to inform HHSC as soon as the SSN is received. Upon receipt, enter the SSN in the system of record.

At the first redetermination, verify that the person applied for an SSN if the person cannot provide an SSN. Failure of the person or authorized representative to follow through and secure an SSN is grounds for denial at the first redetermination. Document the circumstances of the denial in the case comments.

D-6300, Application for Other Benefits Requirement

Body

Revision 09-4; Effective December 1, 2009

Medicaid is intended to be a program of last resort. Therefore, it is important to assess the other benefits for which a person may be eligible based on the person's own activities or on indirect qualifications through family

circumstances.

If a person is not receiving potential benefits, notify the person in writing of the requirement to apply for and comply with the application requirements of the other benefit(s).

A person is not eligible for Medicaid if:

- HHSC informs the person on a written, dated notice of his/her potential eligibility for other benefits; and
- the person does not take all appropriate steps to apply for the benefit within 30 days of receipt of such notice.

The notice informs the person or authorized representative that the person must take all appropriate steps to pursue eligibility for other benefits within 30 days of receipt of such notice. Appropriate steps include:

- applying for the benefit; and
- providing the other benefit source with the necessary information to determine eligibility for the benefit.

D-6310 Other Benefits Subject to Application Requirement

Revision 09-4; Effective December 1, 2009

"Other benefits" includes any payments for which a person can apply that are available to that person on an ongoing or one-time basis of a type that includes annuities, pensions, retirement benefits or disability benefits, including:

- RSDI Title II benefits;
- veterans' pension and compensation payments;
- retirement benefits;
- workers' compensation payments;
- pensions; and
- unemployment insurance benefits.

These benefits are common in that they:

- require an application or similar action;
- have conditions for eligibility; and
- make payments on an ongoing or one-time basis.

See Section D-6340 through Section D-6380 for details regarding benefits subject to the application requirement.

D-6320 Other Benefits Exempt from Application Requirement

Revision 09-4; Effective December 1, 2009

"Other benefits" exempt from the requirement to apply for other benefits are:

- Temporary Assistance for Needy Families (TANF);
- general public assistance;
- Bureau of Indian Affairs general assistance;

- victims' compensation payments;
- other federal (other than SSI), state, local or private programs that make payments based on need; and
- earned income tax credits.

D-6330 Payments That Are Not Other Benefits

Revision 09-4; Effective December 1, 2009

"Other benefits" do **not** include:

- payments that a person may be eligible to receive from a fund established by a state to aid victims of crime; or
- payments such as child support, alimony and accelerated life insurance.

D-6340 Supplemental Security Income (SSI)

Revision 09-4; Effective December 1, 2009

If a person who has no income applies for Medicaid with HHSC, refer that person to the Social Security Administration (SSA) for SSI benefits. SSI eligibility will provide a greater benefit to the person by allowing the person to receive a cash benefit as well as Medicaid.

Exception: Process the application and do not refer a person who has no income to SSA for SSI if the application is for Medicaid coverage for:

- retroactive months for a deceased person or based on an SSI application; or
- treatment of an emergency medical condition.

D-6341 Reserved for Future Use

Revision 19-4; Effective December 1, 2019

D-6350 Veterans Benefits

Revision 09-4; Effective December 1, 2009

The most common types of benefits from the U.S. Department of Veterans Affairs (VA) are:

- pension;
- compensation;
- educational assistance;
- aid and attendance allowance;
- housebound allowance;
- clothing allowance;

- payment adjustment for unusual medical expenses;
- payments to Vietnam veterans' children with spina bifida; and
- insurance payments for disability insurance and life insurance.

Explore the possibility of receipt of, or potential eligibility for, a VA benefit when it appears that a person is:

- a veteran;
- the child or spouse of a disabled or deceased service person or veteran;
- an unmarried widow or widower of a deceased service person or veteran; or
- the parent of a service person or veteran who died before Jan. 1, 1957, from a service-connected cause.

A person who is potentially eligible for some VA benefits must apply for those benefits. When referring a person to the VA, recommend that the person call the VA first to obtain information on application requirements and proof the person may need to bring.

D-6351 VA Pension or Compensation

Revision 10-1; Effective March 1, 2010

Refer a person for VA pension payments (based on a nonservice-connected disability) if **all** of the following conditions are met:

- The veteran or deceased service member served at least 90 days, at least one of which was during a wartime period (see Section D-6352, VA Wartime Periods).
- The person being referred is a veteran, surviving spouse or surviving child.
- The person has not alleged, in a signed statement, having previously applied for the Department of Veterans Affairs Improved Pension Plan (VAIP).

Refer the person for VA compensation payments if the veteran or deceased service person suffered a service-connected disability (even though minor) or died.

Refer a person for VA payment increases for medical expenses. However, do not monitor for the person's compliance to apply for other benefits when it is to increase the VA payment for medical expenses. These VA payment increases for medical expenses are known as aid and attendance, housebound benefits or additional payments for unusual medical expenses and are considered exempt payments that do not affect eligibility or co-payment.

See the following references:

- Section E-1710, Medical Care and Services That are Not Income
- Section E-4315, VA Aid and Attendance and Housebound Payments
- Section B-8430, Special Reviews

Exceptions:

- Do not refer a person who has been eligible for a VA pension since before 1979.
- Do not refer a person who is receiving the $90 VA pension in an institutional setting.

See the following references:

- Section E-4311.1, 1979 VA Pension Plan
- Section E-4311.2, $90 VA Pension and Institutional Setting

D-6352 VA Wartime Periods

Revision 14-1; Effective March 1, 2014

The wartime periods are:

War	Time Periods
World War I	Apr 6, 1917 to Nov 11, 1918
World War II	Dec 7, 1941 to Dec 31, 1946
Korea	Jun 27, 1950 to Jan 31, 1955
Vietnam (served in the Republic of Vietnam)	Feb 28, 1961 to Aug 4, 1975
Vietnam (served other than in the Republic of Vietnam)	Aug 5, 1964 to May 7, 1975
(Persian) Gulf War	Aug 2, 1990 through a date to be set by law or presidential proclamation (per VA)
Operation Enduring Freedom (Afghanistan) and Operation Iraqi Freedom	2001 to present **Note:** This war period is not yet listed on the VA's website. Refer person to VA Benefit Counselor at 1-800-827-1000.

D-6353 VA Payments for Dependents

Revision 09-4; Effective December 1, 2009

The VA may take a dependent's needs into account in determining a pension. Usually, however, the VA does not make a pension payment directly to a dependent during the lifetime of the veteran. Instead, the amount of the veteran's basic pension is increased if the veteran has dependents.

Augmented VA payment — A VA pension payment that has been increased for dependents is an augmented VA payment. For Medicaid purposes, the augmented benefit includes a designated beneficiary's portion and one or more dependents' portions.

Apportioned VA payment — A VA compensation payment made directly to the dependent of a living veteran is an apportioned payment. Apportionment is direct payment of the dependent's portion of VA benefits to a dependent spouse or child. The VA decides whether and how much to pay by apportionment on a case-by-case basis. Apportionment reduces the amount of the augmented benefit payable to the veteran or veteran's surviving spouse.

D-6354 Requirement to Apply for Apportionment of Augmented VA Benefit

Revision 09-4; Effective December 1, 2009

To be eligible for Medicaid, a dependent of a veteran must apply for apportionment (direct payment) of an augmented VA benefit if the dependent specifically:

- is the spouse or child of a living veteran, or the child of a deceased veteran with a surviving spouse, and the veteran or surviving spouse receives VA compensation, pension or educational benefits;
- does not reside with the designated beneficiary (that is, the veteran or the veteran's surviving spouse); **and**
- has not been denied apportionment since living apart from the designated beneficiary.

Dependents who are receiving a VA benefit by apportionment do not receive automatic cost-of-living adjustments. Do not refer these individuals to the VA to request an increase.

D-6400, Treatment of Other Benefits

Body

D-6410 Deeming Situations

Revision 09-4; Effective December 1, 2009

Do not require a deemor to apply for other benefits. If a deemor applies for and receives other benefits on his/her own initiative, the amount of benefits he/she receives and/or retains is subject to the deeming policies for income and resources.

D-6420 Payment Options for Other Benefits

Revision 09-4; Effective December 1, 2009

Most of the types of benefits for which a person must apply offer choices about the method of payment. The person must apply for all other benefits payable at the earliest month and in the highest amount available based on the earliest month.

Note: Irrevocable choices and selections of benefits from pensions or retirement programs made before a person applies for Medicaid do not affect eligibility.

D-6421 Survivor's Benefits for Spouses and Other Dependents

Revision 09-4; Effective December 1, 2009

Certain pensions and retirement programs permit a person to elect survivor's benefits for dependents by electing a reduced retirement benefit. Inform the person that he/she must elect the higher current benefit to retain Medicaid eligibility. Election of the reduced retirement benefit will result in the loss of Medicaid eligibility until such time as the pension or retirement program election is changed or the option for change is no longer available.

Some pensions and retirement programs require a spouse to apply a waiver of rights to a survivor's benefit. The person is not penalized for failing to comply with the requirement to apply for other benefits if the reduced retirement benefit results from the spouse’s refusal to sign a waiver of rights to a survivor's benefit.

D-6422 Lump Sum or Annuity Payment Option

Revision 09-4; Effective December 1, 2009

If a person can choose between a lump sum or an annuity as the payment method for a benefit, inform the person that he/she must choose the **annuity** option**.**
Consider lump sum payments as follows:

- **Request for a Lump Sum Payment –** If an application has been made for a lump sum payment of the monies on which a potential annuity is based and the benefit source permits the person to change the decision and apply for the annuity, the person **must pursue the change** to be eligible for Medicaid. If the benefit source does not permit such a change, accept the person's word that the decision is irreversible, absent evidence to the contrary.
- **Retroactive RSDI Title II Benefit Lump Sum Payment –** Although filing for full retroactive RSDI Title II benefits may result in a lump sum payment, this payment represents the amount of the past due RSDI Title II benefits and is not a fund that determines future regular payments.
- **Lump Sum Only Payments –** Do not require a person to apply if only a lump sum payment is available. In this situation, the **payment** is a resource. (This does not include a lump sum death payment under RSDI Title II.) All sources of available support (unless otherwise excluded) are considered in determining eligibility. This is true even if current needs compel a person to sacrifice future pension benefits.

For a purchased annuity, see related policy in Chapter F, Resources, and Chapter I, Transfer of Assets.

D-6430 Electing the Month of Entitlement

Revision 09-4; Effective December 1, 2009

If a person can select the month in which benefits begin, whether retroactively or prospectively, direct the person to elect the earliest month benefits can begin, regardless of the impact on other benefits from that program. Election of a later month of entitlement to qualify for higher ongoing benefits or to protect benefits paid to other individuals is cause for denying Medicaid. Election of a later month will result in the loss of Medicaid eligibility until such time as the election is changed or the option for change is no longer available.

D-6440 Establishing Eligibility After Denial

Revision 09-4; Effective December 1, 2009

If denial has occurred because of failure to pursue other benefits, establish or reestablish eligibility when:

- the other benefit is no longer available, effective the month following the month the other benefit is no longer available; or
- the person takes the necessary steps to obtain the other benefit, effective the earliest **day** in a month that the person takes appropriate steps to obtain other benefit.

D-6500, Exceptions to the Application for Other Benefits Requirement

Body

Revision 09-4; Effective December 1, 2009

A person is eligible for Medicaid, despite failure to apply for other benefits within the 30-day period or to take other necessary steps to obtain other benefits, if there is good reason for not doing so. For example, there is good reason if:

- the person's guardian or authorized representative is unable to apply for other benefits because of illness; or
- it would be useless to apply because the person had previously applied and the other program has already turned the person down for reasons that have not changed.

According to Public Law 101-508, a person is not required to accept, as a condition of eligibility, payments that a state may make as compensation to victims of crime.

When applying for or receiving benefits under a Medicare Savings Program, a person is not required to apply for SSI benefits in order to be eligible for MSP coverage.

D-6600, When Not to Refer for Other Benefits

Body

Revision 09-4; Effective December 1, 2009

No Apparent Eligibility — If a person does not meet the basic eligibility requirements for a benefit:

- do not refer the person to apply for that benefit; and
- document the case record with the reason.

Prior Denial — If the person alleges having applied for other benefits previously and having been denied for reasons other than failure to pursue, accept the signed statement regarding the denial, unless there is evidence to the contrary.

Contributions Withdrawn — If a person alleges withdrawal of contributions from a public sector pension, accept the person's signed statement regarding the withdrawal unless:

- the employee was a teacher in a public college or university or was employed by a state or local police/fire department (and no precedent exists stating that, once funds are withdrawn, no benefits are payable); or
- there is evidence to the contrary (for example, prior knowledge indicates funds may not be withdrawn).

Application Pending — If a person alleges an application for another benefit is pending:

- send a verification letter to the benefit source; and
- set up a special review to monitor receipt of the benefit.

Consider the followingwhen assessing the possibility of other benefits a person may be eligible for:

- General identification:
  - Employer's name and address.
  - Name and telephone number of the person who can supply pension information.
- Pension plan:
  - Existence of a pension plan.
  - Statement as to whether or not employees contribute and, if they do, what happens to those contributions upon termination of employment for reasons other than retirement or disability.

  - Vesting requirements.
  - Pension plan provisions for survivors and/or dependents (including divorced spouses).
- Union:
  - Whether or not there is a union.
  - If so, whether the union provides a pension.
  - Name, address and local telephone number of the union.
  - Conditions to qualify for the pension.
  - Union contact for additional information on the pension (including the telephone number).
- Any other pertinent information, such as the date pension information was obtained and recorded.

D-7000, Third-Party Resources

D-7100, Texas Administrative Code Rules

Body

Revision 09-4; Effective December 1, 2009

§358.219. Third-party Resources.

(a) Medicaid is considered the payor of last resort for a person's medical expenses. As a condition of eligibility, in accordance with 42 CFR §§433.138 - 433.148, an applicant or recipient must:

(1) assign to the Texas Health and Human Services Commission (HHSC) the applicant's or recipient's right to recover any third-party resources available for payment of medical expenses covered under the Texas State Plan for Medical Assistance; and

(2) report to HHSC any third-party resource within 60 days after learning about the third-party resource.

(b) If HHSC determines that a person's employer-based health insurance is cost-effective, the person must participate in HHSC's Health Insurance Premium Payment program as a condition of eligibility. HHSC denies eligibility to a person who voluntarily drops his or her employer-based health insurance or fails to provide HHSC with the information needed to determine cost effectiveness.

D-7200, Cooperation and Assignment of Rights for Medicaid Eligibility

Body

Revision 09-4; Effective December 1, 2009

Texas requires, as conditions of Medicaid eligibility, that a person must:

- cooperate in providing any third-party resource (TPR) information to HHSC; and
- agree to the assignment of rights (AOR) of any TPR benefits to HHSC.

Medicaid is usually the payer of last resort. A TPR is a source of payment for medical expenses other than the person, HHSC or Medicaid. A TPR must be applied toward the person's medical and health expenses.

Under state law, an applicant or recipient of Medicaid automatically gives HHSC his/her right to financial recovery from personal health insurance, other recovery sources or personal injuries, to the extent HHSC has paid for medical services. This allows HHSC to recover the costs of medical services paid by the Medicaid

program. Any applicant or recipient who knowingly withholds information regarding any sources of payment for medical services violates state law.

Fraud Referrals — Medicaid recipients must report any TPR within 60 days of learning about the coverage or liability. An applicant or recipient who knowingly withholds information regarding any sources of payment for medical services violates state law.

Refer the person for fraud, if the person:

- fails to report any TPR coverage or liability within 60 days; or
- does not reimburse HHSC when a third-party payment for medical services is received and the expenditure is $100 or more.

Denial — Deny the person if the person refuses to:

- cooperate in providing TPR information; or
- agree to the AOR of TPR benefits to HHSC.

See Appendix XVI, Documentation and Verification Guide.

D-7300, Potential Sources of Third-Party Coverage

Body

Revision 18-1; Effective March 1, 2018

TPRs include:

- health insurance;
- group health plans;
- government health insurance;
- liability or casualty insurance and court settlements; and
- long-term care insurance policies.

A TPR is any individual, entity or program, including health insurance, that is or may be legally liable to pay all or part of the costs for medical assistance before money from the Medicaid program is spent.

D–7310 Examples of Third-Party Resources

Revision 18-1; Effective March 1, 2018

Examples of TPRs include, but are not limited to, the following:

- health insurance;
- self-insured plans;
- group health plans;
- service benefit plans;
- employer, private purchase; and
    - union membership-based health insurance;
    - sheltered workshops;
    - continuation of health insurance coverage under statute (COBRA continuation);

  - and coverage available from an employer under the Employee Retirement Income Security Act (ERISA);
- medical support derived from noncustodial parents;
- armed forces and the public health service;
- pending lawsuits or no-fault clauses or state laws covering accidents, product liability and workers' compensation;
- employee conversion/extension rights;
- fraternal and benefit societies and churches and church groups;
- Insurance purchased or endowed as part of a college fee;
- membership in a health maintenance organization (except for those with a contract under Medicare/Medicaid);
- pharmacy other insurance;
- worker's compensation;
- government health insurance;
- liability or casualty insurance and court settlements;
- insurance (including automobile, homeowners and medical malpractice);
- indemnity plans (if review of the plan determines that the policy provides for payment of health care items or services, including policies that pay a cash benefit to the policyholder if the payment is conditional upon the occurrence of a medical event);
- long-term care insurance policies;
- any other parties that are, by statute, contract, or agreement legally responsible for paying a claim for a health care item or service; and
- Medicare.

Liability or casualty insurance and court settlements — Accidental injuries may result in third parties being liable for medical expenses. The usual sources of payment for medical expenses in these situations are automobile insurance; homeowners insurance; owners', landlords' and tenants' insurance; workers' compensation and lawsuit settlements.

Individual or group health insurance — Health insurance policies include individual or group contracts and commercial hospital, medical and surgical policies. A recipient may have medical insurance coverage from current employment, residual coverage from previous employment or private insurance paid for by the recipient or a relative. A recipient's relative may have personal or group insurance that covers the recipient's medical expenses.

TRICARE, formerly known as CHAMPUS, is a health insurance plan available to dependent children and spouses of active, retired and deceased military services personnel.

Parts A and B of Medicare provide a TPR for Medicaid recipients entitled to Medicare.

D-7400, Use of Third-Party Resources

Body

Revision 20-4; Effective December 1, 2020

There are two methods of Third-Party Recovery (TPR):

- cost avoidance, in which available third-party benefits are applied before Medicaid payment is made. This is the method of Third-Party Recovery required by the Centers for Medicare and Medicaid Services (CMS); and
- post-payment recovery, where Medicaid pays the medical costs before seeking reimbursement. This method is typically used when Medicaid is unaware of the TPR at the time of billing or the TPR is not eligible for use at the time of billing (e.g., a trust or annuity).

HHSC uses the cost avoidance method of TPR for Medicaid payments to nursing facilities (NF), hospice providers, and non-state intermediate care facilities for persons with intellectual disabilities (ICF/IID). The cost avoidance method requires providers to bill the recipient's long-term care insurance (if applicable) before billing Medicaid. This ensures that Medicaid is the payer of last resort.

A Medicaid recipient must reimburse HHSC as soon as they receive a third-party payment for medical services already paid by Medicaid.

A provider who receives a third-party payment for medical services already paid by Medicaid must process an adjustment claim and report the third-party payment amount on the claim. The Medicaid paid claim is reduced by the amount of the other insurance payment reported on the adjustment claim.

Providers can contact Texas Medicaid and Healthcare Partnership (TMHP) for assistance with adjustment claims at 800-626-4117, option 3.

Providers may contact TMHP at 800-626-4117, option 6 to report other insurance coverage for a Medicaid recipient.

D–7410 Cost Avoidance

Revision 18-1; Effective March 1, 2018

Inform the person to:

- use health insurance as a resource;
- tell medical providers that the person has insurance coverage; and
- show providers any insurance identification card the person may have.

If the person, the employer or other sources indicate that ...	then complete ...
Medicaid-eligible household members have private health insurance coverage,	information about the private health insurance on: • the TPR screen in TIERS. This screen will interface with the TMHP TPR Unit. • report any changes in insurance coverage for existing recipients via the TPR screen in TIERS.
health insurance coverage is available for Medicaid-eligible household members, but the members are not enrolled in the health insurance plan,	information about the available health insurance on: • the TPR screen in TIERS. This screen will interface with the TMHP TPR Unit. The TMHP TPR Unit will use the information to initiate an inquiry about Health Insurance Premium Payment (HIPP) program eligibility.

To contact the TPR Unit with questions or problems concerning TPR:

- HHSC staff may email MCD_Third_Party@hhsc.state.tx.us.
- Medicaid recipients and providers may call the Medicaid TPR Hotline at 800-846-7307, option 2.

HIPP Program Notes: Individuals approved for the HIPP Program receive reimbursement for the employee's portion of an employer-sponsored health insurance premium payment. For eligibility and co-payment

calculations, HIPP reimbursement checks are not considered income. For co-payment calculations, the reimbursed health insurance premium payment is not considered an incurred medical expense.

TMHP will take action to deny all benefits to a recipient who voluntarily drops his or her health insurance coverage or fails to provide TMHP with the information needed to determine cost effectiveness.

A recipient cannot appeal decisions made by TMHP. To obtain assistance in resolving problems or issues concerning HIPP, contact the TPR HIPP Unit at 800-440-0493.

For more information about the HIPP program, see HHS' HIPP website: https://hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program.

Recipients may also call 800-440-0493 for more information.

D–7420 Post-Payment Recovery

Revision 18-1; Effective March 1, 2018

Major sources for post-payment recovery are liability or casualty insurance and court settlements resulting from accidental injuries. If a recipient reports an injury that requires medical treatment for which liability or casualty insurance may provide payment, ask the recipient to provide the date of the accident.

Report the recipient's name, Medicaid number, and date of the accident to the HHSC TPR Unit and Provider Recoupment and Holds.

Third Party Recovery

HHSC OIG/TPR Unit
Mail Code 1354
4900 North Lamar Blvd.
Austin, TX 78751

Information can be sent via email to:

MCD_Third_Party@hhsc.state.tx.us; and

Provider Recoupments and Holds

Texas Health and Human Services Commission
Mail Code W-406
P.O. Box 149030
Austin, TX 78714-9030
701 W. 51st Street
Austin, TX 78751

When the TPR Unit at HHSC becomes aware of accidental injuries, it will seek cost recovery from recipients who receive a health insurance or settlement payment for medical services already paid by Medicaid.

Use Form H1210, Subrogation (Trusts/Annuities/Court Settlements), to report to Provider Claims any potential subrogation funds available from trusts, annuities and court settlements.

When a recipient reimburses HHSC for medical expenses, the reimbursement should be in the form of a personal check, cashier's check or money order. If reimbursement is received from a recipient, follow these

steps:

Step	Procedure
1	Give the recipient Form H4100, Money Receipt.
2	Enter the types and dates of the medical services in the "For" section of Form H4100.
3	If unsure about which medical services are involved, attach a memorandum giving as much information as possible about the reimbursement.
4	Attach a copy of any other information identifying the nature of the payment, such as a statement from the insurance company.
5	Send the reimbursement, a copy of Form H4100, and other information, if any, to HHSC Accounts Receivable, P.O. Box 149055, Mail Code 1470, Austin, TX 78714-9055.

State office verifies the actual claims paid by Medicaid and refunds any overpayment.

D-7500, Third-Party Resources for SSI Recipients

Body

Revision 18-1; Effective March 1, 2018

Because the Social Security Administration (SSA) determines eligibility for Supplemental Security Income (SSI) recipients, Medicaid eligibility specialists are not routinely involved in TPR information from these individuals. Instead, at the time an SSI recipient is certified for Medicaid and annually thereafter, the state office generates a letter to the recipient requesting information about any insurance coverage they may have. The recipient completes the insurance questionnaire enclosed with the letter and returns it in the envelope provided for that purpose directly to:

Texas Medicaid and Healthcare Partnership (TMHP)
Third Party Resources Unit
P.O. Box 202948
Austin, TX 78720-2948

TMHP enters data from the returned insurance questionnaire into the TPR system. TMHP also maintains a toll-free number (800-846-7307, option 2) that SSI recipients may use to ask questions about the form or about their health insurance.

SSA also reports TPR information for SSI recipients to HHSC. An SSI recipient who refuses to cooperate with HHSC in verifying TPR is ineligible for Medicaid.

Occasionally, an SSI recipient may ask for an explanation or help completing the insurance questionnaire. Explain the purpose of the form and the proper use of available TPRs and help the recipient complete and submit the form, if necessary. If an SSI recipient asks about a change in insurance coverage or about the availability of TPRs related to accidental injury, have the recipient report this information to the TPR Unit at 800-846-7307, option 2 or:

Texas Medicaid and Healthcare Partnership
Third Party Resources Unit
P.O. Box 202948
Austin, TX 78720-2948

D–7510 Social Security Administration (SSA) Role and Supplemental Security Income (SSI) Recipients

Revision 09-4; Effective December 1, 2009

In Texas, SSA must inform SSI applicants and recipients and SSI recipients who move to Texas about the requirement under Section D-7200, Cooperation and Assignment of Rights for Medicaid Eligibility.

D-7600, Long-Term Care Insurance Policies

Body

Revision 17-1; Effective March 1, 2017

Long-term care insurance policies pay for nursing facility care. The policies purchased by individuals specify the benefits covered. Long-term care insurance policies do not affect Medicaid eligibility. For individuals who have such policies, report the policies as a third-party resource (TPR), using Form H1039, Medical Insurance Input.

As of March 1, 2015, HHSC Provider Recoupment and Holds cannot accept other insurance payments for individuals when a managed care organization (MCO) pays the nursing facility claims. Nursing facility providers must contact the appropriate MCO for claims submitted on Medicaid eligible individuals enrolled in MCOs on or after March 1, 2015 with service dates on or after March 1, 2015.

For questions about other insurance on Fee-for-Service (FFS) claims or for claims submitted prior to March 1, 2015, contact HHSC Provider Claims Services at 512-438-2200, Option 4.

Send long-term care insurance checks to Provider Claims Services at the Texas Health and Human Services Commission. The payment of large sums from long-term care insurance companies may affect an individuals' resource eligibility if Provider Claims Services provides a refund.

Procedure for TPR checks received for long-term care insurance coverage on FFS claims:

- give the recipient Form H4100, Money Receipt, correctly documented; and
- send the check, a copy of Form H4100 and other information to:

Provider Recoupments and Holds, W-406
P.O. Box 149081
Austin, TX 78714-9081

The policy and procedures in this section do not apply to Long-Term Care Partnership (LTCP) qualified policies. Information for LTCP qualified policies is located in Chapter P, Long-Term Care Partnership (LTCP) Program.

D-7700, Health Insurance Premium Payment Reimbursement Program

Body

Revision 18-1; Effective March 1, 2018

The HIPP program is a Medicaid benefit that helps families pay for employer-sponsored health insurance.

To qualify for HIPP, an employee must either be Medicaid eligible or have a family member who is Medicaid eligible. The HIPP program may pay for individuals and their family members who receive, or have access to, employer-sponsored health insurance benefits when it is determined that the cost of insurance premiums is less than the cost of projected Medicaid expenditures.

Note: An employee and the employee's Medicaid-eligible family member must be enrolled in the employer-sponsored health insurance in order to receive HIPP reimbursements.

Medicaid-eligible HIPP enrollees do not have to pay out-of-pocket deductibles, co-payments, or co-insurance for health care services that Medicaid covers when seeing a provider that accepts Medicaid. Instead, Medicaid reimburses providers for these expenses.

HIPP enrollees who are not Medicaid eligible must pay deductibles, co-payments, and co-insurance required under the employer's group health insurance policy.

Report individuals who are potentially eligible for HIPP on Form H1039, Medical Insurance Input. Send Form H1039 to HHSC's Third Party Resource (TPR) Unit, Mail Code 1354, or send via email to: MCD_Third_Party@hhsc.state.tx.us.

For the Medicaid Buy-In for Children (MBIC) program, when employer-sponsored insurance is entered into the Texas Integrated Eligibility Redesign System (TIERS), this information is automatically sent to HIPP. HIPP eligibility does impact the MBIC premium amount. See Section N-7400, Premium Amounts.

HHSC's TPR Unit refers Form H1039 to the current state Medicaid contractor, TMHP. If TMHP determines it is cost-effective for Medicaid to pay the individual's employer-sponsored health insurance premiums, then TMHP sends:

- a letter to the individual and requests verification of the employer-sponsored insurance plan and premium payments; and
- a premium reimbursement to the individual upon receipt of complete documentation and proof of the premium payment.

Note: Because an employer-sponsored health insurance premium deduction has already been counted as part of the recipient's income, a HIPP reimbursement check sent to recipients by TMHP is not income. Do not consider an incurred medical deduction for the reimbursed premium as income for recipients participating in HIPP.

TMHP will terminate HIPP enrollment if the individual is no longer enrolled in health insurance coverage or fails to provide TMHP with the information needed to determine cost effectiveness or proof of premium payments.

For more information about the HHSC's HIPP program, see HHSC's website: https://hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program, or contact the Medicaid HIPP program at MCD_HIPP_Program@hhsc.state.tx.us.

Individuals may call 800-440-0493 for more information. Individuals may also visit the HIPP website at https://hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program.

D-7800, Medicaid Estate Recovery Program

Body

Revision 18-1; Effective March 1, 2018

Another post-payment resource is through the MERP. On March 1, 2005, Texas implemented MERP in compliance with federal Medicaid and state laws. The program is managed by HHSC. Under this program,

HHSC may file a claim against the estate of a deceased Medicaid recipient who: 1) was age 55 or older at the time Medicaid services were received; and 2) initially applied for certain long-term care services and supports on or after March 1, 2005. The most complete, current and accurate source of information regarding MERP is the HHS website, Medicaid Estate Recovery Program.

Long-term care services and supports that are subject to MERP include:

- nursing facility services;
- intermediate care facilities for individuals with an intellectual disability or related conditions (ICF/IID) services, which include state supported living centers;
- Medicaid waiver programs, such as:
  - Community Living Assistance and Support Services (CLASS);
  - Deaf Blind with Multiple Disabilities (DBMD);
  - Home and Community-based Services (HCS);
  - Texas Home Living Program (TxHmL); and
  - STAR+PLUS Waiver (SPW);
- Community Attendant Services (CAS); and
- related hospital and prescription drug services.

Notes:

- A person who is placed on an interest list for a Medicaid waiver program is not considered to have applied.
- If a person, aged 55 or older, was eligible for Medicaid or received other Medicaid-paid benefits, such as QMB, SLMB or QI-1, before March 1, 2005, but did not initially apply for or transfer to one of the types of long-term care services and supports subject to MERP until March 1, 2005, or after, the person's estate is subject to recovery of the cost of certain long-term care services and supports received after March 1, 2005.

The acceptance of Medicaid assistance for the covered long-term care services provides a basis for a Class 7 probate claim. (This means there are six other classes of claims that receive priority in payment from the estate before Texas gets paid.) HHSC files a MERP claim in probate court against the estate of a deceased Medicaid recipient to recover the cost of certain Medicaid long-term care services and supports received by the Medicaid recipients. MERP will follow claims procedures specified in the Texas Estates Code and HHSC's Medicaid Estate Recovery Program rules found at 1 TAC, Part 15, Chapter 373.

For notification requirements, see Section B-2620, HHSC MERP Notification Requirements.

D-8000, Alien Status

D-8100, Texas Administrative Code Rules

Body

Revision 09-4; Effective December 1, 2009

§358.203. Citizenship and Qualified Alien Status.

(a) In accordance with 42 CFR §435.406, to be eligible for a Medicaid-funded program for the elderly and people with disabilities (MEPD), a person must be:

(1) a citizen or national of the United States (U.S.);

(2) an alien who entered the U.S. before August 22, 1996, who has lived in the U.S. continuously since entry, and who meets the definition of a qualified alien at 8 U.S.C. §1641; or

(3) an alien who entered the U.S. on or after August 22, 1996, who has lived in the U.S. continuously since entry, and who meets the definition of a qualified alien at 8 U.S.C. §1641 with the eligibility limitations in 8 U.S.C. §1612 and §1613.

(b) A person must provide proof of eligibility under subsection (a) of this section that establishes both identity and citizenship or alien status, unless the person:

(1) receives Supplemental Security Income (SSI) or has ever received SSI and was not denied due to citizenship;

(2) is entitled to or enrolled in any part of Medicare, as determined by the Social Security Administration (SSA); or

(3) is entitled to federal disability benefits based on SSA disability criteria.

§358.205. Alien Status for Treatment of an Emergency Medical Condition.

(a) Title XIX of the Social Security Act (42 U.S.C. §1396 et seq.) and 42 CFR §440.255 require the state to provide Medicaid for the treatment of an emergency medical condition to an alien who is ineligible for regular Medicaid due to immigration status. The Texas Health and Human Services Commission administers the program in Texas.

(b) To qualify for Medicaid for the treatment of an emergency medical condition, an alien must:

(1) be:

(A) a qualified alien as defined in 8 U.S.C. §1641 and not meet the requirements to receive Medicaid as described in 8 U.S.C. §1612 and §1613; or

(B) an undocumented non-qualifying alien as described in 8 U.S.C. §1611;

(2) be otherwise eligible for regular Medicaid services; and

(3) require treatment of an emergency medical condition as described in 42 CFR §440.255.

(c) An undocumented non-qualifying alien applying for Medicaid for the treatment of an emergency medical condition is exempt from providing proof of alien status or providing a Social Security number as described in 42 CFR §435.406(b).

D-8200, Authorized Alien Status

Body

Revision 09-4; Effective December 1, 2009

To lawfully remain in the U.S., a person who is not a U.S. citizen or a U.S. national and is present in the U.S. must have authorization from the Department of Homeland Security (DHS).

D-8210 United States Citizenship and Immigration Services (USCIS) Documents

Revision 21-3; Effective September 1, 2021

Commuter I-551 — An Alien Registration Receipt Card (Type 2) issued to an alien who has been granted Lawful Permanent Resident (LPR) status but lives in Mexico or Canada and commutes to the U.S. to work. The second digit of the ISS/T field identifies the type of card.

Grommeted I-151 — The Alien Registration Receipt Card with a grommet (a hole surrounded by a metal ring), in the upper right corner. This card was previously issued by INS to an alien who had LPR status but lived in Mexico or Canada and commuted to the U.S. to work.

I-94 — The Arrival/Departure Record issued by DHS to all documented nonimmigrants (students, visitors, parolees, refugees and Cuban/Haitian entrants).

I-151 — The version of the Alien Registration Receipt Card issued by the Immigration and Naturalization Service (INS) to aliens from July 1946 through late 1978.

I-551 — The current version of the Alien Registration Receipt Card (Type 1). INS (now DHS) began issuing this card in 1978 to immigrants who have been granted LPR status and are residing in the U.S. The second digit of the ISS/T field identifies the type of card.

I-688 — A temporary resident card that was laminated and issued by INS to legalized aliens and Special Agricultural Workers (SAWs) whose status had been adjusted to lawful temporary resident (LTR). In certain cases, INS placed a label (I-688EXT) on the back of the card to use until the I-551 was issued. This is not a current immigration form and DHS is no longer issuing this document. Currently, there are no valid I-688 cards (or I-688 cards with extension stickers).

I-688A — An employment authorization card issued by INS to legalize SAW applicants who filed an application to adjust their status to LTR. This is not a current immigration form and DHS no longer issues this document. Currently, there are no valid I-688A cards.

I-688B — The employment authorization document that was a laminated card given by DHS to newly admitted nonimmigrants or those with previous employment authorization who needed an extension. The I-688B replaced the “employment authorization” annotation previously placed on other DHS documents. This is not a current immigration form and DHS is no longer issues this document. Currently, there are no valid I-688B cards.

I-688EXT — Form I-688 with an extended period of validity of the Temporary Resident Card. In certain situations, INS placed a sticker on the back of the card. This served as temporary evidence of permanent residence until the alien received an I-551. This is not a current immigration form and DHS no longer issues this document. Currently, there are no valid I-688 cards or I-688 cards with extension stickers.

I-766 — Employment Authorization Document. Currently, the I-766 is the only valid document verifying employment authorization. This form replaced all other employment authorization documents issued previously.

Passport — A travel document issued by a competent authority showing the bearer's origin, identity and nationality, if any, that is valid for the entry of the bearer into a foreign country.

Temporary I-551 — The card issued to either an immigrant who has just been granted a lawful status or to an immigrant who has lost his Alien Registration Receipt Card and has applied for a replacement I-551.

Visa — A document issued by U.S. embassies and consulates in foreign countries that is a permit for a foreign national to proceed to a U.S. port of entry to apply to DHS for admission to the U.S. The DHS immigration

office at the port of entry decides the conditions (that is, category of admission and length of stay in the U.S.) based on the visa category.

D-8220 Groups of Aliens

Revision 17-4; Effective December 1, 2017

For Medicaid eligibility purposes, an alien is any person who is not a natural-born or naturalized citizen or national of the U.S.

Effective Aug. 22, 1996, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) limited an alien's eligibility for Medicaid.

Most aliens must meet two requirements to be eligible for full Medicaid and/or a Medicare Savings Program (MSP):

- the noncitizen must be in a "qualified alien" category (see Section D-8300, Qualified Alien Categories); **and**
- meet an LAPR condition for qualified aliens (see Section D-8400, LAPR Conditions for Medicaid).

Generally, aliens are now referred to as:

- qualified aliens; or
- non-qualified aliens.

Qualified aliens are potentially eligible for ongoing full Medicaid benefits and/or MSP. Non-qualified aliens are not eligible for ongoing Medicaid coverage however, may qualify for limited Medicaid eligibility for the treatment of an emergency medical condition only.

Except when it involves undocumented aliens, use the Systematic Alien Verification for Entitlements (SAVE) Verification Information System (VIS) to verify the alien status on all noncitizens.

D-8221 Date of Qualifying Classification

Revision 19-4; Effective December 1, 2019

Use SAVE VIS to verify the alien status of all documented non-citizens. If a person is undocumented, do not run SAVE.

A qualified alien's eligibility is based on the:

- date of entry with a qualifying classification;
- alien's qualifying classification; and
- Medicaid application date.

Use the date of entry into the U.S. and, if different, the date of entry with a qualifying alien classification to determine the correct category for the qualified alien.

The date on the alien's Department of Homeland Security (DHS) document or card often represents the alien's first date of entry into the U.S.

In some cases, an alien may be present in the U.S. without a qualifying classification, depart, and then return to the U.S. with a qualifying alien classification. Other aliens may have entered the U.S. without a qualifying alien classification and remained continuously present in the U.S. until obtaining qualified immigrant status. For these aliens, the date on their DHS document or card reflects the date of entry with a qualifying alien classification or the date the qualifying alien classification was granted, not the alien's original date of entry.

Allow aliens with a DHS document or card showing an entry date on or after Aug. 22, 1996, who claim to have entered before that date, an opportunity to submit evidence of their claimed date of entry. This evidence may include pay stubs, a letter from an employer, or a lease or utility bill in the alien's name.

Verifying continuous presence

DHS maintains a record of arrivals to and departures from the country for most legal entrants. This record may be used to establish that an alien has continually resided in the U. S. since before Aug. 22, 1996.

Verify via SAVE with DHS-USCIS to confirm continuous presence in the U.S. Any single absence from the U.S. of more than 30 days, or a combined absence of more than 90 days, is considered to interrupt "continuous presence."

Other entrants, including aliens who entered the U.S. without USCIS documents, must provide documentary evidence proving continuous presence, such as a letter from an employer, a series of pay stubs or utility bills in the alien's name, spanning the time in question.

Note: Once an alien obtains a qualifying alien status, the person does not have to continuously remain present in the U.S.

Related Policy

Documentation and Verification Guide, Appendix XVI
Initial Request at Time of Application, D-5510
Verification of Alien Status, D-8700
Documentary Evidence by Classification, D-8710
Secondary Verification of Alien Immigration Status, D-8840
Reasonable Opportunity to Provide Verification of Alien Immigration Status, D-8841
Entry Before 1996, D-8910
Entry on or After Aug. 22, 1996-Qualifed Alien No Waiting Period, D-8920
LPR Aliens With or Without Five-Year Waiting Period, D-8930

D-8222 Reserved for Future Use

Revision 17-4; Effective December 1, 2017

D-8300, Qualified Alien Categories

Body

Revision 17-4; Effective December 1, 2017

MEPD provides full Medicaid and/or MSP to qualified aliens whose eligibility is mandatory under federal requirements. Mandatory qualified aliens fall into three categories. Refer to the following sections for information about the three categories of qualified aliens potentially eligible for full Medicaid and/or MSP:

- Section D-8310, Qualified Aliens Subject to a Seven-Year Limited Period
- Section D-8320, Qualified Aliens Not Subject to a Waiting Period or Limited Period
- Section D-8330, Qualified Aliens with a Five-Year Waiting Period

D-8310 Qualified Aliens Subject to a Seven-Year Limited Period

Revision 14-4; Effective December 1, 2014

The following qualified aliens are immediately eligible for full Medicaid and/or MSP benefits, provided they meet other program requirements, but are limited to seven years of eligibility:

- Refugees under Section 207 of the Immigration and Nationality Act (INA).
- Asylees under Section 208 of the INA.
- Aliens whose deportation is being withheld under Section 243(h) of the INA or whose removal has been withheld under Section 241(b)(3) of the INA.
- Cuban/Haitian entrants under one of the categories in Section 501(e) of the Refugee Education and Assistance Act of 1980, or aliens in a status that is to be treated as a "Cuban/Haitian entrant" for Medicaid purposes.
- Amerasian immigrants under Section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act of 1988. "Amerasian immigrants" are by definition lawfully admitted for permanent residence (LAPR), thus they are qualified aliens. If a person is an "Amerasian immigrant" and meets no other condition permitting eligibility, then the person is potentially eligible for Medicaid for seven years beginning with the date "Amerasian immigrant" status was granted.

Note: Amerasians who enter as legal nonimmigrants as defined in Section D-8610, Ineligible Aliens, (for example, foreign students pursuing studies in the U.S.) cannot be qualified aliens unless their classification changes.

- Afghan and Iraqi special immigrants eligible for resettlement assistance, federal benefits and entitlements. When determining eligibility for full Medicaid and/or MSP, treat these aliens as refugees according to provisions of the Department of Defense Appropriations Act for fiscal year 2010, signed by the president on Dec. 19, 2009.

Under federal law, a qualified alien in this category is limited to seven years of potential eligibility for full Medicaid and/or MSP unless the qualified alien fits into another category or becomes a naturalized citizen.

Start the Clock — The clock on the seven years begins to run from the date the person obtains a qualified alien classification, **not** from the date the person becomes eligible for full Medicaid and/or MSP.

Stop the Clock — The clock on the seven years stops with the beginning of the first month after the seventh anniversary of the date the person obtained qualified alien classification. Once the seven-year period ends, in order to remain eligible for full Medicaid and/or MSP, the alien described in this section must either:

- become a naturalized citizen or meet citizenship status; or
- be eligible for full Medicaid and/or MSP in the same manner as qualified aliens in Section D-8320, Qualified Aliens Not Subject to a Waiting Period or Limited Period.

Consider Medicaid for the treatment of an emergency medical condition when the seven-year period expires and the person does not meet either of the above.

D-8320 Qualified Aliens Not Subject to a Waiting Period or Limited Period

Revision 21-3; Effective September 1, 2021

Certain aliens are exempt from both the five-year waiting period and the seven-year limited period when they meet certain criteria.

The following aliens are eligible for full Medicaid and or MSP if they meet all other eligibility criteria:

- honorably discharged veterans or active duty members of the U.S. armed forces;
- spouses, unmarried surviving spouses or minor unmarried children of honorably discharged veterans or active duty members;
- Canadian born American Indians;
- members of federally recognized Indian tribes;
- aliens receiving SSI and or Medicaid on Aug. 22, 1996, and lawfully residing in the U.S. on or before Aug. 22, 1996;
- LPRs admitted for permanent residence prior to Aug. 22, 1996, and credited with 40 qualifying quarters of Social Security coverage;
- LPRs lawfully admitted on or after Aug. 22, 1996 and five years have passed since their legal date of entry, and have 40 qualifying quarters of Social Security coverage; and
- Compact of Free Association (COFA) citizens residing in the U.S.

Related Policy

Compact of Free Association (COFA) Citizens, D-5220
Qualified Aliens with a Five-Year Waiting Period, D-8330
Veterans, Armed Forces Active Duty and Dependents, D-8410
American Indians Born Outside the U.S., D-8420
LPR Residing in the U.S. on Aug. 22, 1996, D-8430

D-8330 Qualified Aliens with a Five-Year Waiting Period

Revision 14-4; Effective December 1, 2014

Aliens lawfully admitted for permanent residence on or after Aug. 22, 1996, are not eligible for full Medicaid and/or MSP benefits for a period of five years from the date they enter the U.S. or obtain a qualified alien classification, whichever is later, unless they meet:

- certain classifications described in Section D-8310, Qualified Aliens Subject to a Seven-Year Limited Period; or
- one of the LAPR conditions in Section D-8320, Qualified Aliens Not Subject to a Waiting Period or Limited Period.

Start the Clock — The clock on the five-year waiting period begins to run from the date the person:

- enters the U.S. with the qualified alien classification; or
- obtains the qualified alien classification.

Stop the Clock — The clock stops:

- with the beginning of the first month after the fifth anniversary of the date the person obtains the qualified alien classification, or
- earlier than the fifth anniversary if:
  - the alien classification changes and the alien meets criteria in Section D-8310, or
  - the alien meets one of the LAPR conditions in Section D-8320.

Once the five-year period ends, a qualified alien with a five-year waiting period who meets all other eligibility criteria must do one of the following to be eligible for full Medicaid and/or MSP:

- Become a naturalized citizen or meet citizenship status.
- Be credited with 40 qualifying quarters of Social Security coverage.
- Meet an alien classification criterion in Section D-8310 if the clock for the seven years has not ended.
- Meet one of the LAPR conditions in Section D-8320.

Consider Medicaid for the treatment of an emergency medical condition if the person does not meet one of the above or is still within the five-year waiting period.

D-8340 Establishing Qualifying Quarters of Social Security Coverage

Revision 14-4; Effective December 1, 2014

The Social Security Administration (SSA) defines a **quarter** as a period of three calendar months.

- **Quarter 1:** January, February, March
- **Quarter 2:** April, May, June
- **Quarter 3:** July, August, September
- **Quarter 4:** October, November, December

A quarter of coverage is credit for a requisite (necessary) amount of covered earnings assigned to a calendar quarter on a worker's earnings record.

A qualifying quarter is credit for a requisite (necessary) amount of covered earnings and/or non-covered earnings assigned to a calendar quarter for determining eligibility of an LAPR alien.

Individuals can get up to four qualifying quarters of credit each calendar year based on their own earnings. Individuals also can be credited with additional quarters in a calendar year based on the earnings of a parent or spouse.

To be potentially eligible for full Medicaid and/or MSP, an LAPR alien must be credited with 40 qualifying quarters, either from the alien's own record, or combined with the quarters earned by a spouse or parent.

Note: The 40-qualifying-quarter requirement does not exempt the individual from the five-year waiting period (bar).

See the policy that follows to determine if the LAPR alien meets the 40-qualifying-quarter requirement.

D-8341 Combining Qualifying Quarters of Spouse/Parent

Revision 12-4; Effective December 1, 2012

Quarters from a spouse — Aliens can count their spouse's quarters earned during the marriage in addition to their own quarters to meet the 40 qualifying quarter requirement. For example, if each spouse has 20 quarters, the quarters are added and both spouses are credited with 40 quarters.

Count the spouse's quarters earned during the marriage when the spouse is either a citizen or an alien and any of the following conditions apply:

- The couple is currently married.
- A spouse is deceased and the surviving spouse has not remarried.
- The couple is separated but not divorced.

When determining whether to credit a person's quarters to his spouse, count quarters earned beginning with the quarter from the date of marriage.

Do not count quarters earned by divorced spouses for either ex-spouses.

Note: Aliens who divorce after certification retain their eligible alien status through the end of the current certification period. This also applies to stepchildren.

Quarters from a parent – Aliens also can count the quarters earned by a living or deceased parent in addition to their own quarters to meet the 40 qualifying quarter requirement. In this instance, a parent means the natural or adoptive parent or the stepparent.

Count the parent's quarters when the parent is either a citizen or an alien and the quarters were earned before the child turned 18, including quarters earned before the child was born.

Death of a stepparent does not end the relationship. However, if the parent and stepparent are divorced, the stepparent's quarters are not counted.

Note: Quarters earned by a child are **not** counted toward the eligibility of a parent.

D-8342 Qualifying Quarters Earned on or After Jan. 1, 1997

Revision 12-4; Effective December 1, 2012

Federal law requires that quarters earned **on or after** Jan. 1, 1997, cannot be credited if the person who earned the quarters received means-tested public benefits.

When determining the total amount of qualifying quarters earned, do not allow any quarters earned on or after Jan. 1, 1997, if the person received TANF, SNAP, Medicaid or SSI benefits in that quarter.

The Wire Third Party Query (WTPY) system response does not reflect receipt of these benefits. Staff should verify if federal means-tested benefits were received by any person contributing quarters so that applicable quarters are deducted before determining the number of qualifying quarters.

Example: An LAPR alien files an application for benefits on Oct. 10, 2012. He has never worked and has no qualifying quarters of his own. He has been married for 30 years and his spouse, who is a U.S. citizen and who has been working since they were married, earned her 40th qualifying quarter in March 2012.

Spouse received SNAP in January 2012 and February 2012; however, she has not been certified to receive SNAP or to be eligible for any other federal means-tested public benefit since February 2012.

Result: As the 40th qualifying quarter was earned while receiving SNAP, it cannot be allowed. Since the spouse continues working, the 40th qualifying quarter is earned in the quarter ending June 2012. Since all 40 qualifying quarters were earned during their marriage, the LAPR alien meets the 40 qualifying quarter determination.

D-8343 Non-Covered Wages

Revision 14-4; Effective December 1, 2014

Non-covered wages are those earned by a person whose employer was not required to pay into the Social Security system (such as certain city, federal, school or religious organization employees).

If the alien cannot meet the 40-qualifying-quarter requirement using covered or non-covered earnings verified by the SSA, then obtain sufficient income verification from the employer to determine if the alien earned quarters for the period in question using non-covered earned wages.

If the alien reports self-employment with non-covered earned wages, obtain sufficient information about this employment to verify that the alien:

- was engaged in a trade or business, and
- had net earnings from self-employment.

Acceptable documents include, but are not limited to, pay stubs, employer statements, W-2s, and income tax forms including all applicable schedules. If HHSC already has verification of the income, do not request additional information.

Use the chart below to determine if the person earned sufficient non-covered wages to earn a quarter.

Year	Amount Required for a Quarter	Amount Required for 4 Quarters
2014	$1,200	$4,800
2013	$1,160	$4,640
2012	$1,130	$4,520
2010–2011	$1,120	$4,480
2009	$1,090	$4,360
2008	$1,050	$4,200
2007	$1,000	$4,000
2006	$970	$3,880
2005	$920	$3,680
2004	$900	$3,600
2003	$890	$3,560
2002	$870	$3,480
2001	$830	$3,320
2000	$780	$3,120
1999	$740	$2,960
1998	$700	$2,800
1997	$670	$2,680

Year	Amount Required for a Quarter	Amount Required for 4 Quarters
1996	$640	$2,560
1995	$630	$2.520
1994	$620	$2,480
1993	$590	$2,360
1992	$570	$2,280
1991	$540	$2,160
1990	$520	$2,080
1989	$500	$2,000
1988	$470	$1,880
1987	$460	$1,840
1986	$440	$1,760
1985	$410	$1,640
1984	$390	$1,560
1983	$370	$1,480
1982	$340	$1,360
1981	$310	$1,240
1980	$290	$1,160
1979	$260	$1,040
1978	$250	$1,000

Example: A person worked for the school district as a custodian from 2001 through 2011. The school district did not pay into the Social Security system. The specialist requested that the person provide verification of earnings for this particular period. (**Note:** If the State Online Query (SOLQ) shows an F on the 40-quarter record, SSA has verified those non-covered wages, and the specialist does not need to reverify them.)

The person brought a statement from the school district verifying the person's wages. The person earned $9,000 for 2011. Using the chart above, the income required to earn a quarter for 2011 is $1,120. The person can be credited with four quarters for 2011 because the person earned more than the amount required ($1,120 x 4 = $4,480).

D-8344 Procedures for Verifying 40 Quarters

Revision 17-4; Effective December 1, 2017

Determine all persons whose quarters can be included in the quarter coverage count. See D-8341, Combining Qualifying Quarters of Spouse/Parent.

If the alien applicant/recipient and/or person whose quarters will be included did not sign the application form, obtain the person's signature on Form SSA-3288, Social Security Administration Consent for Release of Information. When a completed and signed Form SSA-3288 cannot be obtained because the person refuses to complete it, SSA cannot release information about that individual.

If a person, other than the LPR applicant, refuses to sign the Form SSA-3288, do not request earnings history for that person. Determine eligibility based on the qualifying quarters of the LPR applicant/recipient. If the LPR applicant/recipient does not meet the qualifying quarter requirement, deny the case.

A signed Form SSA-3288 is not required when requesting information on:

- a deceased individual's Social Security number; or
- a spouse's Social Security number when the couple is separated but not divorced.

Use the 40 Quarters Verification System in TIERS to request 40 quarters from SSA to determine how many countable quarters are in the LPR's SSA earnings records.

Note: WTPY may still be used to obtain information on 40 Qualifying Quarters.

Run Inquiry to determine if any person whose quarters are being considered received SSI, SNAP, TANF or Medicaid in any month on or after January 1997. Record the eligibility dates for these benefits so that applicable quarters are deducted from the total before determining if the alien applicant/recipient meets the 40-qualifying-quarter requirement.

Note: Determine if it is possible for the alien to meet the 40-quarter requirement first by obtaining the number of years the alien and each person included in the quarter coverage calculation has lived in the U.S. If the combined number of years totals less than 10 years, the alien will not meet the requirement. (Must earn 4 quarters/year x 10 years = 40 quarters.)

D-8345 Response from WTPY

Revision 12-4; Effective December 1, 2012

SSA does not complete the posting of covered earnings quarters for any one year until the following year (around August). For instance, quarters earned in 2011 may not be posted on the WTPY system until August 2012. These quarters are referred to as Lag quarters.

The quarters of covered earnings are based on the calendar year's **total** earnings. Each year the amount of income needed to earn a quarter changes. State office advises staff of the change each year.

Example: In 2011, an individual must earn $1,120 to earn one quarter. If the individual earned at least $4,480 for 2011 ($1,120 x 4), the individual has four qualifying quarters for the year.

Do not allow credit for an incomplete or future quarter.

Example: The quarter of July-September 2011 cannot be counted until October 2011, even though the individual earned enough income by March 2011 to receive credit for three quarters in 2011.

Note: The WTPY response will not reflect receipt of federal means-tested benefits. Staff should conduct inquiry to verify if SSI, SNAP, TANF or Medicaid benefits were received by any person contributing quarters so that an accurate count of the qualifying quarters is made. See D-8342, Qualifying Quarters Earned on or After Jan. 1, 1997.

D-8400, LAPR Conditions for Medicaid

Body

Revision 14-4; Effective December 1, 2014

Certain aliens lawfully admitted for permanent residence (LAPR) are immediately eligible for full Medicaid and/or MSP benefits, provided they meet other program requirements and certain LAPR conditions.

A description of the LAPR conditions follows.

D-8410 Veterans, Armed Forces Active Duty and Dependents

Revision 14-4; Effective December 1, 2014

This LAPR condition applies to:

- a veteran or active duty member of the U.S. armed forces;
- the spouse of a veteran or active duty member, including a surviving spouse who has not remarried; and
- an unmarried dependent child of a veteran or active duty member.

Verification of honorable discharge or active duty status requires presentation of a copy of the veteran's discharge certificate or current orders showing "Honorable" discharge from, or active duty in, the Army, Navy, Air Force, Marine Corps or Coast Guard.

Neither a general discharge "Under Honorable Conditions" nor service in the National Guard satisfies this LAPR condition.

Contact the local Veterans Affairs (VA) regional office if an applicant presents:

- documentation showing honorable discharge from, or active duty in, any other branch of the military;
- documentation showing any other type of duty (for example, "active duty for training"); or
- if there is any other reason to question whether an applicant satisfies the requirements for this exemption.

Aliens meeting the criteria in this section are immediately eligible for full Medicaid and/or MSP, provided they meet all other eligibility criteria.

D-8411 Loss of "Veteran/Active Duty" Status

Revision 14-4; Effective December 1, 2014

Loss of eligibility related to "Veteran/Active Duty" status can occur under the following circumstances:

Change in Active Duty/Veteran Status

A qualified alien who is eligible based on the veteran/active duty policy (including a spouse or dependent child of an active duty member/veteran) loses full Medicaid and/or MSP eligibility the month after the month the active duty member separates from the armed forces with a discharge that is not characterized as honorable or that is based on alien status.

Spouse of Veteran/Active Duty Member

Eligibility as a spouse of a veteran or active duty member of the armed forces ends with the month after the month any of the following occur:

- Remarriage after the veteran's or service member's death.
- Divorce or annulment of the marriage.
- A determination that a marital relationship does not exist.

- Separation of the person and the spouse, which results in the person not being considered a member of the couple.
- The active duty member separates from the armed forces with a discharge that is not characterized as honorable or that is based on alien status.

Unmarried Dependent Child of Veteran/Active Duty Member

Eligibility as an unmarried dependent child of a veteran or active duty member ends with the month after the month any of the following occur:

- Marriage of the child.
- Loss of dependent status.
- The active duty member separates from the armed forces with a discharge that is not characterized as honorable or that is based on alien status.
- Legal adoption by someone other than the veteran or active duty member of the armed forces or the veteran/active duty member's spouse.

D-8420 American Indians Born Outside the U.S.

Revision 17-4; Effective December 1, 2017

Although born outside the U.S., the following American Indians are considered qualified aliens and are immediately eligible for full Medicaid and/or MSP, provided they meet all other eligibility criteria.

Certain Canadian-born Indians — Canadian-born Indians who establish "one-half American Indian blood" are considered qualified aliens and may freely cross borders and live and work in the U.S. without Department of Homeland Security (DHS) documentation. Accept as evidence of "one-half American Indian blood" a document that indicates the percentage of American Indian blood in the form of a:

- birth certificate issued by the Canadian reservation; or
- letter, card or other record issued by the tribe.

If the person cannot present any listed document to verify the American Indian status, refer the person to DHS to determine the alien status. Do **not** accept a Certificate of Indian Status card ("Band" card) issued by the Canadian Department of Indian Affairs or any other document not directly issued by the individual's tribe.

Federally recognized U.S. Indian tribes — U.S. Indian tribes federally recognized under Section 4(e) of the Indian Self-Determination and Education Assistance Act are each authorized by the Bureau of Indian Affairs to define the requirements for tribal membership. Some tribes afford membership to non-U.S. born individuals. If a foreign-born person claims membership in a federally recognized Indian tribe, request a membership card or other tribal document showing membership in the tribe. If the person has a membership card or other tribal document showing membership in the tribe, contact state office. State office will determine if the tribe is included on the list of recognized Indian tribes published annually by the Bureau of Indian Affairs in the Federal Register.

See Appendix V, Levels of Evidence of Citizenship and Acceptable Evidence of Identity Reference Guide, for information on Form I-872, American Indian Card, as evidence of U.S. citizenship. Form I-872 showing the class code "KIC" indicates **citizenship** status.

D-8430 LPR Residing in the U.S. on Aug. 22, 1996

Revision 17-4; Effective December 1, 2017

To be immediately eligible for full Medicaid and/or MSP, an alien living in the U.S. on Aug. 22, 1996 must:

- have received SSI and/or Medicaid on Aug. 22, 1996, **and** be lawfully residing in the U.S. on or before Aug. 22, 1996 (see **Note:**); or
- meet another LPR condition or alien classification (see D-8300, Qualified Alien Categories, through D-8400, LPR Conditions for Medicaid).

Note: This includes non-qualified aliens who received Medicaid on Aug. 22, 1996, due to permanent residence under color of law (PRUCOL) and continue to meet PRUCOL criteria.

Consider Medicaid for the treatment of an emergency medical condition if the alien described in this section does not meet another LPR condition or alien classification. See D-8600 Non-Qualified Aliens through D-8620 Illegal Aliens.

D-8500, Qualified Aliens, Retroactive Coverage and SSI

Body

Revision 17-4; Effective December 1, 2017

To determine the alien status for retroactive coverage, use the policy in the following:

- Section D-8310, Qualified Aliens Subject to a Seven-Year Limited Period
- Section D-8320, Qualified Aliens Not Subject to a Waiting Period or Limited Period
- Section D-8330, Qualified Aliens with a Five-Year Waiting Period

Note: Before denying SSI, the Social Security Administration (SSA) will test the person for an extension beyond the seven-year limited period. Qualified aliens who were lawfully residing in the U.S. on Aug. 22, 1996 and who are blind or disabled may continue to be eligible for SSI beyond the seventh year, assuming all other factors of eligibility are met, regardless of:

- the alien's age;
- whether onset of blindness or disability occurred before, on or after Aug. 22, 1996; or
- when the SSI application was filed.

If a denied SSI recipient applies for an MEPD program, determine the reason for the SSI denial. If the SSI denial was based on alien status (for example, expiration of the seven-year limited period) to be eligible for an MEPD program, the qualified alien must:

- become a naturalized citizen;
- meet citizenship status; or
- meet an LPR condition in Section D-8320.

Note: Individuals denied SSI whose alien classification is *lawfully residing in the U.S. on Aug. 22, 1996 and are blind or have a disability,* are not eligible for continued Medicaid or a Medicare Savings Program.

D-8600, Non-Qualified Aliens

Body

Revision 14-4; Effective December 1, 2014

Generally, non-qualified aliens are divided into two groups:

- ineligible aliens, and
- illegal aliens.

These groups of non-qualified aliens are not eligible for regular Medicaid and/or MSP. They may be eligible for Medicaid coverage for treatment of an emergency medical condition.

D-8610 Ineligible Aliens

Revision 21-3; Effective September 1, 2021

Except for cases involving undocumented aliens, use the Systematic Alien Verification for Entitlements (SAVE) Verification Information System (VIS) to verify the alien status on all noncitizens.

Some aliens may be lawfully admitted to the U.S. as "legal nonimmigrants," but only for a temporary or specified time.

The following categories of people are "legal nonimmigrants":

- foreign government representatives on official business and their families and servants;
- visitors for business or pleasure, including exchange visitors;
- aliens in travel status while traveling directly through the U.S.;
- crewmen on shore leave;
- treaty traders and investors and their families;
- foreign students;
- international organization representation and personnel and their families and servants;
- temporary workers, including agricultural contract workers; or
- members of foreign press, radio, film or other information media and their families.

These aliens are called “ineligible aliens” because they are not eligible for full Medicaid, MSP or ME-A&D Emergency due to the temporary (non-resident) nature of their admission status.

Exception: In some cases, an alien in a currently valid **legal nonimmigrant** classification may meet the residence rules of Texas. When the residency requirement is met, the person is eligible for Medicaid for the treatment of an emergency medical condition if all other eligibility criteria also are met.

Example 1: A domestic employee for a foreign government representative currently conducting business in Texas receives emergency medical care. She files an application for assistance with the medical expenses. The individual states she does not intend to remain in Texas; she is here only while her employer concludes his business. **Result:** The individual is not eligible for full Medicaid, MSP or ME-A&D Emergency due to the temporary nature of her admission status.

Example 2: An agricultural contract worker suffers an injury while on the job and is hospitalized. He files an application for assistance with the medical expenses, as he does not have any medical insurance. The person states he intends to remain in Texas. He provides verification of his permanent address and rental agreement. **Result:** The person is potentially eligible for ME-A&D Emergency because he meets residence requirements.

Reminder: If a legal nonimmigrant’s time has expired with no changes to the classification status, follow the illegal aliens procedures.

Related Policy

Eligibility, D-3200
Illegal Aliens, D-8620

D-8611 Documents of Ineligible Aliens

Revision 13-4; Effective December 1, 2013

Types of Department of Homeland Security (DHS) documentation for ineligible aliens who are **legal nonimmigrants** include, but are not limited to:

- Form I-766, valid employment authorization documents;
- Form I-94, Arrival-Departure Record;
- Form I-185, Canadian Border Crossing Card;
- Form I-186, Mexican Border Crossing Card;
- Form SW-434, Mexican Border Visitor's Permit;
- Form I-95A, Crewman's Landing Permit; and
- Visitor visas, such as a B1 visa for business or a B2 visa for pleasure, tourism or medical treatment.

Explore eligibility for Medicaid coverage for treatment of an emergency medical condition for an alien if there is no proof of alien status.

D-8620 Illegal Aliens

Revision 13-1; Effective March 1, 2013

Illegal aliens were either never legally admitted to the United States for any period of time or were admitted for a limited period of time and did not leave the United States when the period of time expired.

Illegal aliens are only eligible for Medicaid for treatment of an emergency medical condition if they meet all other eligibility criteria, including residency requirements. See Section D-3200, Eligibility. Illegal aliens do not have to provide a Social Security number.

When an alien receives a final deportation order but continues to stay, consider the alien to be illegal.

Except for cases involving undocumented aliens, use SAVE VIS to verify the alien status on all non-citizens.

Contact with the Department of Homeland Security (DHS) is not allowed except when the person has given written approval and a request to do so.

If an alien does not wish to contact DHS or give permission, explore eligibility for Medicaid coverage for treatment of an emergency medical condition.

D-8700, Verification of Alien Status

Body

Revision 19-4; Effective December 1, 2019

If otherwise eligible, only qualified aliens are eligible for full Medicaid, Medicare Savings Programs or both (MSP). As part of the Medicaid eligibility determination, verify:

- the alien's qualifying classification; and
- the date the alien obtained the qualifying classification.

Complete verification by:

- obtaining a **U.S. Citizenship and Immigration Services** (USCIS) document showing alien classification or the immigrant registration number as explained in Section D-8710, Documentary Evidence by Classification, through Section D-8780, Qualified Alien Based on Battery or Extreme Cruelty; and
- using the Systematic Alien Verification for Entitlements (SAVE) Verification Information System (VIS).

Document the:

- alien's status and how you verified it;
- date of entry;
- continuous presence, if necessary to establish eligibility;
- DHS document's expiration date, if any; and
- basis for the alien's eligibility or ineligibility.

If a certified alien's document expires before the next redetermination, re-verify the alien's immigration status. The alien's immigration status does not require reverification if the USCIS documents have not expired.

Note: If the alien's USCIS document is expired and the SAVE response shows the person is a Lawful Permanent Resident - Employment Authorized and the Date Admitted is "Response is Indefinite," the person meets the alien status criteria.

Related Policy

Documentation and Verification Guide, Appendix XVI
Initial Request at Time of Application, D-5510
Date of Qualifying Classification, D-8221
Documentary Evidence by Classification, D-8710
Secondary Verification of Alien Immigration Status, D-8840
Reasonable Opportunity to Provide Verification of Alien Immigration Status, D-8841
Entry Before 1996, D-8910
Entry on or After Aug. 22, 1996-Qualifed Alien No Waiting Period, D-8920
LPR Aliens With or Without Five-Year Waiting Period, D-8930

D-8710 Documentary Evidence by Classification

Revision 19-4; Effective December 1, 2019

Use SAVE VIS to verify the alien status of all documented non-citizens. If a person is undocumented, do not run SAVE.

Explore eligibility for Medicaid coverage for treatment of an emergency medical condition for non-citizens who do not have a Medicaid qualifying immigration status or who are undocumented.

Documentary evidence in conjunction with DHS verification is provided via the online SAVE response.

Once the documentary evidence (usually an alien status card) and the SAVE verification have been completed, use the charts in Section D-8900, Alien Status Eligibility Charts, for treatment of the alien status in the eligibility determination process.

Related Policy

Documentation and Verification Guide, Appendix XVI
Initial Request at Time of Application, D-5510
Date of Qualifying Classification, D-8221
Verification of Alien Status, D-8700
Secondary Verification of Alien Immigration Status, D-8840
Reasonable Opportunity to Provide Verification of Alien Immigration Status, D-8841
Entry Before 1996, D-8910
Entry on or After Aug. 22, 1996-Qualifed Alien No Waiting Period, D-8920
LPR Aliens With or Without Five-Year Waiting Period, D-8930

D-8720 Lawfully Admitted for Permanent Residence (LAPR)

Revision 13-1; Effective March 1, 2013

If the alien presents an I-551 (Alien Registration Receipt Card) or other acceptable evidence of LAPR status, query SAVE online to verify the document and status. Some LAPR aliens have conditional permanent resident status. This is indicated by an I-551 valid for only a two-year period. These aliens must apply for removal of the conditional basis 90 days before the second anniversary of the admittance date to the U.S. Failure to do so results in termination of the alien's lawful status. A conditional I-551 is identified by an expiration date two years later than the admittance/adjudication date, and status must be re-verified upon expiration. If the alien is a national of Cuba or Haiti who adjusts to LAPR status under the Nicaraguan and Central American Relief Act (NACARA) or the Haitian Refugee Immigration Fairness Act (HRIFA), contact state office for more information on treatment.

For a LAPR, follow policy in:

- Section D-8320, Qualified Aliens Not Subject to a Waiting Period or Limited Period; or
- Section D-8330, Qualified Aliens with a Five-Year Waiting Period.

D-8721 Description of Common Resident Alien Cards

Revision 17-4; Effective December 1, 2017

Permanent Resident Card and Employment Authorization Document (EAD)

As of May 1, 2017, the Permanent Resident Card and EADs:

- display the individual’s photos on both sides;
- show a unique graphic image and color palette:
  - Permanent Resident Cards have an image of the Statue of Liberty and a predominately green palette;
  - EAD cards have an image of a bald eagle and a predominately red palette;
- have embedded holographic images;
- no longer display the individual’s signature; and

- no longer have an optical stripe on the back.

Note: Permanent Resident Cards and EADs will remain valid until the expiration date shown on the card. Some older Permanent Resident Cards do not have an expiration date. The older Permanent Resident Cards without an expiration date also remain valid.

Revised I-551

A revised I-551, Alien Registration Receipt Card (Type 1), was first issued in late 1989.

Card Front — Form I-551 is a laminated card. The background is off pink. The agency name is shown in white on a blue background just under the words “RESIDENT ALIEN.” The seal is light blue. The front includes a photograph of the alien's face, fingerprint and signature. An expiration date is always shown. Cards expire 10 years after issue, but may be renewed.

Note: A modified I-551 was first issued in January 1992. All cards issued Feb. 1, 1993, or later are modified. The only difference is a noticeable removal of the background printing behind the fingerprint block.

Card Back — A map of the U.S. appears on the upper portion of the card back, surrounded by an overlapping rainbow print. The lower portion of the back contains four lines of text, the bottom three of which are machine readable and on a white background.

Original I-551

The original Alien Registration Receipt Card (Type 1) was issued from 1977 to late 1989.

Card Front — Form I-551 is a laminated card. The agency name is shown in white on a pastel blue background just under the words "RESIDENT ALIEN." The seal is light pastel blue. The front includes a photograph of the alien's face, fingerprint and signature.

Card Back — A map of the U.S. appears on the card back, overlaid by machine readable typed data. The first digit of the issue/type code indicates the number of alien registration cards issued to the person. The second digit identifies the type card.

I-151

Form I-151 is the version of the Alien Registration Receipt Card issued to aliens by the former Immigration and Naturalization Service (INS) from July 1946 through late 1977. **Form I-151 is not a valid immigration document.** The card lacks security features and presents more opportunities for alteration and fraud than the immigration documents currently being issued. From 1992 through 1996, the INS conducted a “Green Card Replacement” project to replace the I-151 cards in circulation. Although the card is not a valid immigration document, the person may still retain lawful permanent status.

For pictures of these cards, see Appendix LIV, Description of Resident Alien Cards.

D-8730 Refugees

Revision 17-4; Effective December 1, 2017

If an alien presents Form I-766 annotated with "274a.12(a)(3)" or "A3" as evidence of refugee status, query SAVE online to verify the document and status. If the SAVE online response results in a determination of

ineligibility, verify alien status using Form G-845 and supplement to Form G-845. The Form I-94 annotated with stamp showing admission under section 207 of the Immigration and Nationality Act (INA) is also a DHS document for refugees.

For a refugee, follow policy in:

- Section D-8310, Qualified Aliens Subject to a Limited Period; or
- Section D-8320, Qualified Aliens Not Subject to a Waiting Period or Limited Period.

D-8740 Parolee

Revision 17-4; Effective December 1, 2017

A parolee may present a DHS Form I-94 that indicates the bearer has been paroled pursuant to Section 212(d)(5) of the Immigration and Nationality Act (INA), with an expiration date of at least one year from the date issued or indefinite.

DHS Form I-766 annotated "A4" or "C11" indicates status as a parolee, but does not reflect the length of the parole period.

If the individual cannot provide Form I-94, contact DHS to verify status and length of the parole period before certification.

For a parolee, follow policy in:

- Section D-8310, Qualified Aliens Subject to a Limited Period; or
- Section D-8320, Qualified Aliens Not Subject to a Waiting Period or Limited Period.

D-8750 Asylee

Revision 17-4; Effective December 1, 2017

An asylee may present a Department of Homeland Security (DHS) Form I-94 annotated with a stamp showing grant of asylum under Section 208 of the Immigration and Nationality Act (INA), a grant letter from the Asylum Office or an order of an immigration judge.

Derive the date status granted from the date on Form I-94, the grant letter or the date of the court order. If the date is missing from Form I-94, request the grant letter from the alien. If it is not available, verify the date status was granted with DHS.

DHS Form I-766 annotated "A5" indicate status as an asylee. However, the date of the form does not reflect when the status was granted. Request Form I-94, the grant letter from the Asylum Office of DHS or the alien's copy of a court order of the immigration judge granting asylum to obtain the date status was granted. Verify with DHS if none of these are available.

If the alien alleges having been granted asylum within the previous seven years, contact DHS using Form G-845 and Form G-845 supplement with a copy of Form I-551 attached.

For an asylee, follow policy in:

- Section D-8310, Qualified Aliens Subject to a Limited Period; or
- Section D-8320, Qualified Aliens Not Subject to a Waiting Period or Limited Period.

D-8760 Deportation Withheld

Revision 17-4; Effective December 1, 2017

For an alien whose deportation was withheld under Section 243(h) of the Immigration and Nationality Act (INA) or whose removal was withheld under Section 241(b)(3) of the INA, obtain one of the following:

- Form I-766 annotated "A10."
- The alien's copy of the order from an immigration judge showing deportation withheld under Section 243(h) of the INA as in effect prior to 4/1/97 or removal withheld under Section 241(b)(3) of the INA.
- Letter from asylum officer granting withholding of deportation under Section 243(h) of the INA as in effect prior to 4/1/97 or withholding of removal under Section 241(b)(3) of the INA.

Department of Homeland Security (DHS) Form I-766 annotated "A10" indicate deportation was withheld under Section 243(h) of the INA or removal was withheld under Section 241(b)(3) of the INA, but normally do not reflect the date of withholding. Request the alien's copy of the court order to obtain the date of withholding. If not available, verify with DHS.

If the alien alleges having had deportation/removal withheld within the previous seven years, contact DHS using Form G-845 and supplement with a copy of Form I-551 attached.

Note: Aliens who have been granted a **suspension** of deportation are not eligible for Medicaid benefits on the basis of that status alone. The description and annotations on the DHS documents must be as shown above in order to establish eligibility based on **withholding** of deportation or removal.

For an alien whose deportation was withheld, follow policy in:

- Section D-8310, Qualified Aliens Subject to a Limited Period; or
- Section D-8320, Qualified Aliens Not Subject to a Waiting Period or Limited Period.

D-8770 Cuban/Haitian Entrants

Revision 13-1; Effective March 1, 2013

An alien could meet more than one classification. The seven-year period of limited eligibility, if applicable, begins with the earliest date an alien meets "Cuban/Haitian entrant" classification or one of the other seven-year classifications, such as asylee, refugee, etc. Absent evidence to the contrary, accept any of the following as convincing evidence of Cuban or Haitian nationality for purposes of determining whether an alien is a "Cuban/Haitian entrant:"

- SAVE primary verification (see Section D-8820, Primary Verification of Alien Status).
- DHS or Executive Office of Immigration Review (EOIR) document(s) showing Cuban/Haitian entrant status, or Cuban or Haitian nationality, or Cuba or Haiti as the place of birth.
- Cuban or Haitian passport or identity card.
- Cuban or Haitian birth certificate.
- Secondary verification determination of "Cuban/Haitian entrant" (see Section D-8840, Second Verification of Alien Immigration Status).

For a Cuban/Haitian entrant, follow policy in:

- Section D-8310, Qualified Aliens Subject to a Limited Period; or
- Section D-8320, Qualified Aliens Not Subject to a Waiting Period or Limited Period.

D-8780 Qualified Alien Based on Battery or Extreme Cruelty

Revision 17-4; Effective December 1, 2017

An alien who has been, or whose child or parent has been, battered or subjected to extreme cruelty in the United States by a U.S. citizen or lawful permanent resident spouse or parent can be considered a qualified alien.

For the alien and children to emigrate or remain in the United States, the alien's spouse must file a petition for lawful permanent residence status for the alien relative. Unless the spouse files this petition, the alien and children have no lawful immigrant status and face being deported.

Since the 1994 enactment of the Violence Against Women Act, a battered alien may self-petition for lawful permanent residency via INS Form I-360, Petition for Amerasian, Widow(er) or Special Immigrant, without the cooperation or knowledge of the abuser.

The alien must provide DHS documentation that identifies the alien as the self-petitioning spouse and/or child of an abusive U.S. citizen or lawful permanent resident and does not live with the abuser.

Examples of acceptable DHS documents include:

- I-551 annotated with one of the following status codes: IB-1 to IB-3 or IB-6 to IB-8;
- an I-797, Action Notice, which identifies the alien as a self-petitioning battered alien; or
- other forms of documentation, such as a letter from a DHS judge.

Qualified aliens with a battered alien status do not need to be credited with 40 qualifying quarters of Social Security coverage nor do they have a seven-year limited eligibility period. The following battered aliens meet the alien status criteria if they:

- entered the U.S. and acquired "qualified alien" status prior to Aug. 22, 1996;
- resided in the U.S. before Aug. 22, 1996, adjusted to "qualified alien" status on or after Aug. 22, 1996, and provide proof of continuous residence;
- resided in the U.S. before Aug. 22, 1996, adjusted to "qualified alien" status on or after Aug. 22, 1996, did not provide proof of continuous residence, but meet the five-year waiting period ; or
- entered the U.S. on or after Aug. 22, 1996 and meet the five-year waiting period.

Consider Medicaid for the treatment of an emergency condition when the battered alien does not meet alien status criteria.

D-8790 Victims of Severe Human Trafficking

Revision 17-4; Effective December 1, 2017

The U.S. Department of Health and Human Services certifies individuals who meet the victims of severe human trafficking requirements so they may remain in the U.S. up to four years. Law enforcement authorities can extend the status beyond four years for individuals whose presence is required for a continuing investigation.

These individuals meet the alien status criteria to be potentially eligible for benefits without a five-year waiting period and continue to meet the eligibility criteria without a limited eligibility period as long as the law enforcement extension continues, or they adjust to another acceptable alien status.

Staff must request a copy of the USCIS Notice of Extension to verify the individual has an approved extended Victims of Severe Human Trafficking status based on the law enforcement need. SAVE does not provide verification for victims of trafficking. Staff must call the trafficking verification toll-free number at 866-401-5510 to confirm the validity of the USCIS extension letter.

After four years or expiration of a law enforcement extension, individuals who have not adjusted to another alien status must leave the U.S. If they remain, they are considered undocumented and ineligible for ongoing benefits.

D-8800, Systematic Alien Verification for Entitlements

Body

Revision 17-4; Effective December 1, 2017

The Systematic Alien Verification for Entitlements (SAVE) program's Verification Information System (VIS) is a web-based application that provides alien status information using the applicants' alien registration number.

The SAVE System provides the following types of responses:

- Initial Verification Results: First Name, Last Name, Country, Date of Entry, Date of Birth, Class of Admission (COA) and System Response; and
- Additional Verification Results: Department of Homeland Security (DHS) Response, Expires On, Response Date and DHS Comments.

If the alien's U.S. Citizenship and Immigration Services (USCIS) document is expired and the SAVE response shows the individual is a Lawful Permanent Resident - Employment Authorized and the Date Admitted is "Response is indefinite," the individual meets alien status criteria.

Use the SAVE Verification Information System:

- at application;
- when adding a new household member identified as an alien; or
- if a person's alien documentation has expired.

Exceptions:

When SAVE does not contain information about victims of severe trafficking or non-alien family members, call the trafficking verification toll-free number at 866-401-5510 to confirm the validity of the certification letter or Derivative T Visa and to notify the Office of Refugee Resettlement of the benefits for which the individual is applying.

SAVE does not normally contain information about American Indians born outside of the U.S. See Section D-8420, American Indians Born Outside the U.S.

D-8810 Getting Permission to Access SAVE

Revision 09-4; Effective December 1, 2009

Supervisors complete and route Form 4743, Request for Applications and System Access, to the regional security officer for employees who need access to the SAVE system.

D-8820 Primary Verification of Alien Status

Revision 13-4; Effective December 1, 2013

To obtain primary verification of alien status, follow these steps to access the Systematic Alien Verification for Entitlements (SAVE) System:

1. Open the Verification Information System (VIS) website at https://save.uscis.gov/Web/vislogin.aspx?JS=YES, or in Data Broker through TIERS.
2. Enter your User ID and password.
3. Select Initial Verification from the Case Administration menu. The Initial Verification Information page appears.
4. Enter the document type the applicant provided.
5. Enter the applicant's information as it appears on the document:

- Alien Number – Do not include the letter A when entering the information in SAVE. If the A number has fewer than nine digits, add leading zeros to make it a nine-digit number. USCIS is used on the new I-551 cards instead of Alien Number.
- I-94 Identification Number – Known as the admission number, it consists of an 11-digit field. Enter leading zeros if the I-94 number provided has less than 11 digits.
- Card Number – On older versions of cards, the card number is on the front of the card. It is 13 digits and has three letters in front of the number. On newer versions of the card, the card number is on the back of the card. It is still 13 digits and has three letters in front of the number.
- Last name.
- First name.
- Date of birth.
- Document expiration date, if applicable.

6. Select the benefit type from the Benefits List (Supplemental Nutritional Assistance Program (SNAP) [formerly known as food stamps], Medicaid, TANF).
7. Select Submit Initial Verification. The response appears in the Initial Verification Results section of the same page.
8. The screen displays one of the following messages:

- LAWFUL PERMANENT RESIDENT – EMPLOYMENT AUTHORIZED
- INSTITUTE ADDITIONAL VERIFICATION
- TEMPORARY RESIDENT/TEMPORARY EMPLOYMENT AUTHORIZED

Use the policy found in Section D-8610, Ineligible Aliens, if the message is TEMPORARY RESIDENT/TEMPORARY EMPLOYMENT AUTHORIZED.

9. Review the results and select Print Case Details if using the stand-alone SAVE system. SAVE Case Details should then be imaged and put in the individual's case.

Note: If using Data Broker through TIERS, a copy of the SAVE screen is not needed, as the inquiry will be stored in the Data Broker history.

10. Select Complete and Close Case to close the case (only if additional verification is not necessary). Once a case is closed, the user can view it for an additional 90 days.

Note: Staff should enter the correct alien number as listed on the document, not a default or fictitious number (for example, AAA000000, etc.).

D-8830 Additional Verification — Online Process of Alien Status

Revision 09-4; Effective December 1, 2009

To request additional verification:

1. In the Initial Verification Results section, select Request Additional Verification. The Enter Additional Verification Data section appears.
2. Edit the default information, if necessary; enter required information, and include as much information as possible. Use the Special Comments box to enter additional information to the Immigration Status Verifier (ISV) staff.
3. Submit the request by selecting Submit Additional Verification. The response section appears indicating that the request is in process and will return the response within three working days.
4. To view the status of the case, select View Cases from the Case Administration menu. The Case Search page appears.
5. Enter the Case Search Criteria to search for cases based on the following case status:

- all open cases
- cases requiring action
- cases with additional verification responses
- cases in process
- closed cases

Select Display Case Summary List to open the Case Summary List page. The list displays the Case Status for cases that require action, cases in process and closed cases. Click the Verification Number to view the Case Details. The user is able to print the case details, request additional verification and close the case.

If the system is unable to verify the immigration status with the information provided by the user in the automated additional verification request, or the document appears counterfeit, altered or expired, use the manual process in Section D-8840, Secondary Verification of Alien Immigration Status.

D-8840 Secondary Verification of Alien Immigration Status

Revision 19-4; Effective December 1, 2019

If staff are unable to verify an alien's immigration status through primary verification procedures, use SAVE to request additional information from the U.S. Citizenship and Immigration Services (USCIS) by requesting a Data Broker Combined Report through TIERS or the Data Broker Portal.

Once a request from USCIS is obtained for verification of immigration status, the information received must be processed. Staff receive one of the following responses from SAVE via the Combined Report in TIERS or in the Data Broker Portal:

- 1st Level Verification - initial verification request in TIERS;
- 2nd Level Verification - situations that require additional (secondary) verification in the Data Broker Portal; and

- 3rd Level Verification - situations that require staff to upload documents for verification in the Data Broker Portal via SAVE.

For the 1st Level Verification, staff enter the information provided by the person into TIERS. Once the information is entered and SAVE is requested, SAVE will return an immediate response back indicating if the information entered was able to be verified with USCIS or if more information is needed.

If the information entered can be verified on the 1st Level Verification, staff will see the alien status, category code, and entry date. If the information entered is unable to be verified against USCIS records, then staff will have to proceed to 2nd or 3rd Level Verification responses to correctly verify the person's citizenship and alien status.

For 2nd Level Verification and 3rd Level Verification responses, Data Broker automatically requests additional verification from SAVE. Once obtained from SAVE, staff receive an email from the Data Broker vendor notifying them that the verification requested has been returned from SAVE.

For 2nd Level Verification responses:

- The Data Broker vendor sends a subsequent email notifying staff that the verification has been returned from SAVE.
- Staff must then:
  - login to the Data Broker Portal to retrieve the information; and
  - update the Alien/Refugee Details page in TIERS accordingly.

For 3rd Level Verification responses:

- Staff must:
  - upload the verification documents requested into the Data Broker Portal;
  - not mail the documents to USCIS; and
  - ensure only one PDF file containing all required verification documents is uploaded.
- The Data Broker vendor sends a subsequent email notifying staff SAVE has returned the verification.
  - staff must then login to the Data Broker Portal to retrieve the information; and
  - update the Alien/Refugee Details page in TIERS accordingly.

Note: SAVE only populates alien sponsor information into TIERS for the additional verification response. This is unlike initial verification that populates the response data for the applicant in the appropriate ELDS tables on the TIERS Alien/Refugee-Details page.

Related Policy

Documentation and Verification Guide, Appendix XVI
Initial Request at Time of Application, D-5510
Verification of Alien Status, D-8700
Documentary Evidence by Classification, D-8710
Reasonable Opportunity to Provide Verification of Alien Immigration Status, D-8841
Entry Before 1996, D-8910
Entry on or After Aug.22,1996-Qualifed Alien No Waiting Period, D-8920
LPR Aliens With or Without Five-Year Waiting Period, D-8930

D-8841 Reasonable Opportunity to Provide Verification of Alien Immigration Status

Revision 14-2; Effective June 1, 2014

If you are unable to verify an alien's immigration status through primary or secondary verification procedures, allow the applicant a reasonable opportunity of 95 days following the date on which a notice is sent to an individual to provide another source of citizenship or alien status verification.

D-8900, Alien Status Eligibility Charts

Body

Revision 13-1; Effective March 1, 2013

An alien's eligibility is based on the Department of Homeland Security's qualifying classification and other criteria as shown in the MEPDH and in the following charts.

D-8910 Entry Before 1996

Revision 17-4; Effective December 1, 2017

Chart A — Entry Before 1996

If the alien entered the U.S. before Aug. 22, 1996, and the USCIS document is an ...	then the alien is ...

If the alien entered the U.S. before Aug. 22, 1996, and the USCIS document is an ...	then the alien is ...

• I-94 annotated with one of the following INA sections:
  ◦ 207 – Refugee
  ◦ 208 – Asylee
  ◦ 241(b)(3) or 243(h) – Deportation Withheld
  ◦ 212(d)(5) – Cuban/Haitian Entrant
  ◦ 212(d)(5) – showing admission for at least one year – Parolee
  ◦ 203(a)(7) – Conditional Entrant
• I-766, employment authorization document annotated with one of the following status codes:
  ◦ A3 – Refugee
  ◦ A3 – Conditional Entrant
  ◦ A5 – Asylee
  ◦ A10 – Deportation Withheld
• I-551 annotated with one of the following status codes:
  ◦ AM1, AM2, AM3, AM6, AM7 or AM8 – Amerasians
  ◦ R8-6 or RE1 to RE9 – Refugees
  ◦ AS6 to AS9 – Asylees
  ◦ R8-6, CH-6, CU-6 or CU-7 – Cuban/Haitian Entrants
• U.S. Citizenship and Immigration Services (USCIS) letter from Asylum Office
• Order from an immigration judge:
  ◦ granting asylum, or
  ◦ showing deportation withheld under INA Section 243(h) or 241(b)(3). Consider the date of entry as the date the status is assigned.
	eligible if the alien meets the criteria in Section D-8320, Qualified Aliens Not Subject to a Waiting Period or Limited Period.
	
	Unless the alien meets the criteria in Section D-8320, consider Medicaid for the treatment of an emergency medical condition.

Note: Follow your policy clearance request procedures for questions about documents or immigration statuses not listed in this chart.

D-8920 Entry On or After Aug. 22, 1996 – Qualified Alien No Waiting Period

Revision 17-4; Effective December 1, 2017

Chart B — Entry On or After Aug. 22, 1996 – Qualified Aliens With No Waiting Period

If the alien entered the U.S. on or after Aug. 22, 1996, and the USCIS document is an ...	and ...

If the alien entered the U.S. on or after Aug. 22, 1996, and the USCIS document is an ...	and ...

• I-94 annotated with one of the following INA sections:
  ◦ 207 – Refugee
  ◦ 208 – Asylee
  ◦ 243(h) or 241(b)(3) – Deportation Withheld
  ◦ 212(d)(5) – Cuban/Haitian Entrant
• I-766, employment authorization document annotated with one of the following status codes:
  ◦ A3 – Refugee
  ◦ A5 – Asylee
  ◦ A10 – Deportation Withheld
• I-551 annotated with one of the following status codes:
  ◦ AM1, AM2, AM3, AM6, AM7 or AM8 – Amerasians
  ◦ R8-6 or RE1 to RE9 – Refugees
• USCIS letter from Asylum Office
• Derivative T visa annotated with T-1 – victim of severe trafficking (four-year limit)
• Derivative T visa annotated with T-2, T-3, T-4 or T-5 – family member of victim of severe trafficking (four-year limit)
• Original certification letter from Office of Refugee Resettlement (ORR)
• Order from an immigration judge:
  ◦ granting asylum; or
  ◦ showing deportation withheld under INA Section 243(h) or 241(b)(3). Consider the date of entry as the date the status is assigned.
	If less than seven years have passed since the date of qualified alien classification, usually the entry date, **then** the alien is eligible if the alien meets the criteria in Section D-8310, Qualified Aliens Subject to a Seven-Year Limited Period.
	
	Unless the alien meets the criteria in Section D-8310, consider Medicaid for the treatment of an emergency medical condition.
	
	Note: Victims of Severe Human Trafficking are limited to four years unless status is extended by law enforcement.
	
	If seven years or more have passed from the date of qualified alien classification, usually the entry date, then the alien is eligible if the alien meets the criteria in Section D-8320, Qualified Aliens Not Subject to a Waiting Period or Limited Period.
	
	Unless the alien meets the criteria in Section D-8320, consider Medicaid for the treatment of an emergency medical condition.
	
	Note: The refugee retains this eligibility period even if the refugee has adjusted to lawful permanent resident (LPR) status during the seven-year limited period.

• I-94 annotated with one of the following INA sections:
  ◦ Section 212(d)(5) – showing admission for at least one year – Parolee
  ◦ Section 203(a)(7) – Conditional Entrant
	Not eligible, unless the alien has applied for and been approved by DHS for LAPR.
	
	If LAPR, the alien must meet the LAPR conditions in Section D-8320, Qualified Aliens Not Subject to a Waiting Period or Limited Period.
	
	Unless the alien meets the criteria in Section D-8320, consider Medicaid for the treatment of an emergency medical condition.

If the alien entered the U.S. on or after Aug. 22, 1996, and the USCIS document is an ...	and ...

Afghani or Iraqi Special Immigrant – Special immigrant status under 101(a)(27) of the INA may be granted to Iraqi and Afghan nationals who have worked on behalf of the U.S. government in Iraq or Afghanistan.
 	
Acceptable documentation includes:
 	
• A passport with a stamp noting that the individual has been admitted under a special immigrant visa category IV with one of the following codes:
  ◦ SI-1, SQ-1, SI-6 or SQ-6 for the principal applicant;
  ◦ SI-2, SQ-2, SI-7 or SQ-7 for the spouse of the principal applicant; or
  ◦ SI-3, SQ-3, SI-9 or SQ-9 for the unmarried child under age 21 of the principal applicant; and
  ◦ a DHS stamp or notation on the passport or I-94 showing the date of entry.
 	
For those special immigrants who are adjusting their status to LPR status in the U.S., acceptable documentation includes:
 	
• An I-551 annotated with one of the following status codes:
  ◦ SI-1, SQ-1, SI-6 or SQ-6 for the principal applicant;
  ◦ SI-2, SQ-2, SI-7 or SQ-7 for the spouse of the principal applicant; or
  ◦ SI-3, SQ-3, SI-9 or SQ-9 for the unmarried child under age 21 of the principal applicant.
 	
These special immigrants also may demonstrate nationality with an Afghani or Iraqi passport.
 	
Note: The entry date for an Afghani special immigrant must be Dec. 26, 2007, or later. An Iraqi special immigrant's entry date must be Jan. 26, 2008, or later.
	If less than seven years have passed since the date of qualified alien classification, usually the entry date, **then** the alien is eligible if the alien meets the criteria in Section D-8310, Qualified Aliens Subject to a Seven-Year Limited Period.
	
	Unless the alien meets the criteria in Section D-8310, consider Medicaid for the treatment of an emergency medical condition.
	
	If seven years or more have passed from the date of qualified alien classification, usually the entry date, **then** the alien is eligible if the alien meets the criteria in Section D-8320, Qualified Aliens Not Subject to a Waiting Period or Limited Period.
	
	Unless the alien meets the criteria in Section D-8320, consider Medicaid for the treatment of an emergency medical condition.
	
	Note: The special immigrant retains this eligibility period even if the special immigrant has adjusted to lawful permanent resident (LPR) status during the seven-year limited period.

Note: Follow your policy clearance request procedures for questions about documents or immigration statues not listed in this chart.

D-8930 LPR Aliens With or Without Five-Year Waiting Period

Revision 17-4; Effective December 1, 2017

Chart B — Entry On or After Aug. 22, 1996 – Qualified Aliens With No Waiting Period

If the LPR alien entered the U.S. on or after Aug. 22, 1996, and the DHS document is an ...	then ...
I-551, Resident Alien Card, and does not meet one of the classification codes in Charts A or B, **Notes:** • Any status code that appears on the I-551 is acceptable. • No I-151s were issued after 1978; therefore, any alien admitted after 1978 will have an I-551. • If the LPR alien loses the I-551, the LPR alien may present either an I-94 or a passport with the following annotation: "Processed for I-551, Temporary Evidence of Lawful Admission for Permanent Residence, valid until _____, Employment Authorized." Allow aliens with a DHS document or card showing an entry date on or after Aug. 22, 1996, who claim to have entered before that date, an opportunity to submit evidence of their claimed date of entry.	**If five years or less** have passed since the date of qualified alien classification, usually the entry date, **then** the LPR alien is not eligible. Unless the alien meets criteria other than 40 qualifying quarters in Section D-8320, Qualified Aliens Not Subject to a Waiting Period or Limited Period, the LPR alien is only potentially eligible for Medicaid for the treatment of an emergency medical condition during the five-year waiting period. (Having 40 qualifying quarters does not exempt a person from the five-year waiting period.) **If more than five years** have passed since the date of qualified alien classification, usually the entry date, **then** the LPR alien is eligible if the LPR alien meets the criteria in Section D-8320. Unless the LPR alien meets the criteria in Section D-8320, consider Medicaid for the treatment of an emergency medical condition.

Chart C — LPR Aliens With or Without the Five-Year Waiting Period

If the LPR alien entered the U.S. before Aug. 22, 1996, and the DHS document is an ...	then ...

If the LPR alien entered the U.S. before Aug. 22, 1996, and the DHS document is an ...	then ...
I-551, Resident Alien Card, and does not meet one of the classification codes in Charts A or B, **Notes:** • Any status code that appears on the I-551 is acceptable. • No I-151s were issued after 1978; therefore, any alien admitted after 1978 will have an I-551. • If the LAPR alien loses the I-551, the LAPR alien may present either an I-94 or a passport with the following annotation: "Processed for I-551, Temporary Evidence of Lawful Admission for Permanent Residence, valid until _____, Employment Authorized." • Allow aliens with a DHS document or card showing an entry date on or after Aug. 22, 1996, who claim to have entered before that date, an opportunity to submit evidence of their claimed date of entry.	The LPR alien is eligible if the LPR alien meets the criteria in Section D-8320, Qualified Aliens Not Subject to a Waiting Period or Limited Period, or Section D-8430, LPR Residing in the U.S. on Aug. 22, 1996. Unless the LPR alien meets the criteria in Section D-8320 or Section D-8430, consider Medicaid for the treatment of an emergency medical condition.

Follow your policy clearance request procedures for questions about documents or immigration statuses not listed in this chart.

D-8940 Reserved for Future Use

Revision 17-4; Effective December 1, 2017

D-9000, Alien Sponsorship

Body

Revision 21-1; Effective March 1, 2021

Generally, aliens who seek admission to the U.S. as lawful permanent residents must establish that they will not become "public charges." Many aliens establish that they will not become public charges by having sponsors pledge to support them by signing affidavits of support.

D-9100, Definition of Sponsor and Sponsored Alien

Body

Revision 12-4; Effective December 1, 2012

A sponsored alien is an individual who has been sponsored by a person who signed an affidavit of support (USCIS Form I-864, Affidavit of Support Under Section 213A of the Act, or USCIS Form I-864-A, Contract Between Sponsor and Household Member) on or after Dec. 19, 1997, agreeing to support the alien as a condition of the alien's entry into the U.S.

A sponsor is someone who brings family-based or certain employment-based immigrants to the U.S. and demonstrates that he can provide enough financial support to the immigrant so the individual does not rely on public benefits.

D-9200, Sponsor-to-Alien Deeming Policy

Body

Revision 16-3; Effective September 1, 2016

Note: Sponsor-to-alien deeming policy does not apply to individuals applying for Emergency Medicaid Coverage for Aliens. Please see Section A-2200 for more.

The applicant/recipient must first be eligible based on all eligibility criteria before proceeding with sponsor-to-alien deeming.

Keep in mind that most alien applicants who have sponsors will not be eligible aliens. One example of a sponsored alien who **could** be eligible (and subject to sponsor-to-alien deeming) is a sponsored legally admitted for permanent residence (LAPR) alien who is the spouse of a veteran of the U.S. Armed Forces.

Deeming of income and resources for the eligibility and copayment budgets apply regardless of whether:

- the alien and sponsor live in the same household;
- the income and resources are actually available to the alien; and
- the type of assistance for which the alien is applying.

This is because the sponsor agreed to support the alien as a condition of the alien's admission to the U.S. when signing the affidavit of support.

If the alien's sponsor is the alien's ineligible spouse or parent, **sponsor deeming**, not spouse-to-spouse or parent-to-child deeming, **applies** in the case. If sponsor deeming does not apply, for instance the alien has 40 qualifying quarters or meets another exception in D-9220, then apply spouse-to-spouse or parent-to-child deeming.

The income and resources of the sponsor's spouse are included if the sponsor and his or her spouse live in the same household.

For deeming purposes, a sponsor does not include an organization such as a church congregation or a service club, or an employer who only guarantees employment for an alien upon entry to the U.S. but does not sign an affidavit of support.

D-9210 Deeming Period

Revision 12-4; Effective December 1, 2012

The income and resources of an alien are deemed to include the income and resources of the alien's sponsor beginning from the alien's date of admission into the U.S.

The date of admission is the date established by the U.S. Citizenship and Immigration Services as the date the alien is admitted for permanent residence.

Deeming ceases to apply **the month after the month:**

- the alien becomes a naturalized citizen of the U.S.;
- the sponsor dies; or
- the alien is no longer LAPR and has departed the U.S.

Deeming ceases to apply **in the month** the LAPR alien can be credited with 40 quarters.

If none of the above events occurs, deeming continues indefinitely.

D-9220 Deeming Exceptions

Revision 12-4; Effective December 1, 2012

Sponsor-to-alien deeming does not apply to all aliens.

Deeming does not apply to aliens:

- who were sponsored by an organization or are not required to have sponsors,
- with 40 qualifying quarters,
- with refugee status,
- with asylee status,
- whose deportation has been withheld.

Exceptions also apply when:

- a qualified alien, a qualified alien's child or a qualified alien child's parent has been battered or subjected to extreme cruelty in the U.S., **and**
  - there is a substantial connection between the battery and the need for benefits, **and**
  - the individual subject to such battery or cruelty does not live in the same household with the individual responsible for the cruelty or battery, **and**
  - the Department of Homeland Security (DHS) or the Executive Office for Immigration Review (EOIR) has approved the alien's petition, or has found that the alien's pending petition sets forth a prima facie case, under one of the provisions of the Immigration and Naturalization Act (INA).

    Note: When the battery exception is allowed, deeming can be suspended for 12 months. After 12 months, the exception can be continued **only** under certain specified conditions and on a case-by-case basis.
- sponsor deeming results in **denial and** the alien is unable to obtain both food and shelter. In determining whether the alien is unable to obtain both food and shelter, consider:
  - all of the alien's own income and resources (including income excluded when determining eligibility); and
  - any cash, food, housing or other assistance provided by other individuals (including the sponsor).

  When deeming is suspended under this exception, the only income from the sponsor that is included as the alien's income is the amount of cash or support and maintenance the alien actually receives from the sponsor. A sponsor's resources are considered to be the alien's resources only if the alien has an ownership interest in them, can convert them (if not cash), and is not restricted from using them.

The sponsor may be liable for repayment of benefits received by the alien applicant/recipient when deeming is suspended under this exception.

Note: When this exception is allowed, deeming is suspended for 12 consecutive months. Multiple occurrences of this exception are permissible.

D-9230 Providing Verification of Alien Sponsor's Income and Resources

Revision 12-4; Effective December 1, 2012

When sponsor-to-alien deeming applies, the alien is responsible for providing

- a copy of the sponsor's affidavit of support (USCIS Form I-864 or USCIS Form I-864A); **or**
- name, address and phone number of sponsor and any co-sponsor(s);
- verification of the sponsor's and sponsor's spouse's income and resources; **and**
- the number of tax dependents claimed by sponsor and sponsor's spouse.

Reminder: Sponsor's spouse's information is required when he is the co-sponsor or lives in the same household as the sponsor.

If the alien fails to provide the requested sponsor verification by the required date, **deny** the application based on failure to furnish information.

Note: Normal verification procedures apply. For instance, if the type of assistance allows for acceptance of verbal statements as verification, accept the applicant/recipient's declaration for the required information.

D-9300, Sponsor-to-Alien Resource Deeming

Body

Revision 12-4; Effective December 1, 2012

Evaluate the resources of an alien's sponsor and the sponsor's spouse (if living in the same household). Before deeming a sponsor's resources to an alien, allow the same exclusions to the sponsor's resources as for the applicant/recipient.

Next, allocate for the sponsor or for the sponsor and his spouse a portion of the resources. The amount of the allocation is based on the following.

- **Sponsor Does Not Live With a Spouse or Spouse is the Applicant/Recipient** – equal to the SSI resource limit for an individual.
- **Sponsor Lives With a Spouse and Spouse is Not Alien's Sponsor** – equal to the SSI resource limit for a couple.
- **Sponsor Lives With a Spouse and Spouse is Also a Sponsor of the Alien** – equal to the SSI resource limit for two individuals (twice the SSI individual limit).

Add the remainder to the alien's countable resources. If both members of an eligible couple have the same sponsor, the entire amount of the sponsor's resources is deemed to each member. The couple's countable resources include the sum of their deemed resource amounts.

If an alien is sponsored by more than one individual (other than two sponsors who are married to each other and living together), the sponsor-to-alien deeming rules are applied **separately to the resources of each sponsor** to determine the total resources deemable to the alien.

If only one member of a couple is sponsored, and that member is an **ineligible** spouse, sponsor-to-alien deeming does not apply to the eligible member of the couple (nor would it be applicable to the ineligible member of the couple).

D-9310 Examples of Sponsor-to-Alien Resource Deeming

Revision 12-4; Effective December 1, 2012

Example 1: Sponsor does not live with spouse

After applying all applicable resource exclusions, the specialist determines the sponsor has $3,200 in countable resources. The current resource limit for an individual is $2,000.

$1,200 ($3,200-$2,000) of the sponsor's resources is deemed to the alien.

Example 2: Sponsor lives with non-sponsor spouse

After applying all applicable resource exclusions, the specialist determines the sponsor and sponsor's spouse have combined countable resources of $3,500. The current resource limit for a couple is $3,000.

$500 ($3,500-$3,000) of the sponsor's and sponsor's spouse's resources is deemed to the alien.

Example 3: Sponsor lives with spouse, who is also alien's sponsor

After applying all applicable resource exclusions, the specialist determines the sponsor and sponsor's spouse have combined countable resources of $3,500. The current resource limit for an individual is $2,000.

None of the sponsor's and sponsor's spouse's resources are deemed to the alien, since their value is under $4,000 (twice the individual resource limit of $2,000).

D-9400, Sponsor-to-Alien Income Deeming

Body

Revision 15-4; Effective December 1, 2015

Evaluate the earned and unearned income of an alien's sponsor and the sponsor's spouse (if living in the same household). Unlike the treatment of resources, the sponsor's income does not receive the same income exclusions given to an applicant.

Include all the income of a sponsor of an alien and, when applicable, the income of the spouse of the sponsor, except for support and maintenance assistance and income excluded under federal laws other than the Social Security Act. See D-9500, Income Excluded from Sponsor-to-Alien Deeming, for a list of this excluded income.

Allocations are given to the sponsor and the sponsor's dependents, if applicable. A dependent is defined as someone for whom the sponsor is entitled to take a deduction on his personal income tax return.

Exception: An alien and an alien's spouse are not considered to be dependents of the alien's sponsor for the purposes of these rules.

The dependent's income is not subtracted from the dependent's allocation.

Next, deduct allocations for the sponsor and the sponsor's dependents as follows:

- an amount equal to the federal benefit rate (FBR) for an individual for the sponsor;
- an amount equal to one-half the FBR for an individual for the spouse living in the same household with the sponsor **or** an amount equal to the FBR for an individual for the spouse who is also a **co-sponsor** (spouse allocation is not applicable if the spouse is the applicant/recipient); **plus**
- an amount equal to one-half the FBR for an individual for each dependent of the sponsor. (If both members of a couple are sponsors, only one allocation is given for each dependent even if the person is a dependent of both spouses.)

Deem the balance of the income to the alien as unearned income. If both members of an eligible couple have the same sponsor, the sponsor's income is deemed to **each** member. The couple's countable income includes the sum of their deemed income amounts.

If an alien is sponsored by more than one individual (other than two sponsors who are married to each other and living together), the sponsor-to-alien deeming rules are applied **separately to the income of each sponsor** to determine the total income deemable to the alien.

If only one member of a couple is sponsored and that member is an **ineligible** spouse, sponsor-to-alien deeming does not apply to the eligible member of the couple (nor would it be applicable to the ineligible member of the couple).

Note: When the sponsor's income is deemed to the alien applicant/recipient, cash, support and maintenance provided by the sponsor are **not** counted as income unless the indigence exception is granted. See D-9220, Deeming Exceptions.

D-9410 Examples of Sponsor-to-Alien Income Deeming

Revision 21-1; Effective March 1, 2021

Example 1: Sponsor lives with non-sponsor spouse and children. Only the sponsor has income.

An alien applicant has no income, and the sponsor has a monthly earned income of $3,300 and unearned income of $70. The sponsor's dependents (spouse and three children) have no income.

Add the sponsor's earned and unearned income for a total of $3,370 and apply the allocations for the sponsor and his dependents.

Total allocations equal $2,382: $794 (FBR for an individual) for the sponsor + $397 (one-half the FBR for an individual) for the non-sponsor spouse + $1,191 (one-half the FBR for an individual, $397 each) for the sponsor's three children.

Deduct the allocation amount of $2,382 from the sponsor's total income of $3,370, which leaves $988 to be deemed to the alien as his **unearned** income. This amount is subject to the $20 general income exclusion when determining his eligibility.

Example 2: Sponsor lives with non-sponsor spouse and children. Both the sponsor and spouse have income.

An alien couple with no income applies for benefits. The sponsor has earned income of $2,350, and the non-sponsor spouse has earned income of $450. Their two children have no income.

Combine the sponsor's and spouse's income for a total of $2,800 ($2,350+$450) and apply the allocations for the sponsor and his dependents.

Total allocations equal $1,985: $794 (FBR for an individual) for the sponsor + $397 (one-half the FBR for an individual) for the non-sponsor spouse + $794 (one-half the FBR for an individual, $397 each) for the sponsor's two children.

Deduct the allocation amount of $1,985 from the sponsor's and spouse's total income of $2,800, which leaves $815. This amount must be deemed independently to each applicant. The $1,630 deemed income ($815 each) is unearned income to the alien couple and is subject to the $20 general income exclusion when determining the couple's eligibility.

Example 3: Sponsor lives with spouse, who is also alien's sponsor, and children. Both sponsors have income.

An alien couple with no income is applying for benefits. The sponsor has an earned income of $2,350, and the co-sponsor, who lives with them, has an earned income of $650. Their two children have no income.

Combine the sponsor's and co-sponsor's income for a total of $3,000 ($2,350 + $650) and apply the allocations for the sponsors and dependents.

Total allocations equal $2,382: $1,588 (two times the FBR for an individual, $794 each) for the sponsor and co-sponsor + $794 (one-half the FBR for an individual, $397 each) for the two children.

Deduct the allocation amount of $2,382 from the sponsors' total income of $3,000, which leaves $618. This amount must be deemed independently to each applicant. The $1,236 deemed income ($618 each) is unearned income to the alien couple and is subject to the $20 general income exclusion when determining the couple's eligibility.

D-9500, Income Excluded from Sponsor-to-Alien Deeming

Body

D-9510 Food

Revision 12-4; Effective December 1, 2012

- Value of food coupons under the Food Stamp Act of 1977, Section 1301 of Pub. L. 95-113 (91 Stat. 968, 7 USC 2017(b)).
- Value of federally donated foods distributed under Section 32 of Pub. L. 74-320 (49 Stat. 774) or Section 416 of the Agriculture Act of 1949 (63 Stat. 1058, 7 CFR 250.6(e)(9)).
- Value of free or reduced-price food for women and children under the:
  - Child Nutrition Act of 1966, Section 11(b) of Pub. L. 89-642 (80 Stat. 889, 42 USC 1780(b)) and Section 17 of that Act as added by Pub. L. 92-433 (86 Stat. 729, 42 USC 1786); and
  - National School Lunch Act, Section 13(h)(3), as amended by Section 3 of Pub. L. 90-302 (82 Stat. 119, 42 USC 1761(h)(3)).
- Services, except for wages paid to residents who assist in providing congregate services such as meals and personal care, provided a resident of an eligible housing project under a congregate services program under Section 802 of the Cranston-Gonzales National Affordable Housing Act, Public Law 101-625 (104 Stat. 4313, 42 USC 8011).

D-9520 Housing and Utilities

Revision 12-4; Effective December 1, 2012

- Assistance to prevent fuel cut-offs and to promote energy efficiency under the Emergency Energy Conservation Services Program or the Energy Crisis Assistance Program as authorized by Section 222(a)(5) of the Economic Opportunity Act of 1964, as amended by Section 5(d)(1) of Pub. L. No. 93-644 and Section 5(a)(2) of Pub. L. 95-568 (88 Stat. 2294 as amended, 42 USC 2809(a)(5)).
- Home energy assistance payments or allowances under title XXVI of the Omnibus Budget Reconciliation Act of 1981, Public Law 97-35, as amended (42 USC 8624(f)).

  Note: This exclusion applies to a sponsor's income only if the alien is living in the housing unit for which the sponsor receives the home energy assistance payments or allowances.
- Value of any assistance paid with respect to a dwelling unit under:
  - the United States Housing Act of 1937;
  - the National Housing Act;
  - Section 101 of the Housing and Urban Development Act of 1965; or
  - Title V of the Housing Act of 1949.

  Note: This exclusion applies to a sponsor's income only if the alien is living in the housing unit for which the sponsor receives the housing assistance.
- Payments for relocating, made to persons displaced by federal or federally assisted programs, which acquire real property, under Section 216 of Pub. L. 91-646, the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (84 Stat. 1902, 42 USC 4636).

D-9530 Education and Employment

Revision 12-4; Effective December 1, 2012

- Grants or loans to undergraduate students made or insured under programs administered by the Secretary of Education under Section 507 of the Higher Education Amendments of 1968, Pub. L. 90-575 (82 Stat. 1063).
- Any wages, allowances or reimbursement for transportation and attendant care costs, unless excepted on a case-by-case basis, when received by an eligible handicapped individual employed in a project under title VI of the Rehabilitation Act of 1973 as added by title II of Pub. L. 95-602 (92 Stat. 2992, 29 USC 795(b)(c)).
- Student financial assistance for attendance costs received from a program funded in whole or in part under Title IV of the Higher Education Act of 1965, as amended, or under Bureau of Indian Affairs student assistance programs if it is made available for tuition and fees normally assessed a student carrying the same academic workload, as determined by the institution, including costs for rental or purchase of any equipment, materials or supplies required of all students in the same course of study and an allowance for books, supplies, transportation and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution, under Section 14(27) of Public Law 100-50, the Higher Education Technical Amendments Act of 1987 (20 USC 1087uu).

D-9540 Native Americans

Revision 12-4; Effective December 1, 2012

- **Types of Payments Excluded Without Regard to Specific Tribes or Groups**
  - Indian judgment funds that are held in trust by the Secretary of the Interior or distributed per capita pursuant to a plan prepared by the Secretary of the Interior and not disapproved by a joint resolution of Congress under Public Law 93-134 as amended by Section 4 of Public Law 97-458 (96 Stat. 2513, 25 USC 1408). Indian judgment funds include interest and investment income accrued while such funds are so held in trust. This exclusion extends to initial purchases made with Indian judgment funds. This exclusion does not apply to sales or conversions of initial purchases or to subsequent purchases.

    Note: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.
  - All funds held in trust by the Secretary of the Interior for an Indian tribe and distributed per capita to a member of that tribe are excluded from income under Public Law 98-64 (97 Stat. 365, 25 USC 117b). Funds held by Alaska Native Regional and Village Corporations (ANRVC) are not held in trust by the Secretary of the Interior and therefore ANRVC dividend distributions are not excluded from countable income under this exclusion.

    Note: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.
  - Up to $2,000 per year received by Indians that is derived from individual interests in trust or restricted lands under Section 13736 of Public Law 103-66 (107 Stat. 663, 25 USC 1408, as amended).
- **Payments to Members of Specific Indian Tribes and Groups**
  - Per capita payments to members of the Red Lake Band of Chippewa Indians from the proceeds of the sale of timber and lumber on the Red Lake Reservation under Section 3 of Public Law 85-794 (72 Stat. 958).
  - Per capita distribution payments by the Blackfeet and Gros Ventre tribal governments to members that resulted from judgment funds to the tribes under Section 4 of Public Law 92-254 (86 Stat. 65) and under Section 6 of Public Law 97-408 (96 Stat. 2036).
  - Settlement fund payments and the availability of such funds to members of the Hopi and Navajo Tribes under Section 22 of Public Law 93-531 (88 Stat. 1722) as amended by Public Law 96-305 (94 Stat. 929).

    Note: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.
  - Judgment funds distributed per capita to, or held in trust for, members of the Sac and Fox Indian Nation, and the availability of such funds under Section 6 of Public Law 94-189 (89 Stat. 1094).

    Note: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.
  - Judgment funds distributed per capita to, or held in trust for, members of the Grand River Band of Ottawa Indians, and the availability of such funds under Section 6 of Public Law 94-540 (90 Stat. 2504).

    Note: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.
  - Any judgment funds distributed per capita to members of the Confederated Tribes and Bands of the Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation under Section 2 of Public Law 95-433 (92 Stat. 1047, 25 USC 609c-1).
  - Any judgment funds distributed per capita or made available for programs for members of the Delaware Tribe of Indians and the absentee Delaware Tribe of Western Oklahoma under Section 8 of Public Law 96-318 (94 Stat. 971).

- All funds and distributions to members of the Passamaquoddy Tribe, the Penobscot Nation and the Houlton Band of Maliseet Indians under the Maine Indian Claims Settlement Act, and the availability of such funds under Section 9 of Public Law 96-420 (94 Stat. 1795, 25 USC 1728(c)).

  Note: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.
- Any distributions of judgment funds to members of the San Carlos Apache Indian Tribe of Arizona under Section 7 of Public Law 93-134 (87 Stat. 468) and Public Law 97-95 (95 Stat. 1206).

  Note: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.
- Any distribution of judgment funds to members of the Wyandot Tribe of Indians of Oklahoma under Section 6 of Public Law 97-371 (96 Stat. 1814).
- Distributions of judgment funds to members of the Shawnee Tribe of Indians (Absentee Shawnee Tribe of Oklahoma, the Eastern Shawnee Tribe of Oklahoma and the Cherokee Band of Shawnee descendants) under Section 7 of Public Law 97-372 (96 Stat. 1816).
- Judgment funds distributed per capita or made available for programs for members of the Miami Tribe of Oklahoma and the Miami Indians of Indiana under Section 7 of Public Law 97-376 (96 Stat. 1829).
- Distributions of judgment funds to members of the Clallam Tribe of Indians of the State of Washington (Port Gamble Indian Community, Lower Elwha Tribal Community and the Jamestown Band of Clallam Indians) under Section 6 of Public Law 97-402 (96 Stat. 2021).
- Judgment funds distributed per capita or made available for programs for members of the Pembina Chippewa Indians (Turtle Mountain Band of Chippewa Indians, Chippewa Cree Tribe of Rocky Boy's Reservation, Minnesota Chippewa Tribe, Little Shell Band of the Chippewa Indians of Montana, and the nonmember Pembina descendants) under Section 9 of Public Law 97-403 (96 Stat. 2025).
- Per capita distributions of judgment funds to members of the Assiniboine Tribe of Fort Belknap Indian Community and the Papago Tribe of Arizona under Sections 6 and 8(d) of Public Law 97-408 (96 Stat. 2036, 2038).
- Up to $2,000 of per capita distributions of judgment funds to members of the Confederated Tribes of the Warm Springs Reservation under Section 4 of Public Law 97-436 (96 Stat. 2284).

  Note: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.
- Judgment funds distributed to the Red Lake Band of Chippewa Indians under Section 3 of Public Law 98-123 (97 Stat. 816).
- Funds distributed per capita or family interest payments for members of the Assiniboine Tribe of Fort Belknap Indian Community of Montana and the Assiniboine Tribe of the Fort Peck Indian Reservation of Montana under Section 5 of Public Law 98-124 (97 Stat. 818).
- Distributions of judgment funds and income derived therefrom to members of the Shoalwater Bay Indian Tribe under Section 5 of Public Law 98-432 (98 Stat. 1672).
- All distributions to heirs of certain deceased Indians under Section 8 of the Old Age Assistance Claims Settlement Act, Public Law 98-500 (98 Stat. 2319).

  Note: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.
- Judgment funds distributed per capita or made available for any tribal program for members of the Wyandotte Tribe of Oklahoma and the Absentee Wyandottes under Section 106 of Public Law 98-602 (98 Stat. 3151).
- Per capita and dividend payment distributions of judgment funds to members of the Santee Sioux Tribe of Nebraska, the Flandreau Santee Sioux Tribe, the Prairie Island Sioux, Lower Sioux, and Shakopee Mdewakanton Sioux Communities of Minnesota under Section 8 of Public Law 99-130

(99 Stat. 552) and Section 7 of Public Law 93-134 (87 Stat. 468), as amended by Public Law 97-458 (96 Stat. 2513; 25 USC 1407).

- Funds distributed per capita or held in trust for members of the Chippewas of Lake Superior and the Chippewas of the Mississippi under Section 6 of Public Law 99-146 (99 Stat. 782).
- Distributions of claims settlement funds to members of the White Earth Band of Chippewa Indians as allottees, or their heirs, under Section 16 of Public Law 99-264 (100 Stat. 70).
- Payments or distributions of judgment funds, and the availability of any amount for such payments or distributions, to members of the Saginaw Chippewa Indian Tribe of Michigan under Section 6 of Public Law 99-346 (100 Stat. 677).

  Note: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.
- Judgment funds distributed per capita or held in trust for members of the Chippewas of Lake Superior and the Chippewas of the Mississippi under Section 4 of Public Law 99-377 (100 Stat. 805).
- Judgment funds distributed to members of the Cow Creek Band of Umpqua Tribe of Indians under Section 4 of Public Law 100-139 (101 Stat. 822).
- Per capita payments of claims settlement funds to members of the Coushatta Tribe of Louisiana under Section 2 of Public Law 100-411 (102 Stat. 1097) and Section 7 of Public Law 93-134 (87 Stat. 468), as amended by Public Law 97-458 (96 Stat. 2513; 25 USC 1407).

  Note: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.
- Funds distributed per capita for members of the Hoopa Valley Indian Tribe and the Yurok Indian Tribe under Sections 4, 6 and 7 of Public Law 100-580 (102 Stat. 2929, 2930, 2931) and Section 3 of Public Law 98-64 (97 Stat. 365; 25 USC 117b).

  Note: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.
- Judgment funds held in trust by the United States, including interest and investment income accruing on such funds, and judgment funds made available for programs or distributed to members of the Wisconsin Band of Potawatomi (Hannahville Indian Community and Forest County Potawatomi) under Section 503 of Public Law 100-581 (102 Stat. 2945)

  Note: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.
- Judgment funds distributed per capita, or held in trust, or made available for programs, for members of the Seminole Nation of Oklahoma, the Seminole Tribe of Florida, the Miccosukee Tribe of Indians of Florida and the independent Seminole Indians of Florida under Section 8 of Public Law 101-277 (104 Stat. 145).

  Note: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.
- Per capita distributions of settlement funds under Section 102 of the Fallon Paiute Shoshone Indian Tribes Water Rights Settlement Act of 1990, Public Law 101-618 (104 Stat. 3289) and Section 7 of Public Law 93-134 (87 Stat. 468), as amended by Public Law 97-458 (96 Stat. 2513; 25 USC 1407).
- Settlement funds, assets, income, payments, or distributions from Trust Funds to members of the Catawba Indian Tribe of South Carolina under Section 11(m) of Public Law 103-116 (107 Stat. 1133).
- Settlement funds held in trust (including interest and investment income accruing on such funds) for, and payments made to, members of the Confederated Tribes of the Colville Reservation under Section 7(b) of Public Law 103-436 (108 Stat. 4579).

Note: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.
  - Judgment funds distributed under Section 111 of the Michigan Indian Land Claims Settlement Act, (Pub. L. 105-143, 111 Stat. 2665).
  - Judgment funds distributed under Section 4 of the Cowlitz Indian Tribe Distribution of Judgment Funds Act, (Pub. L. 108-222, 118 Stat. 624).
- **Receipts from Lands Held in Trust for Certain Tribes or Groups—**
  - Receipts from land held in trust by the federal government and distributed to members of certain Indian tribes under Section 6 of Public Law 94-114 (89 Stat. 579, 25 USC 459e).

    Note: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.
  - Receipts derived from trust lands awarded to the Pueblo of Santa Ana and distributed to members of that tribe under Section 6 of Public Law 95-498 (92 Stat. 1677).
  - Receipts derived from trust lands awarded to the Pueblo of Zia of New Mexico and distributed to members of that tribe under Section 6 of Public Law 95-499 (92 Stat. 1680).

D-9550 Other

Revision 12-4; Effective December 1, 2012

- Any assistance to an individual (other than wages or salaries) under the Older Americans Act of 1965, as amended by Section 102(h)(1) of Pub. L. 95-478 (92 Stat. 1515, 42 USC 3020a).
- Amounts paid as restitution to certain individuals of Japanese ancestry and Aleuts for losses suffered as a result of evacuation, relocation, and internment during World War II, under the Civil Liberties Act of 1988 and the Aleutian and Pribilof Islands Restitution Act, Sections 105(f) and 206(d) of Public Law 100-383 (50 USC App. 1989 b and c).
- Payments made on or after Jan. 1, 1989, from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, MDL No. 381 (E.D.N.Y.) under Public Law 101-201 (103 Stat. 1795) and Section 10405 of Public Law 101-239 (103 Stat. 2489).
- Payments made under Section 6 of the Radiation Exposure Compensation Act, Public Law 101-426 (104 Stat. 925, 42 USC 2210).
- The value of any child care provided or arranged (or any payment for such care or reimbursement for costs incurred for such care) under the Child Care and Development Block Grant Act, as amended by Section 8(b) of Public Law 102-586 (106 Stat. 5035).
- Payments made to individuals because of their status as victims of Nazi persecution excluded pursuant to Section 1(a) of the Victims of Nazi Persecution Act of 1994, Public Law 103-286 (108 Stat. 1450).
- Any matching funds from a demonstration project authorized by the Community Opportunities, Accountability, and Training and Educational Services Act of 1998 (Pub. L. 105-285) and any interest earned on these matching funds in an Individual Development Account, pursuant to Section 415 of Pub. L. 105-285 (112 Stat. 2771).
- Any earnings, Temporary Assistance for Needy Families matching funds, and interest in an Individual Development Account, pursuant to Section 103 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Pub. L. 104-193, 42 USC 604(h)(4)).
- Payments made to individuals who were captured and interned by the Democratic Republic of Vietnam as a result of participation in certain military operations, pursuant to Section 606 of the Departments of Labor, Health and Human Services and Education and Related Agencies Appropriations Act of 1996 (Pub. L. 105-78).
- Payments made to certain Vietnam veterans' children with spina bifida, pursuant to Section 421 of the Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies

Appropriations Act of 1997 (Pub. L. 104-204, 38 USC 1805(a)).

- Payments made to the children of female Vietnam veterans who suffer from certain birth defects, pursuant to Section 401 of the Veterans Benefits and Health Care Improvement Act of 2000 (Pub. L. 106-419 (38 USC 1833(c)).
- Payments of the refundable child tax credit made under Section 24 of the Internal Revenue Code of 1986, pursuant to Section 203 of the Economic Growth and Tax Relief Reconciliation Act of 2001, Public Law 107-16 (115 Stat. 49, 26 USC 24 note).
- Assistance provided for flood mitigation activities as provided under Section 1324 of the National Flood Insurance Act of 1968, pursuant to Section 1 of Public Law 109-64 (119 Stat. 1997, 42 USC 4031).
- Payments made to individuals under the Energy Employees Occupational Illness Compensation Program Act of 2000, pursuant to Section 1 [Div. C, Title XXXVI Section 3646] of Public Law 106-398 (114 Stat. 1654A-510, 42 USC 7385e).

D-9600, Notification Requirements

Body

Revision 12-4; Effective December 1, 2012

If deeming income or resources from a sponsor results in the alien being found:

Ineligible — indicate on the notice that the denial was a result of deeming income or deeming resources from the alien's sponsor.

Eligible — indicate on the notice that the sponsor(s) may be liable for repayment of benefits received by the alien applicant/recipient.

Chapter E, General Income

E-1000, General Income

E-1100, Texas Administrative Code Rules

Body

Revision 10-1; Effective March 1, 2010

§358.381. General Treatment of Income.

(a) The Texas Health and Human Services Commission (HHSC) follows §1612 of the Social Security Act (42 U.S.C. §1382a) and 20 CFR §§416.1101 - 416.1104 regarding the definition and general treatment of income for the purpose of determining financial eligibility and calculating a co-payment.

(b) A lump sum payment is countable income in the month of receipt and is a resource thereafter.

(c) A person in an institutional setting may retain a personal needs allowance (PNA) in an amount set by the HHSC executive commissioner in accordance with Chapter 32 of the Texas Human Resources Code.

(1) The PNA is not applied toward the cost of medical assistance furnished in an institutional setting.

(2) For a person receiving the reduced SSI federal benefit rate, HHSC issues a supplement to give the person a PNA at the minimum level set by the HHSC executive commissioner.

(d) An action by a fiduciary agent is the same as an action by the person for whom the fiduciary agent acts.

(1) Monies received by a fiduciary agent for another person are not income to the fiduciary agent. If the fiduciary agent is authorized to keep part of the money as compensation for services rendered, the compensation for services rendered is unearned income to the fiduciary agent.

(2) Monies received by a fiduciary agent for another person are charged as income to the person when the monies are received by the fiduciary agent.

§358.382. Variable Monthly Income.

The Texas Health and Human Services Commission averages monthly countable income that is predictable but varies in amount from month to month.

§358.383. Deeming of Income.

The Texas Health and Human Services Commission follows 20 CFR §§416.1160-416.1166 regarding the definition and treatment of deemed income for a person in a noninstitutional setting.

§358.384. Temporary Absence.

The Texas Health and Human Services Commission follows 20 CFR §416.1149 and §416.1167 regarding the definition and treatment of a temporary absence from a person's living arrangement for deeming purposes for a person in a noninstitutional setting.

§358.385. Cafeteria Plan Benefits.

The Texas Health and Human Services Commission exempts cafeteria plan benefits as defined in and based on §125 of the Internal Revenue Code (IRC), except that:

(1) cash received under a cafeteria plan in lieu of benefits is not exempt, but is counted as earned income; and

(2) payroll deductions used to purchase cafeteria plan benefits in addition to or instead of those purchased under a salary reduction agreement are not exempt, but are part of the employee's wages and are counted as earned income.

§358.386. Reduction of Pension and Benefit Checks for Recoupment of Overpayments.

If a person's pension or benefit checks are reduced because of recovery of overpayments, the following apply:

(1) All overpayments except Retirement, Survivors, and Disability Insurance (RSDI).

(A) If a person was receiving Supplemental Security Income (SSI) or assistance under a Medicaid-funded program for the elderly and people with disabilities (MEPD) at the time of overpayment, the Texas Health and Human Services Commission (HHSC) disregards as income the amount being recovered. HHSC counts the net amount of the benefit (that is, the gross benefit minus the amount being recouped) for the purpose of determining eligibility and calculating a co-payment.

(B) If a person was not receiving SSI or assistance under MEPD at the time of overpayment, HHSC counts the recovered amount as income. HHSC counts the gross amount of the benefit for the purpose of determining eligibility and calculating a co-payment.

(2) RSDI overpayments.

(A) If a person receives an overpayment of Social Security (RSDI or Title II) benefits, recoupment is not voluntary. HHSC counts the net amount of the RSDI benefit (that is, the gross RSDI minus the amount being recouped) for the purpose of determining eligibility and calculating a co-payment.

(B) If a person receives an overpayment of SSI benefits and the person is still eligible for SSI, the recoupment is voluntary. HHSC determines if the person signed a voluntary agreement for recoupment. If there is a signed agreement, HHSC counts the gross RSDI for the purpose of determining eligibility and calculating a co-payment. If there is no signed agreement, there should be no recoupment from RSDI benefits.

(C) If a person receives an overpayment of SSI benefits and the person is no longer eligible for SSI, recoupment of any RSDI or Title II benefits is not voluntary. HHSC counts the net amount of the RSDI benefit (that is, the gross RSDI minus the amount being recouped) for the purpose of determining eligibility and calculating a co-payment.

§358.387. Income Exclusions.

(a) The Texas Health and Human Services Commission (HHSC) follows 20 CFR §416.1112 and §416.1124 regarding income exclusions, except when testing income eligibility under the special income limit HHSC does not allow the exclusions:

(1) in 20 CFR §416.1112(c)(4), (5), and (7); or

(2) in 20 CFR §416.1124(c)(12), unless:

(A) the person meets the criteria under §1929(b)(2)(B) of the Social Security Act (42 U.S.C. §1396t(b)(2)(B)); and

(B) the Centers for Medicare and Medicaid Services has authorized HHSC to allow the exclusion.

(b) HHSC also excludes income described in the appendix to Subpart K in 20 CFR Part 416.

§358.391. Treatment of Other Income.

The Texas Health and Human Services Commission follows the federal regulations indicated in the table in this section regarding the treatment of income not otherwise described in this division

Type of Income	Section(s) in 20 CFR:
Assistance received due to a major disaster; repair or replacement of lost, damaged, or stolen resources due to a disaster	416.1150 416.1151
Earned income	416.1110- 416.1112
Support and maintenance assistance, including home energy assistance	416.1157
Income used to fulfill a plan to achieve self-support (PASS) for a person who is blind or disabled	416.1180- 416.1182
In-kind support and maintenance	416.1130- 416.1148
Unearned income	416.1120- 416.1124

E-1200, General Income

Body

Revision 09-4; Effective December 1, 2009

A person is eligible for Medicaid if the person:

- is aged, blind or disabled;
- meets the income and resource limits; and
- meets all other requirements for the specific MEPD program.

This chapter covers treatment of income to budget to determine eligibility and, if applicable, co-payment. Treatment of budgets is covered in other chapters.

For purposes of Medicaid, income is anything a person receives in cash or in kind that can be used to meet the person's needs for food and shelter. It is the receipt of any property or service a person can apply, either directly or by sale or conversion, to meet basic needs for food and shelter. Income is normally counted on a monthly basis; not all income goes into the budget to determine eligibility and the co-payment.

The receipt of a payment – in the form of cash, property, or service – is income in the month of receipt and a resource as of 12:01 a.m. on the first day of the month after receipt.

E-1210 Other Terms

Revision 09-4; Effective December 1, 2009

Calendar quarter — A period of three full calendar months beginning with January, April, July or October.

Child — A person who is not married, is not the head of a household, and is either under age 18 or is under age 22 and a student.

Couple — An eligible individual and his or her eligible spouse.

Supplemental Security Income (SSI) benefit rate — The payment amount in the SSI program.

Federal benefit rate — The monthly payment rate for an eligible individual or couple. It is the figure from which countable income is subtracted to find out how much a person's federal SSI benefit should be. The federal benefit rate does not include the rate for any state supplement paid by us on behalf of the state.

Shelter — Includes room, rent, mortgage payments, real property taxes, heating fuel, gas, electricity, water, sewerage and garbage collection services. A person is not receiving in-kind support and maintenance in the form of room or rent if the person is paying the amount charged under a business arrangement. A business arrangement exists when the amount of monthly rent required to be paid equals the current market rental value.

Income — The receipt of any property or service a person can apply, either directly or by sale or conversion, to meet basic needs for food and shelter.

Countable income — The amount of a client's income after all exemptions and exclusions.

Income of spouse — Income considered when one member of a couple is institutionalized. Income paid to one spouse is considered to be the income of that spouse, unless a fair hearings process establishes otherwise, or the payor provides evidence that the income is augmented for a spouse, such as VA benefits. Income from community property paid to only one spouse is considered the income of that spouse regardless of state law

governing community property or division of marital property. (Consult the regional attorney about ownership of income from a trust.)

E-1300, Types of Income

Body

Revision 09-4; Effective December 1, 2009

There are two major types of income:

- Unearned
- Earned

Income, whether earned or unearned, is received in either of two forms:

Cash — Currency, checks, money orders or electronic funds transfers (EFT), such as:

- Social Security checks;
- unemployment compensation checks; or
- payroll checks or currency.

In-kind — Noncash items such as:

- real property (including shelter);
- food; and
- noncash wages (for example, room and board as compensation for employment).

Income, whether cash or in-kind, is received in either of two ways:

Fixed — Income received on a regular, predictable schedule (usually monthly) and for the same amount each month, such as:

- Social Security checks;
- VA checks; or
- state retirement checks.

Variable — Income that is either received on a varying schedule or for different amounts, such as:

- payroll checks or currency;
- monthly bank interest; or
- gas production checks.

E-1310 Relationship of Income to Resources

Revision 09-4; Effective December 1, 2009

In general, anything received in a month, from any source, is income to a person, if it meets the person's needs for food and shelter. Anything the person owned prior to the month under consideration is subject to the resource counting rules.

An item received in the current month is income for the current month only. If held by the person until the following month, that item is subject to resource counting rules.

Exceptions: Occasionally, a regular periodic payment (for example, wages, pension or VA benefits) is received in a month other than the month of normal receipt. As long as there is no intent to interrupt the regular payment schedule, consider the funds to be income in the normal month of receipt.

A lump sum payment is income in the month of receipt and is a resource thereafter.

E-1320 Fiduciary Agent

Revision 09-4; Effective December 1, 2009

An action by a fiduciary agent is the same as an action by the person for whom the fiduciary agent acts.

- Monies received by a fiduciary agent for another person are not income to the fiduciary agent. If the fiduciary agent is authorized to keep part of the money as compensation for services rendered, the compensation for services rendered is unearned income to the fiduciary agent.
- Monies received by a fiduciary agent for another person are charged as income to the person when the monies are received by the fiduciary agent.

E-1400, Garnishment or Seizure

Body

Revision 09-4; Effective December 1, 2009

A **garnishment** or **seizure** is a withholding of an amount from earned or unearned income in order to satisfy a debt or legal obligation.

Amounts withheld from income as garnishment to satisfy a debt or legal obligation are countable income.

E-1410 Division of Marital Income and Property

Revision 16-4; Effective December 1, 2016

A division of income and property in a divorce settlement is not considered a garnishment or lien placed against income. When an individual is paying income to a former spouse, consider court documentation before determining the ownership and accessibility of the income. A legal review of the documentation may be necessary to determine ownership and accessibility of income and a pension plan for each of the former spouses. For verification, use one of the following sources:

- court records;
- records of the agency through which the payments are made;
- official documents in the individual's possession (e.g., legal documents) that establish the amount and frequency of the support; or
- report of contact with the source of the payment that includes the amount and frequency of the alimony or spousal support.

If none of the above sources are available, obtain an individual's sworn affidavit that explains why one of the sources above is not available (for example, the documentation does not exist, the court or agency will not release the information or the source refused to cooperate).

A court may issue an order called a domestic relations order that provides income such as spousal support which may also be called alimony (see E-3320 , Alimony and Support Payments), to the former spouse.

- If the court order indicates the applicant/recipient is paying spousal support payments or alimony to the former spouse, the payment is still considered countable unearned income to the applicant/recipient.
- If the former spouse is the applicant/recipient, the receipt of spousal support payments or alimony is also countable income to the former spouse.

A Qualified Domestic Relations Order (QDRO) is a property settlement that assigns all or a portion of a retirement plan to the former spouse. An employer or retirement plan administrator may refuse to recognize a QDRO and separate the retirement plan payments to each individual. Consider the portion of the retirement plan payments as income to each individual as stipulated in the QDRO, regardless if the retirement plan administrator pays each individual their portion or only pays the retiree who then pays the former spouse.

Note: For individuals who are active or retired from the military, a marital division of property may be similar to a domestic relations order or a QDRO. A legal review of the documentation may be necessary to determine ownership and accessibility of income and a pension plan for each of the former spouses.

E-1420 Deeming and Court-Ordered Support Payments

Revision 09-4; Effective December 1, 2009

If income of an ineligible spouse, parent or ineligible child is garnished to pay court-ordered or Title IV-D enforced support payments, do not consider the income used by these individuals to make support payments. Support payments are payments made under a court order or enforced in compliance with a state agreement under Title IV-D. Title IV-D child support payments are usually made directly to the state.

E-1500, Income and Transfer of Assets

Body
Revision 09-4; Effective December 1, 2009

An irrevocable waiver of income must be evaluated for a transfer of assets penalty. See Chapter I, Transfer of Assets.

E-1600, Reduction of Checks for Recoupment of Overpayments

Body

Revision 09-4; Effective December 1, 2009

If a person's pension or benefit checks are reduced because of recovery of overpayments, the amount considered as income is based on the source of the payment.

E-1610 SSA Overpayments

Revision 12-4; Effective December 1, 2012

If a person receives an overpayment of Social Security (RSDI or Title II) benefits, recoupment is not voluntary. HHSC counts the net amount of the RSDI benefit (for example, the gross RSDI minus the amount being recouped) for the purpose of determining eligibility and calculating a co-payment.

If a person receives an overpayment of SSI benefits and the person:

- is still eligible for SSI, the recoupment is voluntary. HHSC determines if the person signed a voluntary agreement for recoupment. If there is a signed agreement, HHSC counts the gross RSDI for the purpose of determining eligibility and calculating a co-payment. If there is no signed agreement, there should be no recoupment from RSDI benefits.
- is no longer eligible for SSI, recoupment of any RSDI or Title II benefits is not voluntary. HHSC counts the net amount of the RSDI benefit (that is, the gross RSDI minus the amount being recouped) for eligibility and applied income purposes.

E-1620 All Other Overpayments

Revision 09-4; Effective December 1, 2009

If a person was receiving SSI or assistance under MEPD at the time of overpayment, HHSC disregards as income the amount being recovered. HHSC counts the net amount of the benefit (for example, the gross benefit minus the amount being recouped) for the purpose of determining eligibility and calculating a co-payment.

If a person was not receiving SSI or assistance under MEPD at the time of overpayment, HHSC counts the recovered amount as income. HHSC counts the gross amount of the benefit for the purpose of determining eligibility and calculating a co-payment.

E-1700, Things That Are Not Income

Body

Revision 09-4; Effective December 1, 2009

Some things a person receives are not income because the person cannot use those things as food or shelter, or cannot use those things to obtain food or shelter. In addition, what a person receives from the sale or exchange of that person's own property is not income; the proceeds of the sale or exchange of the person's property remains a resource. The following are some items that are not income.

E-1710 Medical Care and Services That Are Not Income

Revision 09-4; Effective December 1, 2009

Medical care and services. Medical care and services are not income if they are any of the following:

- Given to a person free of charge or paid for directly to the provider by someone else.

- Room and board a person receives during a medical confinement.
- Assistance provided in cash or in kind (including food or shelter) under a federal, state or local government program whose purpose is to provide medical care or medical services (including vocational rehabilitation).
- In-kind assistance (except food or shelter) provided under a nongovernmental program whose purpose is to provide medical care or medical services.
- Cash provided by any nongovernmental medical care or medical services program.
- Direct payment of the person's medical insurance premiums by anyone on the person's behalf.
- The value of any third-party payment for medical care or medical services furnished to a person.
- The value of advice, consultation, training or other services of a strictly social nature furnished to a person.
- Payments from the Department of Veterans Affairs resulting from unusual medical expenses.
- Cash provided under a health insurance policy (except cash to cover food or shelter) if the cash is either:
  - repayment for program-approved services a person has already paid for; or
  - a payment restricted to the future purchase of a program-approved service.
- Third-party resource (TPR) reimbursements to the person (for example, from medical insurers) for a given medical service that do not exceed the amount spent by the person for that same service.

A premium payment for supplementary medical insurance benefits (SMIB) under Title XVIII (Medicare), paid by a third party directly to the Social Security Administration, is not income.

Refunds to a recipient from the state's Third-Party Recovery Unit are made if TPR payments (for example, from medical insurers) for a given medical service exceed the amount Medicaid paid for that same service. These refunds are income to the person upon receipt.

Examples of medical services include:

- Room and board (food and shelter), provided an individual is an inpatient in a medical treatment facility.
- Payment of bed-hold charges for a nursing facility (NF) resident who is temporarily discharged from the facility.
- In-kind medical items, such as prescription drugs, eyeglasses, and prosthetics and their maintenance. In-kind medical items also include devices intended to make the physical abilities of a person with disabilities equal to those of a person without disabilities, such as electric wheelchairs, modified scooters, specially equipped vehicles, or construction of a carport to a house to protect a specially equipped vehicle. Also included are specially trained animals, such as seeing eye dogs and their maintenance, such as dog food.
- Transportation to and from medical treatment.

E-1720 Social Services That Are Not Income

Revision 18-4; Effective December 1, 2018

A social service is any service, other than medical, that is intended to assist a person with a physical disability or social disadvantage to function in society on a level comparable to that of a person who does not have such a disability or disadvantage. No in-kind items are expressly identified as social services.

Social services. Social services are not income if they are any of the following:

- Assistance provided in cash or in kind (but not received in return for a service the person performs) under any federal, state or local government program whose purpose is to provide social services, including vocational rehabilitation (for example, cash from the Department of Veterans Affairs to purchase aid and attendance).

- In-kind assistance (except food or shelter) provided under a nongovernmental program whose purpose is to provide social services.
- Cash provided by a nongovernmental social services program (except cash to cover food or shelter) if the cash is either:
  - repayment for program-approved services the person already has paid for; or
  - a payment restricted to the future purchase of a program-approved service.

Examples of social service programs:

- Title XX of the Social Security Act provides services directed at the following goals: achieving and maintaining self-sufficiency; preventing and remedying abuse, neglect or exploitation; and preventing inappropriate institutionalization.
- Title IV-B of the Social Security Act, Child Welfare Services, provides for the protection and promotion of the welfare of children.
- Title V of the Social Security Act, Maternal and Child Health and Crippled Children's Services.
- The Rehabilitation Act of 1973 provides services to disabled persons, including vocational rehabilitation, expanding employment opportunities, and promoting self-sufficiency and independence.

Note: Wages and salaries from Title V of the Older Americans Act, such as Green Thumb and Senior Texan Employment Program (STEP), are countable earned income.

Examples of governmental programs that may provide medical and social services in combination are:

- state behavioral mental health programs and programs for individuals with developmental disabilities under the umbrella of services from HHSC; and
- state substance abuse programs.

Examples of nongovernmental organizations that provide medical and social services in combination are the:

- Salvation Army; and
- American Red Cross.

Examples of what is not a social service:

- Training for a specific job skill or trade (vocational training). Do not confuse vocational training with vocational rehabilitation.
- Governmental income maintenance programs, such as SSI, TANF, Bureau of Indian Affairs General Assistance and VA pension or compensation benefits.

Cash received in conjunction with medical or social services:

- Any cash provided by a governmental medical or social services program is not income. An example is cash payments from the Department of Family and Protective Services via the Relative and Other Designated Caregiver Program.
- Any cash from a nongovernmental medical or social services organization is not income if the cash is:
  - for medical or social services already received by the individual and approved by the organization and does not exceed the value of those services; or
  - a payment restricted to the future purchase of a medical or social service.
- Cash from any insurance policy that pays a flat rate benefit to the person without regard to the actual charges or expenses incurred is countable income. An exception to this is if the insurance policy is considered a long-term care insurance policy.

In-kind items received in conjunction with medical or social services:

- In-kind items that meet the definition of medical services are not income regardless of their source.

- Room and board provided during a medical confinement, such as in a medical treatment facility, is not income.
- In-kind items (including food or shelter) provided by a governmental medical or social services program are not income.
- In-kind items (other than food or shelter) provided by a nongovernmental medical or social services organization for medical or social service purposes are not income.
- Food or shelter or other in-kind income provided by a nongovernmental medical or social services organization is income unless excluded under some other section of this handbook (for example, food is provided while a patient is in a medical treatment facility and consequently is not income).

E-1730 Sale of a Resource is Not Income

Revision 09-4; Effective December 1, 2009

Receipts from the sale, exchange or replacement of a resource are not income, but are resources that have changed their form. This includes any cash or in-kind item that is provided to replace or repair a resource that has been lost, damaged or stolen.

Example: If a person sells an automobile, the money a person receives is not income; it is another form of a resource. If fair market value was received for the sale of the automobile, no transfer of assets occurred.

E-1740 Miscellaneous Things That May Not Be Income

Revision 09-4; Effective December 1, 2009

Income tax refunds. Any amount refunded on income taxes the person has already paid is not income. Income tax refunds are subject to restitution policy (in the month of receipt) for co-payment purposes, to the extent that withholding tax was excluded in the co-payment budget.

Payments by credit life or credit disability insurance. Payments made under a credit life or credit disability insurance policy on the person's behalf are not income.

Example: If a credit disability policy pays off the mortgage on the person's home after the person becomes disabled in an accident, neither the payment nor the increased equity in the home is income.

Bills paid for the person. Payment of the person's bills by someone else directly to the supplier is not income. However, the value of anything a person receives because of the payment if it is in-kind income is counted.

Receipt of certain noncash items. Any item a person receives (except shelter as defined in Section E-1210, Other Terms, or food) that would be an excluded nonliquid resource (as described in Chapter F, Resources) if a person kept it is not income.

Example: A community takes up a collection to buy a specially equipped van, which is the person's only vehicle. The value of this gift is not income because the van does not provide the person with food or shelter and will become an excluded nonliquid resource under in the month following the month of receipt.

Replacement of income a person has already received. If income is lost, destroyed or stolen and a person receives a replacement, the replacement is not income.

Weatherization assistance. Weatherization assistance (for example, insulation, storm doors or storm windows) is not income.

E-1750 Proceeds of a Loan

Revision 12-2; Effective June 1, 2012

Money a person borrows or money a person receives as repayment of a loan is not income. However, interest a person receives on money a person has lent is income. Buying on credit is treated as though a person were borrowing money and what a person purchases this way is not income.

A loan requires a bona fide agreement that is legally valid and made in good faith. For the borrower, the loan agreement itself is not a resource. The cash provided by the lender is not income, but is the borrower's resource if retained in the month following the month of receipt.

Proceeds (amount borrowed) of either a commercial loan or an informal loan for which repayment is required with or without interest are not counted as income in the month in which they are received. The proceeds are considered to be a resource in the following month(s). To claim exemption of the proceeds of a loan, a person must prove that he acknowledges an obligation to repay and that some plan for repayment exists. If these conditions can be verified, no written contract is required.

Note: Federal Educational Loans (Federal PLUS Loans, Perkins Loans, Stafford Loans, William D. Ford Loans, etc.) under Title IV of the Higher Education Act (HEA) are exempt from income and resources.

See Chapter F, Resources, and Chapter I, Transfer of Assets.

E-1760 Wage-Related Payments

Revision 10-1; Effective March 1, 2010

See Section E-3110, Wages, for a definition of earned income from wages. Employers make various payments on behalf of their employees that are not earnings and are not available to meet food or shelter needs. If an employer pays an employee's share of Social Security (FICA) or unemployment compensation taxes without making a reduction in the employee's wages, the amount the employer pays is considered income.

The following payments by an employer are not income unless the funds for them are deducted from the employee's salary:

- Funds the employer uses to purchase qualified benefits under a cafeteria plan.
- Employer contributions to a health-insurance or retirement fund.
- The employer's share of FICA taxes or unemployment compensation taxes, in all cases.
- The employee's share of FICA taxes or unemployment compensation taxes paid by the employer on wages for domestic service in the private home of the employer or for agricultural labor only, to the extent that the employee does not reimburse the employer.

E-1770 Mandatory Payroll Deductions

Revision 16-2; Effective June 1, 2016

See Section E-3110, Wages, for a definition of earned income from wages. If an employer pays an employee's share of Social Security (FICA) or unemployment compensation taxes without making a reduction in the employee's wages, the amount the employer pays is considered income. The amount the employer pays is not considered income in the following two work situations:

- The employee is in domestic service in the employer's home.
- The employee does agricultural labor only.

When considering a person's earned income, do not consider mandatory payroll deductions as income for the purpose of determining a co-payment. The mandatory payroll deductions are:

- income tax;
- Social Security tax;
- required retirement withholdings; and
- required uniform expenses.

E-1780 Cafeteria Plan

Revision 09-4; Effective December 1, 2009

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

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

A **qualified benefit** is a benefit the Internal Revenue Service (IRS) does not consider part of an employee's gross income. Qualified benefits include, but are not limited to:

- accident and health plans (including medical plans, vision plans, dental plans, accident and disability insurance);
- group term life insurance plans (up to $50,000);
- dependent care assistance plans; and
- certain profit-sharing or stock bonus plans under section 401(k)(2) of the Internal Revenue Code. IRS does not exclude from income salary reductions made under 401(k)(1) plans. Salary reductions to fund benefits under 401(k)(1) are counted as wages for eligibility and applied income purpose.

Cash is **not** a qualified benefit.

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

Most cafeteria plans are funded by salary-reduction agreements. However, employers may make contributions to fund basic benefit levels under a cafeteria plan without a salary-reduction agreement.

Salary reductions to purchase qualified benefits under a cafeteria plan are not part of the employee's wages and are not income for eligibility or co-payment purposes.

Payroll deductions may be used to purchase cafeteria-plan benefits in addition to or instead of cafeteria-plan benefits provided under a salary-reduction agreement or employer contribution. The amount of the individual's payroll deductions for cafeteria plan benefits is the employee's wages and is earned income.

Important: Pay slips that appear to show payroll deductions may actually show how funds from a salary-reduction agreement have been allotted among qualified benefits.

The following indicators on a pay slip may indicate an approved cafeteria plan: Flex, Choices, Sec. 125, or Cafe Plan.

E-2000, Exempt Income

Body

Revision 20-3; Effective September 1, 2020

This section covers income that is exempt in both the eligibility and co-payment budgets.

Although it is necessary to look into the source and amount of all income, not all income is budgeted when determining eligibility and co-payment. Under federal requirements, some income is exempt from the eligibility budget and the budget to determine co-payment.

For the eligibility budget and co-payment budgets, if income meets certain criteria, document and verify if necessary, but do not include in the budget:

- exempt income in this section; and
- things that are not income (see E-1700), such as:
  - medical care and services;
  - certain social services;
  - receipts from the sale of a resource;
  - miscellaneous items, such as income tax refunds;
  - proceeds of a loan;
  - wage-related payments;
  - mandatory payroll deductions; and
  - cafeteria plans.

E-2100, Income Exempt Under Federal Laws

Body

Revision 09-4; Effective December 1, 2009

Many federal statutes, in addition to the Social Security Act, provide exemptions for payments from certain sources. If the income in this section meets certain criteria, exempt the income from the eligibility budget and the budget to determine co-payment.

E-2110 Food

Revision 09-4; Effective December 1, 2009

Do not count in the eligibility budget or the budget to determine co-payment any receipts for the following:

- Value of SNAP food benefits (formerly known as food stamps) under the Food and Nutrition Act of 2008 (7 U.S.C. §2017(b)).

- Value of federally donated foods distributed under Section 32 of Public Law 74-320 (49 Stat. 774) or Section 416 of the Agriculture Act of 1949 (63 Stat. 1058, 7 CFR 250.6(e)(9)).
- Value of free or reduced price food for women and children under the:
  - Child Nutrition Act of 1966, Section 11(b) of Public Law 89-642 (80 Stat. 889, 42 U.S.C. 1780(b)) and Section 17 of that Act as added by Public Law 92-433 (86 Stat. 729, 42 U.S.C. 1786); and
  - National School Lunch Act, Section 13(h)(3), as amended by Section 3 of Public Law 90-302 (82 Stat. 119, 42 U.S.C. 1761(h)(3)).
- Services, except for wages paid to residents who assist in providing congregate services such as meals and personal care, provided a resident of an eligible housing project under a congregate services program under Section 802 of the Cranston-Gonzales National Affordable Housing Act, Public Law 101-625 (104 Stat. 4313, 42 U.S.C. 8011).

E-2120 Housing and Utilities

Revision 12-2; Effective June 1, 2012

Do not count in the eligibility budget or the budget to determine co-payment any receipt for the following:

- Assistance to prevent fuel cut-offs and to promote energy efficiency under the Emergency Energy Conservation Services Program or the Energy Crisis Assistance Program, as authorized by Section 222(a)(5) of the Economic Opportunity Act of 1964, as amended by Section 5(d)(1) of Public Law No. 93-644 and Section 5(a)(2) of Public Law 95-568 (88 Stat. 2294, as amended, 42 U.S.C. 2809(a)(5)).
- Home energy assistance payments or allowances under title XXVI of the Omnibus Budget Reconciliation Act of 1981, Public Law 97-35, as amended (42 U.S.C. 8624(f)).
- Value of any assistance paid with respect to a dwelling unit under:
  - the United States Housing Act of 1937;
  - the National Housing Act;
  - Section 101 of the Housing and Urban Development Act of 1965;
  - Title V of the Housing Act of 1949; or
  - Section 202(h) of the Housing Act of 1959.
- Payments for relocating, made to persons displaced by federal or federally assisted programs that acquire real property, under Section 216 of Public Law 91-646, the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (84 Stat. 1902, 42 U.S.C. 4636).

E-2130 Education and Employment

Revision 09-4; Effective December 1, 2009

Do not count in the eligibility budget or the budget to determine co-payment any receipt for the following:

- Grants or loans to undergraduate students made or insured under programs administered by the Secretary of Education under section 507 of the Higher Education Amendments of 1968, Public Law 90-575 (82 Stat. 1063).
- Any wages, allowances or reimbursement for transportation and attendant care costs, unless exempted on a case-by-case basis, when received by an eligible person with a disability employed in a project under title VI of the Rehabilitation Act of 1973, as added by Title II of Public Law 95-602 (92 Stat. 2992, 29 U.S.C. 795(b)(c)).
- Student financial assistance for attendance costs received from a program funded in whole or in part under Title IV of the Higher Education Act of 1965, as amended, or under Bureau of Indian Affairs student

assistance programs, if it is made available for tuition and fees normally assessed a student carrying the same academic workload, as determined by the institution, including costs for rental or purchase of any equipment, materials or supplies required of all students in the same course of study, and an allowance for books, supplies, transportation and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution, under Section 14(27) of Public Law 100-50, the Higher Education Technical Amendments Act of 1987 (20 U.S.C. 1087uu).

E-2140 Native Americans – Exempt Income

Revision 09-4; Effective December 1, 2009

E-2141 Types of Payments Excluded Without Regard to Specific Tribes or Groups

Revision 09-4; Effective December 1, 2009

Do not count in the eligibility budget or the budget to determine co-payment any receipt for the following:

- Funds held in trust by the Secretary of the Interior for an Indian tribe and distributed per capita to a member of that tribe under Public Law 98-64 (97 Stat. 365, 25 U.S.C. 117b). Funds held by Alaska Native Regional and Village Corporations (ANRVC) are not held in trust by the Secretary of the Interior and therefore ANRVC dividend distributions are not excluded from countable income under this exclusion.
- Distributions received by an individual Alaska Native or descendant of an Alaska Native from an Alaska Native Regional and Village Corporation pursuant to the Alaska Native Claims Settlement Act, as follows: cash, including cash dividends on stock received from a Native Corporation, to the extent that it does not, in the aggregate, exceed $2,000 per individual each year; stock, including stock issued or distributed by a Native Corporation as a dividend or distribution on stock; a partnership interest; land or an interest in land, including land or an interest in land received from a Native Corporation as a dividend or distribution on stock; and an interest in a settlement trust. This exclusion is pursuant to Section 15 of the Alaska Native Claims Settlement Act Amendments of 1987, Public Law 100-241 (101 Stat. 1812, 43 U.S.C. 1626(c)), effective Feb. 3, 1988.
- Up to $2,000 per year received by Indians that is derived from individual interests in trust or restricted lands under Section 13736 of Public Law 103-66 (107 Stat. 663, 25 U.S.C. 1408, as amended).
- Indian judgment funds that are held in trust by the Secretary of the Interior or distributed per capita pursuant to a plan prepared by the Secretary of the Interior and not disapproved by a joint resolution of the Congress under Public Law 93-134, as amended by Section 4 of Public Law 97-458 (96 Stat. 2513, 25 U.S.C. 1408). Indian judgment funds include interest and investment income accrued while such funds are so held in trust. This treatment extends to initial purchases made with Indian judgment funds. This treatment does not apply to sales or conversions of initial purchases or to subsequent purchases.

E-2142 Payments to Members of Specific Indian Tribes and Groups

Revision 09-4; Effective December 1, 2009

Do not count in the eligibility budget or the budget to determine co-payment any receipt for the following:

- Per capita payments to members of the Red Lake Band of Chippewa Indians from the proceeds of the sale of timber and lumber on the Red Lake Reservation under Section 3 of Public Law 85-794 (72 Stat. 958).
- Per capita distribution payments by the Blackfeet and Gros Ventre tribal governments to members which resulted from judgment funds to the tribes under Section 4 of Public Law 92-254 (86 Stat. 65) and under Section 6 of Public Law 97-408 (96 Stat. 2036).
- Settlement fund payments and the availability of such funds to members of the Hopi and Navajo Tribes under Section 22 of Public Law 93-531 (88 Stat. 1722), as amended by Public Law 96-305 (94 Stat. 929).
- Judgment funds distributed per capita to, or held in trust for, members of the Sac and Fox Indian Nation, and the availability of such funds under Section 6 of Public Law 94-189 (89 Stat. 1094).
- Judgment funds distributed per capita to, or held in trust for, members of the Grand River Band of Ottawa Indians, and the availability of such funds under Section 6 of Public Law 94-540 (90 Stat. 2504).
- Any judgment funds distributed per capita to members of the Confederated Tribes and Bands of the Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation under Section 2 of Public Law 95-433 (92 Stat. 1047, 25 U.S.C. 609c-1).
- Any judgment funds distributed per capita or made available for programs for members of the Delaware Tribe of Indians and the absentee Delaware Tribe of Western Oklahoma under Section 8 of Public Law 96-318 (94 Stat. 971).
- All funds and distributions to members of the Passamaquoddy Tribe, the Penobscot Nation and the Houlton Band of Maliseet Indians under the Maine Indian Claims Settlement Act, and the availability of such funds under Section 9 of Public Law 96-420 (94 Stat. 1795, 25 U.S.C. 1728(c)).
- Any distributions of judgment funds to members of the San Carlos Apache Indian Tribe of Arizona under Section 7 of Public Law 93-134 (87 Stat. 468) and Public Law 97-95 (95 Stat. 1206).
- Any distribution of judgment funds to members of the Wyandot Tribe of Indians of Oklahoma under Section 6 of Public Law 97-371 (96 Stat. 1814).
- Distributions of judgment funds to members of the Shawnee Tribe of Indians (Absentee Shawnee Tribe of Oklahoma, the Eastern Shawnee Tribe of Oklahoma and the Cherokee Band of Shawnee descendants) under Section 7 of Public Law 97-372 (96 Stat. 1816).
- Judgment funds distributed per capita or made available for programs for members of the Miami Tribe of Oklahoma and the Miami Indians of Indiana under Section 7 of Public Law 97-376 (96 Stat. 1829).
- Distributions of judgment funds to members of the Clallam Tribe of Indians of the State of Washington (Port Gamble Indian Community, Lower Elwha Tribal Community and the Jamestown Band of Clallam Indians) under Section 6 of Public Law 97-402 (96 Stat. 2021).
- Judgment funds distributed per capita or made available for programs for members of the Pembina Chippewa Indians (Turtle Mountain Band of Chippewa Indians, Chippewa Cree Tribe of Rocky Boy's Reservation, Minnesota Chippewa Tribe, Little Shell Band of the Chippewa Indians of Montana and the nonmember Pembina descendants) under Section 9 of Public Law 97-403 (96 Stat. 2025).
- Per capita distributions of judgment funds to members of the Assiniboine Tribe of Fort Belknap Indian Community and the Papago Tribe of Arizona under Sections 6 and 8(d) of Public Law 97-408 (96 Stat. 2036, 2038).
- Up to $2,000 of per capita distributions of judgment funds to members of the Confederated Tribes of the Warm Springs Reservation under Section 4 of Public Law 97-436 (96 Stat. 2284).
- Judgment funds distributed to the Red Lake Band of Chippewa Indians under Section 3 of Public Law 98-123 (97 Stat. 816).
- Funds distributed per capita or family interest payments for members of the Assiniboine Tribe of Fort Belknap Indian Community of Montana and the Assiniboine Tribe of the Fort Peck Indian Reservation of Montana under Section 5 of Public Law 98-124 (97 Stat. 818).
- Distributions of judgment funds and income derived therefrom to members of the Shoalwater Bay Indian Tribe under Section 5 of Public Law 98-432 (98 Stat. 1672).
- All distributions to heirs of certain deceased Indians under Section 8 of the Old Age Assistance Claims Settlement Act, Public Law 98-500 (98 Stat. 2319).
- Judgment funds distributed per capita or made available for any tribal program for members of the Wyandotte Tribe of Oklahoma and the Absentee Wyandottes under Section 106 of Public Law 98-602 (98 Stat. 3151).

- Per capita and dividend payment distributions of judgment funds to members of the Santee Sioux Tribe of Nebraska, the Flandreau Santee Sioux Tribe, the Prairie Island Sioux, Lower Sioux and Shakopee Mdewakanton Sioux Communities of Minnesota under Section 8 of Public Law 99-130 (99 Stat. 552) and Section 7 of Public Law 93-134 (87 Stat. 468), as amended by Public Law 97-458 (96 Stat. 2513; 25 U.S.C. 1407).
- Funds distributed per capita or held in trust for members of the Chippewas of Lake Superior and the Chippewas of the Mississippi under Section 6 of Public Law 99-146 (99 Stat. 782).
- Distributions of claims settlement funds to members of the White Earth Band of Chippewa Indians as allottees, or their heirs, under Section 16 of Public Law 99-264 (100 Stat. 70).
- Payments or distributions of judgment funds, and the availability of any amount for such payments or distributions, to members of the Saginaw Chippewa Indian Tribe of Michigan under Section 6 of Public Law 99-346 (100 Stat. 677).
- Judgment funds distributed per capita or held in trust for members of the Chippewas of Lake Superior and the Chippewas of the Mississippi under Section 4 of Public Law 99-377 (100 Stat. 805).
- Judgment funds distributed to members of the Cow Creek Band of Umpqua Tribe of Indians under Section 4 of Public Law 100-139 (101 Stat. 822).
- Per capita payments of claims settlement funds to members of the Coushatta Tribe of Louisiana under Section 2 of Public Law 100-411 (102 Stat. 1097) and Section 7 of Public Law 93-134 (87 Stat. 468), as amended by Public Law 97-458 (96 Stat. 2513; 25 U.S.C. 1407).
- Funds distributed per capita for members of the Hoopa Valley Indian Tribe and the Yurok Indian Tribe under Sections 4, 6 and 7 of Public Law 100-580 (102 Stat. 2929, 2930, 2931) and Section 3 of Public Law 98-64 (97 Stat. 365; 25 U.S.C. 117b).
- Judgment funds held in trust by the United States, including interest and investment income accruing on such funds, and judgment funds made available for programs or distributed to members of the Wisconsin Band of Potawatomi (Hannahville Indian Community and Forest County Potawatomi) under Section 503 of Public Law 100-581 (102 Stat. 2945).
- All funds, assets and income from the trust fund transferred to the members of the Puyallup Tribe under Section 10 of the Puyallup Tribe of Indians Settlement Act of 1989, Public Law 101-41 (103 Stat. 88, 25 U.S.C. 1773h(c)).
- Judgment funds distributed per capita, or held in trust, or made available for programs, for members of the Seminole Nation of Oklahoma, the Seminole Tribe of Florida, the Miccosukee Tribe of Indians of Florida and the independent Seminole Indians of Florida under Section 8 of Public Law 101-277 (104 Stat. 145).
- Payments, funds, distributions or income derived from them to members of the Seneca Nation of New York under Section 8(b) of the Seneca Nation Settlement Act of 1990, Public Law 101-503 (104 Stat. 1297, 25 U.S.C. 1774f).
- Per capita distributions of settlement funds under Section 102 of the Fallon Paiute Shoshone Indian Tribes Water Rights Settlement Act of 1990, Public Law 101-618 (104 Stat. 3289) and Section 7 of Public Law 93-134 (87 Stat. 468), as amended by Public Law 97-458 (96 Stat. 2513; 25 U.S.C. 1407).
- Settlement funds, assets, income, payments or distributions from Trust Funds to members of the Catawba Indian Tribe of South Carolina under Section 11(m) of Public Law 103-116 (107 Stat. 1133).
- Settlement funds held in trust (including interest and investment income accruing on such funds) for, and payments made to, members of the Confederated Tribes of the Colville Reservation under Section 7(b) of Public Law 103-436 (108 Stat. 4579).
- Judgment funds distributed under Section 111 of the Michigan Indian Land Claims Settlement Act (Public Law 105-143, 111 Stat. 2665).
- Judgment funds distributed under Section 4 of the Cowlitz Indian Tribe Distribution of Judgment Funds Act (Public Law 108-222, 118 Stat. 624).

E-2143 Receipts from Lands Held in Trust for Certain Tribes or Groups

Revision 09-4; Effective December 1, 2009

Do not count in the eligibility budget or the budget to determine co-payment any receipt for the following:

- Receipts from land held in trust by the federal government and distributed to members of certain Indian tribes under Section 6 of Public Law 94-114 (89 Stat. 579, 25 U.S.C. 459e).
- Receipts derived from trust lands awarded to the Pueblo of Santa Ana and distributed to members of that tribe under Section 6 of Public Law 95-498 (92 Stat. 1677).
- Receipts derived from trust lands awarded to the Pueblo of Zia of New Mexico and distributed to members of that tribe under Section 6 of Public Law 95-499 (92 Stat. 1680).

E-2150 Other – Exempt Income

Revision 16-3; Effective September 1, 2016

Do not count in the eligibility budget or the budget to determine co-payment any receipt for the following:

- Compensation provided to volunteers by the Corporation for National and Community Service (CNCS), unless determined by the CNCS to constitute the minimum wage in effect under the Fair Labor Standards Act of 1938 (29 U.S.C. 201 et seq.) or applicable state law, pursuant to 42 U.S.C. 5044(f)(1). The Corporation merged ACTION and the Commission on National and Community Service and manages three main programs:
    - Senior Corps incorporated the Foster Grandparents, Retired and Senior Volunteer and Senior Companion Programs;
    - AmeriCorps incorporated the VISTA, National Civilian Community Corps programs and the full-time demonstration program established under the 1990 Act; and
    - Learn and Serve America, formerly known as Serve America.
- Any assistance to an individual (other than wages or salaries) under the Older Americans Act of 1965, as amended by Section 102(h)(1) of Public Law 95-478 (92 Stat. 1515, 42 U.S.C. 3020a).
- Amounts paid as restitution to certain individuals of Japanese ancestry and Aleuts for losses suffered as a result of evacuation, relocation and internment during World War II, under the Civil Liberties Act of 1988 and the Aleutian and Pribilof Islands Restitution Act, Sections 105(f) and 206(d) of Public Law 100-383 (50 U.S.C. App. 1989 b and c).
- Payments made on or after Jan. 1, 1989, from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.) under Public Law 101-201 (103 Stat. 1795) and Section 10405 of Public Law 101-239 (103 Stat. 2489).
- Payments made under Section 6 of the Radiation Exposure Compensation Act, Public Law 101-426 (104 Stat. 925, 42 U.S.C. 2210).
- The value of any child care provided or arranged (or any payment for such care or reimbursement for costs incurred for such care) under the Child Care and Development Block Grant Act, as amended by Section 8(b) of Public Law 102-586 (106 Stat. 5035).
- Payments made to individuals because of their status as victims of Nazi persecution excluded pursuant to Section 1(a) of the Victims of Nazi Persecution Act of 1994, Public Law 103-286 (108 Stat. 1450). This provision supersedes previous provisions for the exclusion of certain payments made by the governments of Germany, Austria and the Netherlands, insofar as they are made to victims of Nazi persecution. Payments from:
    - Germany are identified with the acronym ZRBG;
    - the Netherlands are identified with the acronym WUV; and
    - Austria are identified as DIE BEGUENSTIGUNGSVORSCHRIFTEN FUER GESCHAEDIGTE AUS POLITISCHEN ODER RELIGIOESEN GRUENDEN ODER AUS GRUENDEN DER ABSTAMMUNG WURDEN ANGEWENDET (§500FF ASVG), which translates to “The

regulations which give preferential treatment for persons who suffered because of political or religious reasons or reasons of origin were applied (§500ff ASVG)."

- Any matching funds from a demonstration project authorized by the Community Opportunities, Accountability, and Training and Educational Services Act of 1998 (Public Law 105-285) and any interest earned on these matching funds in an Individual Development Account, pursuant to Section 415 of Public Law 105-285 (112 Stat. 2771).
- Any earnings, Temporary Assistance for Needy Families matching funds and interest in an Individual Development Account, pursuant to Section 103 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193, 42 U.S.C. 604(h)(4)).
- Payments made to individuals who were captured and interned by the Democratic Republic of Vietnam as a result of participation in certain military operations, pursuant to Section 606 of the Departments of Labor, Health and Human Services and Education and Related Agencies Appropriations Act of 1996 (Public Law 105-78).
- Payments made to certain Vietnam veterans' children with spina bifida, pursuant to Section 421 of the Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act of 1997 (Public Law 104-204, 38 U.S.C. 1805(a)).
- Payments made to the children of women Vietnam veterans who suffer from certain birth defects, pursuant to Section 401 of the Veterans Benefits and Health Care Improvement Act of 2000 (Public Law 106-419 (38 U.S.C. 1833(c)).

E-2200, Earned Income Exemptions

Body

E-2210 Income Tax Credits

Revision 10-1; Effective March 1, 2010

An earned income tax credit (EITC) is a special tax credit that reduces the federal tax liability of certain low-income working taxpayers. This tax credit may or may not result in a payment to the taxpayer. EITC payments are allowed as an advance from an employer or as a refund from the Internal Revenue Service.

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

Any refund of federal income taxes a person receives under Section 32 of the Internal Revenue Code (relating to EITC or CTC) and any payment a person receives from an employer under Section 3507 of the Internal Revenue Code (relating to advance payment of an EITC) is exempt. Exempt this income from the eligibility budget and the budget to determine co-payment.

Relationship of income to resources. An unspent EITC or CTC payment is not counted as a resource for the month it is received and for the nine months following the month of receipt. After that, count any remaining funds from the EITC or CTC payment as a resource. See Section F-2260, Exclusions from Resources Provided by Other Statutes.

Example: The EITC payment is received in May. The EITC payment is not income in May. Any remaining funds from the EITC payment are a resource as of the first of March of the following year.

E-2220 Student Earnings

Revision 09-4; Effective December 1, 2009

A person who is under age 22 and regularly attending school is considered a student. A student's income is exempt from the eligibility budget and the budget to determine co-payment, up to the monthly limit but not more than the calendar year annual limit.

This exemption may apply to an eligible or ineligible:

- person;
- child;
- spouse; or
- parent.

Apply the exemption:

- consecutively to months in which there is earned income until the maximum yearly limit is exhausted or the person is no longer a student under age 22; and
- only to a student's own earned income.

The limits are set by the Social Security Administration for the SSI program and published annually in the Federal Register. The monthly and yearly limits are calculated annually based on increases in the cost of living index. Under this calculation, these amounts will never be lower than the previous year's amounts. However, there may be years when no increases result from the calculation.

See "Special Income Exemption for Student" in Appendix XXXI, Budget Reference Chart, for the monthly and yearly amount limits for the exemption.

E-2300, Unearned Income Exemptions

Body

E-2310 Refunds of Taxes Paid on Real Property or Food

Revision 09-4; Effective December 1, 2009

Exempt from the eligibility budget and the budget to determine co-payment any amount received from any public agency as a return or refund of taxes paid on real property or on food purchased.

E-2320 Assistance Based on Need

Revision 09-4; Effective December 1, 2009

Exempt from the eligibility budget assistance based on need that is wholly funded by a state or one of its political subdivisions, including a recognized Indian tribe. Assistance is based on need if it is provided under a program that uses the amount of income as one factor to determine eligibility. The Temporary Assistance for Needy Families (TANF) program is an example.

E-2330 Educational Assistance

Revision 09-4; Effective December 1, 2009

If not totally exempt under policy in Section E-2130, Education and Employment, exempt from the eligibility budget and the budget to determine co-payment any portion of a grant, scholarship, fellowship or gift used for paying tuition, fees or other necessary educational expenses at any educational institution, including vocational or technical education. Any portion of such educational assistance that is not used to pay current tuition, fees or other necessary educational expenses, but will be used for paying this type of educational expense at a future date is excluded from income in the month of receipt. This exclusion does not apply to any portion set aside or actually used for food or shelter.

E-2340 Home Produce for Personal Consumption

Revision 09-4; Effective December 1, 2009

Exempt from the eligibility budget and the budget to determine co-payment the value of food that a person and household raise, if it is consumed by the household.

E-2350 Child Support Payments

Revision 13-2; Effective June 1, 2013

Exempt from the eligibility budget one-third of the total amount of child support payments for an eligible child.

- If a recipient receives child support as fiduciary agent for a child, this is income to the child and not to the recipient, except to the extent that the recipient uses the monies for his/her own needs.
- The eligibility specialist must document how the child support monies are used.

See Section E-3321, Child Support Payments

E-2360 Payment Treated Like Other Exemptions

Revision 10-1; Effective March 1, 2010

Treat the following payments based on policy in Section E-2320, Assistance Based on Need, or do not consider payments as income based on policy in Section E-1700, Things That Are Not Income:

- Alaska longevity bonus
- Foster care payments
- Low income energy assistance
- Home energy assistance
- Federal housing assistance
- Disaster assistance

Consider a utility allowance given under any of these to be income, unless the allowance is paid directly to the utility company and the client has no access to the allowance. Utility benefits under Section E-2120, Housing and Utilities, are exempt.

When considering disaster assistance, payments precipitated by an emergency or major disaster are not counted as income or resources when determining Medicaid eligibility.

- A major disaster is any natural catastrophe such as a hurricane or drought, or, regardless of cause, any fire, flood or explosion, which the President determines causes damage of sufficient severity and magnitude.
- An emergency is any occasion or instance for which the President determines that federal assistance is needed to supplant state and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe.
- Disaster Unemployment Assistance is emergency assistance authorized under P.L. 100-107 and received by individuals who are unemployed as a result of a major disaster. Individuals receiving Disaster Unemployment Assistance are not eligible for other unemployment compensation and cannot receive both at the same time.

If precipitated by an emergency or a major disaster, do not consider the following as income:

- Payments received under the Disaster Relief Act of 1974 (P.L. 93-288, Section 312(d)), as amended by the Disaster Relief and Emergency Assistance Amendments of 1988 (P.L. 100-707, Section 105(i)) and disaster assistance comparable to these payments provided by states, local governments and disaster assistance organizations.
- Payments from the Federal Emergency Management Agency (FEMA), Individual and Family Grant Assistance program (IFG), grants or loans by the Small Business Administration (SBA), voluntary disaster assistance organizations, such as the Red Cross, or private insurance payments for losses due to a major disaster such as flood, wind, land movement.
- Each payment made to farmers under the Disaster Assistance Act of 1988 (P.L. 100-387) for crop losses or failure in a disaster.
- Income received from public and private organizations by individuals working in disaster relief efforts and funded under a National Emergency Grant by WIA, Title 1 (P.L. 105-220).
- Disaster Unemployment Assistance.
- Payments for flood mitigation received by a homeowner under the National Flood Insurance Act of 1968, as amended by P.L. 109-64.
- Government payments designated for the restoration of a home damaged in a disaster.

For treatment of resources from disaster assistance, see Section F-2270, Exclusions from Resources Related to Disaster Payments.

E-2370 Certain Gifts

Revision 09-4; Effective December 1, 2009

Treat the following gifts based on policy in Section E-2320, Assistance Based on Need, or do not consider the payments as income based on policy in Section E-1700, Things That Are Not Income.

E-2371 Certain Gifts

Revision 09-4; Effective December 1, 2009

Gifts from tax-exempt organizations, such as the Make-A-Wish Foundation, to children with life-threatening conditions, as required by Public Law 105-306, effective retroactively to Oct. 28, 1996, are exempt. The exclusions apply to children under age 18. The gift must be from an organization described in Section 501(c)(3)

of the Internal Revenue Code of 1986 and that is exempt from taxation under Section 501(c). Document the case record with an oral or written statement from the organization that the gift was made based on the child having a life-threatening condition. No additional medical development is necessary.

The following gifts to or for the benefit of a child described above are excluded from income:

- Any in-kind gift not converted to cash.
- A cash gift to the extent that the cash excluded under this provision does not exceed $2,000 in any calendar year. Cash in excess of $2,000 received in a calendar year is subject to regular income counting rules.

If an in-kind gift is converted to cash, the cash counts as income in the month converted. For purposes of this exclusion, an in-kind gift is any gift other than cash, including gifts of food or shelter.

The exclusion also applies to a deeming situation if the gift is made to a parent for the benefit of a child with a life-threatening condition.

E-2372 Ticket for Travel

Revision 09-4; Effective December 1, 2009

Do not count the value of any commercial transportation ticket that is received as a gift and is not converted to cash. See Section E-3371, Gifts of Domestic Commercial Transportation Tickets.

E-2380 Relocation Assistance

Revision 09-4; Effective December 1, 2009

Relocation assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970 (Subchapter II, Chapter 61, Title 42 of the U.S. Code) is excluded from income.

Relocation assistance provided by a state or local government that is comparable to assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 that is subject to the treatment required by Section 216 of that Act. State or local relocation assistance payments are excluded from countable resources for nine months after the month of receipt.

E-2390 Crime Victims Compensation

Revision 09-4; Effective December 1, 2009

Do not count in the eligibility budget or the budget to determine co-payment any payment received from a fund established by a state to aid victims of crime. Unspent payments received from a fund established by a state to aid victims of crime are excluded from resources for nine months. A person is not required to apply for benefits from a crime victims' compensation fund.

E-2400, Other Income Exemptions

Body

E-2410 Hazardous Duty Pay

Revision 09-4; Effective December 1, 2009

Do not count hazardous duty pay of a spouse or parent absent from the home because of active military service.

Do not count in the eligibility budget or the budget to determine co-payment any receipt of unearned income for the hostile fire pay or imminent danger pay portion of military income, commonly known as combat pay.

Any unspent hostile fire pay or imminent danger pay becomes a resource if retained into the following month and not otherwise excluded.

In a deeming situation, exclude from deemed resources for the nine-month period following the month of receipt the unspent portion of any retroactive payment of:

- hostile fire and imminent danger pay (pursuant to 37 U.S.C. 310) received by the ineligible spouse or parent from one of the uniformed services; and
- family separation allowance (pursuant to 37 U.S.C. 427) received by the ineligible spouse or parent from one of the uniformed services as a result of deployment to or while serving in a combat zone.

E-2420 Excluded Burial Fund Interest

Revision 09-4; Effective December 1, 2009

Do not count in the eligibility budget or the budget to determine co-payment interest earned on excluded burial funds and any appreciation in the value of an excluded burial arrangement that is left to accumulate and become a part of a separately identifiable burial fund. If the burial funds increase by more than $1,500 because of contributions by client actions, the amount in excess of $1,500 is a countable resource.

E-2430 Certain Designated Accounts

Revision 09-4; Effective December 1, 2009

Public Law 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, requires the representative payees of SSI recipients under age 18 to establish designated accounts when there are retroactive payments for more than six months payable to the recipients. These designated accounts, including accrued interest or other earnings produced by the accounts, are excluded from countable resources. This exclusion was effective Aug. 22, 1996.

Do not count in the eligibility budget or the budget to determine co-payment interest or other earnings on any designated account established for SSI recipients under age 18 for retroactive benefits, as required by Public Law 104-193, effective Aug. 22, 1996.

E-2440 Certain Health-Related Payments

Revision 10-1; Effective March 1, 2010

The following payments, regardless of when received, are not counted as income and are excluded from resources:

- Payments from the Ricky Ray Hemophilia Relief Fund.
- Payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corporation, as required by Public Law 105-33, effective Aug. 5, 1997.
- Payments from the Energy Employees Occupational Illness Compensation Act (EEOICA) (Public Law 106-398, October 2000) for medical benefits and compensation.

E-3000, Earned and Unearned Income

E-3100, Types of Earned Income

Body

Revision 13-2; Effective June 1, 2013

Earned income may be in cash or in-kind. Payment of earned income may be:

- wages,
- net earnings from self-employment,
- farm income,
- payments for services performed in a sheltered workshop or work activities center,
- certain royalties and honoraria, or
- certain refunds of federal income taxes and advance payments by employers made in accordance with the earned income credit provisions of the Internal Revenue Code.

To budget variable earned income:

- determine an average pay amount,
- convert income to a monthly amount, and
- project income for future months if anticipated to continue.

Converting Monthly Income

The eligibility system will convert income that is received other than monthly to a monthly amount by using the following conversion process below:

- Divide yearly income by **12**.
- Multiply weekly income by **4.33**.
- Add amounts received twice a month (semi-monthly).
- Multiply amounts received every other week by **2.17** (bi-weekly).

Weekly earnings are converted to monthly amounts by multiplying weekly earnings by 4.33. For example, if weekly earnings are $150, the calculation is: $150 weekly earnings X 4.33 = $649.50 monthly earnings.

Bi-weekly earnings are converted to a monthly amount by averaging the bi-weekly earnings, then multiplying the average bi-weekly earnings by 2.17. For example, if average bi-weekly earnings are $300, the calculation is: $300 average bi-weekly earnings X 2.17 = $651 monthly earnings.

When projecting earned income, if there is verification of the actual amount of earnings received during an entire calendar month, use the actual amount received instead of the above procedures for converting weekly and bi-weekly earnings to a monthly amount. For example, the client earns $150 each week. During July, he received the following payments: $150 on July 1, $150 on July 8, $150 on July 15, $150 on July 22, and $150 on July 29. The amount budgeted is the actual income received in July ($750), not $649.50 ($150 weekly earnings X 4.33 = $649.50). $649.50 would be used as the projected income for following months beginning in August.

Note: When income is new or terminated **and** only a partial month's income is received in the start or terminated month, **do not convert** the income. Use actual, unconverted income.

E-3110 Wages

Revision 10-2; Effective June 1, 2010

Wages are what a person receives (before any deductions) for working as someone else's employee.

Wages include salaries, commissions, bonuses, severance pay and any other special payments received because of employment. They may also include the value of food, clothing or shelter, or other items provided instead of cash, referred to as in-kind earned income.

If a person is a domestic or agricultural worker, the law requires the value of food, clothing or shelter, or other items provided instead of cash, be treated as in-kind unearned income.

Note: If a person receives wages from an S Corporation and is also a shareholder of the S Corporation, consult the regional attorney.

Wages or Self-Employment

Under certain conditions, services performed as an employee may be considered self-employment rather than wages. Typically, services provided by ministers, real estate agents or newspaper vendors are considered self-employment rather than wages. Statutory employees are independent contractors and are treated as self-employed individuals. There are four categories of statutory employees:

- agent drivers or commission drivers;
- certain full-time life insurance salespeople;
- full-time traveling or city salespeople; and
- home workers.

Kinds of Wages

Some, but not all, forms of wages are:

Salaries — Payments (fixed or hourly rate) received for work performed for an employer.

Commissions — Fees paid to an employee for performing a service (for example, a percentage of sales). Commissions are wages when paid if the payment stems from an employer-employee relationship. The wages of a salesperson paid on a straight commission basis are the gross commissions paid minus any amounts paid specifically as advances or reimbursements for travel or business expenses incurred in the employer's business. Advances against commissions to be earned in the future are wages when paid.

Bonuses — Amounts paid by employers as extra pay for past employment (for example, for outstanding work, length of service, holidays, etc.) as part of the employment relationship.

Severance Pay — Payment made by an employer to an employee whose employment is terminated independently of his wishes or payment is made due to voluntary early retirement and normally considered earned wages. When an employee's severance pay is budgeted, contact state office for special treatment of some severance pay.

Military Basic Pay — The service member's wage, which is based solely on the member's pay grade and length of service. When military personnel wages are budgeted, contact state office for special treatment of the service member's compensation.

Special Payments Received Because of Employment —Items such as vacation pay, advanced/deferred wages, etc. Payments are not wages after the first six months. Any payments, or portion thereof, received by an employee during the first six months period, which according to the employer, are attributable to the employee's own contributions to the plan are not wages. Such payments are a return on the employee's premium rather than pay for service.

Note: Workers' compensation payments are not wages.

References:

- Section E-1300, Types of Income
- Section E-1700, Things That Are Not Income
- Section E-1760, Wage-Related Payments
- Section E-1770, Mandatory Payroll Deductions
- Section E-1780, Cafeteria Plan
- Section E-3120, Self-Employment

E-3120 Self-Employment

Revision 10-1; Effective March 1, 2010

Net earnings from self-employment are the gross income from any trade or business that a person operates, less allowable deductions for that trade or business. Net earnings also include a person's share of profit or loss in any partnership to which a person belongs. These are the same net earnings that a person would report on a federal income tax return.

If a person is both employed and self-employed, his earned income consists of his wages plus net earnings from self-employment. Typically, services provided by ministers, real estate agents or newspaper vendors are considered self-employment rather than wages. Statutory employees are independent contractors and are treated as self-employed individuals. There are four categories of statutory employees:

- agent drivers or commission drivers;
- certain full-time life insurance salespeople;
- full-time traveling or city salespeople; and
- home workers.

See Section E-6000, Self-Employment Income, for more details on treatment of this type of earned income.

E-3130 Farm Income

Revision 09-4; Effective December 1, 2009

Farm income is earned income when either the person or spouse is doing the farming or operating the farm as a business. See Section E-6000, Self-Employment Income, for more details on treatment of this type of earned income.

E-3140 Certain Payments in a Sheltered Workshop

Revision 09-4; Effective December 1, 2009

Payments for services performed in a sheltered workshop or work activities center are what a person receives for participating in a program designed to help a person become self-supporting, even though payment does not meet the definition of wages.

E-3150 Certain Royalties and Honoraria

Revision 09-4; Effective December 1, 2009

Royalties that are earned income are payments to a person in connection with any publication of the person's work. Honoraria that are earned income are those portions of payments, such as an honorary payment, reward or donation, received in consideration of services rendered for which no payment can be enforced by law.

If a person receives a royalty as part of a trade or business, see Section E-3120, Self-Employment. See Section E-6000, Self-Employment Income, for more details on treatment of this type of earned income.

If a person receives another type of royalty or honorarium, investigate unearned income policy.

E-3160 Certain Federal Income Tax Refunds

Revision 09-4; Effective December 1, 2009

Refunds on account of earned income credits are payments made to a person under the provisions of Section 43 of the Internal Revenue Code of 1954, as amended. These refunds may be greater than taxes a person has paid. A person may receive earned income tax credit payments along with any other federal income tax refund a person receives because of overpayment of the person's income tax. Advance payments of earned income tax credits are made by the employer under the provisions of Section 3507 of the same code. A person can receive earned income tax credit payments only if a person meets certain requirements of family composition and income limits.

Federal income tax refunds made on the basis of taxes a person has already paid are not income to a person, as stated in Section E-1740, Miscellaneous Things That May Not Be Income.

E-3170 Census Bureau Wages

Revision 10-1; Effective March 1, 2010

The census is a count of everyone living in the United States and is mandated by the U.S. Constitution. The U.S. Census Bureau conducts the census every 10 years.

Wages paid by the Census Bureau for temporary employment related to census activities are excluded income for the Medicare Savings Programs (MSP). Do not include these wages in the eligibility budget for MSP.

These wages for temporary employment are not countable income in the month of receipt, but are considered a resource thereafter.

Wages paid by the Census Bureau for temporary employment related to census activities **are included** in eligibility or co-payment budgets for any other Medicaid for the Elderly and People with Disabilities (MEPD) program that is not an MSP.

For cases with a combination of regular Medicaid benefits and an MSP, the wages are countable in the eligibility budget (and co-payment, if applicable) for the regular Medicaid program, but are excluded in the eligibility budget for MSP.

Example: Individual is being considered for Pickle with Qualified Medicare Beneficiary (QMB) benefits. The wages paid by the Census Bureau for temporary employment related to census activities are included in the eligibility budget for Pickle, but are excluded in the eligibility budget for QMB.

E-3200, Types of Unearned Income

Body

Revision 16-2; Effective June 1, 2016

Unearned income is any income that is not earned. Unearned income may be in cash or in-kind. Unearned income includes these types of income:

- In-kind
- Fixed
- Other

Income tax refunds are subject to restitution policy (in the month of receipt) for co-payment purposes, to the extent that withholding tax was not included in the co-payment budget.

To determine the amount of unearned income, consider the amount actually available to the person. Reduce the gross amount by any ordinary or necessary expenses incurred in receiving the unearned income. For example, compensation for damages incurred in an accident would be the settlement amount less any legal, medical or other expenses. Medicare premiums, other health insurance premiums and income tax withheld from unearned income are not deductible expenses for eligibility determination. Income tax withheld from unearned income is also not a deductible expense for the co-payment calculation.

E-3300, Sources of Unearned Income

Body

Revision 09-4; Effective December 1, 2009

This section includes sources of unearned income.

E-3310 Annuities, Pensions and Other Periodic Payments

Revision 09-4; Effective December 1, 2009

This unearned income is usually related to prior work or service. It includes, for example, private pensions, Social Security benefits, disability benefits, veterans' benefits, workers' compensation, railroad retirement annuities and unemployment insurance benefits. Payments from these sources are usually stable and fixed. See Section E-4000, Fixed Income.

E-3311 Medicaid Qualifying Trust Payments

Revision 09-4; Effective December 1, 2009

A Medicaid-qualifying trust is one that the person, his spouse, guardian or anyone holding his power of attorney establishes using the person's money, and the person is the beneficiary.

Amounts distributed from the trust to the person or used for the person's health, personal or other maintenance needs are countable income.

For example, if terms of the trust direct the trustee to pay a health care provider for medical services, the person is receiving the benefit of payment although no money is paid directly to him, and the amount is countable income.

E-3312 Testamentary and Inter Vivos Trusts Payments

Revision 09-4; Effective December 1, 2009

Resources in a testamentary or inter vivos trust are countable if the person is the trustee and has the legal right to revoke the trust and use the money for his own benefit. If he does not have access to the trust, the trust is not counted as a resource. If a trust is not counted as a resource, payments or disbursements from the trust made to or on behalf of the person are considered income. Payments or disbursements used to purchase medical or social services for the person are not considered income to the person.

E-3313 Revocable and Irrevocable Trusts

Revision 09-4; Effective December 1, 2009

Payments from the corpus or income generated by the corpus, to or for the benefit of the person, excluding payments for medical/social services, are income.

Payments from the corpus or income generated by the corpus for any other purpose are a transfer of assets.

E-3314 Exception, Special Needs and Pooled Trust

Revision 09-4; Effective December 1, 2009

Any distribution to or for the benefit of the person from corpus or income generated by the trust, except payments for medical and social services, is countable income. A payment to or for the benefit of the person is counted under trust provisions only if such payment is ordinarily counted as income.

E-3315 Qualified Income Trust (QIT)

Revision 10-1; Effective March 1, 2010

Income directed to the trust is disregarded from countable income when testing eligibility for institutional settings.

Any source of non-exempt/non-excludable income which is not directed to the QIT account during the calendar month of receipt is countable income for that month.

If countable income exceeds the special income limit, the person is income-ineligible for the month. Applicants may not be certified for any calendar month(s) in which they are income-ineligible. For active persons, restitution is requested in the amount of the vendor payment for any calendar month(s) in which they are income-ineligible.

Notes:

- When a person does not pay a full month's co-payment because of hospitalization or because Medicare covered 100 percent of the cost of a partial month, the accumulated funds in the QIT trust are not a countable resource, and transfer of assets is not involved.
- A person receiving Home and Community-Based Services waiver services with a QIT covering all waiver costs is not denied. Most waiver programs are based on a waiver for the institutional program. In a waiver program, the applicant with a QIT is receiving the benefit of the contracted rates as opposed to the private rates.

Examples:

- The applicant entered the nursing facility and applied for Medicaid in July. Income totals $4,600. The QIT calls for all income to be directed to the trust account. However, the trustee did not deposit the July income checks to the trust account until Aug. 2. The entire $4,600 is countable income for July, and the applicant is ineligible for that month.
- The person was certified for Medicaid in September. The QIT calls for all income (totaling $4,600) to be directed to the trust account. During the redetermination in August, the eligibility specialist learns that income checks for June were not deposited to the trust account until July. Because the person was ineligible for June, the eligibility specialist requests restitution for that month in the amount of the co-payment.

E-3320 Alimony and Support Payments

Revision 16-4; Effective December 1, 2016

Alimony and spousal support payments are cash or in-kind contributions to meet some or all of an individual's needs for food or shelter. Alimony (sometimes called maintenance) is an allowance made by a court from the

funds of one spouse to the other spouse in connection with a suit for separation or divorce. Support payments may be made voluntarily or because of a court order.

Alimony and spousal support payments are unearned income to the individual receiving the payments. Verify the amount and frequency of alimony or spousal support payments.

For verification, use one of the following sources:

- court records;
- records of the agency through which the payments are made;
- official documents in the individual's possession (e.g., legal documents) that establish the amount and frequency of the support; or
- report of contact with the source of the payment containing the amount and frequency of the alimony or spousal support.

If none of the above sources are available, obtain an individual's sworn affidavit that explains why one of the sources above is not available (for example, the documentation does not exist, the court or agency will not release the information, or the source refused to cooperate). See E-1410, Division of Marital Income and Property.

If the alimony is not received in cash, determine its current fair market value.

To determine countable income, deduct any expenses that may have been incurred in obtaining the income, such as legal fees and court costs.

Determine whether the alimony is to be treated as a lump-sum payment, infrequent or irregular income, or regular and predictable income.

E-3321 Child Support Payments

Revision 13-2; Effective June 1, 2013

Consider payments as child support if:

- a court ordered the support, or
- the child's parent or the person making the payment states the purpose of the payment is to support the child.

Consider cash gifts or donations as cash contributions, not child support. A cash gift or donation is money that only benefits the child for a specific purpose, such as a birthday present, or to purchase clothes, toys or personal items.

Child support collected through the Office of Attorney General (OAG) may be distributed through warrants, direct deposits or the Texas Debit Card. A person also may receive payments through another state's Office of Attorney General. Several other states use debit accounts for the distribution of child support payments.

When child meets definition in D-1210, Definition of a Child:

- Child support payments (including arrearage payments) made on behalf of the child are unearned income **to the child** when the payment is made available to the child. One-third of the amount of a child support payment made to or for an eligible child by an absent parent is excluded. (See E-2350, Child Support Payments, for more information.)

When child does **not** meet definition in D-1210:

- Child support payments (excluding arrearages) made on behalf of the child are income **to the child** whether or not the child lives with the parent or receives any of the child support payment from the parent. Such support payments are not subject to the one-third reduction.
- Child support **arrearage** payments the parent receives and does not give to the adult child are income to the parent. Any amount of the payment the parent gives to the adult child is income to the adult child in the month given, not income to the parent. The one-third child support exclusion does not apply.

If a recipient receives child support for a child (including an adult child) but uses the money for the recipient's personal or household needs instead of the child's, count it as unearned income to the recipient. Do not count the amount actually used for or provided to the child as income to the recipient.

The eligibility specialist must document how the child support monies are used.

If a single payment covers two or more children (including at least one who is not an applicant/recipient) and the support order does not specify a portion for each child, prorate the payment among all of the children. When two or more children receive child support from the same father and one is an eligible child, the payment is always prorated.

E-3330 Dividends, Interest and Royalties

Revision 09-4; Effective December 1, 2009

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

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

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

- under a formal or informal agreement whereby the owner authorizes another person to manage and extract a product (for example, timber or oil); and
- in an amount that is dependent on the amount of the product actually extracted.

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

Royalties are unearned income unless they are:

- received as part of a trade or business, or
- received by a person in connection with any publication of the person's work (for example, from publication of a manuscript, magazine article or artwork).

If royalties are earned income, see Section E-3150, Certain Royalties and Honoraria.

E-3331 Interest and Dividends

Revision 10-1; Effective March 1, 2010

Interest and dividends are returns on loans or investments such as stocks, bonds or savings accounts.

Dividends from insurance policies are not included because those dividends are refunds of overcharges on premiums. Appendix XXXV, Treatment of Insurance Dividends, indicates that when dividends are:

- paid directly to the policy holder, disregard dividends when paid. Count the dividend(s) as a resource if retained after the month of receipt;
- applied to future premium payments, disregard dividends as income or a resource;
- used to purchase term insurance, disregard dividends as income or a resource. Term insurance is not a resource per Section F-4226, Term and Burial Insurance; and
- accumulating in a separate account, count accumulated dividends as a resource, regardless of face value. Treat as a savings account, both as a resource and as income for interest generated.

Note: The dividend accumulation is a countable resource, like the balance of a savings account. The interest earned on the dividends would be excluded from income when paid. Interest left to accumulate becomes part of the countable resources.

References:

- Section E-3331.1, Treatment of Interest/Dividends on Fully Countable Resources
- Section E-3331.2, Treatment of Interest/Dividends on Certain Excluded or Partially Excluded Resources
- Section E-3331.3, Treatment of Interest/Dividends on All Other Resources
- Section F-4220, Personal Property

E-3331.1 Treatment of Interest/Dividends on Fully Countable Resources

Revision 09-4; Effective December 1, 2009

Determine if any interest or dividends are accrued on fully countable resources.

- Do not count the interest or dividends as income in the eligibility budget regardless of the amount or frequency.
- Count the interest or dividends as income in the co-payment budget.

Examples:

- An individual owns an excluded whole life participating insurance policy with a total face value of $1,500. Since this is a participating policy, the policy is accumulating dividends. The accumulating dividends are countable. Like a savings account, the accumulating dividends are accruing interest. Since the accumulating dividends are countable, do not count the interest income from the accumulating dividends in the eligibility budget.
- An individual owns a savings account with a balance of $800. The savings account is a fully countable resource. The savings account is accruing interest quarterly. Since the saving account is countable, do not count the interest income from the savings account in the eligibility budget.

E-3331.2 Treatment of Interest/Dividends on Certain Excluded or Partially Excluded Resources

Revision 16-4; Effective December 1, 2016

Determine if any interest or dividends are accrued on certain excluded or partially excluded resources.

- Do not count the interest or dividends as income in the eligibility budget or co-payment budget if from one of the following sources.

The following are excluded or partially excluded resources based on federal statutes other than the Social Security Act:

- Agent Orange Settlement Funds;
- Nazi Persecution, including Austrian Social Insurance Funds and Netherlands WUV Payments to Victims of Persecution;
- Corporation for National and Community Service (CNCS) (formerly ACTION) Programs;
- Restricted Allotted Indian Lands;
- Individual Development Accounts (IDAs) – TANF Funded;
- IDAs – Demonstration Project;
- Japanese-American and Aleutian Restitution Funds;
- Low Income Energy Assistance;
- Department of Defense (DOD) Payments to Certain Persons Captured and Interned by North Vietnam;
- Radiation Exposure Compensation Trust Funds;
- Ricky Ray Hemophilia Relief Fund;
- Payments to Veterans' Children with Certain Birth Defects; and
- Achieving a Better Life Experience (ABLE) Account.

See Section E-2000, Exempt Income, for other sources and for treatment of interest or dividends accrued on other unspent types of payments.

Example: An individual in a nursing facility received a payment for being a former prisoner of North Vietnam. The payment made by the Department of Defense is not a countable resource. The payment was deposited into an account that accrues interest. Do not count interest accrued on the unspent portion from the payment in the eligibility or co-payment budgets.

E-3331.3 Treatment of Interest/Dividends on All Other Resources

Revision 09-4; Effective December 1, 2009

Determine if any interest or dividends are accrued on all other resources.

- Count the interest or dividends accrued according to the treatment of that particular resource as outlined in the handbook as income in the eligibility budget.
- Count the interest or dividends accrued according to the treatment of that particular resource as outlined in the handbook as income in the co-payment budget.

Examples:

Interest accrued on retained amounts of SSA/SSI lump sums during the nine-month resource exclusion period is not excluded as income. However, some or all of the amount earned may be excluded as infrequent or irregular income.

Burial funds — Continue to follow policy for burial funds in Chapter F, Resources, in all aspects of calculating countable resources and consideration of the interest accrued.

Steps to follow:

When the source of the dividend or interest is received on ...	then ...
a fully countable resource,	the dividends or interest are not counted as income regardless of the frequency and amount in the eligibility budget. Count in the co-payment budgets.
certain excluded or partially excluded resource,	the dividends or interest are not counted as income in either the eligibility or co-payment budgets.
all other resources (different than those above),	the dividends or interest are counted as income in the eligibility or co-payment budgets according to the treatment of that particular resource as outlined in the handbook.

Exclude interest and dividends if they meet the definition of infrequent or irregular income as specified in Section E-9000, Infrequent or Irregular Income.

See Appendix XVI, Documentation and Verification Guide.

Note: In a spousal situation, if the institutionalized person is diverting income to the community spouse, a joint bank account balance is equally divided between the two. Even though only one-half of this balance is countable for the institutionalized person, treat the interest/dividends as if accrued on a fully countable resource.

E-3331.4 Treatment of Interest and Dividends Earned on an Achieving a Better Life Experience (ABLE) Account

Revision 16-4; Effective December 1, 2016

An Achieving a Better Life Experience (ABLE) program allows an individual with a disability or family members of the individual to establish a tax-free savings account to maintain health, independence and quality of life for the benefit of the individual with a disability. The individual must meet the criteria of the state's ABLE program in which the individual enrolls. The ABLE account funds can be used for the individual's disability-related expenses, which supplement, but do not replace, private insurance and/or public assistance.

Interest and dividends earned on an ABLE account are not countable income to the designated beneficiary.

Income of the designated beneficiary of an ABLE account, or an individual whose income is counted when determining eligibility, that is deposited into an ABLE account, remains countable when determining eligibility.

Contributions to an ABLE account from individuals other than the designated beneficiary, and any distributions from an ABLE account, are not considered income to the designated beneficiary.

Request information to verify an ABLE account. Verification must include the following information:

- name of the designated beneficiary;
- state ABLE program administering the account;
- name of the person who has signature authority (if different from the designated beneficiary);
- name of the financial institution; and
- ABLE account number.

Verification documents may vary among states. Examples of acceptable documentation include participation agreements, ABLE account contracts, financial statements, and annual income tax filing documents.

E-3331.5 Treatment of Interest/Dividends on School-Based Savings Accounts

Revision 16-4; Effective December 1, 2016

School-Based Savings Accounts are accounts set up by students or their parents at financial institutions that partner with school districts. Individuals may set up school-based savings programs through savings accounts, Certificates of Deposit (CDs), Series I savings bonds, and Tuition Savings Plans under IRS Code, Section 529 or U.S.C. Section 530.

Interest earned on School-Based Savings Accounts is excluded from income.

Related Policy

F-2320, School-Based Savings Accounts

E-3332 Income from Joint Bank Accounts

Revision 10-1; Effective March 1, 2010

In this context, the term "spouse" includes a spouse whose income is considered in the co-payment determination process. Interest payments on joint bank accounts are considered as follows:

- If the co-holders of the account are not eligible for SSI, TANF or MAO, or do not have spouses or parents whose incomes are deemed to the applicant/recipient, all interest payments and deposits made by the ineligible co-holders are considered as income of the applicant/recipient.
- If one or more co-holders are eligible for TANF, SSI or MAO, or are spouses or parents whose incomes are deemed to the applicant/recipient, a deposit by the co-holder, spouse or parent is not considered to be income to the applicant/recipient.

All interest payments and deposits are divided equally among the applicant/recipient, spouse or parent.

If an applicant/recipient has disproved ownership of all or a part of the funds in a joint account, deposits by co-holders are not considered as income before the change in the account designation. Interest payments are income to the eligible individual in proportion to the amount of the funds owned.

References:

Section F-4121, Joint Bank Accounts
Section E-3331, Interest and Dividends

Determine ownership by verifying bank records and obtaining statements from the co-holders of the account.

E-3333 Mineral and Timber Rights

Revision 09-4; Effective December 1, 2009

Ownership of Land and Mineral/Timber Rights

If the person owns the land to which the mineral rights or timber rights pertain, the current market value of the land can be assumed to include the value of the mineral rights. Additional development is unnecessary.

Ownership of Mineral Rights/Timber Rights Only

If the person does not own the land to which the mineral rights pertain, obtain a current market value estimate from a knowledgeable source.

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

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

Document location/address of property in the case comments section. Document percentage of interest owned in case comments; the accessibility to interest in land resources; and whether land resources are excluded as a resource.

Document calculation of countable equity value in case comments if not excluded.

Notes:

- Clearance of value is not required for subsequent reviews unless circumstances that may change countability or value occur.
- If the mineral rights are non-producing, a $100 "default value" should be assigned. Document reason for $100 default value in case comments.
- If eligibility is negatively impacted by the "default value," a specific value must be verified.

Sources for verifying the value of land resources:

- Tax statement, if assessed.
- Contact a knowledgeable source in the community using telephone contact documentation. (Sources include oil and gas producers, tax assessors/collectors and petroleum lease agents – land men.)
- Form H1242, Verification of Mineral Rights, completed by an authorized employee of the producing company.
- IRS formula of 40 times the average monthly payout in assessing the value of mineral rights for inheritance purposes (to be used only when no other source is available). In TIERS, use "other acceptable" and document information in case comments.

Sources to verify ownership include:

- Copies of deeds, wills or leases. If the terms of the deeds, wills or leases are difficult to understand, obtain the assistance of legal staff.
- Copy of royalty statement.
- Division order, if producing.
- Statement from the person about amount of interest (ownership).
- Completed Form H1242.

Conversion of a resource from the sale of timber is not considered income except when:

- The owner leases the land or resource rights. The income received from the lease is unearned income.

- The sale of the natural resource is part of the person's trade or business. The income received is self-employment income.

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

Note: Consider whether royalty payments are excludable as irregular and/or infrequent income. See Section E-5000, Variable Income.

E-3333.1 Indian Fishing Rights

Revision 09-4; Effective December 1, 2009

In accordance with Public Law 100-647, effective Nov. 10, 1988, income received by a member of an Indian tribe from the exercise of recognized fishing rights is treated as unearned income for SSI and Medicaid purposes. Fishing rights must have been secured as of March 17, 1988, by a treaty, Executive Order or Act of Congress.

E-3340 Rents

Revision 19-2; Effective June 1, 2019

Rent is payment, either as cash or in-kind, that a person receives for the use of real or personal property, such as land, housing or machinery. Rental income is considered unearned income unless it is derived from self-employment, such as rental properties.

Budgeting Rental Income and Expenses

Ordinary and necessary expenses in the same taxable year are deducted from rental payments. These include only those expenses necessary to produce or collect rental income, and the expenses must be deducted when paid, not when they are incurred. Some examples of deductible expenses are interest on debts, state and local taxes on real and personal property and on motor fuels, general sales taxes, and expenses of managing or maintaining the property.

IRS tax records can be used, however, depreciation or depletion of property is not considered a deductible expense.

Net rental income (gross rent less expenses incurred in producing or collecting income) is used when budgeting. Expenses are deducted from the month in which they were paid, regardless of when they were incurred. If deductible expenses exceed gross rent in a month, subtract the excess expenses from the following month's gross rent and continue doing this as necessary until the end of the tax year in which the expense is paid. Do not carry excess expenses over to the next tax year or use them to offset other income.

For both the eligibility and co-payment budgets, regular variable income policy applies. If the monthly rental income is fixed and there are no allowable expenses to deduct, the eligibility budget may be projected for 12 months. Eligibility can also be certified on an annual basis, whether the income is fixed or not, if it is in the person's best interest to do so.

For co-payment purposes, project income and expenses for only six months at a time. Anticipated expenses must be projected for the review period when they are expected to occur. For example, at the January annual renewal staff budget tax deductions based on the amount of taxes paid last year.

Note: The most recent federal tax return, including Schedule E, is helpful in identifying past expenses and in estimating future rental income.

Related Policy

Documentation and Verification Guide, Appendix XVI
Rental Income Paid to a Third Party, E-3341
Mortgage Payment Made by Third Party, E-3342
Prorating Rental Expenses, E-3343
Rental Expenses, E-3344

E-3341 Rental Income Paid to a Third Party

Revision 09-4; Effective December 1, 2009

If the rental agreement is between the authorized representative and the tenant, and the authorized representative provides a statement to the effect that he does not and will not make the payments available to the person, the rental payments are not considered to be the person's income.

A referral to Adult Protective Services (APS) may be appropriate.

However, if the authorized representative is the person's guardian or power of attorney (POA), the payments are countable income to the person, unless extenuating circumstances indicate otherwise.

If the rental agreement is between the person and the tenant, the payments are income to the person, regardless of whether the authorized representative is make them available.

If the authorized representative is not making the rental payments available to the person, a referral to APS may be appropriate.

E-3342 Mortgage Payment Made by Third Party

Revision 09-4; Effective December 1, 2009

If the person's homestead is vacant and a third party is making the person's mortgage payments using his (the third party's) own funds, these payments are not income to the person.

If the person's home is rented and the lease agreement specifies that the tenant pays the person's mortgage company in lieu of rent, these payments are countable income to the person and are treated as rental income.

If the person's home is rented and there is no lease agreement, voluntary payments of the person's mortgage by the tenant directly to the mortgage company are considered to be a "gift" to the person and are countable income.

E-3343 Prorating Rental Expenses

Revision 09-4; Effective December 1, 2009

In multiple family residences, if the units in the building are of approximately equal size, prorate allowable expenses based on the number of units designated for rent compared to the total number of units. If the units are not of approximately equal size, prorate allowable expenses based on the number of rooms in the rental units compared to the total number of rooms in the building. (The rooms do not have to be occupied.)

For rooms in a single residence, prorate allowable expenses based on the number of rooms designated for rent compared to the number of rooms in the house. Do not count bathrooms as rooms; basements/attics are counted only if they have been converted to living spaces.

For land rental, prorate expenses based on the percentage of total acres for rent. There are various types of land rental, including hunting/fishing leases, pasture leases, sharecropping and other farm income not derived from self-employment.

E-3344 Rental Expenses

Revision 09-4; Effective December 1, 2009

The following table lists some common deductions that arise in budgeting rental income. The list is not intended to be all-inclusive; supervisory approval should be obtained when questionable deductions arise.

Expense	Deductibility
Money paid to or for employees not living in the home	Allowable
Money paid to or for employees living in the home	Allowable
Federal, state or local income taxes	Allowable
Sales tax	Allowable
Property tax	Allowable
Utilities for rental property	Allowable
Advertising for tenants	Allowable
Realtor or management company fees	Allowable
Supplies	Allowable
Actual expenses for roomers	Allowable
Interest for loans on property	Allowable
Depreciation related to self-employment	Allowable
Net loss from same period	Allowable
Real estate insurance	Allowable, except for liability insurance
Farming-related expenses (feed, seed, plants, seedlings, farm supplies, breeding fees, fertilizer and lime, crop insurance, crop storage, fees for livestock testing, etc.)	Allowable for self-employment farming Allowable for unearned income farming only if part of the lease agreement

Expense	Deductibility
Repairs or maintenance of property	Allowable if property is rented or between tenants Not allowable, if prior to initial rental of property
Capital asset purchases	Not allowable
Capital asset improvements	Not allowable
Payment on principal of loan for income-producing property	Not allowable
Travel to/from property	Not allowable
Net loss from previous period	Not allowable
Depreciation related to unearned income (for example, rental income)	Not allowable

E-3350 Death Benefits

Revision 09-4; Effective December 1, 2009

Count payments a person gets that were occasioned by the death of another person, except for the amount of such payments that a person spends on the deceased person's last illness and burial expenses. Last illness and burial expenses include related hospital and medical expenses, funeral, burial plot and interment expenses, and other related costs.

Example: If a person receives $2,000 from their uncle's life insurance policy and spends $900 on his last illness and burial expenses, the $1,100 balance is unearned income. If a person spends the entire $2,000 for the last illness and burial, there is no unearned income.

Note: This section does not refer to a person's receipt of proceeds as a result of cashing in his insurance policy. In that situation, consider the proceeds according to the policy for conversion of resource.

Verify countable proceeds of a life insurance policy by one or more of the following methods:

- obtaining a statement from the insurance company;
- viewing or obtaining a copy of the insurance payment check, deposit slip or bank statement; or
- viewing or obtaining receipts or copies of the checks written to pay last illness and burial expenses.

E-3360 Prizes and Awards

Revision 18-2; Effective June 1, 2018

A prize is generally something a person wins in a contest, lottery or game of chance.

An award is usually something a person receives as the result of a decision by a court, board of arbitration or the like. An award is also something of value conferred or bestowed on someone because of merit or need. Awards do not involve competition.

If a prize or award is not in cash, count the current fair market value of the prize or award, less any expenses involved in obtaining it. For example, deduct legal fees from an award received because of a lawsuit.

Consider income from prizes and awards according to frequency and the nature of the prize or award. Count a prize or award as unearned income in the month of receipt. Review Section E-9000, Infrequent or Irregular Income, to determine if the prize or award is to be treated as a lump-sum payment, infrequent or irregular income, or regular and predictable income. Consider regular and predictable awards as monthly unearned income.

See Appendix XVI, Documentation and Verification Guide.

Reference: Section E-3390, Texas Lottery Commission

E-3365 Inheritances

Revision 17-4; Effective December 1, 2017

An inheritance is cash, other liquid resources, noncash items or any right in real or personal property received at the death of another. An inheritance is income in the month of receipt unless the inherited item would be an excluded resource.

Example: An individual inherits a vehicle valued at $4,000 and the individual does not own any other vehicles. Per policy in F-4221 Automobile, one vehicle is excluded regardless of value. Because the vehicle is an excluded resource, the value of the vehicle is not considered as income in the month ownership is received.

Inheritances as a result of the death of another person, to the extent that they are used to pay the expenses of the deceased's last illness and burial, are not considered income.

Notes:

- A person may not have access to their inheritance pending legal action.
- Waiving an inheritance may result in a transfer of assets penalty.

If the inheritance is not received in cash, determine its current fair market value. To determine countable income, deduct any expenses that may have been incurred in obtaining the inheritance, such as legal fees and court costs.

Determine whether the inheritance is to be treated as a lump-sum payment, infrequent or irregular income, or regular and predictable income.

See Section E-5000, Variable Income, and Section E-9000, Infrequent or Irregular Income.

See Appendix XVI, Documentation and Verification Guide.

E-3370 Cash Gifts and Contributions

Revision 17-4; Effective December 1, 2017

A gift is something a person receives which is not repayment to a person for goods or services a person provided and which is not given to a person because of a legal obligation on the giver's part.

A gift is something that is given **irrevocably** (i.e., the giver relinquishes all control).

Donations and **contributions** may meet the definition of a gift.

- A **donation** is a gift given by a person typically for charitable purposes and/or to benefit a cause without expectation of return.
- A **contribution** is a gift or payment to a common fund or collection.

A cash gift or contribution is considered unearned income in the month of receipt.

The value of any non-cash item (other than food or shelter) is considered unearned income in the month of receipt. A non-cash item is not considered income if the item would become a partially or totally excluded non-liquid resource if retained in the month after the month of receipt.

Expenses involved in obtaining the income are excluded.

If the gift is not received in cash, determine its current fair market value. To determine the countable amount, deduct any expenses that may have been incurred in obtaining the gift, such as legal fees and court costs.

Determine whether the gift is to be treated as a lump-sum payment, infrequent or irregular income or regular and predictable income.

Examples

Gift of cash

A cash gift is counted as unearned income in the month of receipt. Review the infrequent or irregular income policy.

Gift of a car

A gift of a car that qualifies as an excluded resource if retained into the month after the month of receipt is not income. If the car does not qualify as an excluded resource (e.g., it is a second car), the car is counted as income in the month it is received and a resource beginning the next month.

See Section E-5000, Variable Income, and Section E-9000, Infrequent or Irregular Income.

See Appendix XVI, Documentation and Verification Guide.

E-3371 Gifts of Domestic Commercial Transportation Tickets

Revision 09-4; Effective December 1, 2009

The value of domestic commercial transportation tickets (given as a gift to the person or spouse) is not income unless converted to cash. Domestic transportation is limited to the 50 states, District of Columbia, Commonwealth of Puerto Rico, Virgin Islands, Guam, American Samoa and Northern Mariana Islands.

E-3372 Effective Date of Receipt of Inheritance; Disclaimers

Revision 09-4; Effective December 1, 2009

Real Property — The effective date of receipt is the date of death unless there is a contested will. If there is a contested will, the effective date of receipt is the date the will is probated.

Personal Property — The effective date of receipt is the date the person actually takes possession.

Note: Prior to Aug. 11, 1993, a disclaimer to an inheritance is not considered as a transfer of resources if transacted before receipt of an inheritance. The disclaimer must be a written statement acknowledged before a notary or other person authorized to take acknowledgement of conveyances of real property.

Examples:

- The will specifies $50,000 in cash for the person. Date of death is 1/5/92, disclaimer is signed 2/5/92 and will is probated 3/5/92. No transfer.
- The will specifies $50,000 in cash for the person. Date of death is 1/5/92, will is probated 2/5/92 and disclaimer is signed 2/10/92. Transfer provisions apply.
- The will specifies 50 acres for the person. Date of death is 3/6/93. If the disclaimer is signed before death, there is no transfer. If after, there is a transfer.
- There is no will. Date of death is 6/20/93. Through descent and distribution, the person will inherit an undivided half-interest in 50 acres. If the disclaimer is signed before death, there is no transfer. If after, there is a transfer.

After Aug. 11, 1993, a disclaimer of inheritance may result in a transfer of assets penalty regardless of the date the disclaimer is signed or effective.

See Chapter I, Transfer of Assets.

E-3373 Facility Payments

Revision 09-4; Effective December 1, 2009

The facility may allow a resident's family to use personal funds to pay an agreed-upon amount (in addition to the Medicaid rate) in order to have a private room.

For Medicaid eligibility purposes, if the family pays the difference, consider how it is being paid.

- If the money is given directly to the person in order to pay the difference to the facility, then that amount is considered income to the person.
- If the family pays the facility directly, do not consider the amount paid as income to the client.

E-3380 Support and Maintenance In Kind

Revision 09-4; Effective December 1, 2009

This is food or shelter furnished to a person based on the living arrangement. See Section E-8000, Support and Maintenance.

E-3390 Texas Lottery Commission

Revision 18-2; Effective June 1, 2018

Count the gross amount of winnings as unearned income in the month received, regardless of the frequency of pay.

The following Texas Lottery Commission information displays on the Data Broker combined report, if applicable:

- winner's full name, date of birth and Social Security number;
- paid date;
- gross, net and tax withheld amounts;
- check ID, claim number and date claim created;
- void date; and
- debt offset (is the same as recoupment), reason for the offset, and the agency name the offset is to, withholding amount, withholding number, withholding sequence number, check ID, and Agency ID.
- **Example:** Applicant wins $1,000/month; however, there is a debt offset (recoupment) of $100 from the Office of Attorney General (OAG) for child support. The income budgeted will be $1,000.

Note:

- Provide the **void date** only if the Texas Lottery Commission voids a check.
- In these situations, the winning are not counted as income.

The information provided by the Texas Lottery Commission through Data Broker is considered verification of winnings.

Notes:

- Staff must budget the gross amount reported by the Texas Lottery Commission.
- Some winners may elect to place their winnings in a trust fund.

Reference:

Trust Funds, F-6000

E-4000, Fixed Income

Body

Revision 18-2; Effective June 1, 2018

Information in this section concerns common periodic payments that are unearned income; however, the information is not inclusive.

E-4100, Social Security Benefits

Body

Revision 18-2; Effective June 1, 2018

The Social Security Administration (SSA) pays Social Security benefits (RSDI) under provisions of the Social Security Act. Black Lung benefits under the Coal Mine Health and Safety Act of 1969. are also Social Security benefits.

A person who receives Social Security benefits may be enrolled in Medicare Part B, in which case the Medicare (SMIB) premiums are taken out of the Social Security checks before the checks are received. Determine whether the person is enrolled. If so, add the SMIB premium (see Appendix XXXI, Budget Reference Chart) to the benefit received to determine the total Social Security benefit used to determine eligibility.

Note: An SMIB premium may be different if a beneficiary enrolled late in Medicare or is eligible for a variable SMIB premium. The person may also have Medicare Part D taken out of the Social Security check.

See Appendix XVI, Documentation and Verification Guide.

For applications, verify gross benefits.

For reviews, if the recipient's statement agrees with the conversion amount and there is no indication that the RSDI benefit has changed, do not reverify.

Verify the amount of Social Security benefit by one or more of the following methods:

- Obtain an SOLQ/WTPY.
- View or obtain a copy of the person's award notice (letter) from the SSA.
- Obtain information from the SDX computer tape if the recipient has SSI and RSDI and is now in an institutional setting.
- Contact a representative of the SSA using telephone contact documentation.
- View or obtain a copy of the person's most recent benefit check or direct deposit slip. This method is least desirable because it may not show the gross amount.
- At review, use the conversion amount in the system of record if there is no indication that the RSDI is different from the converted amount.

Note: The Social Security Administration refigures SSA benefits if the individual has earnings from the previous year and other changes. This refiguring usually occurs during October, but may occur at other times. Staff may need to obtain an SOLQ/WTPY at redeterminations to ensure they have current/updated amounts. See Section F-2150, SSI and RSDI Retroactive Lump Sum Payments; Section F-2151, Examples of SSI and RSDI Retroactive Lump Sum Payments; and Section E-1610, SSA Overpayments.

E-4200, Railroad Retirement Benefits

Body

Revision 09-4; Effective December 1, 2009

Railroad retirement benefits may be paid to a person or to the person's dependents or survivors. Some examples of railroad retirement benefits are sick pay, annuities, pensions and unemployment insurance benefits.

If a person is enrolled in Medicare Part B under his/her railroad retirement annuity number, determine the total railroad retirement benefit by adding the current SMIB premium amount to the benefit received.

See Appendix XVI, Documentation and Verification Guide.

E-4300, VA Benefits

Body

Revision 12-1; Effective March 1, 2012

The U.S. Department of Veterans Affairs (VA) has numerous programs that make payments. Treatment of VA payments depends on the nature of the payment. The most common types of VA payments are:

- pension;
- compensation;
- dependency and indemnity compensation;
- educational assistance;
- aid and attendance allowance;
- housebound allowance;
- payment adjustment for unusual medical expenses;
- clothing allowance;
- payments to Vietnam veterans' children with spina bifida.

Note: VA aid and attendance allowance, housebound allowances and payment adjustment for unusual medical expenses are exempt from both eligibility and co-payment. However, if these payments are deposited into a qualifying income trust (QIT) account, they are countable for co-payment.

E-4310 Augmented and Apportioned VA

Revision 09-4; Effective December 1, 2009

The VA determines the designated beneficiary of a check based on the laws and regulations for payment of each benefit.

Augmented VA payment. A VA pension payment that has been increased for dependents is an augmented VA payment. For Medicaid purposes, the augmented benefit includes a designated beneficiary's portion and one or more dependents' portions. An augmented VA benefit usually is issued as a single payment to the veteran or the veteran's surviving spouse. When veteran’s benefits are augmented for a dependent, the dependent's portion is not countable income to the applicant/recipient (the veteran or veteran's surviving spouse) of the check. If the applicant/recipient is the dependent, the applicant/recipient’s portion is countable income to the applicant/recipient.

Apportioned VA payment. A VA compensation payment made directly to the dependent of a living veteran is an apportioned payment. **Apportionment** is direct payment of the dependent's portion of VA benefits to a dependent spouse or child. The VA decides whether and how much to pay by apportionment on a case-by-case basis. Apportionment reduces the amount of the augmented benefit payable to the veteran or veteran's surviving spouse.

A portion of a VA benefit paid by apportionment to a dependent spouse or child is VA income to the dependent spouse or child. It is not a support payment from the designated beneficiary.

See Section D-6350, Veterans Benefits, for requirements to apply for benefits.

E-4311 VA Pensions

Revision 10-1; Effective March 1, 2010

Pension payments are based on a combination of service and a nonservice-connected disability or death.

Needs-Based Pensions and the $20 General Exclusion

Most VA pension payments are based on need. As such, these payments are unearned income to which the $20 general income exclusion does not apply.

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

Pensions are paid to:

- a wartime veteran determined permanently and totally disabled for nonservice-related reasons;
- the surviving spouse; or
- the child of a veteran because of the nonservice-related death of the veteran.

There are several periodic payments from VA benefits:

- VA compensation
- VA pension
- VA Dependency and Indemnity Compensation (DIC) payments

Because VA pensions and parents' DIC payments are generally based on need, the $20 general income exclusion in the eligibility determination is not applied.

Exceptions:

The following pensions are not based on need:

- Pensions based on a special act of Congress.
- Pensions based on the award of the Medal of Honor.
- Pensions based on service in the:
  - Spanish American War (April 21, 1898, through July 4, 1902);
  - Indian Wars (January 1, 1817, through Dec. 31, 1898); or
  - Civil War (1861-1865).

These pensions are unearned income and the $20 general exclusion does apply to these exceptions. Assume that a VA pension is needs-based unless there is evidence to the contrary. See Section G-4110, Twenty-Dollar General Exclusion.

E-4311.1 1979 VA Pension Plan

Revision 10-1; Effective March 1, 2010

The Jan. 1, 1979, increase in VA pension benefits caused many SSI recipients to become ineligible. Public Law 96-272 gave protection to a person drawing VA pension benefits "grandfathered" from Dec. 31, 1978. A person who has been eligible for a VA pension since before 1979 is not required to apply for an increase in VA payment for medical expenses known as aid and attendance or housebound benefits. These additional payments are for unusual medical expenses and are considered exempt income that does not affect eligibility or co-payment.

Refer persons who have changed to the 1979 pension plan or who initially obtain entitlement to a VA pension after Jan. 1, 1979, to apply for aid and attendance or other potentially available benefits. However, do not monitor for the person’s compliance to apply for other benefits when it is to increase the VA payment for

medical expenses since aid and attendance or housebound benefits are considered exempt income that does not affect eligibility or co-payment.

Determine whether the person is receiving an aid and attendance or housebound allowance as part of his/her VA benefit.

See Section D-6351, VA Pension or Compensation.

E-4311.2 $90 VA Pension and Institutional Setting

Revision 11-4; Effective December 1, 2011

If a veteran without a spouse or child or a surviving spouse without a child is covered by Medicaid for services furnished by a nursing facility, the maximum pension that can be paid to or for the veteran or surviving spouse for any month after the month of admission to such nursing facility is $90. This reduced pension is an aid and attendance allowance in all cases, and not income.

VA law (38 U.S.C. 5503) provides that the amount of the VA pension for an institutionalized Medicaid recipient having neither a spouse nor child (or in the case of a surviving spouse, having no child) cannot exceed $90 per month.

The $90 VA pension may not be used in determining what the person in an institutional living arrangement must pay toward the cost of care. The limited VA pension, up to the amount of $90, is not counted as income in the eligibility or co-payment budget.

There is no association between the reduced pension and the personal needs allowance (PNA). If a veteran has income from other sources, the income from other sources may be considered countable. HHSC is to perform the co-payment calculations to determine the amount of the veteran's liability toward the cost of care.

Do not refer a person who is receiving the $90 VA pension in an institutional setting to apply for other benefits when it is to increase the VA payment for medical expenses since aid and attendance or housebound benefits are considered exempt income that does not affect eligibility or co-payment. If the person's only income is the $90 VA pension, refer the person to the Social Security Administration for SSI.

See Section D-6351, VA Pension or Compensation.

A person who has a capped $90 VA aid and attendance is eligible for the PNA up to $60 per month. See the examples below:

- For a non-SSI Medicaid recipient in an institutional living arrangement who does not have VA aid and attendance capped at $90 per month, the total PNA will be up to the current maximum of $60. The person keeps up to $60 for their personal expenses.
- For a non-SSI Medicaid recipient in an institutional living arrangement who has VA aid and attendance capped at $90 per month, the total PNA may be up to $60. The person keeps up to $150 for their personal expenses ($90 plus up to $60).
- State supplementation is not allowed for a Medicaid recipient who is not an SSI recipient.
- The VA $90 capped aid and attendance and PNA calculation does not impact the Protected Earned Income Allowance.

In a situation in which a veteran has a $90 capped VA aid and attendance and does not have another source of income from which to deduct the $60 PNA, the person will have $90 for their personal expenses and the co-payment is zero. In a situation in which a veteran has a $90 capped VA aid and attendance and the veteran's other source of income is less than $60, the PNA will be up to, but not exceed, $60. This person will have up to

$150 for their personal expenses ($90 plus up to $60). There is no state supplement to bring the PNA up to $60 if the veteran does not have other income from which to subtract the PNA. The PNA deduction comes **first** in the order of all co-payment deductions, including those for incurred medical expenses (IME).

If a person's only income in a facility is the VA pension capped at $90 per month, certify the person for Medicaid, provided the person meets other program requirements, and refer the person for SSI.

E-4312 VA Compensation

Revision 11-4; Effective December 1, 2011

VA compensation is unearned income and is based primarily on service in the armed forces. Payments are made to veterans, dependents or survivors.

The VA makes compensation payments to a veteran because of a service-related disability. The VA also makes compensation payments to a spouse, child or parent of a veteran because of the service-related death of the veteran.

Note: If a person or a recipient moves from a community setting to an institutional setting, entitlements to additional VA benefits may be appropriate due to a change in the situation or increased medical needs. If a person is a veteran or an unmarried widow or widower of a deceased veteran, explore possible entitlement to VA benefits. If the person is potentially eligible but no payment is reported, the person may be required to file for a VA benefit. See Section D-6350, Veterans Benefits, for requirements to apply for benefits.

Budgeting Information

Because VA compensation is not based on need, deduct the $20 general income exclusion in the eligibility determination. See Section G-4110, Twenty-Dollar General Exclusion.

Note: The $20 exclusion does not apply to VA pensions or parents' DIC payments.

Neither the beneficiary's award letter nor the VA check indicates whether aid and attendance is included in a person's total VA payment. To verify the type and amount of benefits received, contact the VA using Form H1240, Request for Information from Bureau of Veterans Affairs and Client's Authorization.

Do not include aid and attendance allowance, housebound allowance and VA reimbursement for unusual medical expenses as a part of the total VA benefit. See Section E-4315, VA Aid and Attendance and Housebound Payments.

E-4313 Dependency and Indemnity Compensation

Revision 11-4; Effective December 1, 2011

Dependency and Indemnity Compensation (DIC) is a monthly benefit paid to eligible survivors of certain deceased veterans:

- Military service member who died while on active duty.
- Veteran whose death resulted from a service-related injury or disease.

- Veteran whose death resulted from a non service-related injury or disease, and who was receiving, or was entitled to receive, VA compensation for service-connected disability that was rated as totally disabling:
  - for at least 10 years immediately before death;
  - since the veteran's release from active duty and for at least five years immediately preceding death; or
  - for at least one year before death if the veteran was a former prisoner of war who died after Sept. 30, 1999.

The surviving spouse is eligible if he/she:

- validly married the veteran before Jan. 1, 1957;
- was married to a service member who died on active duty;
- married the veteran within 15 years of discharge from the period of military service in which the disease or injury that caused the veteran's death began or was aggravated;
- was married to the veteran for at least one year; or
- had a child with the veteran; and
  - cohabited with the veteran continuously until the veteran's death or, if separated, was not at fault for the separation; and
  - is not currently remarried.

Note: A surviving spouse who remarries on or after Dec. 16, 2003, and on or after attaining age **57** is entitled to continue to receive DIC.

The $20 exclusion does not apply to VA pensions or parents' DIC payments.

A surviving child is eligible if the child is:

- unmarried; and
- under age 18, or between the ages of 18 and 23 and attending school.

Whenever there is no surviving spouse of a deceased veteran entitled to DIC, the children of the deceased veteran are eligible for DIC.

Additional allowances could be included in the DIC benefit for aid and attendance or housebound.

Neither the beneficiary's award letter nor the VA check indicates whether aid and attendance is included in a person's total VA payment. To verify the type and amount of benefits received, contact the VA using Form H1240, Request for Information from Bureau of Veterans Affairs and Client's Authorization.

Do not include aid and attendance allowance, housebound allowance and VA reimbursement for unusual medical expenses as a part of the total VA benefit. See Section E-4315, VA Aid and Attendance and Housebound Payments.

E-4314 Educational Assistance

Revision 09-4; Effective December 1, 2009

The VA provides educational assistance through different programs, including vocational rehabilitation. Medicaid policies on income and resources depend on the nature of the VA program. The veteran’s period of eligibility to receive benefits for educational assistance are as follows:

- Veterans generally have up to 10 years after leaving the service to complete their education.
- Veterans enrolled in a vocational rehabilitation program have up to 12 years to complete the program.

- Veterans participating under the Chapter 33 program, "Post-9/11 GI Bill," have up to 15 years to complete their education.

Dependents and survivors of veterans may also be eligible for educational benefits. The VA makes payments under Chapter 35, Survivors and Dependents Educational Assistance Program (a non-contributory program), to:

- children (between ages 18 and 26) of veterans who died in the service;
- surviving spouses of veterans who died in the service;
- children of living veterans who are 100% disabled due to a service-connected injury; and
- spouses of living veterans who are 100% disabled due to a service-connected injury.

Note: Survivors and dependents have 10 years from the date of the veteran's service-connected death or date of 100% disability to participate in this program.

Do not consider as income the following:

- Payments made by VA to pay for tuition, books, fees, tutorial services or any other necessary educational expenses.
- Payments made as part of a VA program of vocational rehabilitation, including any augmentation for dependents.
- Any portion of a VA educational benefit that is a withdrawal of the veteran's own contribution is conversion of a resource and is not income. However, any portion of the withdrawal that is retained into the month following the month of receipt is a countable resource.

References: The policy in the following items details VA payments that are either not considered as income or exempt as income.

- Section E-1720, Social Services that are Not Income
- Section E-2130, Education and Employment
- Section E-2330, Educational Assistance

Do consider the following as income:

- The portion of the VA educational payment designated as a stipend for shelter.
- Payments made by VA that are used to pay for those things other than necessary educational expenses.

Note: The $20 general income exclusion applies to countable VA educational assistance and these payments are subject to deeming. See Section G-4110, Twenty-Dollar General Exclusion.

E-4315 VA Aid and Attendance and Housebound Payments

Revision 16-4; Effective December 1, 2016

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

This special VA allowance can be paid to:

- disabled veterans;
- disabled veterans' spouses;
- widows; or
- parents.

If an individual is in an institutional setting (for example, a nursing facility) because of mental or physical incapacity, the VA presumes eligibility for aid and attendance.

Based on policy regarding medical expenses paid by a third party, do not consider in the eligibility and co-payment budgets the following VA payments:

- aid-and-attendance allowances;
- housebound allowances; and
- reimbursement for unusual medical expenses.

Reference: Section E-1720, Social Services That Are Not Income.

Exception: If aid-and-attendance allowances, housebound allowances and reimbursements for unusual medical expenses are deposited into a QIT, the amount deposited is countable for co-payment budgeting. Aid-and-attendance allowances, housebound allowances, and reimbursements for unusual medical expenses are not countable for co-payment budgeting if separated from the pension or compensation benefit before depositing the VA pension into a QIT. Separating and depositing the VA pension amount does not invalidate the QIT.

If it appears that the individual may be entitled to an aid-and-attendance allowance and is not receiving one, refer the individual to the VA. While living in the community, an individual receives a housebound allowance, but that allowance is adjusted to the aid-and-attendance allowance if the individual moves to an institutional setting. Do not monitor for the individual's compliance to apply for other benefits when it is to increase the VA payment for medical expenses since aid-and-attendance or housebound benefits are not considered income and will not affect eligibility or co-payment.

Neither the beneficiary's award letter nor the VA check indicates whether aid-and-attendance is included in an individual's total VA payment. To verify the type and amount of benefits received, contact the VA using Form H1240, Request for Information from Bureau of Veterans Affairs and Client's Authorization.

When the income is not considered for the eligibility and co-payment budgets, enter aid-and-attendance allowance, housebound allowance, and VA reimbursement for unusual medical expenses as a separate income source. See Appendix XVI, Documentation and Verification Guide.

E-4316 VA Clothing Allowance

Revision 09-4; Effective December 1, 2009

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

A VA clothing allowance is not income.

Reference: Section E-1720, Social Services That Are Not Income

E-4317 Payments to Vietnam Veterans' Children with Spina Bifida

Revision 09-4; Effective December 1, 2009

Do not consider the following types of VA benefits as income or resources for Medicaid purposes:

- VA payments made to or on behalf of certain Vietnam veterans' natural children, regardless of their age or marital status, for any disability resulting from spina bifida suffered by such children.
- VA payments made to or on behalf of certain Korea service veterans' natural children, regardless of their age or marital status, for any disability resulting from spina bifida suffered by such children.
- VA payments made to or on behalf of women Vietnam veterans' natural children, regardless of their age or marital status, for certain birth defects.

Note: Interest and dividends earned on unspent payments are exempt from income.

Reference: Section E-2150, Other – Exempt Income

E-4318 VA Contracts

Revision 09-4; Effective December 1, 2009

A VA contract for payment of nursing facility services does not affect Medicaid eligibility. If an application is filed, proceed with the eligibility determination. If the person is certified while the contract is still in effect, the VA contract is reported as a third-party resource on Form H1039, Medical Insurance Input.

E-4400, Other Annuities, Pensions and Retirement Plans

Body

Revision 15-3; Effective September 1, 2015

There are two types of annuities:

- An annuity can be a periodic payment calculated on an annual basis that is a return on prior service. A civil service payment is an example of this type of annuity. It is treated the same as pension or retirement income.

  Example: A person retired from federal service in 1980 after 30 years of employment. Her gross annual Civil Service Annuity (CSA) payment is $5,400, which is paid in 12 monthly installments of $450 each. Because this type of annuity produces a stream of income only, it has no resource value. The monthly payment is countable income.
- An annuity can also be a contract or agreement for an amount to be paid yearly or at other regular intervals in return for prior payments made by the person. For this type of annuity, the language of the annuity dictates whether disbursements are countable income and describes the payment schedule. See Section F-7000, Annuities, for treatment of pre-DRA and post-DRA annuities.

Pension or retirement payments may be made directly by a former employer or from a fund, insurance or any similar source. An example of a retirement payment is teacher retirement.

Determine the gross and net amounts of the monthly payments. Also determine whether the organization making the payments is providing any other benefits to the person.

Note: When income tax is withheld from retirement, pension or disability benefits, use the gross income amount for the eligibility and co-payment calculations.

See Chapter G, Eligibility Budgets, and Chapter H, Co-Payment.

See Appendix XVI, Documentation and Verification Guide.

Certain pension and retirement payments allow for the person to request a reduced amount. If the reduction is irrevocable, accept the reduced amount in determining the person's eligibility. However, for a person in an institutional setting (for example, a nursing facility or a Home and Community-Based Services waiver program), investigate the reduction for transfer of assets in Chapter I, Transfer of Assets.

If the person is receiving a reduced benefit, ask the person to provide a written statement from an official of the organization addressing the amount of the original benefit, the amount of the reduced benefit, the date of the reduction, and information about the revocability or irrevocability of the reduction.

If the pension or retirement payments are revocable, the person must apply for maximum entitlements.

Reference: Section I-1400, Transfer of Income

If a person's income from annuities, pensions and retirement plans is greater than the special income limit, but not enough to pay private-pay costs in an institutional setting, the person can consider a QIT. QITs allow people to legally divert their income into a trust, after which the income is not counted for eligibility purposes. For more information, see Appendix XXXVI, Qualified Income Trusts (QITs) and Medicaid for the Elderly and People with Disabilities (MEPD) Information. The payments are countable in the co-payment budget.

E-4500, Workers' Compensation

Body

Revision 09-4; Effective December 1, 2009

Workers' compensation benefits are unearned income. A portion of a person's workers' compensation may be designated for medical, legal or related expenses. Request the person to provide verification of payment and, in addition, any expense required to obtain the benefit.

A person who suffers a work-related injury or illness may be eligible for workers' compensation benefits. These benefits are administered by the Industrial Accident Board under the Texas Workers' Compensation Act. If a person dies as a result of a work-related injury or illness, his dependents or beneficiaries may be eligible for workers' compensation benefits.

Determine the monthly amount of workers' compensation benefits by multiplying the weekly benefit by 4.33. (These benefits are usually paid on a weekly basis.) Also determine the expected duration of the workers' compensation benefits.

Determine and exclude the portion, if any, of the workers' compensation that is considered an expense required to obtain the benefit.

Reference: See Section D-7400, Use of Third-Party Resources, for policies governing recovery of Medicaid payments when additional workers' compensation is received for medical expenses incurred after Medicaid eligibility began.

Verify workers' compensation benefits by one or more of the following methods:

- Viewing or obtaining a copy of the person's notice of workers' compensation benefits.
- Obtaining a letter from an official of the Industrial Accident Board.
- Viewing or obtaining copies of the person's weekly checks (least desirable method).
- Obtaining proof of any medical, legal or other related expenses if that information is not included in information already provided.
- Documenting a contact with a knowledgeable source.

E-4600, Unemployment Benefits

Body

Revision 11-4; Effective December 1, 2011

Unemployment benefits are unearned income.

A person who loses employment may be entitled to unemployment benefits through the Texas Workforce Commission (TWC). To receive unemployment benefits, a person must file an application with TWC. Determine the expected duration and the amount of the unemployment benefits per month. Unemployment benefits may be received on a weekly or biweekly schedule.

Reference: Do not use TWC's Form B-11 to verify unemployment benefits. This form does not verify the actual receipt or amount of benefits.

Verify unemployment benefits by one or more of the following methods:

- Obtain TWC information through a Data Broker report.
- Obtain a letter from TWC.
- Document a contact with a representative of TWC.
- View or obtain a copy of the person's most recent benefit checks.

Data Broker report will verify quarterly earnings and unemployment benefits. Information is obtained using the person's name and Social Security number. A match will result if the person has applied, is receiving or has received unemployment benefits with TWC. Result response time is generally immediate.

A match by name will provide the person's name, alias name, address, telephone number, Social Security number and date of birth.

Available information includes:

- if the person has applied for benefits;
- wages the person earned (per quarter) during the past 24 months;
- the status of a current claim; and
- the amount of weekly unemployment benefits, deductions and payment dates.

E-4700, Disability Insurance Benefits

Body

Revision 09-4; Effective December 1, 2009

Disability benefits are unearned income.

Some insurance policies pay benefits based on the period of time a person is disabled and not on the amount of medical expenses. These policies may be called "income maintenance" policies. Benefits from these policies are unearned income to the extent that they are not used to pay for medical expenses.

Disability benefits normally are paid to a person who has suffered injury or impairment. These payments may be from an employer, insurance or other public or private fund.

Determine the source of the benefit. If the source is covered by one of the unearned income items, such as Social Security or a private pension, use the procedures for that item.

E-5000, Variable Income

E-5100, Calculations for Variable Income

Body

Revision 09-4; Effective December 1, 2009

Average monthly income that is predictable but varies in amount from month to month. Types of monthly income that require averaging include, but are not limited to:

- earned income;
- royalty income; and
- interest income.

Variable income can be from one source or a combination of sources.

For eligibility budgets, treatment of variable income is the same whether the person is in the community or in an institutional setting.

Treatment of variable income in co-payment budgets applies only to a person in an institutional setting (for example, a Home and Community-Based Services waiver program or a nursing facility).

There are additional treatments for variable income for the co-payment budgets that include reconciliation and restitution. See Chapter H, Co-Payment.

As specified in Section E-9000, Infrequent or Irregular Income, do not average income for the eligibility test that meets the definition of irregular or infrequent.

See Chapter G, Eligibility Budgets, for instructions on determining income eligibility. The examples in this section are for demonstration purposes only. They may not reflect the current spousal allowance amounts.

E-5200, When to Project Variable Income

Body

Revision 09-4; Effective December 1, 2009

1. The person has income that fluctuates from month to month (such as earnings, royalties, dividends, interest, rents, etc.) and the average from all sources is $5 or more.
2. Variable income from any combination of sources was received during at least three of the preceding six months, is anticipated to reoccur, and the average from all sources is $5 or more.

   Example: The person entered a nursing facility (NF) in January and applied for Medicaid the same month. During the six months preceding the month the case is worked (February), the person received the following variable income payments, all of which are anticipated to reoccur during the projection period (March through August).

Month	Source #1	Source #2	Payment Received
Aug.			
Sept.	$20		X
Oct.			

Month	Source #1	Source #2	Payment Received
Nov.	$20	X	
Dec.			
Jan.			

Because the person did not receive variable income from all sources during at least three of the preceding six months, do not average and project variable income, even though the payments are anticipated to reoccur with the same frequency during the coming six months.

Note: If an eligibility budget is being calculated for the prior month of November, the $20 payment received that month is excluded as infrequent/irregular income in the eligibility budget. There is no co-payment for November because the person did not enter the NF until January.

3. In spousal impoverishment cases, the community-based spouse received variable income from any combination of sources during at least three of the preceding six months, the variable income is anticipated to reoccur, and the monthly average from all sources is $5 or more.

   Example: The person entered the NF in January and applied for Medicaid the same month. The person has no variable income. However, the community-based spouse receives monthly royalty payments from a mineral lease. During the six months preceding the month the case is worked (February), the community-based spouse received monthly royalties as follows: August = $25; September = $30; October = $20; November = $15; December = $22; and January = $25.

   Because the community-based spouse received variable income during at least three of the preceding six months, all payments are anticipated to reoccur during the coming six months, and the average from all sources is $5 or more ($25 + $30 + $20 + $15 + $22 + $25 = $137 ÷ 6 months = $22.83 monthly average), the eligibility specialist projects the $22.83 average as the community-based spouse's income in the co-payment calculation.
4. For applications, variable income that is anticipated to reoccur is calculated into the co-payment budget for the month of certification and is projected over the next six months. If eligibility is being tested for prior months, the amount of variable income actually received during a given month is budgeted as income for that month.
5. For ongoing cases, variable income (earned or unearned) is not calculated into the co-payment budget until the month following the month in which the person received his/her first variable payment.

   Example: (Reviews Only) The person's first monthly variable payment (such as earned income or interest) is received in October. This payment is calculated into the co-payment budget in November to be effective December.

E-5300, When Not to Project Variable Income

Body

Revision 09-4; Effective December 1, 2009

1. Variable income is received from all sources in fewer than three of the preceding six months and is not anticipated to increase in frequency. Variable income that is not projected is restituted at the annual redetermination, if the amount in the month of receipt is $5 or more.

   Example: The person entered an NF in January and applied for Medicaid in the same month. During the six months preceding the month the case is worked (February), the person received the following variable payments, which are anticipated to reoccur during the projection period (March through August).

Month	Source #1	Source #2	Payment Received
Aug.			
Sept.	$20		X
Oct.			
Nov.		$20	X
Dec.			
Jan.			

Because the person did not receive variable income from all sources during at least three of the preceding six months, do not average and project variable income, even though these payments are anticipated to reoccur with the same frequency during the coming six months.

Note: If an eligibility budget is being calculated for the prior month of November, the $20 payment received that month is excluded as infrequent/irregular income in the eligibility budget. There is no co-payment budget for November because the person did not enter the NF until January.

2. Variable income is received during three of the preceding six months from any combination of sources, but payment from at least one of the sources is not anticipated to reoccur during the next six months, and payments from remaining sources were not received during three of the preceding six months.

   Examples:

   - The person entered an NF in January and applied for Medicaid the same month. During the six months preceding the month the case is worked (February), the person received the following unearned variable payments, but the payment from Source #3 was a one-time payment and is not anticipated to continue.

Month	Source #1	Source #2	Source #3	Payment Received
Aug.	$30			X
Sept.				
Oct.		$30		X
Nov.				
Dec.				
Jan.			$50	X

     Although the person received variable income from all sources during three of the preceding six months, the payment from Source #3 is not anticipated to reoccur. Therefore, the variable payments from Sources #1 and #2 are not averaged and projected for future months.

     Note: If eligibility is being determined for the prior month of October, the unearned variable income of $30 received during that month is not countable income, as the amount is less than the infrequent or irregular exclusion of the first $60 unearned in a calendar quarter. (See Section E-9000, Infrequent or Irregular Income.) There is no co-payment budget for October because the person did not enter the NF until January.

   - The person entered the NF in January and applied for Medicaid the same month. During the six months preceding the month in which the case is worked (February), the person received the following variable payments, but the payment from Source #3, received in October, was a one-time payment and is not anticipated to recur.

Month	Source #1	Source #2	Source #3	Payment Received
Aug.	$20			X
Sept.		$20		X
Oct.			$20	X

Month	Source #1	Source #2	Source #3	Payment Received
Nov.				
Dec.	$20	$20		X
Jan.				

Because the person received variable income from Sources #1 and #2 during three of the preceding six months, the income from Sources #1 and #2 is averaged and projected into the co-payment budget for the coming six months (March through August). However, since the one-time $20 payment from Source #3 is not anticipated to recur, it is not included in the average of variable income to be projected.

3. Variable income from all sources was received during three of the preceding six months and is anticipated to recur, but the average of income from all sources is less than $5.

   Example: The person entered the NF in January and applied for Medicaid the same month. During the six-month period preceding the month in which the case is worked (February), the person received the following variable payments, all of which are anticipated to recur.

Month	Source	Payment Received
Aug.	$2	X
Sept.	$1	X
Oct.	$2	X
Nov.	$5	X
Dec.	$3	X
Jan.	$4	X

   The person received variable payments from all sources during each of the six preceding month; however, because the average of all payments is less than $5 ($2 + $1 + $2 + $5 + $3 + $4 = $17 ÷ 6 months = $2.83) and is not anticipated to increase, that average is not projected into the co-payment budget.

E-5400, How to Budget Variable Income at Applications

Body

Revision 09-4; Effective December 1, 2009

If a person routinely receives variable income that is anticipated to continue, use an average of variable income received during the six months preceding the application file date, or the six months preceding any month up to the certification month, and project that average for the coming six-month period. Schedule a special review for the sixth month after the case is certified to re-budget applied income.

Examples:

- The person applied in January and is now being certified in February. The eligibility specialist verifies that the person received variable income totaling $300 from August through January, which is anticipated to reoccur, and obtains an average of $50 per month ($300 ÷ 6 months). This average ($50) is budgeted as variable income in the applied income calculation. A special review is scheduled for the following August, six months from the certification date.
- The person applied in January and is now being certified in March. The eligibility specialist has the option of averaging variable income for any one of the following six-month periods:
  - July through December (six months prior to January, the month in which the application was filed);

- August through January (six months preceding February, which is a month prior to the March certification month); or
- September through February (six months prior to the certification month of March).

If variable income is received on a monthly basis and is anticipated to continue, the amount to be projected is an average of variable income received during preceding months. If variable income was received during all six of the preceding months, divide the total received by 6; if there are only five months of variable income, divide the total by 5; if there are only four months of variable income, divide the total by 4, and so on.

Examples:

- The application was filed in January and is being certified in February. The person began receiving monthly variable income six months ago, in August. Variable income received from July through December totaled $400. The average to be projected over the coming six months is $66.67 ($400 total ÷ 6 months = $66.67). A special review is scheduled for the following August to re-budget variable income.
- The application was filed in January and is being certified in February. The person began receiving monthly variable income two months ago, in December. Variable income received for December and January totals $75. The average to be projected over the coming six months is $37.50 ($75 total ÷ 2 months = $37.50). A special review is scheduled for the following August to re-budget variable income.

In spousal impoverishment cases, if the community spouse has variable income that is anticipated to continue, in the co-payment budget use an average of variable income received during the six months preceding the application file date, or the six months preceding any month up to the certification month, and project that average for the coming six-month period. Schedule a special review for the sixth month after the case is certified to re-budget applied income.

Note: If the co-payment is $0 and there is a wide margin of variability for variable income, semi-annual reviews are not required. Variable income should be re-budgeted at each annual redetermination.

Note: Cases with significant month-to-month differences in income amounts should be reviewed quarterly rather than every six months. This quarterly averaging will minimize the impact on a person if he receives income in very low amounts for several months. If the monthly average of variable income from all sources is less than $5, the variable income need not be budgeted for applied income purposes.

If variable income from all sources was received during at least three of the preceding six months and is anticipated to reoccur, total the variable income received during the preceding six months and divide by six to determine the initial budget. Schedule a special review for the sixth month after the case is worked to re-budget applied income.

Example: The application is worked in February. The preceding six months are August through January. Variable income totaling $65 from two different sources was received in August, October, December and January and is anticipated to continue. The average to be projected (from March through August) is $10.83 ($65 ÷ 6 months = $10.83).

Spend down situations. Amounts of variable income received during preceding months may differ from amounts anticipated for future months. In these situations, obtain a statement of anticipated income amounts from the source, if possible. If the source cannot provide a statement, expected income must be determined based on other information.

Examples:

- Interest income — The person entered an NF in September, and her Medicaid application is being worked in February. She owns an interest-bearing bank account, but has been spending down resources since September. The current bank account balance is sufficient to continue generating interest. The eligibility specialist budgets the anticipated interest amount based on the best estimate available, considering the

reduced account balance and current interest rates, rather than averaging the interest posted during preceding months when the account balance was much higher. A special review is scheduled for no later than August to reconcile.
- Rental income — The amount of rental income to be projected is a net amount based on gross rents anticipated to be received, less allowable expenses anticipated to be paid, during the six months following the month the case is worked (the month the case is certified).

E-5500, How to Budget Variable Income at Redeterminations

Body

Revision 09-4; Effective December 1, 2009

When projecting variable income, it is permissible to overlap months (or to skip a month), if verification is unavailable.

Examples:

The redetermination is in February and verification of variable income for January is unavailable. The options are:

- Average variable income from July through December (total divided by six months), and project that average through the following August. (This is true even though variable income received in July was used in the average calculated at the preceding semi-annual review in August [when the income from the preceding February through July was averaged].) Also at this February semi-annual review, reconcile the months of August through December.

  Note: Do not reconcile for July because that month was reconciled at the previous semi-annual review last August. Never reconcile the same month twice!
- Average variable income from August through December (total divided by five months), and project that average through the following August. Reconcile for August through December.

Options at the next redetermination (the following August):

- Average variable income received from January through July (total divided by seven months), and project that average through the following February. Reconcile for January through July.
- Skip January altogether, and average February through July (total divided by six months), and project that average through the following February. Reconcile for January through July.
- If verification of variable income received in July is unavailable, average variable income received from February through June (total divided by five months), or variable income received from January through June (total divided by six months), and project that average through the following February.

E-6000, Self-Employment Income

Body

Revision 21-2; Effective June 1, 2021

Self-employment income is usually income from a person's own business, trade, or profession rather than from an employer. The method and rate of payment involved in self-employment will differ, as will the allowable expenses involved in producing the income.

E-6100, Materially Participating

Body

Revision 16-4; Effective December 1, 2016

For earned income to be considered self-employment, either the person individual or the individual's spouse must be actively involved or materially participating in producing the income. See Section E-3100, Types of Earned Income.

Materially participating. An individual business owner is determined to be materially participating if the individual meets any one of the following criteria:

- the individual engages in periodic advice and consultation with the tenant, inspection of the production activities, and furnishing of machinery, equipment, livestock and production expenses;
- the individual makes management decisions that affect the success of the enterprise;
- the individual performs a specified amount of physical labor to produce the commodities raised; or
- the individual does not meet the full requirements above, but the individual's involvement in crop production is nevertheless significant.

Consider income from the sale of timber "farm" income if:

- the timber was grown on the farm;
- the income is not treated as capital gains; and
- the timber operations are incidental to or tied in with the operation of the farm to constitute one business.

E-6200, Net Self-Employment Earnings

Body

Revision 09-4; Effective December 1, 2009

Net earnings (gross income less allowable deductions) are used in budgeting. Net earnings from self-employment also include any profit or loss incurred in partnership agreements (within a self-employment related context). Verified net losses from self-employment can be deducted from other earned income received in the same year the loss was incurred.

In a couple case, the loss can be deducted from either spouse's earned income, regardless of which spouse incurred the loss.

Losses cannot be deducted from unearned income or carried over from a previous period.

E-6210 Self-Employment Expenses

Revision 21-2; Effective June 1, 2021

The chart below contains a list of common types of expenses related to self-employment income. The chart is not intended to be all-inclusive. A policy clearance request should be submitted when questionable deductions arise or to determine how to budget self-employment expenses not listed in the chart.

Self-Employment Expenses

Allowable self-employment expenses are based on costs that can be deducted from federal income taxes according to the IRS Schedule C, Form 1040 - Profit or Loss from Business.

Expense Types	MEPD Programs
Advertising	Allowed
Car and truck expenses	Allowed
Commissions and fees	Allowed
Contract labor	Allowed
Costs not related to self-employment	Non-Allowed
Costs related to producing income gained from illegal activities, such as prostitution and the sale of illegal drugs	Non-Allowed
Depletion	Allowed
Depreciation	Allowed
Employee benefit programs	Allowed
Insurance	Allowed
Interest *	Allowed
Legal and professional services	Allowed
Net loss that occurred in a previous period	Non-Allowed
Office expense	Allowed
Pension and profit-sharing plans	Allowed
Rent or lease **	Allowed
Repairs and maintenance	Allowed
Supplies	Allowed
Taxes and licenses	Allowed
Travel, meals, and entertainment	Allowed
Travel to and from place of business	Non-Allowed
Utilities	Allowed
Wages	Allowed
Other expenses	Allowed

*Interest includes mortgage (paid to banks, etc.) or other interest.

**Rent or lease may include rent of vehicles, machinery, equipment, or other business property.

When determining transportation costs, the person may choose to use the standard mileage reimbursement rate of 56 cents per mile instead of keeping track of actual expenses.

The IRS Schedule F, Form 1040 - Profit or Loss from Farming, lists the deductible expenses for farm income.

E-6300, Budget Options for Self-Employment

Body

Revision 09-4; Effective December 1, 2009

The procedure for calculating the eligibility budget may differ, and will depend on which method is more advantageous to the person.

E-6310 Annual Projection

Revision 16-4; Effective December 1, 2016

Divide the individual's entire taxable year's income (as shown on the previous year's income tax, IRS Schedule C, Form 1040 - Profit or Loss from Business, or IRS Schedule F, Form- 1040 - Profit or Loss from Farming, Schedule F) equally among 12 months. This procedure should be followed even if the business is seasonal, starts late in the year, or ceases operation before the end of the taxable year.

Note: If the payments were received no more than once per calendar quarter, the income is considered as infrequent or irregular. If the total earnings for each calendar quarter are $30 or less, the income is not counted in the eligibility budget and is considered in the co-payment budget. If the total earnings for each calendar quarter exceed $30, allow the $30 deduction and count the excess income in the eligibility budget. Consider the income for the co-payment budget.

If the person's tax statement is used to predict variable income, there is no need to set a six-month special review to redetermine eligibility unless a change has been reported.

E-6320 Six Months Projection

Revision 16-4; Effective December 1, 2016

When the previous year's tax statement is unavailable, or if using the IRS Schedule F, Form 1040 - Profit or Loss from Farming, or the IRS Schedule C, Form -1040 - Profit or Loss from Business, makes the person individual ineligible, request verification of earnings and allowable deductions for the previous six months. In this situation, a six-month special review is required.

E-6400, Variable Income for Self-Employment

Body

Revision 09-4; Effective December 1, 2009

Follow established variable income procedures when calculating the co-payment budget. Pay attention to anticipated rate of receipt in projecting co-payment, as there is often a high degree of variability in the receipt of self-employment income. Schedule a special review when lump sum payments are anticipated to occur, so that restitution can be requested. Monitor the case and adjust the budget (if applicable) when projected variable income is expected to cease.

Because most self-employment income involves deductible expenses, inform the person to keep accurate records of all incurred expenses and receipts.

E-6500, Self-Employment Income Examples

Body

Revision 16-4; Effective December 1, 2016

1. An individual who resides in a nursing facility owns a 160-acre farm where the individual's spouse continues to live. One hundred acres of land are set aside in a Conservation Reserve Program (CRP). The other 60 acres are farmed by the couple's son, who pays all expenses. In return for use of the land, the son pays the individual one-quarter of the net profit he produces. For several years, the individual has received $6,000 from the CRP during the month of September. The son's most recent IRS Schedule C form shows net farming income of $7,000 for the year.

   Action:

   The income from the land set aside for CRP is considered lease or rental income. As neither the individual nor the individual's spouse participates in the production of farm income, this is also considered rental income and no deductions are given for expenses. If expenses are incurred by either the individual or the individual's spouse, consider these expenses as deductions in netting the income. Other common examples of lease income include hunting or fishing leases, subsidy payments, surface exploration, or bonuses. An individual supplements their Social Security income by making quilts. The quilts are sold through a consignment shop, which keeps 10 percent of the sales price. Each month the individual produces and sells two quilts, which retail for $450 each. The material for each quilt costs $75; additionally, the individual pays her niece $150 per quilt to do the actual quilting stitch. The individual's business is run out of a rented apartment, which includes a living area, kitchen, bathroom, and two bedrooms. One of the bedrooms is used as the workshop. The individual pays $400 per month in rent; utilities for the apartment run $150 per month. The individual is also repaying their son at the rate of $50 per month for money he loaned the individual for the purchase of a new sewing machine, which is used to produce the quilts.

2. An individual supplements their Social Security income by making quilts. The quilts are sold through a consignment shop, which keeps 10 percent of the sales price. Each month the individual produces and sells two quilts, which retail for $450 each. The material for each quilt costs $75; additionally, the individual pays her niece $150 per quilt to do the actual quilting stitch. The individual's business is run out of a rented apartment, which includes a living area, kitchen, bathroom, and two bedrooms. One of the bedrooms is used as the workshop. The individual pays $400 per month in rent; utilities for the apartment run $150 per month. The individual is also repaying their son at the rate of $50 per month for money he loaned the individual for the purchase of a new sewing machine, which is used to produce the quilts.

   Action:

Amount	Action
$900.00	gross monthly income (two quilts @ $450 each)
– 90.00	consignment fee (10 percent of $900)
–150.00	cost of materials ($75 X 2)
–300.00	payment to niece ($150 X 2)
–100.00	rental expense for work space ($400/four rooms)
– 37.50	utility expense for work space ($150/four rooms)
$222.50	net monthly income from sale of two quilts

   Note: The $50 payment on the principal of the loan to the son is not an allowable expense. Similarly, if the individual bought the sewing machine outright (purchase of a capital asset), the purchase would also not be an allowable deduction. However, the rental of a sewing machine would be allowable. See the chart in the previous section.

3. An eligible couple produces a yearly cotton crop. The couple belongs to a co-op that stores the cotton to await a better price. The co-op members receive coupons, which are actually a loan against the eventual

sale price of the crop.

Action:

Proceeds from the sale of the crop become income in the month the individual actually receives the profit. Any coupons cashed against the eventual sale price of the crop are considered income at the time they are cashed.

E-7000, Deeming Income

E-7100, Living Arrangement

Body

Revision 09-4; Effective December 1, 2009

If the living arrangement is in a community setting, deeming of income and resources affect the budget. See Section D-4200, Living Arrangements.

If a person lives in the same household with an ineligible spouse or parent and parent's spouse, if any, the income of the ineligible person(s) may be counted with the income of the person. This countable income of the spouse or parent is said to be "deemed" to the person. Although an ineligible parent's income may be earned income, it is counted as unearned income after being deemed to the person.

If neither a person's spouse nor child is in an institutional setting, deeming from spouse-to-spouse or parent-to-child applies in household situations. Only those residing in the household are considered part of the household for deeming purposes. For the purposes of deeming, the household comprises the eligible person, the spouse and any children of the couple (or either member of the couple), or the eligible child, the parent(s) and other children of the parent(s). See Section D-4210, Deeming, for exceptions to the household situations for deeming.

Deeming only applies in household situations. Unless temporarily absent, only those persons residing in the household are a part of the household for deeming purposes. A person is not a member of the household for deeming purposes if he is absent from home for a period that is not a temporary absence. A temporary absence exists when a person (eligible person or child, or ineligible spouse, parent or child) leaves the household but intends to, and does, return in the same month or the following month. If the absence is temporary, deeming continues to apply. An ineligible spouse or parent who is absent from a deeming household solely because of an active duty military assignment continues to be considered a member of the household for income deeming purposes. If the absent service member's intent to continue living in the household changes, deeming stops beginning with the month following the month in which the intent changed.

E-7200, When Deeming Procedures Are Not Used

Body

Revision 16-3; Effective September 1, 2016

The following exceptions apply to deeming of income:

- If the individual's spouse, parent or parent's spouse is a member of a TANF group, the income of the spouse, parent or parent's spouse is not deemed to the individual.
- All income used to determine eligibility for assistance based on need is excluded for deeming purposes. For example, if the individual's spouse, parent or parent's spouse is a member of a TANF group or is

eligible for SSI, that individual's income is not deemed to the individual. **Note:** Most VA pensions are based on need. See Section E-4311, VA Pensions.

- In certain Home and Community-Based Services waiver programs, an ineligible spouse's or parent(s)'s income is not deemed to an individual.
- Deeming does not apply when an eligible individual and ineligible spouse are living in an institution, even when they are sharing a room. Deeming does apply in non-institutional care situations, such as adult foster care and personal care facilities, if payment for care does not include payment for medical services and/or supplies.
- If an ineligible spouse or parent becomes eligible, discontinue deeming beginning with the month the spouse or parent becomes eligible.
- If spouses separate or divorce, discontinue deeming beginning with the first of the month following the month of the event.
- If an ineligible parent(s) or child no longer lives in the same household, discontinue deeming beginning with the first month following the month in which either the parent(s) or child leaves the household.
- When a child attains age 18, discontinue deeming in the month following the month the child attained age 18.
- When an ineligible spouse or parent(s) dies, discontinue deeming beginning with the month following the month the spouse or parent(s) died.

E-7300, When Deeming Procedures Begin

Body

Revision 09-4; Effective December 1, 2009

Deeming procedures begin when:

- an ineligible spouse or parent(s) begins living in the same household with a person, with the first month following the month of change; and
- an eligible spouse or parent(s) becomes ineligible, in the first month that the spouse or parent(s) become ineligible.

E-7400, Special Income Exemptions Used in Deeming

Body

Revision 11-1; Effective March 1, 2011

Exempt income is not included in the income budget for deeming or eligibility.

Exempt certain types of income that may be received by people living in the household who are:

- a person's ineligible spouse;
- an ineligible parent;
- a parent's ineligible spouse; or
- any ineligible children.

Do not deem the following types of income to the person:

- all income in Section E-2000, Exempt Income;
- all cash or in-kind payments in Section E-1700, Things That Are Not Income;
- the value of in-kind support and maintenance provided to the ineligible person;
- income used by the ineligible person to make support payments under a court order or an agreement authorized by Title IV-D. The amount exempted is stated in the court order or agreement or the amount of

the actual payment, whichever is less;
- payments made to the ineligible person through block grants or other government programs that include family care services and attendant services; and
- income based on need such as SSI, TANF and most VA pensions.

Common exempt income sources used in deeming:

- Amount of income of a dependent who is receiving SSI or TANF, because this income has already been considered in determining the dependent's need for SSI or TANF.
- Infrequent or irregular income.
- Payments for foster care of a child if the child is not eligible for SSI and was placed in the person's home by a public or private, nonprofit child placement or child care agency.
- Student earnings.
- Value of meals and benefits provided under the Child Nutrition Act of 1966.
- Value of meals provided under the National School Lunch Act, as amended by Public Law 90-302 of 1968.
- Payments by the Federal Disaster Assistance Administration authorized by the Disaster Relief Act, as amended.
- Value of any housing assistance payment paid on a house under the United States Housing Act of 1937, the National Housing Act, Section 101 of the Housing and Urban Development Act of 1965, or Title V of the Housing Act of 1949, as authorized by Public Law 94-375.

Note: Consider a utility allowance given under any of these titles to be income, unless the allowance is paid directly to the utility company and the person has no access to the allowance.

E-7410 Military Unearned Income

Revision 09-4; Effective December 1, 2009

Note: Do not count the hostile fire pay or imminent danger pay portion from military income as income during the month of receipt. Any unspent hostile fire pay or imminent danger pay becomes a resource if retained into the following month and not otherwise excluded.

For the nine-month period following the month of receipt, exclude from deemed resources the unspent portion of any retroactive payment of:

- hostile fire and imminent danger pay (pursuant to 37 U.S.C. 310) received by the ineligible spouse or parent from one of the uniformed services; and
- family separation allowance (pursuant to 37 U.S.C. 427) received by the ineligible spouse or parent from one of the uniformed services as a result of deployment to or while serving in a combat zone.

E-8000, Support and Maintenance

Body

Revision 18-4; Effective December 1, 2018

In-kind support and maintenance (S/M) is the value of food and shelter received through a medium other than legal tender.

Any cash payments given directly to a person for food or shelter are cash income and not in-kind S/M.

E-8100, General Information

Body

Revision 11-3; Effective September 1, 2011

In-kind S/M is unearned income in the form of food or shelter or both. Federal requirements stipulate that S/M, along with other forms of unearned income, be considered when determining Medicaid eligibility.

Do not consider S/M in budgeting for Medicaid Buy-In for Children (MBIC).

Two rules are used to determine the value of S/M a person receives:

- the one-third reduction rule; and
- the one-third reduction + $20 rule.

See Appendix XXXI, Budget Reference Chart.

Base the decision on which rule to use on:

- the person's living arrangement; and
- whether a person receives:
  - both food and shelter; or
  - either food or shelter.

E-8110 One-Third Reduction Rule

Revision 09-4; Effective December 1, 2009

Reference: Appendix XIV, Chart A

Instead of determining the actual dollar value of in-kind S/M as unearned income, use the one-third reduction rule; that is, count one-third of the federal benefit rate (FBR) as additional income if a person (or a person and the person's eligible spouse):

- live in another person's household for a full calendar month, except for temporary absences; and
- receive both food and shelter from the other person's household.

Example: Bess Black lives in her son's home. There are no other household members. Monthly household expenses total $650 ($325 pro-rata share). Mrs. Black contributes nothing toward household expenses. Count one-third of the FBR as S/M.

The one-third reduction rule applies in full or not at all. If a person lives in another person's household, and the one-third reduction rule applies, do not apply any income exclusions to the reduction amount. However, do apply appropriate exclusions to any other earned or unearned income received.

If the one-third reduction rule applies, do not count any other in-kind S/M received.

E-8120 One-Third Reduction + $20 Rule

Revision 13-4; Effective December 1, 2013

If a person receives in-kind S/M and the one-third reduction rule is not applicable, use the one-third reduction + $20 rule. Instead of determining the actual dollar value of any food or shelter a person receives, presume that it is worth a maximum value. This presumed maximum value is one-third of the federal benefit rate (FBR), plus the amount of the general income exclusion ($20).

The one-third reduction + $20 rule allows a person to show that the S/M is not equal to the presumed maximum value. Do not use the one-third reduction + $20 rule if the person shows that:

- the current market value of any food or shelter the person receives, minus any payment the person makes for them, is lower than the presumed maximum value; or
- the actual amount someone else pays for the person's food or shelter is lower than the presumed maximum value.

Use the one-third reduction + $20 rule as part of the unearned income if either:

- the person chooses not to question the use of the presumed maximum value, or
- the presumed maximum value is less than the actual value of the food or shelter the person receives.

Use the actual value of the food or shelter received as part of the unearned income if the person shows that the presumed maximum value is higher than the actual value of the food or shelter the person receives.

Note: A religious order has an express obligation to provide full support and maintenance for members of the order who have taken a vow of poverty. Due to this express obligation, in-kind support and maintenance subject to the one-third FBR + $20 must be developed. Income turned over by a member to the religious order is considered to be in fulfillment of the vow of poverty and is not considered a contribution toward the food and shelter received from the order.

E-8121 Community Attendant Services

Revision 09-4; Effective December 1, 2009

Reminder: If a person receives S/M and the one-third reduction + $20 rule applies, count the presumed maximum amount, that is, 1/3 federal benefit rate (FBR) + $20. If the person is income-eligible, no further development is required. If counting 1/3 FBR + $20 results in ineligibility, prior to denial the person must be offered an opportunity to rebut and show that the actual value of the S/M is less.

If a person is applying for or receiving Community Attendant Services (CAS), count 1/3 FBR + $20 as S/M. If the person is income-eligible, no further development is required. If counting 1/3 FBR + $20 results in ineligibility, prior to denial the person must be given an opportunity to rebut and show that the actual value is less.

Example: Jim Morgan, a CAS applicant, lives in his sister's home. The sister's husband and their child also live there. Mr. Morgan does not pay his pro-rata share of household expenses. Count 1/3 FBR + $20 as S/M. If Mr. Morgan is income-eligible, no further development is needed. If counting 1/3 FBR + $20 results in ineligibility, prior to denial Mr. Morgan must be given an opportunity to rebut and show that the actual value is less. Monthly household expenses total $1,050 ($262.50 pro-rata share). Mr. Morgan contributes $200 per month toward general household expenses. The actual value is $62.50 ($262.50 pro-rata share − $200 client's contribution = $62.50).

Note: No S/M for Home and Community-Based Services waivers.

E-8130 Support and Maintenance (S/M) Items

Revision 09-4; Effective December 1, 2009

What Is S/M	What Is Not S/M
Food/board	Value of Supplemental Nutrition Assistance Program (SNAP) food benefits (formerly known as food stamps)
Shelter/room	Cable TV
Mortgage	Telephone bill (basic, plus extra services and long distance)
Real property taxes (less any tax rebate credit)	Credit card bills
Rent	VA clothing allowance for medical reasons
Heating fuel (for example, coal, wood and butane)	Life insurance premiums
Gas	Medical care
Electricity	Transportation
Water	Repair of roof, plumbing, etc.
Sewer	General upkeep on home
Garbage removal	Lawn maintenance
Property insurance required by mortgage holder	Paint for the house

E-8140 Exceptions to Counting Support and Maintenance (S/M) Income

Revision 18-1; Effective March 1, 2018

The general rule is to count S/M to a person when he or she receives food or shelter, regardless of who is liable for payment of the cost of the food or shelter item received.

There are numerous exceptions to the general rule. When an exception applies, the food or shelter a person receives is not countable S/M. Some of these exceptions result from federal statutory exclusions that specifically exclude from income the value of food or shelter received. Other exceptions result from situations in which the food or shelter received does not constitute income in accordance with regulations.

Do not count S/M if a person receives food or shelter that:

- is specifically excluded by federal law (for example, the Disaster Relief and Emergency Assistance Act) (see Section E-2000, Exempt Income);
- meets the criteria for exclusion of infrequent or irregular unearned income (see Section E-9000, Infrequent or Irregular Income);
- has no current market value;
- is provided under a governmental (federal, state or local) medical or social service program (see Section E-1700, Things That Are Not Income);
- is assistance based on need from a state or one of its political subdivisions (see Section E-2000, Exempt Income);

- is provided by someone living in the same household whose income is subject to deeming to the person;
- is food or shelter received at school by a child under age 22, not subject to deeming, who receives food or shelter only at school while temporarily absent from his parental household;
- is food or shelter received during a temporary absence;
- is received as a replacement of a lost, damaged or stolen resource (this includes temporary housing) (see Section E-1740, Miscellaneous Things That May Not Be Income, and Section E-2000, Exempt Income);
- is excluded under an approved plan for self-support;
- is received because of payments made under the terms of a credit life or credit disability policy (see Section E-1740); or
- is received during medical confinement in an institution.

Support and maintenance are not included as income in the eligibility budget if the person:

- is in an institutional setting and eligibility is being tested for a Home and Community-Based Services waiver program (**Note:** Community Attendant Services is not a Home and Community-Based Services waiver program); or
- is in an institutional setting for the month, but entered after the first of the month.

Example: Mr. John Bono lives in his own home. His daughter reports that she pays Mr. Bono's garbage removal bill directly to the vendor each calendar quarter, which amounts to no more than $20. Because S/M meets the definition of infrequent or irregular income, it is not counted in the eligibility budget.

Support and maintenance are also not included as income in the eligibility budget if the person:

- lives with a deemor (ineligible spouse/parent) and there are no non-deemors in the household;
- lives in a commercial room-and-board establishment;
- is placed in personal care, adult foster care or supervised living by a public agency, such as Adult Protective Services (APS) or HHSC; or
- pays his pro-rata share of all household expenses.

Example: Alice Beckman lives with her son in his home. Monthly household food and shelter expenses total $350 ($175 pro-rata share). Ms. Beckman contributes $185 per month toward general household expenses. Because Ms. Beckman pays more than her pro-rata share of general household expenses, there is no S/M.

Support and maintenance are also not included as income in the eligibility budget if the person:

- lives in a public assistance household, defined as one in which each member receives cash or vendor payments from one of the following:
  - Temporary Assistance for Needy Families (TANF);
  - SSI;
  - Refugee Assistance Act of 1980;
  - a Bureau of Indian Affairs (BIA) general assistance program;
  - payments based on need provided by a state/local government income maintenance program;
  - Veterans Affairs (VA) pension for veterans or widows;
  - VA dependency and indemnity compensation (DIC) for parents; or
  - payments under the Disaster Relief Act of 1974; or
- is receiving free use of land on which the shelter the person owns is located, or free use of shelter situated on land the person owns.

Example: Marcie Bennett lives in her own mobile home on property owned by her daughter. The daughter charges her no rent for use of the land. Ms. Bennett pays all of her food and utility expenses. There is no S/M because the use of land alone is not a shelter cost.

Example: Janet Smith lives in a mobile home owned by her daughter. The mobile home is situated on a lot owned by Ms. Smith. The daughter does not charge Ms. Smith rent for use of the mobile home. There is no S/M

because the use of shelter alone (but not the land) is not a shelter cost.

E-8150 Food, Clothing or Shelter as Wages

Revision 09-4; Effective December 1, 2009

If a person receives food, clothing or shelter that constitutes wages or remuneration for work, this is earned income valued at its current market value (CMV) or current market rental value (CMRV).

In this situation, the principles of S/M do not apply; however, the earned income exclusions of $65 and one-half the remainder do apply, unless eligibility is being determined under the institutional income limit.

Example: Joe Ball works as an apartment manager. His employer pays him $300 per month in cash wages and provides a free room, which has a monthly rental value of $200. Because provision of the room by Mr. Ball's employer constitutes wages, Mr. Ball receives $500 in earned income each month. This in-kind earned income in the form of shelter is valued at its CMRV ($200), and the one-third reduction rule and the one-third reduction + $20 rule do not apply. The earned income exclusions of $65 and one-half the remainder apply to Mr. Ball's total earnings of $500 ($300 cash wages + $200 free room), unless eligibility is being determined under the institutional income limit.

E-8160 Living Arrangement

Revision 09-4; Effective December 1, 2009

Use a person's living arrangement to determine if S/M is being received and whether the S/M is to be valued under the one-third reduction rule or under the one-third reduction + $20 rule. Some common living arrangements are:

- noninstitutional care;
- home ownership;
- rental liability, including flat fee for room and board;
- public assistance (PA) households (that is, presumed sharing);
- separate consumption;
- separate purchase of food;
- sharing;
- earmarked sharing; and
- home of another.

E-8200, Individual Budgets

Body

E-8210 Household of Another Person

Revision 09-4; Effective December 1, 2009

E-8211 Contributing Less Than Pro-Rata Share

Revision 09-4; Effective December 1, 2009

Reference: Appendix XIV, Chart A

If a person contributes less than his or her pro-rata share of general household expenses, use the one-third reduction rule. No opportunity for rebuttal is offered.

Example: Alice Beckham lives with her son in his home. General household expenses total $350 ($175 pro-rata share). Mrs. Beckham contributes only $125 per month. Count 1/3 FBR as support and maintenance.

E-8212 Contributing an Earmarked Share of Food and Shelter

Revision 15-4; Effective December 1, 2015

If a person contributes a specific amount for food and/or shelter, but the amount contributed is less than the person's pro-rata share for each earmarked expense, use the one-third reduction rule. No rebuttal is offered.

Example 1: A person lives in his sister's home with his sister, the sister's spouse and child. The monthly household food expenses total $240 ($60 pro-rata share); the monthly household shelter expenses total $320 ($80 pro-rata share). The person pays his sister $55 a month for food and nothing for shelter. The person does not pay his pro-rata share of either food or shelter expenses. Count 1/3 FBR as S/M.

Example 2: Another person lives in his daughter's home with her family of five. The household receives SNAP food benefits for all six members, but these benefits do not cover the household's total food expenses. The person does not contribute toward the food expenses not covered by SNAP, nor does he pay anything toward shelter costs. Count 1/3 FBR as S/M.

E-8213 Contributing an Earmarked Share of Either Food or Shelter

Revision 09-4; Effective December 1, 2009

If a person contributes an earmarked pro-rata share of either food or shelter expenses, but not both, count 1/3 FBR + $20. If the person is income-eligible, no further development is needed. If counting 1/3 FBR + $20 results in ineligibility, prior to denial the person must be given an opportunity to rebut and show that actual value is less.

Example: Emily Fairchild lives with her brother and his family of three. Ms. Fairchild contributes her pro-rata share of shelter expenses but not of food expenses. Count 1/3 FBR + $20 as S/M. If the person is income-eligible, no further development is needed. If counting 1/3 FBR + $20 results in ineligibility, prior to denial Mrs. Fairchild must be given an opportunity to rebut and show that the actual value is less. Monthly household food expenses total $240 ($60 pro-rata share); monthly household shelter expenses total $320 ($80 pro-rata share). Ms. Fairchild contributes $50 per month for food and $85 per month for shelter. The actual value is $5.00 ($140 client's total pro-rata share - $135 client's total contribution = $5.00).

Example: Gladys Haley lives with her son in his home. She pays her pro-rata share of food expenses but not of shelter expenses. Count 1/3 FBR + $20 as S/M. If the person is income-eligible, no further development is needed. If counting 1/3 FBR + $20 results in ineligibility, prior to denial Ms. Haley must be given an

opportunity to rebut and show that the actual value is less. Monthly household food expenses total $200 ($100 pro-rata share); monthly household shelter expenses total $400 ($200 pro-rata share). Ms. Haley contributes $100 for food, but does not contribute anything for shelter. In this situation the actual value is $200 ($300 total pro-rata Share - $100 client's contribution = $200.) Count the presumed maximum S/M of 1/3 FBR + $20 if this is less than the actual value.

E-8214 Separate Food Purchases

Revision 15-4; Effective December 1, 2015

If the person purchases his food separately from other household members, then shelter is the only consideration. Count 1/3 FBR + $20. If the person is income-eligible, no further development is needed. If counting 1/3 FBR + $20 results in ineligibility, the person must be offered an opportunity to rebut and show that the actual value is less.

Example: A person lives in her daughter's home. The daughter's spouse and their two children also live there. The person purchases her food separate from the rest of the household, but does not pay her pro-rata share of shelter expenses. Count 1/3 FBR + $20. If the person is income-eligible, no further development is required. If counting 1/3 FBR + $20 results in ineligibility, prior to denial, the person must be given an opportunity to rebut and show that the actual value is less. The monthly household shelter expenses total $700 ($140 pro-rata share), and the person contributes $100. The actual value is $40 ($140 pro-rata share – $100 person's contribution = $40).

E-8220 Ownership or Rental Liability

Revision 09-4; Effective December 1, 2009

A person has an ownership interest or rental liability, and someone else is directly paying all or part of the person's pro-rata share of household expenses. Cash is not given to the person.

If the person is the householder (has ownership interest or rental liability), count 1/3 FBR + $20. If the person is income-eligible, no further development is needed. If counting 1/3 FBR + $20 results in ineligibility, prior to denial the person must be given an opportunity to rebut and show that the actual value of the S/M is less.

Note: The one-third reduction rule never applies if the person is the householder.

E-8221 Receipt of Support and Maintenance (S/M) from Inside the Household

Revision 09-4; Effective December 1, 2009

A person living in his or her own household may be provided in-kind S/M from other household members living in the household.

Note: S/M should be developed only if the 1/3 FBR + $20, in combination with other countable income, would cause ineligibility.

If the person is the householder, others live with him/her, but he/she pays a pro-rata share of household expenses, there is no S/M.

Example: Scott Nance lives in his own home. His daughter and her two children live with him. Household shelter expenses are as follows: annual property taxes of $1,200 ($100 monthly) and monthly utility costs of $110. The pro-rata share of shelter costs is $52.50 ($100 taxes + $110 utilities = $210 total shelter expenses divided by 4 household members = $52.50 pro-rata share). Household food expenses total $550 ($137.50 pro-rata share). Thus, the pro-rata share of total household expenses is $190 ($52.50 for food + $137.50 for shelter = $190). Mr. Nance's daughter pays the taxes and utilities of $210 per month; Mr. Nance pays the $550 for food. Since Mr. Nance pays more than his pro-rata share of household expenses, there is no S/M.

If the person is the householder and others live with him/her, but he/she does not pay his pro-rata share of household expenses, count 1/3 FBR + $20. If the person is income-eligible, no further development is needed. If counting 1/3 FBR + $20 results in ineligibility, prior to denial the person must be given an opportunity to rebut and show that the actual value is less.

Examples:

- Vicki Neal lives in her own home. Her adult son lives with her. Ms. Neal and her son purchase their food separately, but she does not pay her pro-rata share of shelter expenses. Count 1/3 FBR + $20 as S/M. If Ms. Neal is income-eligible, no further development is required. If counting 1/3 FBR + $20 results in ineligibility, prior to denial Ms. Neal must be given an opportunity to rebut and show that the actual value is less. Ms. Neal pays the cost of butane, which is $35 per month. Her son pays the entire electricity bill of $80 per month directly to the vendor. Thus, shelter costs total $115 ($57.50 pro-rata share). The actual value is $22.50 ($57.50 pro-rata share - $35 client's contribution = $22.50 S/M).
- Donna Hipple lives in her own home. Her adult son lives with her. Ms. Hipple does not pay her pro-rata share of household expenses. Count 1/3 FBR + $20 as S/M. If Ms. Hipple is income-eligible, no further development is required. If counting 1/3 FBR + $20 results in ineligibility, prior to denial Ms. Hipple must be given an opportunity to rebut and show that the actual value is less. Monthly household expenses consist of $500 for shelter ($250 pro-rata share) and $300 for food ($150 pro-rata share). Ms. Hipple buys all food ($300), and her son pays all shelter costs ($500). Since the pro-rata share of total household expenses is $400 ($250 pro-rata for shelter + $150 pro-rata for food = $400), the actual value of S/M is $100 ($400 pro-rata share - $300 Ms. Hipple's contribution = $100).

E-8222 Receipt of Support and Maintenance (S/M) from Outside the Household

Revision 18-4; Effective December 1, 2018

If the person is the householder (has ownership interest or rental liability) and someone else outside the household is directly paying all or part of the person's pro-rata share of household expenses, count 1/3 of the Federal Benefit Rate (FBR) + $20.

If counting 1/3 FBR + $20 does not make the person ineligible, no further development of S/M is needed.

If counting 1/3 FBR + $20 results in ineligibility, prior to denial, allow the person the opportunity to rebut and show that the actual value of the S/M is less.

Example: Elizabeth Smith lives alone in a rented apartment. Her rent is $1400 a month. Ms. Smith pays $700 and her daughter, who does not live in the household, pays the other $700 directly to the landlord. Ms. Smith pays all other bills. Current Market Rental Value (CMRV) $1400 -$700 = $700 > 1/3 FBR +$20. S/M = 1/3 FBR + $20.

Note: The one-third reduction rule never applies if the person is the householder.

E-8222.1 Rental Subsidy - Receipt of Support and Maintenance (S/M) from Outside the Household

Revision 18-4; Effective December 1, 2018

Reference: Appendix XIV, Chart B

Rental subsidy is unearned income that represents S/M from outside the household. Rental subsidy policy applies only when:

- someone in the household has a rental liability;
- the rental property is owned by a parent or child of someone in the household; and
- the One-Third Reduction Rule (1/3 FBR) does not apply.

If the amount of rent required by the property owner equals or exceeds either the current market rental value (CMRV) or 1/3 FBR + $20, then there is no rental subsidy countable as outside S/M.

If the amount of rent required by the property owner is less than both the CMRV and 1/3 FBR + $20, then the rental subsidy countable as outside S/M is the lessor of the:

- difference between 1/3 FBR + $20 and the amount of rent required; or
- difference between the CMRV and the amount of rent required.

Example: Royce Jones, a disabled adult, lives alone in a home owned by his parents. He pays all his own utilities, but does not pay the CMRV. Mr. Jones pays $50 per month rent. His parents state that the normal rate to rent the house is $250 per month (not including utilities). The difference between the CMRV and the rent value is $200 ($250 - $50). The difference between 1/3 FBR + $20 and the amount of rent required is $126.66 ($176.66 - $50). Because $126.66 is less than $200, $126.66 is countable S/M.

Notes:

- As Rental Subsidy considers only the rental expense, explore potential S/M for remaining household expenses (e.g., utilities or food).
- Accept owner declaration of CMRV. Contact with a knowledgeable source, such as a realtor, is not required unless the eligibility specialist considers the value questionable.

Related Policy

Receipt of Support and Maintenance (S/M) from Inside and Outside the Household, E-8223

E-8223 Receipt of Support and Maintenance (S/M) from Inside and Outside the Household

Revision 09-4; Effective December 1, 2009

If a person receives S/M from both inside and outside the household, count 1/3 FBR + $20. If the person is income-eligible, no further development is needed. If counting 1/3 FBR + $20 results in ineligibility, prior to

denial the person must be given an opportunity to rebut and show that the sum of S/M from inside the household and S/M from outside the household is less.

Example: Bob Davis lives in his own home. His daughter and her child live with him. He receives S/M from both inside and outside the household. Count 1/3 FBR + $20 as S/M. If he is income-eligible, no further development is required. If counting 1/3 FBR + $20 results in ineligibility, prior to denial Mr. Davis must be given an opportunity to rebut and show that the actual value is less. Monthly household food expenses total $300 ($100 pro-rata share). Monthly household shelter expenses total $600 ($200 pro-rata share). The daughter buys the food, but Mr. Davis gives her $50 per month. Mr. Davis' son pays all shelter costs directly to the vendors (taxing authority and utility company). In this situation, the actual value of S/M is $250 ($100 pro-rata share for food - $50 client's contribution = $50 S/M from inside the household + $200 S/M from outside the household = $250). Count the maximum S/M of 1/3 FBR + $20 if this is less than the actual value.

E-8300, Companion and Couple Budgets

Body

E-8311 Companion Case Not Contributing Pro-Rata Share

Revision 15-4; Effective December 1, 2015

If a person and the person's ineligible spouse do not contribute their pro-rata share of household expenses, count 1/6 Couple FBR (1/3 Couple FBR divided by 2) as S/M for the person. Do not consider the S/M received by the ineligible spouse (the other 1/6 Couple FBR) in the eligibility determination when deeming.

Example: A couple lives in their daughter's home. The daughter's spouse and their three children also live there. Only one member of the couple is applying for the Qualified Medicare Beneficiary (QMB) program. The couple does not contribute toward household expenses. Count 1/6 Couple FBR (1/3 Couple FBR divided by 2) as S/M. No S/M is considered for the ineligible spouse in the eligibility budget when deeming.

E-8312 Companion Case Contributing Pro-Rata Share

Revision 15-4; Effective December 1, 2015

If a person and the person's ineligible spouse contribute their pro-rata share of either food or shelter expenses but not both, count 1/6 Couple FBR + $10 as S/M for the person. (The S/M attributable to the ineligible spouse is not counted in the eligibility budget when deeming.) If the person is income-eligible, no further development is required. If counting 1/6 Couple FBR + $10 results in ineligibility, the person must be offered an opportunity to rebut and show that the actual value is less.

Example: A couple lives in their son's home. The son's spouse also lives there. Only one member of the couple is applying for QMB. The couple pays more than their pro-rata share of food expenses, but does not pay their pro-rata share of shelter expenses. Count 1/6 Couple FBR + $10 as S/M for the applicant spouse. (Do not consider S/M received by the non-applicant spouse in the eligibility budget when deeming.) If the applicant is income-eligible, no further development is needed.

If counting 1/6 Couple FBR + $10 results in ineligibility, prior to denial, the applicant must be given an opportunity to rebut and show that the actual value is less. The monthly household food expenses total $600 ($150 pro-rata share for one person x 2 = $300 pro-rata share for the couple); the monthly household shelter expenses total $750 ($187.50 pro-rata share for one person x 2 = $375 couple's pro-rata share). The couple contributes $350 ($175 each) for food, but does not contribute toward shelter. The actual value is $162.50 ($300

couple's pro-rata share for food + $375 couple's pro-rata share for shelter = $675 couple's total pro-rata share – $350 couple's contribution = $325 actual value for both spouses divided by 2 = $162.50 actual value for the applicant). Count the maximum S/M of 1/6 Couple FBR + $10 if this amount is less than the actual value. Any S/M received by the non-applicant spouse is not considered in the eligibility budget when deeming.

E-8313 Couple Case Not Contributing Pro-Rata Share

Revision 09-4; Effective December 1, 2009

If neither spouse in a couple case contributes a pro-rata share of household expenses, count 1/3 Couple FBR.

E-8314 Couple Case Contributing Pro-Rata Share

Revision 15-4; Effective December 1, 2015

If both spouses in a couple case contribute their pro-rata share of either food or shelter expenses but not both, count 1/3 Couple FBR + $20. If the couple is income-eligible, no further development is needed. If counting 1/3 Couple FBR + $20 results in ineligibility, prior to denial, the couple must be given an opportunity to rebut and show that the actual value is less.

Example: A couple lives with their daughter in the daughter's home. The couple pays their pro-rata share of food expenses but not shelter expenses. Count 1/3 Couple FBR + $20 as S/M. If couple is income-eligible, no further development is needed. If counting 1/3 Couple FBR + $20 results in ineligibility, prior to denial, the couple must be given an opportunity to rebut and show that the actual value is less. The monthly household food expenses total $350 ($116.66 pro-rata share for one person x 2 people = $233.32 pro-rata share for the couple). The monthly household shelter expenses total $600 ($200 pro-rata share for one person x 2 people = $400 pro-rata share for the couple). The couple contributes $250 ($125 each) for food, but does not contribute toward shelter. In this situation, the actual value is $383.32 ($233.32 couple's pro-rata share for food + $400 couple's pro-rata share for shelter = $633.32 total pro-rata share – $250 couple's contribution = $383.32). Count the maximum S/M of 1/3 Couple FBR + $20 if this is less than the actual value.

E-8320 Ownership or Rental Liability

Revision 09-4; Effective December 1, 2009

E-8321 Couple Case Not Contributing Pro-Rata Share

Revision 15-4; Effective December 1, 2015

If the person and spouse do not pay their pro-rata share of household expenses, count 1/3 Couple FBR + $20. If the couple is income-eligible, no further development is needed. If counting 1/3 Couple FBR + $20 results in ineligibility, prior to denial, the couple must be given an opportunity to rebut and show that the actual value is less.

Example: A couple lives in their own home. Their adult son lives with them. The couple does not contribute their pro-rata share of household expenses. Count 1/3 Couple FBR + $20 as S/M. If the couple is income-eligible, no further development is needed. If counting 1/3 Couple FBR + $20 results in ineligibility, prior to denial, the couple must be given an opportunity to rebut and show that the actual value is less. The monthly household expenses total $750 ($250 pro-rata share for one person x 2 people = $500 pro-rata share for the couple). The son pays the shelter costs of $350 per month. The couple buys all of the food, paying $400 ($200 each) per month. The actual value is $100 ($500 couple's pro-rata share – $400 couple's contribution = $100).

E-8322 Companion Case Not Contributing Pro-Rata Share

Revision 15-4; Effective December 1, 2015

If a person and the person's spouse do not pay their pro-rata share of household expenses, count 1/6 Couple FBR + $10 as S/M for the person. (Do not consider S/M received by the ineligible spouse in the eligibility determination when deeming.) If the person is income-eligible, no further development is needed. If counting 1/6 Couple FBR + $10 results in ineligibility, prior to denial, the person must be given an opportunity to rebut and show that the actual value is less.

Example: A couple lives in their own home. Only one member of the couple is applying for QMB. Two of their adult children live with them. The couple does not pay their pro-rata share of household expenses. Count 1/6 Couple FBR + $10 as S/M for the applicant. (The amount of S/M received by the non-applicant spouse is not considered in determining eligibility when deeming.) If the applicant is income-eligible, no further development is required. If counting 1/6 Couple FBR + $10 results in ineligibility, prior to denial, the applicant must be given an opportunity to rebut and show that the actual value is less. The monthly household expenses total $1,200 ($300 pro-rata share for one person x 2 people = $600 couple's pro-rata share). The children pay the shelter costs of $900 per month, and the couple buys all food, paying $300 ($150 each) per month. The actual value of S/M for the applicant is $150 ($600 couple's pro-rata share – $300 couple's contribution = $300 actual value for both spouses divided by 2 = $150 actual value to the applicant). (The remaining $150 S/M attributed to the non-applicant spouse is not considered in determining eligibility when deeming.) Count the maximum S/M of 1/6 Couple FBR + $10 if this is less than the actual value.

E-8323 Companion Case with Contributions Toward Household Expenses

Revision 15-4; Effective December 1, 2015

If an ineligible spouse's contribution toward household expenses exceeds the ineligible spouse's pro-rata share, then the excess amount is allocated equally as a contribution among the eligible spouse and the couple's children (if any). Persons among whom the ineligible spouse's excess contribution is allocated (for example, the eligible spouse and the couple's children) are referred to as the "deeming unit."

Example: A couple and their 14-year-old child live in a home they are buying. One of the spouse's adult sisters also lives with them. The other spouse is the only one applying for ME-Pickle. The couple pays more than their pro-rata share of food expenses, but does not contribute toward shelter.

Count 1/6 Couple FBR + $10 as S/M for the applicant. (Do not consider S/M received by the non-applicant spouse or the child in the eligibility determination when deeming.)

If the applicant is income-eligible, no further development is required. If counting 1/6 Couple FBR + $10 results in ineligibility, the applicant must be given an opportunity to rebut and show that the actual value is less. The monthly household food expenses total $450 ($112.50 pro-rata share); the monthly household shelter expenses total $600 ($150 pro-rata share). The non-applicant spouse buys all food ($450), but does not contribute toward shelter expenses. The applicant and the child do not personally contribute. The non-applicant spouse's sister pays all remaining household expenses ($600).

The non-applicant's "excess contribution" is $187.50 ($112.50 pro-rata share for food + $150 pro-rata share for shelter = $262.50 total pro-rata share – $450 non-applicant's contribution = -$187.50 excess contribution). The $187.50 is divided equally as a contribution among the applicant and the child in the deeming unit. Thus, $187.50 divided by 2 = $93.75 each as a contribution by the applicant and the child. The actual value of the applicant's S/M is $84.38 ($112.50 pro-rata share for food + $150 pro-rata share for shelter = $262.50 total pro-rata share – $93.75 applicant's contribution = $168.75 actual value of S/M for both spouses divided by 2 = $84.38), which is less than 1/6 Couple FBR + $10.

E-8400, Rent-Free Shelter

Body

Revision 09-4; Effective December 1, 2009

In rent-free shelter, no household member has ownership interest or rental liability. This type of S/M is subject to the maximum of 1/3 of FBR + $20.

In rent-free shelter situations, a person outside the household provides the dwelling, but the household has no obligation to pay rent in return for shelter.

If the household contributes nothing for shelter, count 1/3 FBR + $20 as S/M. If the person is income-eligible, no further development is needed. If counting 1/3 FBR + $20 results in ineligibility, prior to denial the person must be given an opportunity to rebut and show that the actual value is less. Actual value is based on the current market rental value (CMRV).

Example: Margie Ballard lives in a house owned by her son. She purchases her food and pays all utilities. Her son allows her to live in the home without paying rent. The son reports the CMRV (without utilities) to be $250. Count 1/3 FBR + $20 as S/M. If the person is income-eligible, no further development is required. If counting 1/3 FBR + $20 results in ineligibility, prior to denial Ms. Ballard must be given an opportunity to rebut and show that the actual value is less. In this situation, the actual value is the CMRV of $250. Count the maximum S/M of 1/3 FBR + $20 if this is less than the actual value.

Example: Keith Linder lives in a house owned by his son. The son has requested that Mr. Linder pay his (the son's) monthly mortgage payments of $150 directly to the mortgage-holder in lieu of rent. Mr. Linder pays his own utilities. The son reports the CMRV (without utilities) to be $175. Since the son has requested that Mr. Linder pay his mortgage payment in lieu of rent, this is allowed as a shelter expense. Count 1/3 FBR + $20 as S/M. If Mr. Linder is income-eligible, no further development is needed. If counting 1/3 FBR + $20 results in ineligibility, prior to denial Mr. Linder must be given an opportunity to rebut and show that the actual value is less. The actual value is $25 ($175 CMRV - $150 payment on loan = $25).

The actual value of S/M may be reduced by the amount of the household's voluntary payments directly to the provider only for the property owner’s mortgage, real property taxes or rent (in sublease situations). Use only these voluntary payments made directly to vendors to reduce the actual value of the S/M.

Example: Barry Williams lives in a house owned by a relative. He pays his own utilities. The relative allows him to live there free of charge, but states that the CMRV (without utilities) is $300 per month. Although Mr. Williams pays no rent, last month he voluntarily paid his relative's annual real property taxes of $1,000 (or

$83.33 monthly prorated taxes) directly to the taxing authority. Mr. Williams' payment of $83.33 for taxes does not equal the CMRV ($300). Count 1/3 FBR + $20 as S/M. If he is income-eligible, no further development is needed. If counting 1/3 FBR + $20 results in ineligibility, Mr. Williams must be given an opportunity to rebut and show that the actual value is less. In this situation, the actual value of the S/M is $216.67 ($300 CMRV - $83.33 client's voluntary payment = $216.67). Count the maximum S/M of 1/3 FBR + $20 if this is less than the actual value.

E-8500, Change of Permanent Living Arrangement

Body

Revision 09-4; Effective December 1, 2009

Receipt of in-kind S/M must be re-evaluated if a person changes his/her permanent living arrangement. Temporary absences from the permanent living arrangement do not affect S/M.

Example: A person lives in her own home. A friend lives with her. The friend pays more than her own pro-rata share of household expenses, so the person receives S/M of 1/3 FBR + $20. On March 8, the person was hospitalized and was subsequently discharged to her son's home on March 25. The person remained in the son's home while convalescing until April 12, when she returned to her own home. Because the person did not change her permanent living arrangement, continue to count 1/3 FBR + $20 as S/M.

E-8600, Deeming-Eligible Child and Ineligible Parents

Body

E-8610 Excess Contributions Towards Household Expenses

Revision 09-4; Effective December 1, 2009

If an ineligible parent's contribution towards household expenses exceeds that ineligible parent's pro-rata share, then the excess amount is allocated equally as a contribution among the parent's children (eligible and ineligible) and eligible spouse (if any). Persons among whom the ineligible parent's excess contribution is allocated (for example, children and eligible spouse, if any) are referred to as the "deeming unit."

E-8620 Child Living with Parents and Siblings Only

Revision 11-4; Effective December 1, 2011

If an eligible child lives only with his parent(s) and minor children, no S/M is developed for that child.

Example: John Voss, aged 14, is applying for ME-SSI Prior. He lives with his parents and two younger siblings in a home owned by his parents. John does not personally contribute toward household expenses. There is no S/M because John lives with his parents and minor siblings.

E-8630 Child Living in Own Household with Parents and Another Adult

Revision 15-4; Effective December 1, 2015

If an eligible child lives with his parent(s) and another adult in his parent's(s') household, the child may receive S/M subject to the maximum of 1/3 FBR + $20. (Any S/M received by the parent(s) or ineligible children is not considered in the eligibility determination when deeming.) Any contribution by a parent of the eligible child toward household expenses that is in excess of the parent's own pro-rata share is divided equally as a contribution among all members of the deeming unit (for example, the ineligible parent's children and eligible spouse, if any).

Example 1: A child, age 14, is applying for ME-SSI Prior. He lives with his parents and two minor siblings in a home owned by his parents. His aunt also lives in the home. The applicant does not personally contribute toward household expenses. Count 1/3 FBR + $20 as S/M. If the applicant is income-eligible, no further development is required. If counting 1/3 FBR + $20 results in ineligibility, the applicant must be given an opportunity to rebut and show that the actual value is less. The general household expenses total $1,200 ($200 pro-rata share). One of the applicant's parents contributes $500 toward household expenses; the other parent does not contribute. The applicant's aunt pays $700. The one parent's excess contribution is $300 ($500 contribution – $200 pro-rata share = $300 excess contribution). The $300 is divided equally among the applicant and his two siblings. Thus, $300 divided by 3 = $100 applicant's contribution. The actual value of S/M received by the applicant is $100 ($200 pro-rata share – $100 applicant's contribution = $100 actual value of S/M), which is less than 1/3 FBR + $20.

Example 2: Same situation as above, except that both of the applicant's parents now contribute — one parent contributes $200 and the other parent contributes $300. The applicant's aunt contributes $700. Count 1/3 FBR + $20 as S/M. If the applicant is income-eligible, no further development is required. If counting 1/3 FBR + $20 results in ineligibility, the applicant must be given an opportunity to rebut and show that the actual value is less. The one parent does not have an excess contribution ($200 contribution – $200 pro-rata share = $0 excess contribution). The other parent's excess contribution is $100 ($300 contribution – $200 pro-rata share = $100 excess contribution). The $100 is divided equally as a contribution among the parents' children in the household. Thus, the applicant's contribution is $33.33 ($100 excess contribution divided by 3 children = $33.33). The actual value of S/M received by the applicant is $166.67 ($200 pro-rata share – $33.33 applicant's contribution = $166.67), which is less than 1/3 FBR + $20.

Example 3: Same situation, except that both of the applicant's parents each contribute $275 ($550 total) and the aunt contributes $650. Count 1/3 FBR + $20 as S/M. If the applicant is income-eligible, no further development is required. If counting 1/3 FBR + $20 results in ineligibility, the applicant must be given an opportunity to rebut and show that the actual value is less. The excess contribution for each of the applicant's parents is $75 ($275 parent's contribution – $200 pro-rata share = $75 excess contribution). The total excess contribution for both parents is $150 ($75 x 2 = $150). The $150 is divided equally as a contribution among all three children. Thus, the applicant's contribution is $50 ($150 divided by 3 = $50). The actual value of S/M received by the applicant is $150 ($200 pro-rata share – $50 applicant's contribution = $150), which is less than 1/3 FBR + $20.

Example 4: Same situation, except that one of the applicant's parents is an SSI recipient and contributes nothing personally toward household expenses. Count 1/3 FBR + $20 as S/M for the applicant. If the applicant is income-eligible, no further development is required. If counting 1/3 FBR + $20 results in ineligibility, the applicant must be given an opportunity to rebut and show that the actual value is less. The applicant's non-SSI parent contributes $500 toward household expenses, and the aunt contributes $700. The contributing parent's excess is $300 ($500 contribution – $200 pro-rata share = $300 excess contribution). The $300 is divided equally as a contribution among all members of the deeming unit (the three children and the eligible parent). The applicant's contribution is $75 ($300 divided by 4 people = $75). The actual value of S/M received by the applicant is $125 ($200 pro-rata share – $75 applicant's contribution = $125), which is less than 1/3 FBR + $20.

E-8640 Child Living with Parents in Household of Another Person

Revision 11-4; Effective December 1, 2011

If an eligible child lives with his parent(s) in someone else's household, and the child does not contribute his pro-rata share of household expenses, the child receives S/M valued at 1/3 FBR. (Any S/M received by the parent(s) and ineligible children is not considered in the eligibility determination when deeming.) Any excess contribution by an ineligible parent (for example, contribution in excess of that parent's pro-rata share) is divided equally among the parent's children and eligible spouse (if any).

Example: Rachel Brown, aged 14, is applying for ME-SSI Prior. She lives with her mother and aunt in the aunt's household. General household expenses total $420 ($140 pro-rata share). Rachel has no income, but her mother contributes $200 toward household expenses. The mother's excess contribution is $60 ($140 pro-rata share - $200 mother's contribution = - $60 mother's excess contribution). This $60 is divided equally among the mother's children in the household (Rachel is the only one) and the mother's eligible spouse (there is none). Thus, Rachel's contribution is $60. Since Rachel's contribution of $60 does not equal her pro-rata share ($140) of household expenses, count 1/3 FBR as S/M. No rebuttal is offered.

If an eligible child lives with his/her parent(s) in someone else's household and the child contributes his pro-rata share of either food or shelter expenses, but not both, count 1/3 FBR + $20 as S/M. (Any S/M received by the parent(s) and ineligible children is not considered in the eligibility determination when deeming.) If the child is income-eligible, no further development is required. If counting 1/3 FBR + $20 results in ineligibility, the person must be given an opportunity to rebut and show that the actual value is less. Any excess contribution by a parent (for example, contribution in excess of the parent's pro-rata share) is divided equally as a contribution among the parent's children and eligible spouse (if any).

Example: Sonia Barrett, aged 14, is applying for ME-SSI Prior. She lives with her parents and her aunt in the aunt's household. Household food expenses total $350 ($87.50 pro-rata share); household shelter expenses total $500 ($125 pro-rata share). Each of Sonia's parents contributes $150 ($300 total) for food expenses. The parents do not contribute toward shelter expenses. Sonia has no income. Count 1/3 FBR + $20 as S/M. If she is income-eligible, no further development is required. If counting 1/3 FBR + $20 results in ineligibility, the person must be given an opportunity to rebut and show that the actual value is less. The excess contribution for each parent is $62.50 ($87.50 pro-rata share for food + $125 pro-rata share for shelter = $212.50 total pro-rata share - $150 parent's contribution = $62.50 excess contribution per parent). The total excess contribution for both parents is $125 ($62.50 per parent x 2 parents = $125). The $125 is divided equally among all of the parents' children in the home (Sonia is the only one). Thus, Sonia's contribution is $125. The actual value of S/M received by Sonia is $87.50 ($87.50 pro-rata share for food + $125 pro-rata share for shelter = $212.50 total pro-rata share - $125 Sonia's contribution = $87.50), which is less than 1/3 FBR + $20.

E-8700, Long-Term Care Facilities

Body

Revision 09-4; Effective December 1, 2009

Food and shelter are not considered in the eligibility or co-payment budgets for the month of entry to a long-term care facility (for example, a nursing facility).

E-8800, Verification and Documentation

Body

Revision 09-4; Effective December 1, 2009

See Appendix XVI, Documentation and Verification Guide.

E-9000, Infrequent or Irregular Income

E-9100, Definitions

Body

Revision 09-4; Effective December 1, 2009

An infrequent payment is a payment that is received no more than once per calendar quarter.

An irregular payment is a payment made without an agreement or understanding and without any reasonable expectation that payment will occur again.

E-9200, When Income is Not Considered Infrequent

Body

Revision 09-4; Effective December 1, 2009

Income is not considered infrequent when it is received:

- more than once per calendar quarter from a single source; or
- only once during a calendar quarter from a single source and another payment was received from the same source in the month immediately preceding or the month immediately following. It does not matter that the payments fall into different calendar quarters.

Note: If the payment in the month immediately preceding or the month following is not a normal quarterly payment from that source, consider this one-time payment as irregular.

Determine the calendar quarter in which the income is received. Calendar quarters are:

- January - March;
- April - June;
- July - September; and
- October - December.

Based on the receipt of the infrequent or irregular income, exclude the following amount of income from the eligibility budget:

- the first $30 per calendar quarter of earned income; and
- the first $60 per calendar quarter of unearned income.

E-9300, When to Apply the Infrequent or Irregular Exclusion

Body

Revision 09-4; Effective December 1, 2009

Exclude income that is either infrequent or irregular, as defined in Section E-9100, Definitions. In order to be excluded, the income need only be one or the other (infrequent or irregular).

If income is infrequent or irregular and the total from all sources per calendar quarter is greater than $30 earned or $60 unearned, count the amount that exceeds the $30 or $60. Apply the exclusion to the first infrequent or

irregular income received in a calendar quarter.

The infrequent or irregular income exclusion applies only to the eligibility budget. Infrequent or irregular income must be considered for the co-payment budget.

For income received too infrequently or irregularly to be averaged for a projected co-payment, follow procedures for restitution in Section H-8300, Restitution, through Section H-8350, Steps for Submitting Restitution Payment.

E-9400, Special Treatment for Interest or Dividends

Body

Revision 09-4; Effective December 1, 2009

One of the most common types of unearned income received infrequently or irregularly is interest or dividends. For treatment of this type of income consider the following:

- If the income source is either interest or dividends, first consider if the income is countable or not based on policy in Section E-3331, Interest and Dividends.
- If the interest or dividend income is determined non-countable in the eligibility budget based on policy in Section E-3331, do not consider infrequent or irregular policy.
- If the interest or dividend income is determined to be countable in the eligibility budget based on policy in Section E-3331, consider infrequent or irregular policy.

Example 1: Received $25 on March 31 and $26 on June 30. Each was received only once during a calendar quarter from a single source and meets Infrequent or Irregular. Both payments are excluded in the eligibility budget as they are less than $60 per calendar quarter. Consider for co-payment budget.

Example 2: Received $29 on March 1 from book royalty (earned income) and $58 on March 31 from oil royalty (unearned income). Each was received from a different source only once during a calendar quarter and meets Infrequent or Irregular. Both payments are excluded in the eligibility budget, as they are less than $30 earned and $60 unearned per calendar quarter. Consider for co-payment budget.

Example 3: Received $50 mineral royalty on March 31 and $49 mineral royalty on April 30. Each was received only once during a calendar quarter, but the April 30 payment was received in the month immediately following the payment in the previous quarter, thus does not meet the definition of infrequent. Consider both the $50 and $49 in the eligibility and co-payment budgets.

Exception: If the payment in the month immediately preceding or the month following is not a normal quarterly payment from that source, consider this one-time payment as irregular. The regular quarterly payment is still considered as infrequent.

Example 4: Mineral royalty payment of $15 received in the second month of each quarter. The mineral royalty payment has been routinely excluded as infrequent as the individual has no other infrequent or irregular income. The oil company changes its accounting system and, as a result, in June the individual receives $2.03 one-time payment in addition to the regular $15 mineral royalty payment in May. The $15 is still excludable as infrequent, but the unexpected $2.03 is irregular. The total of this calendar quarter is $17.03 and less than $60 and is not counted in the eligibility budget. Consider for co-payment budgets.

Example 5: A person's daughter gives her $100 for her birthday in January. The person also purchased a lottery ticket in March and won $25. Both are considered irregular. Both were received in the same quarter.

The $60 infrequent or irregular exclusion reduces the $100 payment in January, as it was the first infrequent or irregular income received in that quarter. This leaves $0 exclusion and $40 is counted in the eligibility budget for

the month of January. Because the lottery winning was in the same quarter as the gift income, there is $0 remaining exclusion and the $25 is counted in the eligibility budget for the month of March.

These payments are considered in the co-payment budgets.

Example 6: The person's daughter gives her $100 in January and then in February gives her another $50. The daughter stated she will continue to periodically give her mother money, but not on a set schedule. The person also purchased a lottery ticket in March and won $25. All were received in the same quarter. The gift income is not considered infrequent or irregular. The lottery winnings are considered irregular, as they are not anticipated to continue.

As the two gift incomes are not considered irregular or infrequent, they must be counted in the month of receipt – $100 in January and $50 in February. The $60 infrequent or irregular exclusion reduces the $25, as it was the first infrequent or irregular income received in that quarter. This leaves a countable balance of $0 in the eligibility budget for the month of March.

These payments are considered in the co-payment budgets.

Example 7: The person's daughter gives her $100 for her birthday in January. The person also purchased a lottery ticket in March and won $25. Then in April the person purchases another lottery ticket and wins $40. All sources are irregular, as they are not anticipated to continue. Two sources were received in the same quarter (January - March) and one in the next quarter (April - June).

The $60 infrequent or irregular exclusion reduces the $100, as it was the first infrequent or irregular income received in that quarter. This leaves a countable balance of $40 in the eligibility budget for the month of January. Since the lottery winning was in the same quarter as the gift income, there is $0 remaining exclusion and the $25 is counted in the eligibility budget for the month of March.

The April lottery winnings of $40 can be reduced by the $60 infrequent or irregular exclusion, as it is the first infrequent or irregular income received in that quarter. Thus $0 is counted in April and $20 of the infrequent or irregular exclusion remains to be used if other infrequent or irregular income is received within that quarter.

Example 8: Don Edwards has three separate mineral royalty accounts from one oil company. He received a payment of $20 from Account A in January; $20 from Account B in February; and $20 from Account C in March.

Do not count any of the three payments in the eligibility budgets because:

- each is from a separate source;
- no payment is received more frequently than once per quarter; and
- total infrequent unearned income does not exceed $60 per calendar quarter. The $60 infrequent or irregular exclusion reduces the $20 payment in January to $0, leaving $40 exclusion that can still be applied. The remaining $40 exclusion is then applied to the $20 February payment, reducing it to $0, leaving $20 exclusion that can still be applied. The remaining $20 exclusion is then applied to the $20 March payment, reducing the countable to $0.
    - $60 unearned exclusion
    - − $20 January
    - = $40 exclusion remaining/$0 countable amount for January
    - − $20 February
    - = $20 exclusion remaining/$0 countable amount for February
    - − $20 March payment
    - = $0 exclusion remaining/$0 countable for March

These payments are considered in the co-payment budgets.

At the case review the following year, verification is received on the mineral royalties on all three accounts in January. Each mineral royalty payment was $35, for a total of $105.

This income is still considered infrequent and is greater than $60. The total in this calendar quarter is $105.

If income is infrequent or irregular and is greater than $30 earned or $60 unearned, count the amount that exceeds the $30 or $60. Apply the exclusion to the first infrequent or irregular income received in a calendar quarter.

$105 − $60 = $45 counted in the eligibility budget.

Note: If the change in frequency continues, an adjustment may be needed for the co-payment budget.

Example 9: Harry Jones has three separate mineral royalty accounts from one oil company. He received a payment of $50 from Account A in January; $20 from Account B in February; and $75 from Account C in March.

Consider these payments in the eligibility budgets because total infrequent unearned income does exceed $60 per calendar quarter.

The $60 infrequent or irregular exclusion reduces the $50 payment in January to $0, leaving $10 exclusion that can still be applied. The remaining $10 exclusion is then applied to the $20 February payment, reducing it to $10, leaving $0 exclusion. Ten dollars from the February payment is counted in the eligibility budget and the $75 March payment is counted in the March eligibility budget.

- $60 unearned exclusion
- − $50 January
- = $10 exclusion remaining/$0 countable amount for January
- − $20 February
- = $0 exclusion remaining/$10 countable amount for February

These payments are considered in the co-payment budgets.

Example 10: Emma Washington has received a mineral royalty payment of $20 in January and $20 in March.

Count both mineral royalty payments because the total payment is from a single source and is received more than once in the calendar quarter. This does not meet the definition or infrequent or irregular.

Example 11: Lucy Horton received a mineral royalty payment of $15 in the calendar quarter. In the month that the mineral royalty is paid, however, Ms. Horton also receives a cash gift of $20 from her nephew.

The mineral royalty payment is considered as infrequent and the cash gift is considered as irregular. Total the income received from both sources. Because the total does not exceed $60 in the calendar quarter, do not count either payment in the eligibility budget.

These payments are considered in the co-payment budgets.

Note: In the examples, the unearned income is considered as lump-sum payments. Restitution may be requested for nursing facility cases. (Restitution is not appropriate for non-nursing facility cases.)

Chapter F, Resources

F-1000, General Principles of Resources

F-1100, Texas Administrative Code Rules

Body

Revision 09-4; Effective December 1, 2009

The following is taken from Division 2, Resources, Subchapter C, Financial Requirements.

§358.321. General Treatment of Resources.

(a) The Texas Health and Human Services Commission (HHSC) follows §1613 of the Social Security Act (42 U.S.C. §1382b) and 20 CFR §416.1201 regarding the general treatment of resources.

(b) HHSC follows 20 CFR §416.1207 regarding the determination of resources. Resource determinations are made as of 12:01 a.m. on the first day of the month.

(c) If a person's countable resources exceed the resource limit as of 12:01 a.m. on the first day of the month, the person is not eligible for the entire month. Eligibility may be reestablished no sooner than the first day of the next month.

§358.322. Conversion of Resources.

If a person converts one type of resource to another, the new resource is counted according to the policy governing that type of resource. Cash received from the sale of a resource is counted as a resource, not as income. This includes proceeds from the sale of a natural resource, such as cutting timber from the person's home property and selling it as firewood, except as follows:

(1) If the owner leases the land or resource rights, the income received from the lease is unearned income.

(2) If the sale of the natural resource is part of the person's trade or business, the income received is self-employment income.

§358.323. Resource Limits.

A person or a couple meets resources eligibility criteria if the value of all countable resources does not exceed the resource limits in 20 CFR §416.1205.

(1) Individual resource limit. The individual resource limit applies to:

(A) an adult who is single, even if he or she lives with relatives;

(B) a child; and

(C) a person whose spouse lives in a different household.

(2) Couple resource limit. The couple resource limit applies to married adults who live in the same household.

§358.324. Deeming of Resources.

(a) The Texas Health and Human Services Commission (HHSC) follows deeming of countable resources in accordance with 20 CFR §416.1202.

(b) If a parent is a caretaker or a recipient in the Temporary Assistance for Needy Families Program, the parent's resources are not counted when considering deeming to a child.

(c) If a member of a household is temporarily absent as defined in 20 CFR §416.1167, HHSC continues to consider the absent person a member of the household for the purposes of deeming during a temporary absence, in accordance with 20 CFR §416.1167.

§358.325. Ownership Interest and Legal Right to Access a Resource.

The Texas Health and Human Services Commission (HHSC) follows 20 CFR §416.1201(a)(1) when considering whether a person has the right, authority, or power to liquidate a property or the person's share of the property.

§358.326. Unknown Assets.

If a person is unaware of the ownership of an asset, the asset is not counted as a resource for the period during which the person is unaware of the ownership. The asset is counted as income in the month that the person discovers the ownership. The asset is counted as a resource effective the first of the month after the month of discovery.

§358.327. Transactions Involving Agents.

(a) An action by a fiduciary agent is the same as an action by the person for whom the fiduciary agent acts.

(1) An asset held by a fiduciary agent for another person is not a countable asset to the fiduciary agent.

(2) An asset held by a fiduciary agent for another person is a countable asset to the person for whom the fiduciary agent acts, unless otherwise excludable.

(b) A person's resources are available if the resources are being managed by a legal guardian, representative payee, power of attorney, or fiduciary agent. If, however, a court denies a guardian or fiduciary agent access to the person's resources, the resources are not considered available to the person.

(1) If a person's guardianship papers do not show that a legal guardian is prohibited access, and if the court has not subsequently ruled a prohibition, the resources are considered available.

(2) A guardian's routine need to petition the court for permission to dispose of a person's resources is not a prohibition.

(3) When the court rules on a petition to dispose of a person's resources, resources are considered available only to the extent to which the court has made the resources available for the person's benefit.

§358.331. General Exclusions from Resources.

The Texas Health and Human Services Commission follows 20 CFR §416.1210 in determining what resources to exclude, and also excludes:

(1) patrimonial assets that are irrevocably turned over to a religious order following a vow of poverty, which are not considered a transfer of assets;

(2) reparation payments received under Sections 500 - 506 of the Austrian General Social Insurance Act;

(3) payments received under the Netherlands' Act on Benefits for Victims of Persecution 1940 - 1945; and

(4) payments made in the class settlement of the Susan Walker v. Bayer Corporation lawsuit.

§358.333. Treatment of Employment-and Retirement-Related Annuities.

(a) In this section:

(1) an employment-related annuity means an annuity that provides a return on prior services, as part of or in a similar manner to a pension or retirement plan; and

(2) a retirement-related annuity means an annuity purchased by or on behalf of an annuitant in an institutional setting.

(b) An employment-related annuity or a retirement-related annuity established before February 8, 2006, is not a countable resource. Income from such an annuity is treated in accordance with 20 CFR §§416.1120 - 416.1124.

(c) An employment-related annuity established or having a transaction on or after February 8, 2006, is not a countable resource. Income from such an annuity is treated in accordance with 20 CFR §§416.1120 - 416.1124.

(d) A retirement-related annuity with a purchase or transaction date on or after February 8, 2006, is not a countable resource, if the annuitant's income eligibility is determined under the special income limit. Income from such an annuity is treated in accordance with 20 CFR §§416.1120 - 416.1124, if the annuity:

(1) is an annuity described in subsection (b) or (q) of §408 of the Internal Revenue Code of 1986; or

(2) is purchased with proceeds from:

(A) an account or trust described in subsection (a), (c), or (p) of §408 of the Internal Revenue Code of 1986;

(B) a simplified employee pension (within the meaning of §408(k) of the Internal Revenue Code of 1986; or

(C) a Roth IRA described in §408A of the Internal Revenue Code of 1986.

§358.334. Treatment of a Nonemployment-Related Annuity with a Purchase or Transaction Date before February 8, 2006.

(a) This section describes the Texas Health and Human Services Commission's (HHSC's) treatment of nonemployment-related annuities purchased or having a transaction date before February 8, 2006. In this section, a nonemployment-related annuity means a revocable or irrevocable annuity a person may purchase to provide income.

(b) A nonemployment-related annuity is not a countable resource if the annuity:

(1) is irrevocable;

(2) pays out principal in equal monthly installments and pays out interest in either equal monthly installments or in amounts that result in increases of the monthly installments at least annually;

(3) is guaranteed to return within the person's life expectancy at least the person's principal investment plus a reasonable amount of interest (based on prevailing market interest rates at the time of the annuity purchase, as determined by HHSC);

(4) names the state of Texas or HHSC as the residual beneficiary of amounts payable under the annuity contract, not to exceed any Medicaid funds expended on the person during the person's lifetime, except as described in subsection (c) of this section; and

(5) is issued by an insurance company licensed and approved to do business in the state of Texas.

(c) If a person in an institutional setting is married and the spousal impoverishment provisions of §358.413 of this subchapter (relating to Spousal Impoverishment Treatment of Income and Resources) apply, the requirement in subsection (b)(4) of this section does not apply to a nonemployment-related annuity purchased by or for a community spouse.

(d) A nonemployment-related annuity that does not meet the requirements of subsection (b) or (c) of this section is a countable resource.

(1) HHSC applies transfer-of-assets provisions in Division 4 of this subchapter (relating to Transfer of Assets) to an annuity that is a countable resource and does not meet the criterion in subsection (b)(3) of this section. The date of the transfer of assets is the date of the annuity purchase or, if applicable, the date the annuity contract was last amended in exchange for consideration. HHSC determines the amount of the transfer by assessing the difference between the life expectancy of the person and the number of years remaining until the annuity is paid out. The amount payable during that period is the amount of the transfer of assets.

(2) If the annuity is a countable resource and is revocable, HHSC:

(A) counts the amount refundable upon revocation of the annuity as the value of the resource; and

(B) applies transfer-of-assets provisions in Division 4 of this subchapter if the person sells the annuity for less than the amount refundable upon revocation.

(3) If the annuity is a countable resource and is irrevocable, HHSC:

(A) counts fair market value as the value of the resource and presumes fair market value is 80% of the annuity's total remaining payout;

(B) applies transfer-of-assets provisions in Division 4 of this subchapter if the annuity is sold for less than the purchase price minus the amount of principal already paid; and

(C) if the terms of the annuity contract are non-negotiable, applies transfer-of-assets provisions in Division 4 of this subchapter to the total remaining payout.

(e) Income from a nonemployment-related annuity that is not a countable resource under subsection (c) of this section is treated in accordance with 20 CFR §§416.1120 - 416.1124.

§358.335. Treatment of Annuities with a Purchase or Transaction Date on or after February 8, 2006.

(a) This section describes the Texas Health and Human Services Commission's (HHSC's) treatment of nonemployment-related annuities purchased or having a transaction date on or after February 8, 2006. In this section, a nonemployment-related annuity means a revocable or irrevocable annuity a person may purchase to provide income.

(b) A nonemployment-related annuity is not a countable resource if the annuity:

(1) is irrevocable;

(2) is nonassignable;

(3) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made;

(4) is guaranteed to return within the person's life expectancy at least the person's principal investment (that is, it is actuarially sound, as determined in accordance with actuarial publications of the Office of the Chief Actuary

of the United States Department of Health and Human Services); and

(5) names the state of Texas as the remainder beneficiary in the first position for at least the total amount of Medicaid paid on behalf of a person in an institutionalized setting.

(c) If a person in an institutionalized setting is married and the spousal impoverishment provisions of §358.413 of this subchapter (relating to Spousal Impoverishment Treatment of Income and Resources) apply, a nonemployment-related annuity is not a countable resource if the annuity meets the requirements of subsection (b)(1) - (4) of this section and the annuity:

(1) names the state of Texas as the remainder beneficiary in the first position for at least the total amount of Medicaid paid on behalf of the person in an institutional setting; or

(2) names the state of Texas in the second position if the community spouse or a minor or disabled child is named in the first position.

(d) A nonemployment-related annuity that is revocable is a countable resource. For a revocable nonemployment-related annuity, HHSC:

(1) uses fair market value to determine the value of the resource; and

(2) applies transfer-of-assets provisions in Division 4 of this subchapter (relating to Transfer of Assets) based on the amount already paid out of the annuity.

(e) A nonemployment-related annuity that is irrevocable is not a countable resource. For an irrevocable nonemployment-related annuity, HHSC:

(1) applies transfer-of-assets provisions in Division 4 of this subchapter to the purchase price of the annuity; and

(2) for a transaction involving an existing annuity, applies transfer-of-assets provisions to the remaining payout value at the time of the transaction.

(f) Income from an annuity that is not a countable resource is treated in accordance with 20 CFR §§416.1120 - 416.1124.

§358.336. Treatment of Testamentary or Inter Vivos Trusts.

(a) In this section, the following words have the following meanings, unless the context clearly indicates otherwise.

(1) Testamentary trust--A trust established by will.

(2) Inter vivos trust--A trust established while the person creating the trust is still living.

(b) Resources in a testamentary or inter vivos trust are countable to a person if the person is the trustee and has the legal right to revoke the trust and use the money for the person's own benefit.

(1) If a person does not have access to the trust, then the trust is not counted as a resource.

(2) If a person's access to a trust is restricted (that is, only the trustee (other than the person) or the court may withdraw the principal), then the value of the trust as a resource is not counted, even if:

(A) the person's legal guardian is the trustee;

(B) the trust provides a regular, specified payment to the person; or

(C) the trust provides for discretionary withdrawals by the trustee.

(3) If a trust is not counted as a resource, payments from the trust made to or for the benefit of the person may be counted as income only if the payments would ordinarily be counted as income in accordance with 20 CFR §416.1102.

§358.337. Treatment of a Medicaid-qualifying Trust.

(a) A Medicaid-qualifying trust (MQT) is a trust that a recipient, the recipient's spouse or guardian, or anyone holding the recipient's power of attorney establishes using the recipient's money. The recipient is the beneficiary of an MQT. A trust meeting this definition that was established between June 1, 1986, and August 10, 1993, is an MQT. A trust meeting this definition that was established before June 1, 1986, is treated as a standard inter vivos trust.

(b) Except as described in §358.338 of this division (relating to Treatment of a Trust Established with Zebley v. Sullivan Settlement Funds), the Texas Health and Human Services Commission (HHSC) counts potential distributions from an MQT as resources available to a person, whether or not distributions are actually made.

(1) The amount available to the person is the maximum amount the trustee could distribute under the terms of the trust.

(2) If distribution is not made, the maximum amount the trustee may distribute under terms of the trust is considered an available resource.

(3) If a trust does not specify an amount for distribution, and if the trustee has access to and use of the principal, then HHSC counts:

(A) the corpus of the trust as a resource; and

(B) payments from the trust to or for the benefit of the person as income only if the payments would ordinarily be counted as income in accordance with 20 CFR §416.1102.

§358.338. Treatment of a Trust Established with Zebley v. Sullivan Settlement Funds.

(a) The Texas Health and Human Services Commission excludes a Medicaid-qualifying trust established for a minor child using a lump sum payment received in the settlement of Zebley v. Sullivan from countable resources under undue hardship provisions. Undue hardship exists because the minor child would otherwise be forced to spend the settlement funds on services now covered by Medicaid when the funds will be needed once the minor child reaches majority.

(b) A trust established using Zebley v. Sullivan settlement funds is excluded under undue hardship policy, even when the trust is set up on or after August 11, 1993.

§358.339. Treatment of Trusts on and after August 11, 1993.

(a) Introduction. The Texas Health and Human Services Commission (HHSC) follows §1917(d) of the Social Security Act (42 U.S.C. §1396p(d)) regarding the treatment of trusts established on or after August 11, 1993, using a person's assets. The trust provisions apply to a person receiving benefits under a Medicaid-funded program for the elderly and people with disabilities (MEPD), whether the person is in an institutional or a noninstitutional setting. However, transfer-of-assets provisions apply only to a person in an institutional setting.

(b) Limited partnerships.

(1) A limited partnership is a "similar legal device" to a trust. In accordance with the definition of a trust in §1917(d)(6) of the Social Security Act (42 U.S.C. §1396p(d)(6)), HHSC treats a limited partnership as a trust and applies the provisions of this section to a limited partnership. The general partners of a limited partnership act as trustee, and the limited partners are the equivalent of beneficiaries of an irrevocable trust. To the extent that the general partners can make each limited partner's ownership interest available to him, that interest is a countable resource and not a transfer of assets. However, a transfer of assets has occurred to the extent that:

(A) the value of the share of ownership purchased by the limited partner is less than the amount the limited partner invested; and

(B) the general partners cannot make the limited partner's share available to the limited partner.

(2) If transfer-of-assets provisions apply, a limited partnership is not considered a trust instrument when determining the look-back period.

(c) Qualified income trust (QIT).

(1) A QIT is an irrevocable trust established for the benefit of a person or the person's spouse, or both, the corpus of which is composed only of the person's or the couple's income (including accumulated income). The trust must include a provision that the State is designated as the residuary beneficiary to receive, at the person's death, funds remaining in the trust equal to the total amount of Medicaid paid on the person's behalf.

(2) Characteristics of a QIT are as follows:

(A) The trust must be irrevocable.

(B) The trust must contain only the person's income. If resources are placed in the trust, it is not a QIT. However, some banks may require nominal deposits to establish a financial account to fund the trust. Nominal amounts of the person's resources, or another party's funds, may be used to establish the account without invalidating the trust or being counted as gift income to the person. Once the trust account is established, however, only the person's income should be directed to the trust account.

(C) The person's income does not have to be directly deposited into the trust. However, the income for which the trust is established must be deposited into the trust during the month it is received by the person.

(D) A QIT may be established with any or all sources of a person's income, but the income source must be identified and the entire income source must be deposited. For example, the trust may be established for a person's private pension income, but not the person's Social Security income. If a trust is established with only half of the pension income, it is not a QIT.

(3) A QIT is not counted as a resource.

(4) Income directed to a QIT is not counted when testing eligibility for services in an institutional setting.

(A) Income must be directed to the trust account during the calendar month in which it is received. Any source of nonexempt or nonexcludable income that is not directed to the QIT account during the calendar month of receipt is countable income for that month. If countable income exceeds the income limit, the person is income-ineligible for the month. An applicant may not be certified for any calendar month in which the applicant is income-ineligible. For a recipient, HHSC requests restitution in the amount of the provider payment for any calendar month in which the person is income-ineligible.

(B) Income directed to the trust is counted in determining eligibility for a person in a noninstitutional setting and for a person applying for or receiving benefits from a Medicare Savings Program as described in Chapter 359 of this title (relating to Medicare Savings Program).

(C) Income paid from the trust for an institutional setting co-payment or to purchase other medical services for the person is not countable income for eligibility purposes. Income paid from the trust directly to the person or otherwise spent for the person's benefit is countable income for eligibility purposes.

(D) A person cannot use income from a QIT to purchase eligibility for a §1915(c) waiver program.

(E) If the trustee directs to the trust account different sources of income than those identified in the QIT, but directs entire sources and countable income remains within the special income limit, eligibility is not affected.

(5) If the trust instrument requires that the income placed in the trust must be paid out of the trust for the person's care in an institutional setting, transfer-of-assets provisions do not apply because the person receives fair market value for the income that was placed into the trust. However, if there is no such requirement or the income is not used for the person's care, transfer-of-assets provisions apply. The income must be paid out by the end of the month after the month funds were placed in the trust to avoid application of the transfer-of-assets provisions. Transfer-of-assets provisions do not apply when the QIT provisions allow payments to or for the benefit of the person's spouse.

(6) The institutional setting co-payment amount is based on the person's total income (income directed to the trust as well as income not directed to the trust), minus the standard co-payment deductions. Costs of trust administration are not budgeted in the co-payment calculation. Transfer-of-assets provisions do not apply when legal and accounting fees necessary to maintain the trust are paid from the trust.

(7) HHSC disregards the income placed in a QIT for eligibility purposes for the first month that the person has a valid signed trust and enough income is placed in the account to reduce the remaining income below the special income limit.

(d) Undue hardship.

(1) As provided under §1917(d) of the Social Security Act (42 U.S.C. §1396p(d)(5)), this section does not apply if application of the trust provisions in this section would work an undue hardship on the person. Undue hardship exists if application of the trust provisions would:

(A) deprive the person of medical care so that the person's health or his life would be endangered; or

(B) deprive the person of food, shelter, or other necessities of life.

(2) Undue hardship does not exist if a person is inconvenienced or must restrict his or her lifestyle but is not at risk of serious deprivation. Undue hardship relates to hardship to the person, not to relatives or authorized representatives of the person.

(3) Before requesting a waiver of the trust provisions on the grounds of undue hardship, a person must make reasonable efforts to recover assets placed in a trust, such as petitioning the court to dissolve the trust. HHSC determines undue hardship after receiving a request for a waiver of the trust provisions on the grounds of undue hardship. The person has the right to appeal HHSC's determination on undue hardship.

§358.345. Entrance Fees for Continuous Care Retirement Communities.

The Texas Health and Human Services Commission follows §1917(g) of the Social Security Act (42 U.S.C. §1396p(g)) regarding the treatment of entrance fees of a person residing in a continuous care retirement community.

§358.346. Funds Held in Financial Institution Accounts.

The Texas Health and Human Services Commission follows 20 CFR §416.1208 regarding the treatment of funds held in financial institution accounts, except the balance of funds in a financial institution account as of 12:01

a.m. on the first day of the month is reduced by the amount of any funds encumbered before that time, including any checks written, that have not yet been processed by the financial institution.

§358.347. Nonliquid Resources.

The Texas Health and Human Services Commission follows 20 CFR §416.1201(c) regarding the definition and treatment of nonliquid resources, except with regard to the treatment of an automobile as described in §358.354 of this division (relating to Automobiles).

§358.348. Exclusion of a Home.

(a) The Texas Health and Human Services Commission follows 20 CFR §416.1212 regarding the treatment of a home, except HHSC does not count the equity value of a home that is the principal place of residence of an applicant or recipient or the applicant's or recipient's spouse:

(1) if the home is in Texas, and the applicant or recipient occupies or intends to return to the home; or

(2) if the home meets the criteria in §358.415(b) of this subchapter (relating to Calculation of the Spousal Protected Resource Amount).

(b) For a person or couple living in an institutional setting, if the person or couple transfers ownership of the home for less than market value while the home is excluded, the transfer automatically nullifies the exclusion.

§358.349. Exceptions to Treatment of Excess Real Property.

(a) The Texas Health and Human Services Commission (HHSC) follows 20 CFR §416.1245 regarding the treatment of excess real property, except the property continues to be excluded for as long as:

(1) the person continues to make reasonable efforts to sell it; and

(2) including the property as a countable resource would result in a determination of excess resources.

(b) Once the property is sold, the equity value received is a countable resource in the month following the month of sale. If the sale was for less than the fair market value or current market value, the sale of the property is subject to the transfer-of-assets provisions in Division 4 of this subchapter (relating to Transfer of Assets).

§358.350. Life Estates and Remainder Interest.

The Texas Health and Human Services Commission (HHSC) counts both a life estate and a remainder interest in property as resources, except as described in paragraph (3) of this section.

(1) Life estates. A life estate provides a person, for the person's lifetime, certain rights in a property, while transferring ownership of the property to another person. The duration of a life estate is measured by the lifetime of the owner of the life estate, or by the occurrence of some event. The contract establishing a life estate, however, may restrict one or more rights of the owner of the life estate. The owner of a life estate does not have fee simple title to the property nor the right to sell the entire property. In most situations, the owner of a life estate has the right to:

(A) possess the property;

(B) use the property;

(C) get profits from the property; and

(D) sell his or her life estate interest.

(2) Remainder interest. A remainder interest, which is created when a life estate is established, gives a person owning a remainder interest the right to ownership of the property upon the death of the owner of the life estate. A person owning a remainder interest in the property has the right to sell his or her remainder interest unless the person is prohibited from doing so by a legal restriction.

(3) Exclusion for life estates and remainder interests. Life estates and remainder interests are not counted as resources if:

(A) the property is the person's home and can be excluded under §358.348 of this division (relating to Exclusion of a Home);

(B) a contract restriction prevents the person from disposing of the person's interest;

(C) the property is producing income and may be excluded under 20 CFR §§416.1220, 416.1222, and 416.1224; or

(D) the property is placed for sale and the person is in an institutional setting.

(4) Determination of value. If a person has a life estate or remainder interest that is not excludable under paragraph (3) of this section, HHSC determines the value of the resource according to the age of the owner of the life estate and the equity value of the property. The person has the right to rebut HHSC's determination of the value of the resource. To do so, the person must present a statement from a knowledgeable source.

(5) A purchase of a life estate before April 1, 2006, is not considered a transfer of assets, unless the purchase price of the life estate exceeds the fair market value (FMV) of the life estate. If the purchase price of the life estate exceeds the FMV of the life estate, the transfer-of-assets provisions in Division 4 of this subchapter (relating to Transfer of Assets) apply.

(6) A purchase of a life estate on or after April 1, 2006, is a transfer of assets, subject to the transfer-of-assets provisions in Division 4 of this subchapter, unless the person purchasing a life estate in another person's home resides in the home and continues to reside in the home for at least one year after the date of purchase.

§358.351. Mineral Rights.

(a) The Texas Health and Human Services Commission counts the equity value of a person's ownership of or interest in mineral rights as a resource, unless the mineral rights are:

(1) connected with property excluded as a home; or

(2) excluded as property essential to self-support under 20 CFR §§416.1220, 416.1222, and 416.1224.

(b) Ownership of mineral rights may or may not be associated with ownership of land. Surface rights are ownership interests in the exterior or upper boundary of land. Ownership of mineral rights does not automatically indicate ownership of surface rights.

§358.352. Burial Spaces.

The Texas Health and Human Services Commission follows 20 CFR §416.1231 regarding the definition, treatment, and exclusion of burial spaces, except that a burial space purchased by a person is:

(1) excluded from countable resources if it is held for the person, the person's spouse, or anyone of the person's choosing; and

(2) counted as a resource if the purchase was made for investment purposes.

§358.353. Term and Burial Insurance.

The Texas Health and Human Services Commission does not count term insurance or burial insurance as a resource, except as described in paragraphs (3) and (4) of this section.

(1) Term insurance is a contract of temporary protection. The insured pays relatively small premiums for a limited number of years, and the company agrees to pay the face amount of the policy only if the insured dies within the time specified in the policy. It has no cash surrender value.

(2) Burial insurance is a form of term insurance. By its terms, burial insurance can only be used to pay the burial expenses of the insured.

(3) If a term insurance policy has been purchased by a life insurance company and premiums are used to purchase separate whole life coverage, the whole life coverage is subject to the provisions of 20 CFR §416.1230.

(4) If a term insurance policy is a participating life insurance policy, any dividend accumulation at interest is a countable resource.

§358.354. Automobiles.

(a) The Texas Health and Human Services Commission (HHSC) follows 20 CFR §416.1218 regarding the definition, treatment, and exclusion of automobiles.

(b) In addition to the one automobile HHSC excludes regardless of value, HHSC excludes a second automobile, in accordance with 20 CFR §416.1218(b)(1), if:

(1) the automobile has been modified to accommodate a person with a disability, and there is a household member (other than the applicant or recipient) who has a disability and must use the automobile; or

(2) the household is made up of more than one person and:

(A) a household member (other than the applicant or recipient) requires an additional automobile for transportation to and from work; and

(B) the applicant or recipient requires one automobile available for medical use at all times.

§358.355. Qualified Long-Term Care Partnership Program Insurance Policies.

(a) This section describes the Long-Term Care Partnership Program under which a person's resources are disregarded in the eligibility determination equal to the amount of benefits paid to or on behalf of a person by a Long-Term Care Partnership policy.

(b) The Texas Health and Human Services Commission (HHSC) administers the Long-Term Care Partnership Program.

(c) In this section, the following words and terms have the following meanings, unless the context clearly indicates otherwise:

(1) "Long-Term Care Partnership Program" means the program established under the Texas Human Resources Code, Chapter 32, Subchapter C.

(2) "Qualified plan holder" means the beneficiary of a qualified long-term care benefit plan that meets the requirements set forth in subsection (d) of this section.

(3) "Resource disregard" means the total equity value of resources not exempt under rules governing Medicaid eligibility that are disregarded in determining eligibility for Medicaid.

(4) "Resource protection" means the extension to a plan holder of an approved plan of a dollar-for-dollar resource disregard in determining Medicaid eligibility.

(5) "Dollar-for-dollar resource disregard" means a resource disregard in which the amount of the disregard is equal to the sum of benefit payments made on behalf of the approved plan holder.

(d) A Long-Term Care Partnership Program policy is one that meets all of the following requirements:

(1) On the date the policy was issued, the state in which the insured resided had in place an approved Medicaid state plan amendment under 42 U.S.C. §1396p(b).

(2) The policy meets the requirements set forth by the Texas Department of Insurance under Title 28, Part 1, Chapter 3 of the Texas Administrative Code (relating to Life, Accident and Health Insurance and Annuities).

(e) At application for long-term care services, the qualified plan holder receives a dollar-for-dollar disregard of his or her resources.

(1) HHSC determines Medicaid eligibility in accordance with this chapter.

(2) A person may apply for Medicaid before exhausting the benefits of a Long-Term Care Partnership Program policy. If a person applies for and is eligible to receive Medicaid before the Long-Term Care Partnership Program policy is exhausted, the Long-Term Care Partnership Program insurer must make payment for medical assistance to the maximum extent of its liability before Medicaid funds may be used to pay providers for covered services as established in this chapter.

(3) If a person has applied for and been found eligible to receive Medicaid and subsequently receives additional resources, the person continues to be eligible for Medicaid if the total resources do not exceed the individual resource limit after applying the dollar-for-dollar resource disregard.

(f) If the Long-Term Care Partnership Program is discontinued, a person who purchased a Long-Term Care Partnership Program policy before the date the program is discontinued remains eligible to receive the dollar-for-dollar resource exclusion.

§358.371. Treatment of Other Resources.

The Texas Health and Human Services Commission follows the federal regulations indicated in the table in this section regarding the treatment of resources not otherwise described in this division:

Type of Resource	Section(s) in 20 CFR:
Assistance received due to a major disaster	416.1237
Certain housing assistance	416.1238
Crime-related compensation	416.1229
Earned income tax credit	416.1235
Funds in a dedicated account in a financial institution established and maintained in accordance with 20 CFR §416.640(e)	416.1247

Type of Resource	Section(s) in 20 CFR:
Funds set aside for burial expenses for an applicant or recipient and the applicant's or recipient's spouse	416.1231(b)
Gifts from a nonprofit organization to a child with life-threatening conditions	416.1248
Grants, scholarships, fellowships, and gifts	416.1250
Household goods and personal effects	416.1216
Indian lands	416.1234
Life insurance	416.1230
Liquid resources	416.1201(b)
Property essential to self-support	416.1220, 416.1222, 416.1224
Payments or benefits provided under a federal statute, other than Title XVI of the Social Security Act, if required by federal statute	416.1210(j), 416.1236
Relocation assistance from a state or local government	416.1239
Replacement value of lost, damaged, or stolen excluded resources	416.1232
Resources in an approved plan to achieve self-support (PASS) for a person who is blind or disabled	416.1225-416.1227
Restitution for misuse of benefits for Title II, Title VIII, or Title XVI benefits by a representative payee	416.1249
Title II or Title XVI retroactive payments	416.1233

F-1200, General Principles of Treatment of Resources

Body

Revision 11-3; Effective September 1, 2011

There is no resource test for the Medicaid Buy-In for Children (MBIC) program. However, the income from income-producing resources is considered. See Section N-4200, Income.

F-1210 Definition

Revision 09-4; Effective December 1, 2009

Resources are cash, other liquid assets, or any real or personal property or other nonliquid assets that a person, a person’s spouse or parent could convert to cash to be used for his or her support and maintenance. Support and maintenance assistance not counted as income is not considered a resource.

F-1220 Ownership and Accessibility

Revision 09-4; Effective December 1, 2009

A person’s resource is property that:

- is owned, solely or in part, by the person; and
- is accessible to the person.

If the person has the right, authority or power to liquidate the property or his share of it, the property is a resource.

Federal guidelines do not provide any leeway for hardship cases in determining the availability of resources. Unless a court has judged a person to be incompetent and a guardian or other agent is appointed to act for the person, the person has access to resources he owns.

Questions concerning ownership and accessibility may arise with respect to co-owned resources. In certain proceedings, such as divorce, the community property owned by the applicant/recipient and spouse may be divided by the court and ownership awarded to one or the other of the spouses. If the court documents indicate that there is division of marital property, only consider the property awarded to the applicant/recipient as owned and accessible to the applicant/recipient.

When dealing with legal documents, such as deeds, wills or trusts, always consult with the regional attorney to determine the type of asset and therefore the appropriate treatment. See Section F-1230, Guardians, Fiduciaries and Other Agents.

F-1221 Co-owned Resources

Revision 11-4; Effective December 1, 2011

Treatment of co-owned resources differs depending on the person's marital status, living arrangement and program requested.

For a person who has an ineligible community spouse and that person is in an institutional setting when determining eligibility for the institutional setting program, do not use the following policy. Instead, use the policy in Chapter J, Spousal Impoverishment.

For determination of Medicare Savings Programs (MSP) eligibility on these spousal institutional setting cases, the following does apply.

For an individual who has a co-owned resource with a sibling, parent, etc., and lives in an institution, the following does apply.

Note: Institutional settings are any Medicaid-certified long-term care facility or any §1915(c) waiver program.

For a person in a noninstitutional setting, co-owned resources may also be counted in certain situations, as follows:

- If a person's co-owned resource is available to him without obtaining the consent of the co-owner, the full value of the resource is counted.
- If a co-owner's consent is required for the resource to be available to the person, and if that co-owner gives the consent, the full value of the available resource is counted.
    - If a co-owner refuses to consent, the resource is neither considered available nor counted.
    - If, however, the co-owner who refuses to consent is an ineligible spouse living with the person, the resource is considered available to the person and is counted against the resource limit.
- If a person has partial ownership in undivided real property, the value of his interest in the property is counted because each co-owner usually has the right to sell his share with or without the co-owner's consent.

Texas law prohibits the sale of the Texas community homestead property without the consent of both spouses. If an ineligible spouse is unwilling to dispose of Texas community homestead property and the person does not live with the ineligible spouse, the Texas community homestead property is not an available resource for the person.

References:

- See Section F-4000, Liquid and Nonliquid Resources, for treatment of liquid resources including treatment of joint bank accounts.
- See Section F-5000, Potential Resource Exclusions, for treatment of nonliquid resources.
- See Section F-4330, Business Property, for treatment of business property.

F-1221.1 Co-owned Resource Examples

Revision 09-4; Effective December 1, 2009

- Co-owned liquid resource

  A joint bank account that requires both owners' signatures to withdraw funds is an example of a co-owned resource requiring the consent of the other co-owner before it is available to the person. These accounts are usually established as "Jean Brown and Doris Brown."
- Co-owned undivided real property:

  An example of co-owned, undivided real property is land acquired by heirs to an estate.

If a person has a co-owned resource, determine the amount of interest owned, accessibility and the value of the person's interest in the co-owned resource.

Determine accessibility according to whether the co-owner's consent is required for the person to dispose of his interest.

Verify and document ownership and the value of the resource according to the verification and documentation requirements for the type of resource involved.

After contacting a knowledgeable source to determine the equity value of an interest in property, provide the following information:

- Location and a description of the property.
- Percentage of the person's ownership interest in the total resource.
- Amount and a description of any debts, liens (including federal tax liens) or taxes.
- Explanation of factors that may affect the value of an ownership interest, such as need to partition.

Verify and document accessibility from:

- ownership papers or other legal documents; or
- statement from the co-owner, if his/her consent is required, indicating if he/she is planning to make the resource available to the person.

F-1230 Guardians, Fiduciaries and Other Agents

Revision 09-4; Effective December 1, 2009

F-1231 Guardians and Other Agents

Revision 16-3; Effective September 1, 2016

Guardian of the estate. Under Sections 1151.101 and 1151.151, Texas Estates Code, it is the duty of the guardian of the estate to take care of and manage the estate as a prudent individual would manage the individual's own property. The guardian of the estate collects all debts, rentals or claims due to the ward, enforces all obligations in favor of the ward, and brings and defends suits by or against the ward. Only the guardian of the estate can deal with resources.

Guardian of the person. Under Section 1151.051, Texas Estates Code, the guardian of the person has the:

- right to have physical possession of the ward;
- right to establish the ward's legal domicile;
- duty of care, control and protection of the ward;
- duty to provide the ward with clothing, food, medical care and shelter; and
- power to consent to medical, psychiatric and surgical treatment other than the in-patient psychiatric commitment of the ward.

For HHSC purposes, the guardian of the person can sign documents, represent the individual at hearings and deal with small amounts of money. The guardian of the person is like any other responsible party in that the guardian of the person has the authority to protect the interests of the ward.

Under Section 1151.004, Texas Estates Code, a court may appoint the same individual to be both guardian of the estate and guardian of the person. If there are two guardians, one of the estate and one of the person, then the eligibility specialist must examine the court orders establishing the guardianships to decide which is the most appropriate to represent the individual with HHSC.

Note: When a guardianship exists, only that person can act on the individual's behalf to sign applications and review forms.

An individual's resources are available to the individual if they are being managed by a legal guardian, representative payee, power of attorney or fiduciary agent. If, however, a court denies a guardian or agent access to the resources, HHSC does not consider the resources available to the individual.

If individual's guardianship papers do not show that the legal guardian is prohibited access, and if a court has not subsequently ruled a prohibition, the resources are considered available. A guardian's routine need to petition the court for permission to dispose of individual's resources is not a prohibition. When the court rules on a petition to dispose of individual's resources, resources are considered available only to the extent to which the court has made them available for the individual's benefit.

If a legal guardian exists, obtain a copy of the guardianship or power of attorney document.

F-1231.1 Examples of Treatment of Resources

Revision 09-4; Effective December 1, 2009

Situation 1: Louis Bennett has resources valued at $1,300, which are being managed by his son. The son claims that as the power-of-attorney he is the only one who has access to the funds.

Treatment 1: Because a power-of-attorney is given voluntarily, and management of the resources is with the person's consent and for his benefit, Louis Bennett's resources are available to him.

Situation 2: John Morgan's parents used their own funds to purchase a certificate of deposit (CD) for John. The CD was issued as "John Morgan, by Paul and Jean Morgan, Joint Representative Payees."

Treatment 2: The CD is an available resource to John Morgan because the designation indicates that the parents are acting in a fiduciary capacity in controlling funds belonging to John, regardless of the fact that Mr. and Mrs. Morgan paid the purchase price.

Situation 3: Amy Wilson recently left the hospital and entered a long-term care facility. She is in a coma, and there are no known living relatives or friends. After Ms. Wilson had a stroke, her landlady looked through Ms. Wilson's papers and found a $600 term life insurance policy and a checkbook showing a balance of $3,840.65. The bank balance verified by bank statements.

Treatment 3: Although court action to appoint a guardian would be necessary to allow disposal of Ms. Wilson's excess funds, the resources are available to her. Until a court judges Ms. Wilson to be incompetent and unable to handle her affairs, the eligibility specialist cannot assume that the court will prohibit an appointed guardian from disposing of any of the funds in the checking account. Ms. Wilson is ineligible because of excess resources.

F-1232 Fiduciary Agent

Revision 09-4; Effective December 1, 2009

A fiduciary agent is a person or organization acting on behalf of and/or with the authorization of another person. The term applies to anyone who acts in a financial capacity, whether formal or informal, regardless of title, such as representative payee, guardian or conservator. In the case of a trustee, refer to the trust instrument.

An action by a fiduciary agent is the same as an action by the person for whom the fiduciary agent acts.

Assets held by a person in his/her capacity as fiduciary agent for someone else are not countable assets to the person. Assets held by a fiduciary agent for a person are considered as available to the person, unless otherwise excludable.

Identify a fiduciary relationship by the way in which a resource is styled. A bank account established in two names connected by "for" or "by" indicates a fiduciary relationship. Another indication is an account established in two names with the designation of "representative payee" next to one of the names, or an account with the designation "special."

A Medicaid recipient may receive a lump sum payment as the payee for an individual who is not a Medicaid recipient. Consider the Medicaid recipient a fiduciary agent for the individual. Do not consider the individual’s lump sum funds as an available countable asset to the Medicaid recipient when all of the following conditions are met:

- The individual has no bank account.
- The Medicaid recipient is acting as the fiduciary agent.
- Deposits of the lump sum funds are made into the Medicaid recipient’s bank account.

F-1232.1 Medicaid Recipient Responsibilities as Fiduciary Agent

Revision 09-4; Effective December 1, 2009

If the individual's lump sum funds held in the Medicaid recipient's bank account are not considered as an available asset to the Medicaid recipient, the Medicaid recipient, as fiduciary agent for the individual, must:

- indicate the current needs of the individual such as food, clothing, housing, medical care and other personal comfort items;
- indicate reasonably foreseeable needs of the individual;
- keep accounting records of how lump sum funds are spent for the individual; and
- establish a separate fiduciary account with the remaining lump sum funds for the individual allowing the person until the next annual redetermination.

Do not use Form H1299, Request for Joint Bank Account Information, when the individual's lump sum funds have been deposited into the Medicaid recipient's account and the Medicaid recipient is allowed time to separate the individual's funds and deposit them into a separate fiduciary account.

F-1240 Ownership of Unknown Assets

Revision 09-4; Effective December 1, 2009

If a person is unaware that he/she owns an asset, the asset is not counted as a resource for the period during which he/she is unaware of his ownership. For example, he/she may inherit property and not know about the inheritance for some time.

The asset is counted as income in the month that the person discovers his/her ownership.

Begin counting the asset as a resource effective the first of the month after the month of discovery.

F-1250 Patrimonial Assets

Revision 09-4; Effective December 1, 2009

Patrimonial assets are assets irrevocably turned over to a religious order following a vow of poverty. The assets are not countable resources and the transfer of assets penalty does not apply.

F-1260 Conversion of Resources

Revision 09-4; Effective December 1, 2009

If a person converts one type of resource to another, HHSC considers the new resource according to the policy governing that type of resource.

Any cash received from the sale of a resource is considered a resource, not income. This includes proceeds from the sale of a natural resource, such as cutting timber from the person's home property and selling it as firewood. There are two exceptions:

- The owner leases the land or resource rights. The income received from the lease is unearned income.
- The sale of the natural resource is part of the person's trade or business. The income received is self-employment income.

See Section E-3333, Mineral and Timber Rights.

See Section F-4000, Liquid and Nonliquid Resources, for nonliquid resources converted to cash.

F-1270 Replacement Value of Excluded Resources

Revision 09-4; Effective December 1, 2009

If an excluded resource is lost, damaged or stolen, the cash, including interest earned on the cash, or the in-kind replacement that the person receives from any source to repair or replace the resource, is excluded. This exclusion applies if the cash and the interest are used to repair or replace the excluded resource within nine months of the date the person received the cash.

Any of the cash or interest that is not used to repair or replace the excluded resource is counted as a resource beginning with the month after the nine-month period expires.

The initial nine-month time period can be extended for a reasonable period up to an additional nine months when the person has good cause for not replacing or repairing the resource. Good cause exists when circumstances beyond the person's control prevent the repair or replacement or the contracting for the repair or replacement of the resource. The nine-month extension can only be granted if the person intends to use the cash or in-kind replacement items to repair or replace the lost, stolen or damaged excluded resource and has good cause for not having done so. If good cause is found, any unused cash and interest are counted as a resource beginning with the month after the good cause extension period expires.

When the president of the United States declares a catastrophe to be a major disaster, the extension period described above can be extended for a reasonable period up to an additional 12 months if:

- the excluded resource is geographically located within the disaster area as defined by the presidential order;
- the person intends to repair or replace the excluded resource; and
- the person demonstrates good cause when he has not been able to repair or replace the excluded resource within the 18-month period.

If an extension of the time period is made for good cause and the person changes his/her intent to repair or replace the excluded resources, funds previously held for replacement or repair are counted as a resource effective with the month that the person reports this change of intent.

Determine the amount of the payment and the date of receipt. Schedule a special review to monitor for replacement or repair within the period allowed.

Sources for verifying the amount of money received are:

- statement from the payment source;
- copy of the person's check; and
- bank deposit slip.

Sources for verifying replacement or repair of the excluded resources are:

- receipt; or

- repair bill.

F-1300, Resource Limits

Body

Revision 11-4; Effective December 1, 2011

A person or a couple meet resources criteria if the value of all countable resources does not exceed the appropriate established limit.

Individual limit. This limit applies to adults who are single, even if the person lives with relatives. The individual limit also applies to children and to adults whose spouses live in different households. The individual limit also applies to the institutional spouse in spousal impoverishment policy. Use the individual limit for the following:

- An adult person who is not married, even if the person lives with relatives. Consider only the person's own resources.
- A person with a spouse not living in the same household. If the spouse is eligible, consider the person's own resources, plus half the resources owned jointly by the person and spouse. If the spouse is not eligible, consider the person's own resources, plus any jointly owned resources available to the person.
- A child. Consider the child's own resources, plus certain deemed resources of the parents with whom the child lives.
- An institutional spouse using policy in Chapter J, Spousal Impoverishment.

Couple limit. This limit applies to married adults who live in the same household with their spouses, even if the spouses are ineligible. Consider the combined resources of the person and spouse. Use the couple limit for the following:

- A married person living in the same household with his spouse, when both spouses are eligible.
- A married person living in the same household with his spouse, when the spouse is ineligible.

The value of all countable resources must not exceed the following limits:

Year	Individual	Couple
1989 through present	$2000	$3000
1988	$1900	$2850
1987	$1800	$2700
1986	$1700	$2550
1985	$1600	$2400
1984	$1500	$2250

See Section Q-2000, Qualified Medicare Beneficiaries (QMB) – MC-QMB, Medicare Savings Programs (MSP), where the resource limit is higher for certain MSP programs.

If the countable resources are within $100 of the resource limit, set a special review to monitor eligibility. See Section B-8430, Special Reviews.

F-1310 Points in Time for Establishing Resource Values

Revision 19-2; Effective June 1, 2019

The resources in an account as of 12:01 a.m. on the first day of the month are considered a countable resource. Changes in the amount of resources after the first day of the month do not affect what is considered countable resources for that month.

If countable resources exceed the resource limit as of 12:01 a.m. on the first day of the month, a person or couple is not eligible for Medicaid for the entire month. Eligibility may be reestablished no sooner than the first day of the next month.

For applications that require full verification, verify resources as of 12:01 a.m. on the first day of the month for ongoing eligibility and for each of the three preceding months, if applicable.

For community based applications for which client statement is acceptable, verify resources as of 12:01 a.m. on the first day of any one month beginning with date of application through the month of certification. Do not verify resources for any months falling between the date of application and certification date unless there is a change in the total resources.

For all redeterminations, verify resources as of 12:01 a.m. on the first day of:

- the month the redetermination form was received;
- either of the preceding two months before the redetermination form was received; or
- any month between the month the redetermination was received and the month the redetermination is completed.

All resources must be verified as of 12:01 a.m. on the first day of the same month.

Related Policy

Appendix XVI
Applications, B-3000
Eligibility Determination, B-6000
Redeterminations, B-8000

F-1311 Encumbered Funds

Revision 19-1; Effective March 1, 2019

When determining countable resources, a bank account balance may be reduced by the amount of funds encumbered (legally obligated) before 12:01 a.m. on the first day of the month.

Encumbered funds should be explored if the case is going to be denied due to excess resources. The account balance as of 12:01 a.m. on the first day of the month should be reduced by the amount of any outstanding checks that have not been processed by the financial institution.

Eligibility staff must:

- not deny the case before determining if excess resources can be reduced;
- pend using Form H1020, Request for Information or Action, to request verification of any encumbered funds that may reduce the account balance; and
- determine the purpose of the payments for which the checks were written in advance and explore the potential for a transfer of assets.

Payments for legally owed debts, such as health care expenses, or credit card charges and recurring monthly expenses consistent with routine banking activity are not a transfer of resources.

Payments made to reduce the 12:01 a.m. balance for items or services for which a person may not receive compensation, may be a transfer of assets. For example, an institution makes advance payments for future housing expenses made by a person in a nursing facility who is unlikely to return home during that time.

Related Policy

Missing Information Due Dates, B-6420
Failure to Furnish Missing Information, B-6510
Refunds for Payments Before Medicaid Eligibility Approval, F-1312.2
Compensation, I-4100

F-1312 Nursing Facility Payments and Refunds

Revision 16-4; Effective December 1, 2016

Following an individual's approval for Medicaid, a Medicaid-contracted, long-term services and supports facility, such as a nursing facility, must refund any advance payments that exceed an individual's co-payment amount for periods covered by Medicaid. This refund policy also applies to advance payments made to home health agencies for Community Attendant Services recipients.

A Medicaid-contracted, long-term services and supports provider may charge a private pay rate that is different from the Medicaid rate, when Medicaid is not the payer of the bill. This private arrangement may occur:

- during a transfer of assets penalty;
- during a substantial home equity penalty; or
- before Medicaid eligibility is approved.

A Medicaid-contracted, long-term services and supports facility may allow a resident's family or friends to use personal funds to pay an agreed-upon amount, in addition to the Medicaid rate, in order to have a private room. These payments in excess of an individual's co-payment do not need to be refunded. However, for Medicaid eligibility purposes, if the family or friends pay the difference, consider how it is being paid:

- If the money is given directly to the individual to pay the difference between the Medicaid rate and a private room rate, that amount is considered income to the individual.
- If the family or friends pay the facility directly, do not consider the amount paid as income to the individual.

F-1312.1 Payment During a Penalty

Revision 16-4; Effective December 1, 2016

During a transfer of assets or substantial home equity penalty, Medicaid does not pay the long-term services and supports provider. Payments for long-term services and supports are a private arrangement between the recipient and the provider. Private pay rates may be collected during a penalty. In these situations, the individual is not owed a refund when the transfer of assets penalty period ends or there is no longer a substantial home equity penalty.

F-1312.2 Refunds for Payments Before Medicaid Eligibility Approval

Revision 19-1; Effective March 1, 2019

If a person paid a provider private pay rates or a deposit that exceeded the person's co-payment amount, once Medicaid eligibility is approved, and there is no penalty from a transfer of assets or substantial home equity, the excess amount must be refunded for those months Medicaid eligibility is established.

Consider the advance payment as encumbered funds in the resource test for the initial eligibility determination.

Do not consider the refund as income in the month of receipt.

Consider the refund or any remaining part of the refund as a resource as of 12:01 a.m. on the first day of the month after the month of receipt of the refund.

Related Policy

Encumbered Funds, F-1311
Special Reviews, B-8430

F-1400, Deeming of Resources

Body

Revision 09-4; Effective December 1, 2009

The word "deeming," as used in this handbook, means counting all or part of the income or resources of another person (parent or spouse) as income or resources available to the person.

HHSC does not deem income or resources from an alien's sponsor.

F-1410 Deeming for Spouses

Revision 11-4; Effective December 1, 2011

HHSC deems spouse's resources as follows:

- If a married person lives in the same household with an ineligible spouse, HHSC counts both the ineligible spouse's and the person's resources and applies the couple resource limit to the combined countable resources. The spouse's resources are counted even if they are not available to the person.

  Note: Pension funds owned by an ineligible spouse or parent are excluded from resources for deeming purposes. If the ineligible spouse is a TANF caretaker, his resources are not counted. Pension funds are monies held in a retirement fund under a plan administrated by an employer or union, or an individual retirement account (IRA) or Keogh account as described in the Internal Revenue Code.
- An ineligible spouse or parent who is absent from a deeming household solely because of an active duty military assignment continues to be considered a member of the household for resources deeming purposes. If the absent service member's intent to continue living in the household changes, deeming stops beginning with the month following the month in which the intent changed.

If the person does not live in the same household as his ineligible spouse, HHSC does not apply deeming policies. In situations where an institutionalized person has an ineligible spouse also living in a facility, only the person's resources are counted against the individual resource limit. HHSC includes in the person's resources the total amount of checking and savings accounts to which he has access.

Note: Follow joint bank account policy and exclude any separate resources of the ineligible spouse.

Example: Wayne and Ethel Thomas live together in their own home. Wayne was receiving SSI and RSDI as a disabled person. His most recent cost-of-living increase in RSDI benefits made him ineligible for SSI.

The eligibility specialist received Mr. Thomas' application for ME-Pickle. The reported and verified resources were:

Description	Amount
joint checking account with a balance of	$410.00
ownership of the home in which the couple lives	Excluded
1975 automobile	Excluded
savings account in Wayne's name with a balance of	$700.00
savings account in Ethel's name with a balance of	$576.00
The countable resources for Wayne Thomas are less than the couple's resource limit.	$1,686.00

F-1420 Deeming for Children

Revision 11-3; Effective September 1, 2011

Note: Deeming from parents does not apply in certain §1915(c) waiver programs.

Deeming of resources does not apply to Medicaid Buy-In for Children (MBIC). There is no resource test for MBIC.

Regarding deeming for children, HHSC requirements are as follows:

If a disabled child under 18 lives with his parents in the same household, HHSC must deem to the child certain resources of the parents. If a parent is a TANF caretaker or a recipient, his resources are not counted.

An ineligible spouse or parent who is absent from a deeming household solely because of an active duty military assignment continues to be considered a member of the household for resources deeming purposes. If the absent service member's intent to continue living in the household changes, deeming stops beginning with the month following the month in which the intent changed.

To determine the amount of resources deemed to an eligible child, HHSC:

- applies any appropriate resource exclusions to the resources of the parents to determine countable resources. Pension funds owned by a parent are excluded from resources for deeming purposes. See note in Section F-1410, Deeming for Spouses;
- deems to the child any resources in excess of the individual resource limit for one parent or the couple resource limit for two parents. If more than one child is potentially eligible for an SSI-related Medicaid program, the amount to be deemed is equally divided among the otherwise eligible children. None of the parents' resources are deemed to ineligible children; and
- excludes from deeming gifts from tax-exempt organizations to a parent for the benefit of a child with a life-threatening condition, per Public Law 105-306.

A parent is defined as a child's natural or adoptive parent or the spouse of the natural or adoptive parent.

F-2000, Resource Exclusions – Limited and Related to Exempt Income

F-2100, Resource Exclusions – Limited

Body

F-2110 Cash Reimbursement of Medical or Social Services Expenses

Revision 09-4; Effective December 1, 2009

When a person receives a cash reimbursement of medical or social services expenses that the person has already paid, the cash received for the medical or social services is not considered income and is not a resource for the calendar month following the month of its receipt, if the unspent money is identifiable from other resources. The remainder of the cash reimbursement of medical or social services expenses retained until 12:01 a.m. on the first of the second calendar month following its receipt is a resource at that time.

If the money is commingled with other funds and is no longer separately identified, that amount will count toward the resource limit as of the 12:01 a.m. on the first of the month after receipt rather than 12:01 a.m. on the first of the second month after receipt.

F-2120 Death Benefits

Revision 11-4; Effective December 1, 2011

Death benefits, including gifts and inheritances received by a person, are not income in the month of receipt when they are to be spent on costs resulting from the last illness and burial of the deceased, and are not resources for the calendar month following the month of receipt. However, such death benefits retained until the 12:01 a.m. on the first of the second month following their receipt are resources at that time.

Death benefits exceeding the cost of the expenses for the last illness and burial of the deceased, or not used to pay these expenses, are countable income in the month of receipt and resources on the first day of the month following month of receipt.

If death benefits are not excluded as income, they also are not excluded as a resource.

F-2130 Earned Income Tax Credits (EITC)

Revision 09-4; Effective December 1, 2009

An EITC is a special tax credit that reduces the federal tax liability of certain low-income working taxpayers.

Relationship of income to resources. An unspent EITC payment is not counted as a resource for the month after the month the payment or refund is received.

Example: The EITC payment is received in May. The EITC payment is not income in May. The remaining funds from the EITC payment are not a resource as of June 1. Any remaining funds from the EITC payment are

a resource as of the first of July.

F-2140 Hazardous Duty Pay

Revision 09-4; Effective December 1, 2009

Any unspent hostile fire pay or imminent danger pay becomes a resource if retained into the following month and not otherwise excluded.

In a deeming situation, exclude from deemed resources for the nine-month period following the month of receipt the unspent portion of any retroactive payment of:

- hostile fire and imminent danger pay (pursuant to 37 U.S.C. 310) received by the ineligible spouse or parent from one of the uniformed services; and
- family separation allowance (pursuant to 37 U.S.C. 427) received by the ineligible spouse or parent from one of the uniformed services as a result of deployment to or while serving in a combat zone.

F-2150 SSI and RSDI Retroactive Lump Sum Payments

Revision 12-1; Effective March 1, 2012

SSI and RSDI retroactive lump sum payments are excluded from countable resources for nine months after the month of receipt. The exclusion applies only to the lump sum payments. If the recipient spends the payments, the exclusion does not apply to items purchased with the payments unless those items are otherwise excludable. This is true even if the exclusion period has not expired.

Otherwise, excludable funds must be identifiable in order to be excluded. Identifiability does not require that the excluded funds be kept physically apart from other funds (such as in a separate bank account).

HHSC assumes, when withdrawals are made from an account with commingled funds in it, that nonexcluded funds are withdrawn first, leaving as much of the excluded funds as possible in the account. If excluded funds are withdrawn, the excluded funds left in the account can be added to only by:

- deposits of subsequently received funds that are excluded under the same provision; and
- excluded interest.

Interest earned on excluded lump sum payments from SSI and RSDI is exempt income in the month of receipt and a resource thereafter. See Section E-3331.2, Treatment of Interest/Dividends on Certain Excluded or Partially Excluded Resources.

Request the verification of the retroactive payment and all expenditures from it.

The eligibility specialist must document spend down of the lump sum payment and determine countable resources as of the first day of the 10th month after receipt of the lump sum payment.

F-2151 Examples of SSI and RSDI Retroactive Lump Sum Payments

Revision 09-4; Effective December 1, 2009

1. One-time receipt and deposit of excluded funds

   A recipient deposits a $1,000 RSDI check ($800 for the preceding four months and $200 for the current month) in a checking account. The account already contains $300 in nonexcluded funds.
   - Of the new $1,300 balance, $800 is excluded as retroactive RSDI benefits.
   - The recipient withdraws $300. The remaining $1,000 balance still contains the excluded $800.
   - The recipient withdraws another $300, leaving a balance of $700. All $700 is excluded.
   - The recipient deposits $500, creating a new balance of $1,200. Only $700 of the new balance is excluded.
2. Periodic receipt and deposit of excluded funds

   A recipient deposits $200 in excluded funds in a non-interest bearing checking account that already contains $300 in nonexcluded funds.
   - The recipient withdraws $400. The remaining $100 is excluded.
   - The recipient then deposits $100 in nonexcluded funds. Of the resulting $200 balance, $100 is excluded.
   - The recipient next deposits $100 in excludable funds. Of the new $300 balance, $200 is excluded.
3. Interest

   A $1,000 savings account includes $800 in excluded disaster assistance when a $10 interest payment is posted. Since 80% of the account balance is excluded at the time the interest is posted, 80% of the interest ($8) is excluded. The amount of excluded funds now in the account is $808.

F-2160 Gifts to Children with Life-Threatening Conditions

Revision 09-4; Effective December 1, 2009

Gifts from tax-exempt organizations, such as the Make-A-Wish Foundation, to children with life-threatening conditions are excluded as resources.

The exclusion applies to children under age 18. The gift must be from an organization described in Section 501(c)(3) of the Internal Revenue Code of 1986 and that is exempt from taxation under Section 501(c).

The eligibility specialist documents the case record with an oral or written statement from the organization that the gift was made based on the child having a life-threatening condition. No additional medical development is necessary.

The following gifts to or for the benefit of a child described above are excluded from resources:

- Any in-kind gift, not converted to cash.
- A cash gift to the extent that the cash excluded does not exceed $2,000 in any calendar year. Retained cash in excess of $2,000 received in a calendar year is subject to regular resource counting rules.
- If an in-kind gift is converted to cash, any cash remaining in the month following the month converted is a resource. For purposes of this exclusion, an in-kind gift is any gift other than cash, including gifts of food, clothing or shelter.
- The exclusion also applies to a deeming situation if the gift is made to a parent for the benefit of a child with a life-threatening condition.

F-2170 Exclusion of State or Local Relocation Assistance Payments

Revision 09-4; Effective December 1, 2009

State or local relocation assistance payments are excluded from countable resources for nine months after the month of receipt.

F-2200, Resource Exclusions Related to Exempt Income

Body

F-2210 Crime Victims' Compensation

Revision 09-4; Effective December 1, 2009

Unspent payments received from a fund established by a state to aid victims of crime are excluded from resources for nine months. A person is not required to apply for benefits from a crime victims' compensation fund.

F-2220 Certain Designated Accounts

Revision 09-4; Effective December 1, 2009

Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996, requires the representative payees of SSI recipients under age 18 to establish designated accounts when there are retroactive payments for more than six months payable to the recipients. These designated accounts, including accrued interest or other earnings produced by the accounts, are excluded from countable resources. This exclusion was effective Aug. 22, 1996.

Do not count in the eligibility budget or the budget to determine co-payment interest, or other earnings on any designated account established for SSI recipients under age 18 for retroactive benefits, as required by Public Law 104-193, effective Aug. 22, 1996.

F-2230 Certain Health-Related Payments

Revision 10-1; Effective March 1, 2010

The following payments, regardless of when received, are not counted as income and are excluded from resources:

- Payments from the Ricky Ray Hemophilia Relief Fund.
- Payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corporation, as required by Public Law 105-33, effective Aug. 5, 1997.
- Payments to Vietnam veterans' children with spina bifida.
- Payments from the Energy Employees Occupational Illness Compensation Act (EEOICA) (Public Law 106-398, October 2000) for medical benefits and compensation.

See Section E-2440, Certain Health-Related Payments.

F-2240 Indian-Related Exclusions

Revision 09-4; Effective December 1, 2009

If a person or spouse is of Indian descent from a federally recognized Indian tribe, any interests of the person or the person's spouse in trust or restricted lands are excluded from resources.

Many federal statutes provide for the exclusion from income and resources of certain payments made to members of Indian tribes and groups. Some statutes pertain to specific tribes or Indian groups, while others apply to certain types of payments. See the following sections:

- Section E-2140, Native Americans – Exempt Income
- Section E-2141, Types of Payments Excluded Without Regard to Specific Tribes or Groups
- Section E-2142, Payments to Members of Specific Indian Tribes and Groups
- Section E-2143, Receipts from Lands Held in Trust for Certain Tribes or Groups

F-2250 Reparations and Compensation

Revision 09-4; Effective December 1, 2009

HHSC excludes from countable resources the following payments:

- Payments made under Section 6 of the Radiation Exposure Compensation Act, Public Law 101-426 (104 Stat. 925, 42 U.S.C. 2210).
- Payments made to individuals because of their status as victims of Nazi persecution excluded pursuant to Section 1(a) of the Victims of Nazi Persecution Act of 1994, Public Law 103-286 (108 Stat. 1450). This provision supersedes previous provisions for the exclusion of certain payments made by the governments of Germany, Austria and the Netherlands, insofar as they are made to victims of Nazi persecution.

See Section E-2150, Other – Exempt Income.

F-2260 Exclusions from Resources Provided by Other Statutes

Revision 16-3; Effective September 1, 2016

Exclude as a resource funds from the following:

- Payments made under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (84 Stat. 1902, 42 U.S.C. 4636).
- Indian judgment funds held in trust by the Secretary of the Interior or distributed per capita pursuant to a plan prepared by the Secretary of the Interior and not disapproved by a joint resolution of the Congress under Public Law 93-134, as amended by Public Law 97-458 (25 U.S.C. 1407). Indian judgment funds include interest and investment income accrued while the funds are so held in trust. This exclusion extends to initial purchases made with Indian judgment funds. This exclusion will not apply to proceeds from sales or conversions of initial purchases or to subsequent purchases.

- The value of the coupon allotment in excess of the amount paid for the coupons under the Food Stamp Act of 1964 (78 Stat. 705, as amended, 7 U.S.C. 2016(c)).
- The value of assistance to children under the National School Lunch Act (60 Stat. 230, 42 U.S.C. 1751 et seq.) as amended by Public Law 90-302 (82 Stat. 117, 42 U.S.C. 1761(h)(3)).
- The value of assistance to children under the Child Nutrition Act of 1966 (80 Stat. 889, 42 U.S.C. 1780(b)).
- Any grant or loan to any undergraduate student for educational purposes made or insured under any program administered by the commissioner of education, as provided by Section 507 of the Higher Education Amendments of 1968, Public Law 90-575 (82 Stat. 1063).
- Incentive allowances received under Title I of the Comprehensive Employment and Training Act of 1973 (87 Stat. 849, 29 U.S.C. 821(a)).
- Compensation provided to volunteers by the Corporation for National and Community Service (CNCS), unless determined by the CNCS to constitute the minimum wage in effect under the Fair Labor Standards Act of 1938 (29 U.S.C. 201 et seq.), or applicable state law, pursuant to 42 U.S.C. 5044(f)(1).
- Distributions received by an individual Alaska Native or descendant of an Alaska Native from an Alaska Native Regional and Village Corporation pursuant to Section 15 of the Alaska Native Claims Settlement Act, Amendments of 1987, Public Law 100-241 (43 U.S.C. 1626(c)), effective Feb. 3, 1988, as follows:
    - cash, including cash dividends on stock received from a native corporation, is disregarded to the extent that it does not, in the aggregate, exceed $2,000 per individual each year (the $2,000 limit is applied separately each year, and cash distributions up to $2,000 which an individual received in a prior year and retained into subsequent years will not be counted as resources in those years);
    - stock, including stock issued or distributed by a native corporation as a dividend or distribution on stock;
    - a partnership interest;
    - land or an interest in land, including land or an interest in land received from a native corporation as a dividend or distribution on stock; and
    - an interest in a settlement trust.
- Value of federally donated foods distributed pursuant to Section 32 of Public Law 74-320 or Section 416 of the Agriculture Act of 1949 (7 CFR 250.6(e)(9), as authorized by 5 U.S.C. 301).
- All funds held in trust by the Secretary of the Interior for an Indian tribe and distributed per capita to a member of that tribe under Public Law 98-64. Funds held by Alaska Native Regional and Village Corporations (ANRVC) are not held in trust by the Secretary of the Interior and therefore ANRVC dividend distributions are not excluded from resources under this exclusion. For the treatment of ANRVC dividend distributions, see paragraph (a)(10) of this section.
- Home energy assistance payments or allowances under the Low-Income Home Energy Assistance Act of 1981, as added by Title XXVI of the Omnibus Budget Reconciliation Act of 1981, Public Law 97-35 (42 U.S.C. 8624(f)).
- Student financial assistance for attendance costs received from a program funded in whole or in part under Title IV of the Higher Education Act of 1965, as amended, or under Bureau of Indian Affairs student assistance programs if it is made available for tuition and fees normally assessed a student carrying the same academic workload, as determined by the institution, including costs for rental or purchase of any equipment, materials or supplies required of all students in the same course of study; and an allowance for books, supplies, transportation and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution, under Section 14(27) of Public Law 100-50, the Higher Education Technical Amendments Act of 1987 (20 U.S.C. 1087uu), or under Bureau of Indian Affairs student assistance programs.
- Amounts paid as restitution to certain individuals of Japanese ancestry and Aleuts under the Civil Liberties Act of 1988 and the Aleutian and Pribilof Islands Restitution Act, Sections 105(f) and 206(d) of Public Law 100-383 (50 U.S.C. app. 1989 b and c).
- Payments made on or after Jan. 1, 1989, from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.) under Public Law 101-201 (103 Stat. 1795) and Section 10405 of Public Law 101-239 (103 Stat. 2489).

- Payments made under Section 6 of the Radiation Exposure Compensation Act, Public Law 101-426 (104 Stat. 925, 42 U.S.C. 2210).
- Payments made to individuals because of their status as victims of Nazi persecution excluded pursuant to Section 1(a) of the Victims of Nazi Persecution Act of 1994, Public Law 103-286 (108 Stat. 1450). This provision supersedes previous provisions for the exclusion of certain payments made by the governments of Germany, Austria and the Netherlands, insofar as they are made to victims of Nazi persecution. Payments from:
    - Germany are identified with the acronym ZRBG;
    - the Netherlands are identified with the acronym WUV; and
    - Austria that are exempt are identified as DIE BEGUENSTIGUNGSVORSCHRIFTEN FUER GESCHAEDIGTE AUS POLITISCHEN ODER RELIGIOESEN GRUENDEN ODER AUS GRUENDEN DER ABSTAMMUNG WURDEN ANGEWENDET (§500FF ASVG), which translates to "The regulations which give preferential treatment for persons who suffered because of political or religious reasons or reasons of origin were applied (§500ff ASVG)."
- Any matching funds and interest earned on matching funds from a demonstration project authorized by Public Law 105-285 that are retained in an Individual Development Account, pursuant to Section 415 of Public Law 105-285 (112 Stat. 2771).
- Any earnings, Temporary Assistance for Needy Families matching funds, and accrued interest retained in an Individual Development Account, pursuant to Section 103 of Public Law 104-193 (42 U.S.C. 604(h)(4)).
- Payments made to individuals who were captured and interned by the Democratic Republic of Vietnam as a result of participation in certain military operations, pursuant to Section 606 of Public Law 105-78 and Section 657 of Public Law 104-201 (110 Stat. 2584).
- Payments made to certain Vietnam veterans' children with spina bifida, pursuant to Section 421 of Public Law 104-204 (38 U.S.C. 1805(d)).
- Payments made to the children of women Vietnam veterans who suffer from certain birth defects, pursuant to Section 401 of Public Law 106-419 (38 U.S.C. 1833(c)).
- For the nine months following the month of receipt, any unspent portion of any refund of federal income taxes under Section 24 of the Internal Revenue Code of 1986 (relating to the child care tax credit), pursuant to section 431 of Public Law 108-203 (118 Stat. 539).

In order for payments and benefits to be excluded from resources, such funds must be segregated and not commingled with other countable resources so that the excludable funds are identifiable.

F-2270 Exclusions from Resources Related to Disaster Payments

Revision 10-1; Effective March 1, 2010

If precipitated by an emergency or a major disaster, do not consider the following as a resource:

- Payments received under the Disaster Relief Act of 1974 (P.L. 93-288, Section 312(d)), as amended by the Disaster Relief and Emergency Assistance Amendments of 1988 (P.L. 100-707, Section 105(i)) and disaster assistance comparable to these payments provided by states, local governments and disaster assistance organizations.
- Payments from the Federal Emergency Management Agency (FEMA), Individual and Family Grant Assistance program (IFG), grants or loans by the Small Business Administration (SBA), voluntary disaster assistance organizations, such as the Red Cross, or private insurance payments for losses due to a major disaster such as flood, wind, land movement.
- Each payment made to farmers under the Disaster Assistance Act of 1988 (P.L. 100-387) for crop losses or failure in a disaster.
- Income received from public and private organizations by individuals working in disaster relief efforts and funded under a National Emergency Grant by WIA, Title 1 (P.L. 105-220).

- Disaster Unemployment Assistance.
- Payments for flood mitigation received by a homeowner under the National Flood Insurance Act of 1968, as amended by P.L. 109-64.

In order for payments and benefits to be excluded from resources, such funds must be segregated and not commingled with other countable resources so that the excludable funds are identifiable. Interest earned on disaster assistance is excluded from resources.

Government payments designated for the restoration of a home damaged in a disaster are excluded as income or resources in the month of receipt and as a resource in subsequent months, if the household is subject to a legal sanction if the funds are not used as intended.

For treatment of exempt income from disaster payments, see Section E-2360, Payment Treated Like Other Exemptions.

F-2300, Additional Resource Exclusions

Body

F-2310 Achieving a Better Life Experience (ABLE)

Revision 16-4; Effective December 1, 2016

An Achieving a Better Life Experience (ABLE) program allows an individual with a disability or family members of the individual to establish a tax-free savings account to maintain health, independence and quality of life for the benefit of the individual with a disability. The individual must meet the criteria of the state's ABLE program in which the individual enrolls. The ABLE account funds can be used for the individual's disability-related expenses, which supplement, but do not replace, private insurance and/or public assistance.

Funds held in an ABLE account are excluded from countable resources when determining eligibility.

Note: For Supplemental Security Income (SSI), ABLE account balances over $100,000 are countable resources to the designated beneficiary and could result in suspension of SSI cash benefits. The individual retains Medicaid eligibility if the excess balance does not cause the individual to exceed the SSI resource limit. Due to the limitation on annual contributions, ABLE account balances will not result in SSI suspensions for several years.

Request information to verify an ABLE account. Verification must include the following information:

- name of the designated beneficiary;
- state ABLE program administering the account;
- name of the person who has signature authority (if different from the designated beneficiary);
- name of the financial institution; and
- ABLE account number.

Verification documents may vary among states. Examples of acceptable documentation include participation agreements, ABLE account contracts, financial statements, and annual income tax filing documents.

F-2320 School-Based Savings Accounts

Revision 16-4; Effective December 1, 2016

School-Based Savings Accounts are accounts set up by students or their parents at financial institutions that partner with school districts. Individuals may set up school-based savings programs through savings accounts, Certificates of Deposit (CDs), Series I savings bonds, and Tuition Savings Plans under IRS Code, Section 529 or U.S.C. Section 530.

Funds in School-Based Savings Accounts are excluded up to an amount set by the Texas Higher Education Coordinating Board (THECB) each year. The current excludable amount is $11,896. Any excess over the excluded amount counts as a resource.

Note: This amount will be updated annually.

F-3000, Home

Body

Revision 21-1; Effective March 1, 2021

The value of a home that is a person's or the person's spouse's principal place of residence is not a resource of the person or the spouse.

A home is a structure in which a person lives (including mobile homes, houseboats and motor homes), other buildings and all adjacent land.

Note: The words home and homestead can be used interchangeably in this section.

A home is a structure in which the person or the person's spouse lives. All land adjacent to the home includes any land separated by roads, rivers or streams. Land is adjacent as long as it is not separated by intervening property owned by another person. This means all the land associated with the home, whether or not there is a business operated in connection with the home or property.

Adjacent property is a part of the home even if there is more than one document of ownership (for example, separate deeds), the home was obtained at a different time from the rest of the land or the holdings are assessed and taxed separately.

Home property may be jointly owned, or ownership may be in the form of a life estate or interest in an intestate estate.

For property to be considered a home for Medicaid eligibility purposes, the person or spouse must consider the property to be their home and:

- have ownership interest in the property; and
- reside in the property while having ownership interest.

F-3100, The Home and Resource Exclusions

Body

Revision 10-1; Effective March 1, 2010

An exclusion to the home as a countable resource is possible if the person or spouse has ownership interest in the property and the property currently is the principal place of residence of either the person or the spouse. Exclude the property as a home even if the person leaves the home without the intent to return as long as a spouse or dependent relative of the person continues to live in the property.

If a non-institutionalized person is a victim of domestic abuse and is fleeing from an abusive situation, exclude the property as a home even if the person leaves the home without the intent to return but still maintains an ownership interest in an otherwise excluded home. Continue this exclusion until the non-institutionalized person establishes a new principal place of residence or takes other action rendering the home no longer excludable.

F-3110 Principal Place of Residence

Revision 09-4; Effective December 1, 2009

An exclusion to the home as a countable resource is possible if the person or spouse has ownership interest in the property and the property currently is the principal place of residence of either the person or the spouse. Exclude the property as a home even if the person leaves the home without the intent to return as long as a spouse or dependent relative of the person continues to live in the property.

F-3111 The Home as the Principal Place of Residence

Revision 19-2; Effective June 1, 2019

Only one place may be established as a person's or couple's principal place of residence. If the person or couple lives in more than one place or owns more than one residence, they must designate only one as their principal place of residence.

If the person or couple is unable to make this decision, and they have a guardian or authorized representative, make the determination based on the statements provided by the guardian or AR and:

- the address the person or couple uses on their voter registration, federal benefits, federal income tax returns; or
- the home that's listed in the appraisal district property records as the homestead.

The home can be real or personal property, fixed or mobile, and located on land or water.

The property ceases to be the principal place of residence and not excludable as the home as of the date the person or couple leaves the home if they do not intend to return to it.

Note: Form H1245, Statement of Intent to Return Home, should reflect the property the person or couple chooses to exclude as their homestead.

Related Policy

The Home and Resource Exclusion, F-3100
Principal Place of Residence, F-3110
Intent to Return Home, F-3120
Intent to return Home Policy, F-3121

F-3112 Spouse or Dependent Relative Living in the Home

Revision 09-4; Effective December 1, 2009

See also Section F-3500, Out-of-State Home Property.

If a person lives in a long-term care facility and his or her spouse or dependent relative lives in the person's principal place of residence, the home is not considered an available resource.

A relative is a son, daughter, grandson, granddaughter, stepson, stepdaughter, half sister, half brother, grandmother, grandfather, in-laws, mother, father, stepmother, stepfather, aunt, uncle, sister, brother, stepsister, stepbrother, nephew or niece. A dependent relative is one who was living in the person's home before the person's absence and who is unable to support himself/herself outside of the person's home due to medical, social or other reasons.

See Appendix XVI, Documentation and Verification Guide.

F-3120 Intent to Return Home

Revision 13-4; Effective December 1, 2013

An exclusion to the home as a countable resource is possible if the person or spouse has ownership interest in the property, the property was the principal place of residence of either the person or the spouse while having ownership interest, and the person and spouse no longer live there but intend to return to the home.

The primary evidence of intent to return home is the applicant's/recipient's statement, as documented on a signed Form H1245, Statement of Intent to Return Home, or a comparable written statement from the applicant's/recipient's spouse or authorized representative.

F-3121 Intent to Return Policy

Revision 14-4; Effective December 1, 2014

Consider intent to return policy if the person:

- has ownership interest in the property, and
- previously resided in the property while having ownership interest.

The primary evidence of intent to return home is the applicant's/recipient's statement, as documented on a signed Form H1245, Statement of Intent to Return Home, or a comparable written statement from the applicant's/recipient's spouse or authorized representative.

The property cannot be excluded as a home with intent to return if the person:

- has ownership interest in the property, but
- has not resided in the property while having ownership interest.

Exception: If a home was excluded for intent to return and the individual purchases a replacement home, the replacement home retains that exclusion even if the individual has not physically occupied the new home.

Exclude the property as a home even if the person leaves the home without the intent to return, as long as a spouse or dependent relative of the person continues to live in the property.

See Section F-3400, Replacement of the Home; Section F-3500, Out-of-State Home Property; and Section F-3121.1, Temporary Absence from the Home.

F-3121.1 Temporary Absence from the Home

Revision 09-4; Effective December 1, 2009

Absences from home for trips, visits and medical treatment do not affect the home exclusion as long as the person continues to consider the home to be his or her principal place of residence and intends to return home. If a person owns a residence but lives elsewhere, HHSC determines whether the person continues to consider the home to be his/her principal place of residence and whether he/she intends to return.

See Appendix XVI, Documentation and Verification Guide.

F-3130 Home and Other Real Property Placed for Sale

Revision 16-3; Effective September 1, 2016

The value of real property, including a home, life estates and remainder interests in the property, is exempt if the person places the property for sale. The exemption continues until the proceeds of the sale are available to the person.

Reasonable efforts to sell the property require the individual take all necessary steps to sell it. Reasonable efforts to sell property include:

- listing the property with a local real estate agent; or
- advertising in local media, placing a "For Sale" sign on the property, conducting open houses, and showing the property to interested parties.

An individual must accept an offer to buy the property that is at least two-thirds of the current market value of the property. If an offer is rejected, the individual must present evidence that proves the offer is unreasonable and that the individual is continuing to make reasonable efforts to sell the property.

The value of the resource is not counted until the proceeds of the sale are available. See Section F-1260, Conversion of Resources, for treatment from the proceeds of a sale of a resource. Determination of resources is completed as of 12:01 a.m. on the first day of the month. However, if the individual is purchasing a replacement home, the proceeds of the sale of the original home are not countable resources for three full months following the month of receipt.

See Section F-3400, Replacement of the Home.

Note: This policy also applies to out-of-state home property. See Section F-3500, Out-of-State Home Property.

F-3200, The Home and Resources in a Trust

Body

Revision 09-4; Effective December 1, 2009

If the home property is in an irrevocable or revocable trust ("Living Trust"), see Section F-3300, The Home as a Countable Resource.

F-3210 Treatment of a Home in a Revocable or Living Trust

Revision 09-4; Effective December 1, 2009

A home placed in a revocable or living trust (or similar type trust) loses the exclusion as a homestead and becomes a countable resource based on trust policy found in Section F-6400, Revocable Trusts.

Note: If the home is in an irrevocable trust, see Section F-6500, Irrevocable Trusts. Seek agency legal evaluation of the trusts and their treatment.

Presume the tax value as the countable value of the property in a revocable trust when making a determination of countable resources. The person has a right to rebut the presumed value and provide verification of the equity value.

Note: The fair market value (FMV) of a resource is the going price for which it can reasonably be expected to sell on the open market in the particular geographic area involved. Equity value (EV) is the FMV of a resource minus any encumbrance on it. An encumbrance is a legally binding debt against a specific property. Such a debt reduces the value of the encumbered property, but does not have to prevent the property owner from transferring ownership (selling) to a third party. However, if the owner of encumbered property does sell it, the creditor will nearly always require debt satisfaction from the proceeds of sale.

If the homestead property is removed from the revocable trust (or the trust is dissolved), the person may be able to re-establish the property as a homestead. Also see Section F-3121.1, Temporary Absence from the Home.

F-3211 Re-established Intent to Return Home

Revision 09-4; Effective December 1, 2009

Intent to return home must be re-established if the homestead property is removed from the revocable trust (or the trust is dissolved). A completed Form H1245, Statement of Intent to Return Home, or the response on the application is used to establish and designate the homestead property.

If the property is designated as homestead property, determine the home equity value of the property and follow policy in Section F-3600, Substantial Home Equity.

If the person takes action to remove the home property from the trust, the medical effective date cannot precede the first of the month after the date the home was officially removed from the trust.

Example: Due to the countable home property in a revocable trust, Mr. Jones has excess resources January of this year and is not eligible. Mr. Jones removes the home from the living trust on March 10 of this year. Mr. Jones re-applies for Medicaid on March 15 of this year. Due to the countable home property in a revocable trust, Mr. Jones has excess resources as of 12:01 a.m. on the first day of January, February and March. The medical effective date can be no earlier than April 1 of this year.

F-3300, The Home as a Countable Resource

Body

Revision 09-4; Effective December 1, 2009

Count the equity value in the reported home property if the home property:

- does not meet homestead criteria (see Section F-3100, The Home and Resource Exclusions);
- is in a revocable trust; or
- meets homestead criteria, but cannot be excluded as a resource based on any of the following exclusion reasons:
  - principal place of residence (see Section F-3111, The Home as the Principal Place of Residence);
  - intent to return home (see Section F-3120, Intent to Return Home); or
  - home is placed for sale (see Section F-3130, Home Placed for Sale)

See also Section F-3500, Out-of-State Home Property.

Note: If the home is in an irrevocable trust, see Section F-6500, Irrevocable Trusts. Follow regional procedures to request assistance from HHSC Legal regarding the terms and conditions of trusts. See Appendix XVI, Documentation and Verification Guide.

F-3400, Replacement of the Home

Body

Revision 14-4; Effective December 1, 2014

If a person is purchasing a replacement home, the proceeds of the sale of the original home are not countable resources for three full months following the month of receipt. For example, if the person received the proceeds on Jan. 13, the exclusion period ends April 30. There are no extensions.

Expenses related to selling the original home and purchasing and occupying the replacement home are deducted from the proceeds. Allowable costs for selling the home include broker fees; commissions; legal fees; mortgage-related fees, such as "points" paid by the seller; inspection and settlement fees; and transfer and other accrued taxes paid by the seller. The person does not have to have paid allowable costs for purchasing and occupying the replacement home by the end of the exclusion period, but the person must have obligated himself to pay them. Allowable costs include down payments; settlement costs; loan processing fees and points; moving expenses; costs of necessary repairs or replacements to the replacement home's existing structure or fixtures, such as furnace, plumbing and built-in appliances; and mortgage payments on the replacement home for periods before occupancy.

Any proceeds in excess of the cost of replacing and occupying the home are countable resources.

If the original home was excluded for intent to return, the replacement home retains that exclusion even if the individual has not physically occupied the new home.

See Section F-3121, Intent to Return Policy.

F-3500, Out-of-State Home Property

Body

Revision 09-4; Effective December 1, 2009

With the following exceptions, a person who applies for and receives Medicaid benefits in Texas is not allowed to exclude a home in another state. Otherwise, if the person considers his home in another state to be his principal place of residence, he is not a Texas resident, and he must apply for assistance in his home state.

If the community spouse lives in another state in a house that the person claims is not his homestead, to determine the protected resource amount and initial eligibility, HHSC excludes the out-of-state property as a part of resources totally excluded regardless of value. If the person still has an ownership interest in the property at the first annual redetermination, HHSC considers the value of the property a countable resource that is real property. This situation does not affect residency requirements. As long as the institutionalized spouse intends to remain in the state where he is institutionalized, he is considered a resident.

If the community spouse lives in another state in a house that is the person's homestead, the home is excluded in the resource assessment and throughout the initial eligibility period of 12 months. If the person still has an ownership interest in the property at the first annual redetermination, the home is a countable resource. If the community spouse is not living in the out-of-state home, the community spouse must sign a statement of intent to return for the home to be excluded for the resource assessment and initial eligibility period of 12 months.

If there is no community spouse, the out-of-state home property is a countable resource unless it is placed for sale. If there is no community spouse, the home is not placed for sale, and the person considers his home in another state to be his principal place of residence, the person is not a Texas resident; he must apply for Medicaid in his home state. If the person does not consider the out-of-state home as his principal place of residence, it is a countable resource.

See Section F-3130, Home Placed for Sale.

F-3600, Substantial Home Equity

Body

Revision 21-1; Effective March 1, 2021

As part of Public Law 109-171, Deficit Reduction Act of 2005 (DRA), a person with a home whose equity interest in the home exceeds the established limit is not eligible for vendor payment in an institution or for Home and Community-Based Services (HCBS) waiver services.

Exception: If the person's spouse, child or adult child with a disability is living in the home, substantial home equity policy does not apply.

Treatment of a homestead as a resource in Section F-3000, Home, continues but does not impact the disqualification determination for vendor payment in an institutional setting, or denial of HCBS waiver services or services in a state supported living center or a state center due to substantial home equity.

Once eligibility for services in an institutional setting is determined, consider if the equity value of the home disqualifies the person for vendor payment in a Medicaid-certified long-term care facility. When eligibility for HCBS waiver services or services in a state supported living center or a state center is requested, consider if the equity value in the home results in denial.

Home Equity Treatment

For a person who is determined eligible for Medicaid in an institutional setting based on an application filed on or after Jan. 1, 2006, the person is not eligible for Medicaid for services in an institutional setting if the equity interest in their home exceeds $603,000 (this dollar amount may increase from year to year based on the percentage increase in the consumer price index (CPI) for all urban consumers (all items; United States city average), rounded to the nearest $1,000).

Substantial home equity policy does not apply if either of the following lawfully resides in the person's home:

- the person's spouse; and
- the person's child, if the child is under 21, or is blind or permanently and totally disabled as defined by SSA.

This policy does not prevent a person from using a reverse mortgage or home equity loan to reduce the total equity interest in their home.

The secretary of the U.S. Department of Health and Human Services shall establish a process to waive this policy in the case of a demonstrated hardship.

F-3610 Persons Impacted by Substantial Home Equity Disqualification

Revision 21-1; Effective March 1, 2021

Substantial home equity disqualification policy impacts any person who is:

- Medicaid-eligible in the community and requests a program transfer for Medicaid in an institutional setting or Medicaid for home and community-based waiver services;
- Residing in an institutional setting and applying for Medicaid; or
- Applying for home and community-based waiver services.

  This includes:
  - Applicants — For initial applications, consider substantial home equity disqualification policy for the first determination of eligibility.
  - Program transfer requests — For program transfer requests from any Medicaid program to Medicaid in an institutional setting, consider substantial home equity disqualification policy for the determination of eligibility.
  - Redeterminations — For redeterminations, consider substantial home equity disqualification policy at all redeterminations.
  - Reported changes in homestead status — For reported changes in homestead status, consider substantial home equity disqualification policy.

Notes:

- Substantial home equity disqualification affects payments for Medicaid-certified long-term care facility services (nursing facility care, ICF/IID vendor services, care in a state supported living center or a state center, and care in institutions for mental diseases) and eligibility for Home and Community-Based Services (HCBS) waiver services.
- People who are getting Medicaid-certified long-term care facility services (nursing facility care, ICF/IID vendor services, care in institutions for mental diseases) remain eligible for all other Medicaid benefits and continue to get Medicaid benefits other than vendor payment for as long as the equity value of the home exceeds the limit. People in a state supported living center or a state center or who get HCBS waiver services are not eligible for benefits.
- For people in a state supported living center or a state center, Medicaid eligibility is denied for any period when the equity value of the home exceeds the limit. This is because the only benefit the person receives is vendor payments.
- If the HCBS waiver program requires receipt of waiver services, the HCBS waiver person is ineligible for all Medicaid benefits. Based on substantial home equity disqualification policy, a HCBS waiver applicant is ineligible as long as the equity value of the home exceeds the limit.

- Denial based on substantial home equity disqualification does not disqualify a person for Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) benefits. If the person meets all eligibility criteria for QMB or SLMB, certify the person, as appropriate.
- At all complete redeterminations, evaluation of substantial home equity is required for all recipients in an institutional setting. At redetermination, the appreciation of home equity could result in disqualification or denial if the home equity value exceeds the limit.

The substantial home equity limit is:

Effective Date	Limit
Jan. 1, 2021 to present	$603,000
Jan. 1, 2020 to Dec. 31, 2020	$595,000
Jan. 1, 2019 to Dec. 31, 2019	$585,000
Jan. 1, 2017 to Dec. 31, 2018	$572,000
Jan. 1, 2017 to Dec. 31, 2017	$560,000
Jan. 1, 2016 to Dec. 31, 2016	$552,000
Jan. 1, 2015 to Dec. 31, 2015	$552,000
Jan. 1, 2014 to Dec. 31, 2014	$543,000
Jan. 1, 2013 to Dec. 31, 2013	$536,000
Jan. 1, 2012 to Dec. 31, 2012	$525,000
Jan. 1, 2011 to Dec. 31, 2011	$506,000
Jan. 1, 2006 to Dec. 31, 2010	$500,000

F-3620 Persons Not Impacted by Substantial Home Equity Disqualification

Revision 09-4; Effective December 1, 2009

Any person who has a date of application or program transfer request date for Medicaid in an institutional setting before Jan. 1, 2006, and who has continued to receive services with no break in coverage will not be impacted by the value of the home equity.

Regardless of the date of application or program transfer request date, any person who has either a spouse, minor child or disabled adult child residing in the home will not be impacted.

F-3630 When the Equity Value is Greater Than the Limit

Revision 09-4; Effective December 1, 2009

If an institutionalized person has a home with equity value greater than the limit, follow notice and procedures in Appendix XXIII, Procedure for Designated Vendor Number to Withhold Vendor Payment, and indicate on Form H3618-A, Resident Transaction Notice for Designated Vendor Numbers, the vendor number 5988 for the Home Equity Manor. Unlike a transfer of assets penalty period, there is no end date for Home Equity Manor unless the home equity value changes to be less than or equal to the limit. When the person's home equity value is less than or equal to the limit, do not impose this penalty.

A person applying for waiver services or requesting a program transfer to waiver services, who has home equity greater than the limit and does not have a spouse, child or disabled adult child living in the home, is not eligible for waiver services. A person must receive waiver services to be eligible for a waiver program. Follow current denial procedures for the applicable Home and Community-Based Services waiver program. Determine if the person is eligible for Medicaid programs other than Home and Community-Based Services waiver services.

F-3640 Reverse Mortgage or Home Equity Loan

Revision 09-4; Effective December 1, 2009

A person may use a reverse mortgage or home equity loan to reduce the person's total equity interest in the home. If the person has a reverse mortgage or home equity loan, consider this in determining countable home equity.

Based on conversion of a resource policy (see Section F-1260, Conversion of Resources), do not consider funds from the reverse mortgage or home equity loan as a countable resource or income in the month of receipt. Any remaining funds from a reverse mortgage or home equity loan become a countable resource as of 12:01 a.m. on the first day of the month after the month of receipt.

Although the funds are not considered a countable resource or income during the month of receipt, consider transfer of assets policy if the funds from a reverse mortgage or home equity loan are transferred during the month of receipt.

The money received is a countable resource the month after receipt. See Section F-4150, Promissory Notes, Loans and Property Agreements. Consider transfer of assets policy if the funds from a reverse mortgage or home equity loan are transferred after the month of receipt.

Follow regional procedures to request assistance from HHSC Legal regarding the terms and conditions of reverse mortgage or home equity loan information to assist in determining the appropriate amount of the reduction in home equity value.

F-3650 Documentation

Revision 09-4; Effective December 1, 2009

Obtain verification of home equity value, including a copy of the reverse mortgage or home equity loan, for the case record. Thoroughly document in case comments the home equity value and information about the reverse mortgage or home equity loan, if applicable.

F-3660 Undue Hardship

Revision 09-4; Effective December 1, 2009

Undue hardship may be considered when a person is impacted by the substantial home equity policy. Use the transfer of asset hardship criteria for undue hardship consideration due to substantial home equity policy. See Chapter I, Transfer of Assets, for undue hardship.

F-3700, Continuing Care Retirement Communities

Body

Revision 10-1; Effective March 1, 2010

A continuing care retirement community (CCRC) offers life care to a person in one setting. For example, the facility may accommodate independent living, assisted living and nursing care as a person's needs change. A person may be required to pay a substantial entrance fee as a prerequisite to admission to a CCRC.

For purposes of determining a person's eligibility for, or amount of, benefits under the State Plan, this policy applies to persons residing in CCRCs or life care communities that collect an entrance fee on admission from such persons.

A person's entrance fee in a CCRC or life care community is considered a resource available to the person to the extent that:

- the person has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the person be insufficient to pay for such care;
- the person is eligible for a refund of any remaining entrance fee when the person dies or terminates the CCRC or life care community contract and leaves the community; and
- the entrance fee does not confer an ownership interest in the CCRC or life care community.

Treat an entrance fee to a CCRC as a countable resource of a person applying for Medicaid in an institutional setting on or after Oct. 1, 2006, if the entrance fee meets all of the following requirements:

- Person can use the fee to pay for care.
- Person is eligible for a refund of any remaining fee upon death or leaving the CCRC.
- Entrance fee does not confer an ownership interest in the CCRC.

The countable amount of the resource is the entrance fee value, minus the amount of the entrance fee spent on care.

If there is a community spouse, consider the countable entrance fee amount in the computation of the spousal share.

If an applicant for Medicaid in an institutional setting has a CCRC contract, obtain a copy for the case record and document the following elements in case comments:

- CCRC contract date;
- CCRC facility name;
- CCRC entry date;
- resource accessible (yes/no);
- contract specifies fee be used to pay for care (yes/no);
- eligible for refund on termination of contract or departure from the CCRC (yes/no);
- CCRC entrance fee value;
- amount of entrance fee spent on care; and
- refundable amount.

See Section E-3331, Interest and Dividends.

F-3800, The Home and Transfer of Assets

Body

Revision 09-4; Effective December 1, 2009

For treatment of all transfers of assets, consider common elements to transfer, including but not limited to, the following:

- Look-back period
- Person participation in transfers
- Exceptions to the transfer of assets
- Spouse-to-spouse transfers under spousal impoverishment provisions
- Rebuttal of the presumption
- Compensation
- Undue hardship
- Return of transferred asset

See policy beginning in Chapter I, Transfer of Assets.

F-3810 Transfer of an Excluded Home Cancels the Exclusion

Revision 09-4; Effective December 1, 2009

If a person who is not living in the home transfers ownership of his/her home for less than market value while it is excluded because of his intent to return, the transfer automatically nullifies the exclusion.

Ownership of property is evaluated as of 12:01 a.m. on the first day of the month. Changes related to resources after the first day of the month become effective as of 12:01 a.m. on the first day of the following month.

Example: Mr. Holmes owns a home. The value of the home is excluded from countable resources because of intent to return. During the middle of this month, Mr. Holmes transfers full ownership in his home to his grandson. Resource value of the home for this month is $0 because as of 12:01 a.m. the home was an excluded resource. Resource value of the home for next month is $0 because Mr. Holmes no longer has ownership in the home. After evaluating the transfer of the home to the grandson, this transfer does not meet any of the exceptions for a transfer outlined in Chapter I, Transfer of Assets, for exceptions to the transfer of assets. First, consider Mr. Holmes' equity value in the home as of 12:01 a.m. this month. Next, consider the amount of compensation Mr. Holmes received. The difference is the uncompensated value of the transfer on which the penalty would be based.

F-3811 Person Retains Some Interest

Revision 09-4; Effective December 1, 2009

Because ownership of property may be in whole or in part, if the person owns a home and gives it away during the look-back period, but retains an undivided partial interest or life estate in the property, evaluate the transaction for transfer of assets.

First, consider the person's equity value in the home as of 12:01 a.m. during the month of transfer. Next, consider the value of the retained undivided partial interest or life estate effective as of 12:01 a.m. during the month of transfer. The difference between the equity value and the value of the retained undivided partial interest or life estate is the presumed uncompensated transfer.

To determine the value of the retained undivided partial interest or life estate, take the following steps:

1. Use the age of the person at the time of transfer.
2. Use Appendix X, Life Estate and Remainder Interest Tables, to find the corresponding life estate interest factor.
3. Multiply the corresponding life estate interest factor by the person's equity value in the home as of 12:01 a.m. during the month of transfer.
4. The result is the value of the life estate.
5. Subtract the equity value from the life estate value for the presumed uncompensated amount of transfer.

Example: Mr. House's equity value in the home as of 12:01 a.m. during the month of transfer was $200,000. Mr. House was age 72 during the month of the transfer. The corresponding life estate interest factor is .57261. The value of the life estate at the time of transfer is $200,000 × .57261 = $114,522. The difference between the equity value and the life estate is $200,000 − $114,522 = $85,478 presumed uncompensated transfer.

A person has a right to rebut the determination of the value of the retained undivided partial interest or the life estate as well as the presumed uncompensated transfer.

If the person owns a home and gave it away before the look-back period, but retained an undivided partial interest or life estate in the property, the person may be able to exclude the life estate based on the exclusions allowable for a home discussed in Section F-3100, The Home and Resource Exclusions.

See Appendix XVI, Documentation and Verification Guide.

F-4000, Liquid and Nonliquid Resources

Body

Revision 20-1; Effective March 1, 2020

Resources generally are categorized as either "liquid" or "nonliquid." The difference between the two types of resources is important when determining if a resource can be excluded as non-business property essential to self-support. See Section F-4300, Resources Essential to Self-Support.

Liquid resources are cash or other assets, which can be converted to cash within 20 workdays.

Nonliquid resources consist of real and personal property, as well as financial instruments that cannot be converted to cash within 20 workdays (excluding holidays).

Ownership of real or personal property can include either sole possession or a partial interest.

Real property includes, but is not limited to:

- land;
- houses or immovable objects permanently attached to the land, whether associated with the home or separate from the home;
- mineral rights;
- burial spaces; and
- life estates.

Personal property includes, but is not limited to:

- automobiles and other motor vehicles,
- household goods and personal effects, and
- insurance.

Equity is the fair market value of the resource minus all money owed on it. Evaluate nonliquid resources, with the exception of some automobiles, according to their equity value.

F-4100, Types of Liquid Resources

Body

F-4100 Types of Liquid Resources

Revision 10-3; Effective September 1, 2010

Liquid resources are cash or other assets, which can be converted to cash within 20 workdays.

Examples of resources that are ordinarily liquid are:

- Annuities (see Section F-7000, Annuities)
- Bonds
- Cash
- Financial institutions accounts (including savings, checking and time deposits, also known as certificates of deposit)
- Life insurance policies
- Loans
- Mortgages
- Mutual fund shares
- Promissory notes
- Retirement accounts (including individual retirement accounts and 401(k) accounts)
- Stocks
- Trusts, including revocable trusts and trusts in which the person can direct the use of the funds

Presume that these assets (and similar financial accounts and instruments) can be converted to cash within 20 workdays and are countable as resources. However, some liquid resources are not convertible to cash within 20 working days due to prevailing conditions of the assets. For example, the liquidity of U.S. savings bonds occurs after a minimum of one year. You can redeem them anytime after that time period.

F-4110 Cash

Revision 09-4; Effective December 1, 2009

Cash is a countable resource. Accept the person's word for the amount of cash on hand.

See Appendix XVI, Documentation and Verification Guide

F-4120 Bank Accounts

Revision 20-1; Effective March 1, 2020

A person's bank balance, as of 12:01 a.m. on the first day of the month for which eligibility is being tested, is a countable resource.

Reduce the bank account balance by the amount of any funds encumbered before 12:01 a.m. on the first day of the month. See Section F-1311, Encumbered Funds.

Verify the bank account balance with:

- bank statements reflecting balances as of 12:01 a.m. for the first day of the appropriate month(s);
- Form H1239, Request for Verification of Bank Accounts (HHSC does not pay financial institutions to complete the form);
- a letter from the financial institution that provides the balance(s) as of 12:01 a.m. for the first day of the appropriate month(s);
- contact by phone with an employee of the financial institution using phone contact documentation; or
- written follow-up if unable to obtain information by phone or if the information obtained by phone makes the person ineligible.

The verification must include all of the following:

- name of the financial institution;
- complete account number(s); and
- amount of the balance as of 12:01 a.m. for the appropriate test month(s).

If the verification provided does not include the required information listed above, send Form H1020, Request for Information or Action to request the missing information.

Note: An account reported as closed by the applicant or recipient must be verified as having a $0 balance for the appropriate test month(s).

Related Policy

Documentation and Verification Guide, Appendix XVI
Failure to Provide Missing Information, B-6510
Points in Time for Establishing Resources Values, F-1310
Encumbered Funds, F-1311
Nursing Facility Payments and Refunds, F-1312
Administrative Procedures of Transfers of Nominal Amounts, I-3600
Consideration of AVS Information, R-3744

F-4121 Joint Bank Accounts

Revision 09-4; Effective December 1, 2009

If a person has a joint bank account and can legally withdraw funds from it, all the funds in the account are considered a resource to the person.

If two or more eligible persons have a joint account with unrestricted access, the department considers that each owns an equal share of the funds. Eligible persons include any Qualified Medicare Beneficiaries (QMB) and Medicaid persons.

This equal ownership [principle] also applies when income is being diverted from the eligible spouse to the ineligible spouse and when income is deemed from an ineligible spouse or parent. In spousal diversion cases after the initial 12-month eligibility period, if the account has not been separated, the funds in the account are divided equally between the spouses for resource eligibility purposes beginning with the 13th month.

If a person is determined ineligible because of excess funds in a joint account, the person must be allowed an opportunity to disprove the presumed ownership of all or part of the funds. He must also be allowed to disprove ownership of joint accounts that do not currently affect his eligibility but may in the future.

Transfer-of-resources policy does not apply when a person changes a joint bank account to establish separate accounts in order to reflect correct ownership of and access to the funds.

In determining whether a person has successfully disproved ownership of funds, the department considers the following information.

- If the source of the funds and all deposits are the person's money, but withdrawals are not made or used for the person's benefit, the department considers that the account is owned by the person.
- If the source of the funds and deposits are from all the joint owners, but withdrawals are not made or used to benefit all joint owners, the department evaluates deposits and withdrawals to determine the amount owned by the person.
- If the source of the funds and deposits are from individuals other than the person, and the withdrawals are used to benefit individuals other than the person, the department considers the disproval of ownership successful. In the same situation for source and deposit of funds, if withdrawals are used for the person's benefit, ownership of the funds may still be successfully disproved. However, the department considers any cash contributions as a potential source of income.

An example of an acceptable rebuttal of ownership of funds is when an account reflects a fiduciary relationship. See Section F-1232, Fiduciary Agent.

Note: Disproval of ownership policy applies to accounts in which there is no co-owner, but the person can show he does not own all of the funds, provided the funds are duly separated.

See Section E-3332, Income from Joint Bank Accounts, regarding treatment of income in these cases.

If a person wishes to disprove full or partial ownership, send him a form specifying the documentation needed and the date by which he is expected to provide it. Keep a copy of the form in the case record. Allow the person up to 30 days to provide:

- completed, signed and dated Form H1299, Request for Joint Bank Account Information; and
- evidence of a change in the account designation to remove the person's name from the account, restrict the person's access to the funds or establish separate accounts.

Notes:

- If eligibility is affected, the items must be received prior to certification. If eligibility is not affected, do not delay certification pending receipt of the items.
- If the person has been given time to disprove ownership and redesignate an account, monitor for compliance within the period specified.
- If either the person or the co-holder is mentally incompetent or a minor, obtain the statement from a knowledgeable third party.

Reference: Refer to Section E-3332, Income from Joint Bank Accounts, regarding interest and deposits by co-holders of a joint account.

See Appendix XVI, Documentation and Verification Guide; Appendix XXV, Accessibility to Income and Resources in Joint Bank Accounts; and Section E-3331, Interest and Dividends, for treatment of income.

F-4122 Time Deposits

Revision 09-4; Effective December 1, 2009

The resource value of a time deposit is the net amount due after penalties are imposed for early withdrawal. If the funds cannot be withdrawn before maturity, the time deposit is not a resource until it matures. Time deposits include, but are not limited to, certificates of deposit, savings certificates and individual retirement accounts (IRAs).

A time deposit is a contract between an individual and a financial institution whereby the individual deposits funds for a specified period. In return, the financial institution agrees to pay an interest rate higher than the passbook rate.

The availability of funds is the controlling factor in determining whether a time deposit is a resource. Examine the person's time deposit certificate to determine when the funds can be withdrawn and which penalties to impose. Subtract the amount of the penalties from the total value to determine resource value.

If the person is a co-owner of a time deposit, use the procedures for jointly-owned resources.

The following information must be included in the case record documentation:

- name of financial institution and account number,
- account accessibility by person,
- cash value as of 12:01 a.m. on the first day of the appropriate month, and
- source of verification.

For applications, verify the account balance for the appropriate month(s). For redeterminations, use the most recent monthly bank statement, unless something indicates that the person may have exceeded the resource limit on the first day of the review month. Verify balance, name of financial institution and account number.

Note: If the statements are not received monthly and the statement does not cover the appropriate month, use other verification. There may be a penalty for early withdrawal.

A time deposit that is closed does not have to be reverified at subsequent redeterminations.

Sources of verification include:

- bank statements,
- completed Form H1239, Request for Verification of Bank Accounts,
- letter from the financial institution, and
- documented telephone contact with a knowledgeable source at the financial institution.

If a person cannot make an early withdrawal of the funds, verify and document the restriction. Also document the date that the time deposit matures. If maturity occurs before the next periodic review, schedule a special review.

F-4123 Patient Trust Funds

Revision 18-1; Effective March 1, 2018

A person may authorize a long-term care facility to manage his funds. The facility then acts as a fiduciary agent, using the funds only for the person's personal needs. The money in a patient trust fund is a countable resource.

See Appendix XVI, Documentation and Verification Guide.

Some facilities call the patient trust fund a "petty cash fund" and do not keep a ledger. In this case, check with a bookkeeper or other nursing home staff to determine if any funds are being held for a person.

Note: If a facility does not keep patient funds, record the fact that no patient trust fund exists. Use discretion to verify at applications or redeterminations that the facility does not maintain patient funds.

See Section F-1312, Nursing Facility Refunds.

F-4124 Debit Accounts

Revision 13-4; Effective December 1, 2013

A debit card allows individuals electronic access to their personal funds. Debit cards can be attached to a bank account or can be preloaded with an individual user's funds. Prepaid or preloaded debit cards can also be established with direct deposit of an individual's wages.

Government benefits payments may be direct deposited to a debit card.

The most common prepaid debit cards used for **deposit of government benefits,** which **do not** have a separate account attached, include:

- electronic benefit transfer (EBT) card accounts for TANF cash benefits;
- TWC UI Visa® Debit Card issued by US Bank for unemployment insurance benefits (UIB);
- Texas Debit Card issued by Wells Fargo® Bank, N.A. for child support payments through the Office of Attorney General (OAG);
- debit cards for direct deposit of child support payments from other states; and
- Direct Express® Debit MasterCard® issued by Comerica Bank exclusively for direct deposit of Social Security, Retirement, Survivors and Disability Insurance (RSDI) or Supplemental Security Income (SSI) benefits payments.

Wage payments may also be direct deposited to a debit card.

Some prepaid debit cards used for **deposit of wage payments**, which **do not** require a separate account, include:

- ACE Elite Visa® Prepaid Debit Card,
- Green Dot Prepaid Debit Card,
- NetSpend® Prepaid Debit Card,
- Prepaid Visa® RushCard, and
- Walmart MoneyCard.

This list is not intended to be all inclusive as more agencies and businesses move toward the use of debit cards to issue benefits.

These types of cards function like prepaid debit cards and **are not attached** to a checking/savings account, so the requirement to provide the **complete** account number is not applicable. The number on the front of the debit card is not considered an account number. Do not copy or image the actual debit card.

The remaining cash value of the debit card as of 12:01 a.m. on the first day of the month following the month of the income deposit is a countable resource.

Account inquiry is accessible to:

- TANF recipients, by calling the Lone Star Help Desk automated voice response system at 1-800-777-7328 (1-800-777-7EBT);
- UIB recipients, online at https://www.usbankreliacard.com/ or at any automated teller machine (ATM) free of charge;
- child support recipients in some states, online at www.eppicard.com*; and
- Social Security recipients, online at www.USDirectExpress.com, by calling 1-888-741-1115, or balance information may be obtained free of charge at any ATM that displays the MasterCard® logo.

* Some states do not use the EPPICard for child support payments.

Verify the debit card balance with:

- debit card statements, such as a printout from a website;
- telephone contact with an employee of the financial institution using telephone contact documentation; or
- the client's statement, when client declaration is allowed.

When it involves a Social Security recipient, the specialist must also verify and document whether the person has a Direct Express® debit card or similar debit card that **does not** have a bank account number attached, or an Electronic Transfer Account (ETA) that **is attached** to a bank account and has an account number that must be verified. Follow policy in Section F-4120, Bank Accounts, when a person has an ETA.

For a debit card, the following information must be in the case record:

- Name and address of the financial institution that issued the debit card
- Last four digits of the debit card number
- Amount of the balance as of 12:01 a.m. for the appropriate month(s)

If the verification that the person provides does not meet the three criteria listed, ask explicitly for the information that is missing.

Note: Direct Express® does not allow other income to be deposited, does not pay interest, and does not require a checking/savings account. It does allow one card for multiple beneficiaries, if the payee desires it.

F-4130 Stocks

Revision 10-2; Effective June 1, 2010

The resource value of a share of stock is the closing price on the last business day of the month before the month of redetermination or the last business day of the month before an appropriate "trial" month. For example:

- SPRA month
- Application month
- Prior month
- First eligible month

Shares of stock represent ownership in a corporation. The value of a stock fluctuates from day to day.

Determine the person's ownership of or interest in the stock. Also determine the current market value as of 12:01 a.m. for the appropriate date.

Note: Brokerage fees for selling a person's stocks are not allowable deductions when determining the value of the stocks.

See Section E-3331, Interest and Dividends, for treatment of income.

See Appendix XVI, Documentation and Verification Guide.

F-4140 Bonds

Revision 09-4; Effective December 1, 2009

The cash value of a bond is a countable resource. If a person can convert his bond into cash within 20 workdays, the bond is considered a liquid resource.

A bond is a written obligation to pay a sum of money at a future date.

Municipal and corporate bonds are negotiable instruments and they are transferable. U.S. savings bonds are not transferable, but they may be sold back to the government.

It generally takes seven to 10 days to sell a municipal or corporate bond. Certain U.S. savings bonds, however, must be held for a minimum period from the date of issue before they can be converted into cash. These bonds are not a countable resource during the period they cannot be converted into cash. Once the minimum period is passed, the bonds can be converted within one or two days.

Treat a municipal, corporate or government (other than U.S. savings bond) in the same way that stocks are treated. Depending on demand, the cash value may be more or less than the face value.

Determine ownership and cash value of a U.S. savings bond. (The value depends on the type of bond and the issue date.) Also determine whether the bond is a liquid or nonliquid resource. If the bond is a nonliquid resource, follow up with appropriate action when the minimum retention period has passed.

Certain additional conditions may prevail. For example, Series HH Bonds (for which interest is paid to the owner twice a year) may be cashed only after six months and after the first interest check is received. If the bond is cashed before maturity, there is a penalty.

See Section E-3331, Interest and Dividends, for treatment of income. See Appendix XVI, Documentation and Verification Guide.

F-4150 Promissory Notes, Loans and Property Agreements

Revision 17-4 ; Effective December 1, 2017

This policy applies to an individual who is a creditor and owns an agreement such as a promissory note or a property agreement. A creditor is a seller of property.

A promissory note is a written or oral, unconditional agreement by the purchaser to pay the seller a specific sum of money at a specified time or on demand.

A loan is a transaction whereby one party advances money to another party who promises to repay the debt in full, with or without interest. The terms of the loan may be in writing or they may be an informal oral agreement. A formal written loan agreement is a type of promissory note. A reverse mortgage is treated as a loan. See F-3640 Reverse Mortgage or Home Equity Loan. The money received is not income. It is a resource the month after receipt. See Section E-1750, Proceeds of a Loan.

A property agreement is a pledge or security of a particular property or properties for the payment of a debt or the performance of some other obligation within a specified time. Property agreements on real estate (land and buildings) are generally referred to as mortgages, but may also be called land contracts, contracts for deed or deeds of trust.

Discounting is the advancement of money on a negotiable note or agreement and the deduction of interest or a premium in advance.

For example, a bank may be willing to pay $450 for a $500 promissory note due in one year's time. For a true discounting situation to exist, ownership of the note or agreement must transfer to the discounting agent.

A negotiable, secured promissory note or property agreement is a countable resource. Negotiable means that the owner (lender) has the legal right to sell the instrument (for valuable consideration, such as cash) to anyone. Secured means the instrument identifies a particular asset of at least equal value to the face value of the instrument that can be reclaimed by the seller, should the instrument fall into default. The owner also possesses a transferable interest in the instrument that can be converted to cash and could be subject to a transfer of assets penalty if not retained or spent down properly. The terms of the agreement may be in writing or may be an oral agreement. If the agreement is oral, the person is responsible for furnishing a statement of facts of the agreement signed by the second party. Real property, sold or exchanged for a negotiable note, is not a transfer for less than fair market value if the note is secured by the original property or by another redeemable resource of equal or greater value. A formal written loan agreement is a form of promissory note.

A negotiable non-secured promissory note or property agreement is a countable resource and a potential transfer of assets. Non-secured means the seller has no recourse to reclaim the original or like resource should the purchaser cease payments. By not securing the note, the seller has purposefully reduced the value of the note. The actual fair market value of the note should be determined and the difference between the actual market value of the note and the value of the original resource is a transfer of assets for less than fair market value. The actual fair market value of the note remains a countable resource. Normal transfer of assets rebuttal policy applies.

See Section E-3331, Interest and Dividends, for the treatment of the interest.

Payment on the principal reduces the transfer penalty. The transfer penalty period is recalculated at each annual review until the expiration of the penalty period falls before the next scheduled annual review. Then a special review should be scheduled accordingly.

A non-negotiable promissory note, loan or property agreement is not a countable resource because it has no marketable value. Non-negotiable means the seller cannot sell or transfer ownership interest in the note, causing the note to have no market value. Therefore, the dollar value of the original resource is considered to be transferred for less than fair market value, subject to normal transfer of asset penalties, if the instrument was created within the look-back period. If payments are being received, the transfer penalty must be reduced based on the amount of principal received. Both the principal and interest are considered as income in the month received. The transfer penalty period is recalculated at each annual review, until the expiration of the penalty period falls before the next scheduled annual review. Then a special review should be scheduled accordingly. Normal transfer of assets rebuttal policy applies.

Note: This transaction is considered a transfer of assets for less than fair market value because the person/authorized representative knew or should have known that transferring ownership of the asset in exchange for a non-marketable note severely lessened the value of the note and in effect automatically reduced the countable assets of the person.

When determining the value of a negotiable promissory note, loan or property agreement, the outstanding principal balance is the countable value unless the person furnishes reliable evidence from a knowledgeable source that the instrument cannot be sold for the amount of the outstanding principal balance. A knowledgeable source is someone recognized as being in the business of purchasing notes.

If a person furnishes evidence to establish a lesser value on a note, the market value established by the knowledgeable source is the countable value of the resource. However, if the person/authorized representative placed any restrictions/encumbrances (such as creating a note with interest due of less than the market value at the time the note was made or the note becomes paid in full at the time of the person's death), then the difference in the current market value and the outstanding principal balance is a transfer of assets for less than fair market value.

Although the seller/person keeps title to the original property until the promissory note, loan or property agreement is paid in full, the original property is not counted as a resource (the value of the negotiable instrument is the resource). The property is not available while the buyer is making a good faith effort (making scheduled payments) in fulfilling the contractual obligation.

A note cannot be excluded under the $6,000/6% policy. This exclusion applies only to real property, or a degree of interest in real property, such as mineral rights.

See Appendix XVI, Documentation and Verification Guide.

F-4160 Prepaid Burial Contracts

Revision 09-4; Effective December 1, 2009

A prepaid (or preneed) burial contract is an agreement in which a person prepays his burial expenses and the seller agrees to furnish the burial.

Burial space items can be excluded only when the contract has been paid in full, or the contract specifies that burial space items are paid before funeral service items, and the refund value equals or exceeds the value of burial space items specified in the contract.

Otherwise, the amount paid toward the contract is treated as burial funds. If the contract has been paid in full or if the contract specifies that burial space items are paid first, burial space items must be separately itemized in the contract for the exclusion to apply.

Note: Paid in full means that the person owes no more payments.

The refund value is the amount that a person would receive upon revocation or liquidation of his burial contract.

A refund value is considered an available resource.

A refund penalty, often 10%, may be assessed for cancellation of a contract.

Note: Effective Sept. 1, 1993, under HB 2499 passed by the 73rd Texas Legislature, a person can irrevocably waive the right to cancel a prepaid burial contract. In these situations, there is no refund value. The prepaid contract is not a countable resource, but its value reduces the $1,500 burial fund exclusion dollar for dollar.

An irrevocable prepaid burial contract owned by the person, but not paid in full, reduces the $1,500 maximum burial fund exclusion by the face value of the contract, with no deduction for the value of burial spaces itemized in the contract.

If a prepaid burial contract is made irrevocable before an application is certified, the contract is considered irrevocable for the month of application and the three prior months.

Use the following procedure to calculate the exclusion for burial space items in a burial contract that contains separately identifiable burial space items/services.

F-4161 Treatment of Refund Penalty

Revision 09-4; Effective December 1, 2009

F-4161.1 No Refund Penalty

Revision 09-4; Effective December 1, 2009

Exclude the total value of the burial space items, which must be itemized in the contract.

F-4161.2 Refund Penalty

Revision 09-4; Effective December 1, 2009

Burial space items must be itemized in the contract.

Step	Procedure
1	Divide the total value of burial space items in the contract by the face value of the contract. This is the percentage of the burial space value.
2	Multiply the refund value of the contract by the percentage from Step 1. This is the dollar amount of excludable burial space items.
3	Subtract the excludable amount from Step 2 from the refund value. This is the countable value of the contract.

F-4161.3 Examples of Refund Penalty

Revision 09-4; Effective December 1, 2009

Example 1:

The prepaid burial contract has a face value of $3,000. There was a 10% refund penalty, giving a refund value of $2,700. The value of burial space items is $1,500.

Step 1.

$1,500 ÷ $3,000 = 50%

Step 2.

Amount	Description
$2,700	refund value
x .500	percentage from Step 1 (round to third decimal place)
$1,350	value of excludable burial space items

Step 3.

Amount	Description
$2,700	refund value
–1,350	excludable value from Step 2
$1,350	countable value of prepaid contract

Example 2:

The prepaid burial contract has a face value of $2,405. There was a 10% refund penalty, giving a refund value of $2,164.50. The value of burial space items is $1,255.

Step 1.

$1,255 ÷ $2,405 = .5218

Step 2.

Amount	Description
$2,164.50	refund value
x .522	percentage from Step 1 (round to third decimal place)
$1,129.87	value of excludable burial space items

Step 3.

Amount	Description
$2,164.50	refund value
–1,129.87	excludable value from Step 2
$1,034.63	countable value of prepaid contract

Note: If there is a refund penalty, but the terms of the contract specify that the burial space items are paid first, exclude the total value of the burial space items that are itemized in the contract. The countable value is the refund amount minus the total value of the itemized burial space items.

The following information must be included in the case record documentation:

- name of funeral home or insurance company, and contract number;
- face value of contract and who owns it;
- current cash value, if owned by the person;
- reason for exclusion, if excluded; and
- source of verification.

Verify purchaser, company name, contract number and beneficiary of contract.

Verify current refund value. If a prepaid burial contract is reported as owned by someone other than the person, verify ownership.

If a prepaid burial contract is owned by someone other than the person, determine whose money was used to purchase the contract and availability of funds to the person.

Sources of verification include the following:

- copy of contract,
- letter from funeral home, and
- contact with funeral home representative.

Although this procedure may be used to complete the case if near the delinquency deadline, immediately follow up with verification by obtaining a copy of the contract or a letter from the funeral home.

Sources for verifying the refund value of a prepaid burial contract are the same as those in the preceding paragraph. In addition to the information required for verifying ownership and accessibility, the actual refund value after penalty involved in liquidation must be indicated on the contract or statement.

F-4170 Burial Contracts Funded by Life Insurance

Revision 12-3; Effective September 1, 2012

If life insurance is used to fund a burial contract, the person owns a life insurance policy. The contract has no value and is merely an instrument that explains the burial arrangement. Because the person purchased insurance and not the actual funeral service or merchandise items that may be listed in a burial arrangement, the person does not own the funeral service or merchandise items. The burial space items are treated differently based on the assignment of a burial contract funded by life insurance.

Some burial arrangements funded with life insurance have the life insurance ownership or proceeds assigned to a funeral director or home or a trust-type instrument. These assignments may be either revocable or irrevocable.

Ownership of a life insurance policy can be transferred or assigned to a funeral home without a transfer penalty if a prearranged contract provides burial services to the person. If a prearranged contract does not exist at the time of transfer, consider the cash value as a transfer of assets and explore a transfer penalty. See Chapter I, Transfer of Assets.

F-4171 Revocable Assignment

Revision 09-4; Effective December 1, 2009

If the assignment is revocable, the life insurance cash value is an accessible resource. Therefore, if the face value exceeds $1,500, the cash value is a countable resource. The burial space items are not excluded, but the $1,500 designated burial fund exclusion may apply.

Example: A person purchases a $3,000 face-value life insurance policy to fund a burial arrangement. The life insurance policy has a cash value of $1,800. The proceeds of the life insurance policy are revocably assigned to Sleepyhollow funeral director. The burial arrangement includes a casket for $1,200, a vault for $500, grave opening and closing costs for $100 and service items (transportation, flowers, clothing, use of chapel) for $1,200.

The burial space items are not excluded. The face value of the life insurance policy exceeds $1,500; therefore, the cash value is a countable resource that is accessible because the assignment is revocable. The $1,800 cash value is designated for burial and $1,500 is excluded. The remaining $300 is a countable resource.

F-4172 Irrevocable Assignment

Revision 09-4; Effective December 1, 2009

If assignment of ownership is irrevocable, the life insurance is not a resource because it is no longer owned by the person. The prepaid burial contract also is not a resource because it has no value independent of the life insurance policy. If the terms of the contract itemize the burial space items that have been purchased, the value of those items is disregarded in determining the amount of the irrevocable arrangement that reduces the $1,500 allowable burial fund exclusion.

If an irrevocably assigned, insurance-funded, prepaid burial contract is paid in full, HHSC automatically assumes that burial space items would be provided to the person, and the value of those items is disregarded in determining the amount of the irrevocable arrangement that reduces the $1,500 allowable burial fund exclusion.

Irrevocable assignment of life insurance policy ownership to the funeral home or director or to a trust-type instrument is not a transfer of resources.

An irrevocable prepaid burial contract for the person's burial, which is in force and which is owned by someone other than the person, whether paid in full or not, reduces the $1,500 maximum burial fund exclusion by the face value of the contract, with no deduction for the value of burial spaces itemized in the contract.

If a prepaid burial contract is made irrevocable before an application is certified, the contract is considered irrevocable for the month of application and the three prior months.

Example: Taking the above situation, the ownership is irrevocably assigned. The insurance-funded prepaid burial contract is paid in full or the terms of the contract indicate that the burial space items are actually owned by the person and that the provider is obligated to provide the items to the person upon request rather than only at the time of death.

The $1,200-casket + $500 vault + $100 grave opening and closing total $1,800. The $1,500 allowable for a designated burial fund is reduced by the $1,200 irrevocable funeral service arrangement. Up to $300 in additional designated burial funds is allowed for exclusion.

Amount	Description
$3,000	face value
–1,800	excludable burial space items
$1,200	irrevocable funeral arrangement

Example: If the terms of the above contract do not obligate the provider to immediately make the burial space items available, the entire $3,000 irrevocable arrangement would be considered as a burial fund and no other funds allowed for exclusion as a designated burial fund.

F-4200, Nonliquid Resources

Body

Revision 09-4; Effective December 1, 2009

There are two types of nonliquid resources:

- Real property
- Personal property

F-4210 Real Property

Revision 09-4; Effective December 1, 2009

Real property is the land and houses or immovable objects attached to the land. The terms real estate, realty and real property are synonymous, and for eligibility purposes, these terms designate real property in which an individual has ownership rights and interests. An individual also may have ownership of only the right to the use of the real property such as life estates or mineral rights. Real property also includes burial spaces.

The equity value of a person's ownership or part ownership in real property other than the home is a resource.

Determine ownership, current market value and equity value of non-home real property.

F-4211 Real Property in Excess of the Limit

Revision 16-3; Effective September 1, 2016

HHSC excludes the value of excess real property if the individual has put the property up for sale. The exclusion continues for as long as:

- the individual continues to make reasonable efforts to sell the property (reference Section F-3130); and
- including the property as a countable resource would result in a determination of excess resources.

Once the individual sells the property, the equity value the individual receives is a countable resource in the month following the month of sale. If the sale was for less than the fair market value or current market value, the sale of the property is subject to transfer-of-assets policy.

If the property rights involved are a life estate or if the individual has a remainder interest in the property, follow the procedures in Section F-4212, Life Estates and Remainder Interests. If the non-home real property produces income, follow the procedures in Section F-4300, Resources Essential to Self-Support.

See Appendix XVI, Documentation and Verification Guide.

If an individual's real property is producing income, use the procedures in Section F-4300.

F-4212 Life Estates and Remainder Interests

Revision 09-4; Effective December 1, 2009

When evaluating the life estate or remainder interest, determine when the interest was established.

If established before the look-back period, do not consider transfer of assets policy.

If established during the look-back period, consider transfer of assets policy:

- If the individual retains an undivided partial interest or life estate in the property during the look-back period, see Section F-3100, The Home and Resource Exclusions.

- If the purchase price of a life estate exceeds the fair market value of the life estate or a life estate is purchased on or after April 1, 2006, see Section I-6100, Purchase of a Life Estate, for evaluation of a transfer of assets.

The life estate or remainder interest may be excluded as follows.

A person may, without affecting his eligibility, maintain his life estate or remainder interest in property if:

- the property is his home and can be excluded under Section F-3000, Home;
- a contract restriction exists that prevents the person from disposing of his interest;
- the property is producing income and may be excluded under the exclusion rule for income-producing property; or
- the property is placed for sale. See Section F-3130, Home Placed for Sale.

If a life estate is excluded because of a person's intent to return to the property in which the person holds a life estate or remainder interest, and if that property is the person's principal place of residence, use the procedures in Section F-3000.

References:

- Use the procedures in Section F-3000, Home, when a spouse or dependent relative is living in the home property in which the person has a life estate or remainder interest.
- If a person's life estate or remainder interest property is producing income, use the procedures in Section F-5000, Potential Resource Exclusions.
- If the purchase price of a life estate exceeds the fair market value of the life estate or a life estate is purchased on or after April 1, 2006, see Section I-6100, Purchase of a Life Estate, for evaluation of a transfer of assets.
- See Appendix XVI, Documentation and Verification Guide.

F-4212.1 Calculation of Value of Life Estate or Remainder Interest

Revision 10-1; Effective March 1, 2010

When the life estate or remainder interest cannot be excluded, determine the value of the life estate or remainder interest as follows:

If the person has a life estate or remainder interest that is not excludable, determine the value of the resource according to the life estate holder's age and the equity value of the property. The person has the right to rebut this determination. To do so, he must present a statement from a knowledgeable source.

Note: Also see Appendix X, Life Estate and Remainder Interest Tables.

If the value given by the knowledgeable source is less than the value determined by the tables, use the rebuttal value.

For an individual's lifetime, a life estate transfers to the individual certain rights in property. The duration of the life estate is measured by the lifetime of the tenant, or by the occurrence of some event, such as remarriage of the tenant. In most situations, the owner of a life estate has the right to:

- possess the property,
- use the property,
- get profits from the property, and
- sell his life estate interest.

The contract establishing the life estate, however, may restrict one or more rights of the individual. The individual does not have fee simple title to the property nor the right to sell the entire property.

A remainder interest, which is created at the same time that a life estate is established, gives the "remainderman" (or remaindermen) the right to ownership of the property when the life estate holder dies.

An individual holding a remainder interest in property has the right to sell the remainder interest, unless prohibited from doing so by a legal restriction.

Use the following steps to determine the value of a life estate or remainder interest that cannot be excluded.

Step	Procedure
1	Obtain the current market value of the property.
2	Obtain the equity value of the property by subtracting any amount owed on the property.
3	Select the table in Appendix X, Life Estate and Remainder Interest Tables, for life estate or remainder interest.
4	Find the line for the life estate holder's age as of the holder's last birthday.
5	Multiply the figure in the appropriate life estate column or remainder interest column by the current equity value of the property.

F-4213 Mineral Rights

Revision 10-1; Effective March 1, 2010

Mineral rights are the ownership interests in natural resources such as coal, oil or natural gas, which normally are extracted from the ground.

The value of a person's ownership of or interest in mineral rights is a resource.

- A person's mineral rights do not affect his eligibility if his equity in them does not exceed $6,000 and he receives a net annual rate of return of at least 6% of the equity value. See Section F-4310, Nonbusiness Property – $6000/6%.
- Ownership of mineral rights may or may not be associated with ownership of land. Surface rights are ownership interests in the exterior or upper boundary of land. Ownership in one does not automatically indicate ownership in the other.
- If the person owns the land to which the mineral rights pertain, the value of the land can be assumed to include the value of the mineral rights. Additional development is unnecessary.

In many instances, owners of mineral interests may lease their rights to an oil or mining company for exploration and development. Terms of leases may vary from one to five years or more, although five is most common. Besides a yearly rental fee for each acre, it is customary for a company to pay a one-time bonus to an individual for signing the lease. The specific amounts are stated in the lease agreements. If minerals are produced from the property, the company may suspend yearly rental payments.

Although under lease, the owner may sell his mineral rights at any time. Their value is based on the probability of oil, gas or minerals being present if the land is not in production. If minerals are being produced, value is decided by the size of the interest, length of time the minerals have been produced, quality of the product (oil or gas) being produced and many other factors.

Determine the person's ownership share of the mineral rights and the equity value.

Reference: If the mineral rights cannot be excluded under the $6,000/6% rule, count the individual's equity together with his other countable resources.

See Appendix XVI, Documentation and Verification Guide.

F-4214 Burial Spaces

Revision 17-4; Effective December 1, 2017

A burial space, or an agreement that represents the purchase of a burial space held for the burial of the person, the person's spouse or any other member of the person's immediate family, is an excluded resource, regardless of value. The person or a family member whose resources are deemed to the person must own the burial space or purchase agreement.

Burial Space — A burial space is a burial cemetery plot, gravesite, crypt or mausoleum.

Burial space items are a casket, urn, niche or other repository customarily and traditionally used for the deceased's bodily remains. The term also includes necessary and reasonable improvements or additions to these spaces, including but not limited to: vaults, headstones, markers or plaques; burial containers (for example, liners or concrete liners for caskets); arrangements for the opening and closing of the gravesite and contracts for care and maintenance of the gravesite. Contracts for care and maintenance are sometimes referred to as endowment or perpetual care.

For items that serve the same purpose, exclude only one per person. For example, a cemetery plot and a casket for the same person can be excluded, but not a casket and an urn.

Immediate family includes the person's spouse, minor and adult children, stepchildren, adopted children, brothers, sisters, parents, adoptive parents and the spouses of those individuals. It does not include grandchildren or the immediate family of the person's spouse.

If a person owns a burial space that is not excludable, count the equity value of the space as a resource.

Until the purchase price is paid in full, a burial space is not "held for" a person under an installment sales contract or similar device if the:

- person does not currently own the space;
- person does not currently have the right to use the space; and
- seller is not currently obligated to provide the space.

Until the contract is paid in full, the amount already paid is considered as burial funds.

Accumulated interest earned on the value of a burial space agreement is excluded from income and resources.

See Appendix XVI, Documentation and Verification Guide.

Exclude all burial cemetery plots that are fully paid, regardless of designation. However, if the individual acknowledges that the cemetery plots are purchased as an investment, count the equity value.

Ownership of a burial cemetery plot in another state does not affect residency requirements or excludability.

F-4215 Nonliquid Resources Located Outside the State

Revision 09-4; Effective December 1, 2009

If a person owns or has an interest in property outside the state, equity in that property is a resource if it is available to him. The exclusion provision for a person's home does not apply when the home property is located outside the state.

Reference: See Section F-3000, Home, and Section F-4211, Real Property in Excess of the Limit.

Determine the type of property and its location. Also determine ownership and availability, current market value and equity value. If legal questions about the availability of the person's property or other states' property laws occur, consult the regional attorney.

Follow this handbook's verification and documentation procedures for the particular resource owned by the person.

F-4220 Personal Property

Revision 09-4; Effective December 1, 2009

The following items cover nonliquid resources other than real property.

F-4221 Automobile

Revision 15-4; Effective December 1, 2015

As used in this section, the term automobile includes, in addition to passenger cars, other automobiles used to provide necessary transportation.

Document the year, make and model of all automobiles.

Exclude one automobile, regardless of value.

Exclude a second automobile when the household is made up of more than one individual and:

- the additional member of the household **requires** an additional automobile for transportation to and from work because the original individual needs one automobile for medical use at all times; **or**
- the additional member of the household **requires** a vehicle modified for someone with a disability for transportation, and the automobile is specially equipped for that additional household member.

For all other automobiles, use the current market value. If the applicant/person still owes on the automobile, consider the current market value and equity value. If the equity value is less than the market value, document the formula used to determine the countable value. Indicate the source used to verify the current market value and equity value.

Verify the market value of an automobile in any of the following situations:

- The applicant's/person's statement is not reasonable.
- The applicant/person owns more than one automobile.

Sources for verifying the value of an automobile include:

- Kelley Blue Book or NADA guidebook (trade-in wholesale value),
- Hearst Corporation Black Book,
- statement from an automobile dealer,
- newspaper ads, or
- a source knowledgeable about antique automobiles. (In the Texas Integrated Eligibility Redesign System [TIERS], use "other acceptable" and document in case comments.)

Note: If the automobile is being declared as "junk" (not running or fixable), a $0 default value may be assigned.

For additional information about automobiles, see Appendix XVI, Documentation and Verification Guide.

Examples:

- A person and the person's ineligible spouse owned an automobile that had a current market value of $5,800. They still owed $2,000 toward the total price. The eligibility specialist did not count the automobile as a resource. (The equity value is irrelevant for the first automobile.)
- The person's spouse later obtained a job and purchased a second automobile. The eligibility specialist reviewed the person's case. It was discovered that a family member stays with the person while the spouse works. The family member used the first automobile to transport the person to the doctor and to therapy. The spouse was using the second automobile for transportation to and from the job. The eligibility specialist excluded the total value of the second automobile since the spouse used it to go back and forth to work and the first automobile was being used to take the person for medical treatment at the same time.
- The following year, the spouse encountered mechanical difficulties with the second automobile and decided to buy another used automobile that was in better condition for $6,000. No automobiles were traded in as part of the purchase. The spouse made a down payment of $400 on the third automobile and made two monthly payments of $200 each.

The eligibility specialist reviewed the case and excluded the first automobile. The eligibility specialist excluded the third automobile because the spouse was using the automobile for transportation to and from work.

The eligibility specialist will need to develop the current equity value of the second automobile that has mechanical difficulties to determine the countable resource value for this non-excluded automobile.

F-4222 Household Goods and Personal Effects

Revision 12-4; Effective December 1, 2012

Do not count household goods as a resource to an individual (and spouse, if any) if they are:

- items of personal property, found in or near the home, that are used on a regular basis; or
- items needed by the householder for maintenance, use and occupancy of the premises as a home.

Such items include, but are not limited to, furniture, appliances, electronic equipment such as personal computers and television sets, carpets, cooking and eating utensils, and dishes.

Do not count personal effects as resources to an individual (and spouse, if any) if they are:

- items of personal property ordinarily worn or carried by the individual;
- items having an intimate relation to the individual;
- items of cultural or religious significance to the individual; or
- items required because of the individual's impairment.

Such items include, but are not limited to, personal jewelry (including wedding and engagement rings), personal care items, prosthetic devices, and educational or recreational items such as books or musical instruments.

Do count items that were acquired or are held for their value or as an investment These items are:

- countable resources (unless excluded under a different resource exclusion);
- not considered a household good or personal effect for the purposes of this exclusion; and
- treated as other personal property.

See F-4222.1, Other Personal Property, for more information.

F-4222.1 Other Personal Property

Revision 12-4; Effective December 1, 2012

Items that were acquired or held for their value or as investments are considered other personal property and are countable resources unless excluded under normal resource exclusions.

Other personal property can include, but is not limited to gems, animals purchased for breeding, re-sale or investment, or collectibles such as coin, stamp or doll collections.

Example: A coin collection is considered other personal property (nonliquid personal property) and the countable resource amount is based on the collector's value. The individual coins in the collection are not liquid resources based on their face value.

Other personal property may be contained in a safe deposit box. If the person's application shows that he has a safe deposit box, question him about its contents.

The following information must be included in the case record documentation:

- description of property and person's estimate of value;
- reason for exclusion, if excludable; and
- equity value and source of verification, if not excludable.

To develop the value of other personal property, obtain the market value of the items and determine whether the person has clear ownership. If any encumbrances exist, such as payments due, deduct the unpaid portions to arrive at the equity value of the items.

Sources for verifying the value of other personal property are:

- retailers;
- antique dealers;
- collectors (for example, stamp or coin collectors/dealers); and
- newspaper ads.

Sources for verifying a person's equity value in other personal property are:

- copy of the purchase contract;
- statement from the creditor showing the amount paid for an item and the amount still due; and
- payment schedule.

F-4223 Life Insurance

Revision 12-3; Effective September 1, 2012

Reference: See also Section F-4170, Burial Contracts Funded by Life Insurance.

If the total face value of life insurance policies owned by a person (or spouse, if any) is $1,500 or less per person, HHSC does not consider as a resource the value of the life insurance.

If the total face value of all life insurance policies owned by a person, eligible spouse or ineligible spouse whose resources are deemed to the person are more than $1,500 per insured person, the cash surrender values of the policies are resources.

This also includes policies owned on other individuals. HHSC does not include dividend additions with the face value of a life insurance policy to determine if the policy is excluded as a resource. A life insurance policy is a resource available only to the owner of the policy, regardless of whom it insures.

The following terms are used in connection with life insurance policies: The **insured** is the individual upon whose life a whole life or straight life policy is affected.

- The **beneficiary** is the individual (or entity) named in the contract to receive the proceeds of the policy upon the death of the insured.
- The **owner** is the individual with the right to change the policy as he may see fit. The owner is the only individual who can receive the cash surrender amount of the policy.
- The **insurer-assurer** is the company that contracts with the owner.
- The **face value amount** is the basic death benefit or maturity amount, which is specified on the policy's face. The face value does not include dividends, additional amounts payable because of accidental death or other special provisions.
- The **cash surrender value** is the amount that the insurer pays if the policy is cancelled before death or before it has matured. The cash surrender value usually increases with the age of the policy.
- A **participating life insurance policy** is one in which dividends are distributed to the policy holder.
- A **nonparticipating life insurance policy** means that dividends are not distributed to the policy holders.
- **Default** is the failure to pay the insurance premiums. There may be conditions in the policy relating to default.
- **Ordinary life insurance** (also known as whole life or straight life) is a contract for which the owner pays premiums and the insurer pays the face amount of the policy to the beneficiary upon the death of the insured.
- An **individual policy** is a policy that is paid for entirely by the owner.
- A **group policy** is usually issued through an employer or organization. The premiums may include some contribution from the employer. Group insurance is usually term insurance.
- **Dividends** are shares of surplus funds allocated to the policy holders of participating insurance policies. They generally represent a previous overpayment of premiums. Dividends may be received as cash payments; used to reduce future premium payments; applied to the existing insurance to increase coverage; or left as a separate accumulation of funds that draw interest.

Note: Ownership of a life insurance policy can be transferred or assigned to a funeral home without a transfer penalty if a prearranged contract provides burial services to the person. If a prearranged contract does not exist at the time of transfer, consider the cash value as a transfer of assets and explore a transfer penalty. See Chapter I, Transfer of Assets.

F-4223.1 Policy and Procedure

Revision 15-4; Effective December 1, 2015

A life insurance policy is a resource if it generates a cash surrender value (CSV). The life insurance contract's value as a resource is the amount of the CSV. In this case, the term contract refers to an insurance policy. An insurance policy is considered to be a contract between the insurance company and the policyholder.

Ordinary life insurance (also known as whole life or straight life) has a CSV usually after the second year. The policy is flexible in premium payments if the dividends are used to pay off the contract at an earlier date, or the premium payment period can be limited to suit the financial resources of the insured. In a situation of this type, the policy is a limited payment life insurance policy.

This resource has a limited exclusion. A life insurance policy is an excluded resource if its face value (FV) and the FV of any other life insurance policies the person owns on the same insured person total $1,500 or less. The family relationship between the person who owns the policy and the insured does not affect this exclusion.

FV is the amount of basic death benefit contracted for at the time the policy is purchased. The face page of the policy may show it as such, or as the:

- amount of insurance,
- amount of this policy,
- sum insured, etc.

A policy's FV does **not** include:

- the FV of any dividend addition, which is added after the policy is issued (see Section 4224.1, Dividend Additions and Accumulations);
- additional sums payable in the event of accidental death or because of other special provisions; or
- the amount(s) of term insurance, when a policy provides whole life coverage for one family member and term coverage for the other(s).

In determining whether the total FV of the life insurance policies a person owns on a given insured person is $1,500 or less, the FV of the following are not taken into account:

- burial insurance policies, and
- term insurance policies that do not generate a CSV.

Do not include the FV of dividend additions in determining whether a policy is a countable or excludable resource. If the policy is a countable resource, include the CSV of dividend additions in determining the resource value of the policy.

Example: A person and his spouse each own a $1,500 whole life policy. The person also owns a $1,000 policy on each of his three children and a nephew. Although the total FV of the insurance owned by the person exceeds $1,500, none of the cash value is countable because the FV per insured individual does not exceed $1,500.

Relation to Burial Fund Exclusion — The maximum of $1,500 that can be excluded and set aside for the burial fund expenses of the person must be reduced by the FV of:

- any excluded insurance policy covering the life of the person (or spouse, if applicable) that is excluded under this provision; and
- any amount held in an **irrevocable** trust, burial contract or other irrevocable arrangement for the individual's (or spouse's) burial expenses, except to the extent that it represents excludable burial spaces.

This includes the FV of a life insurance policy for which a funeral provider has been made the irrevocable beneficiary, if the policy owner has irrevocably waived his or her right to, and cannot obtain, any CSV that the policy may generate. The burial fund exclusion is based on family relationship. The maximum of $1,500 that can be excluded as set aside for burial expenses is only allowed for the recipient and the recipient's spouse

unless deeming of assets is involved. See Section F-4227, Burial Funds, for more details on the burial fund exclusion.

F-4223.2 Documentation and Verification

Revision 09-4; Effective December 1, 2009

The following information must be included in the case record documentation:

- name of insurance company, policy number and face value(s);
- type of insurance coverage (whole, term or burial insurance); and
- source of verification.

Sources of verification include:

- copy of policy;
- letter from insurance company or organization, as appropriate;
- completed Form H1238, Verification of Insurance Policies; and
- documented telephone contact with representative of issuing company or organization.

If a person owns any life insurance policies, determine the:

- FV of each policy,
- type of insurance,
- insured per policy, and
- cash surrender value if not excluded.

Verify with the insurance company whether there is a policy in force if the person reports any whole life insurance policies that are now lapsed due to non-payment.

To determine the approximate cash value of a whole life policy, use the table of values on all whole life insurance policies.

Obtain the actual cash surrender value from the insurance company when:

- the person cannot provide a copy of the insurance policy;
- the person's total resources, including the approximate cash value of whole life insurance policies, is approaching maximum resource limits. Request cash value as of 12:01 a.m. first day of the month;
- prior to denial of assistance because of excess resources; and
- the person reports any outstanding loans against the policy.

To verify the actual cash surrender value, send Form H1238 and Form H0003, Agreement to Release Your Facts, to the insurance company or contact the insurance company by telephone and follow up with these forms.

Determine if a policy is paying dividends to the insured by looking for the words participating or non-participating on the document. If unable to locate these identifying words, send a letter to the insurance company.

If a policy is non-participating and verification substantiates an exclusion of the policy, no further verification is necessary.

If a policy is participating, obtain the following information from the insurance company:

- how dividends are paid,
- the amount of dividends paid, and
- how often the dividends are paid.

If a person has a participating policy, determine whether dividends are used to:

- purchase additional insurance,
- increase the value of existing insurance policy coverage,
- apply toward the payment of premiums, or
- pay cash to the policyholders.

If the dividends are left to accumulate, treat them as a savings account. The dividends are not considered as part of the cash value. The person can withdraw them without touching the cash value.

Note: Separate accumulation of funds that draw interest. These funds are always a countable resource, even if the face value is less than $1,500. These funds may be designated for burial.

See Appendix XVI, Documentation and Verification Guide.

F-4224 Life Insurance Dividends

Revision 10-1; Effective March 1, 2010

Periodically (annually, as a rule), the life insurance company may pay a share of any surplus company earnings to the policy owner as a dividend. Depending on the life insurance company and type of policy involved, dividends can be applied to premiums due or paid by check or by an addition or accumulation to an existing policy. When dividends are used to increase cash value (CV) but they do not increase face value (FV) of the policy, exclude the dividends if the FV of all whole life polices per individual is no greater than $1,500 and count the cash surrender values of the policies as resources if the FV of all whole life policies per insured person is greater than $1,500.

See Appendix XXXV, Treatment of Insurance Dividends.

F-4224.1 Dividend Additions and Accumulations

Revision 09-4; Effective December 1, 2009

Additions — Dividend additions are amounts of insurance purchased with dividends and added to the policy, increasing its death benefit and cash surrender value (CSV). The table of CSVs that comes with a policy does not reflect the added CSV of any dividend additions.

Do not include the face value (FV) of dividend additions in determining whether a policy is a countable or excluded resource. If the policy is:

- a countable resource, include the CSV of dividend additions in determining the resource value of the policy.
- an excluded resource, do not include the CSV of dividend additions in determining the individual's countable resources.

Accumulations — Dividend accumulations are dividends that the policy owner has constructively received but left in the custody of the life insurance company to accumulate interest, like money in a bank account. They are not a value of the policy, but the owner can obtain them at any time without affecting the policy's FV or CSV.

Dividend accumulations cannot be excluded from resources under the life insurance exclusion, even if the policy that pays the accumulations is excluded from resources.

Unless dividend accumulations can be excluded under another provision (for example, as set aside for burial under the burial fund exclusion), they are a countable resource.

Do not exclude dividend accumulations under the life insurance provision, even if the policy that pays the accumulations is excluded. Unless the accumulations are excludable under another provision (for example, because they have been set aside for burial), count the accumulations as resources, even if the policy itself is excluded because the policy's FV is $1,500 or less.

F-4225 Accelerated Life Insurance Payments

Revision 09-4; Effective December 1, 2009

Other insurance issues can occur, such as accelerated life insurance payments.

Accelerated life insurance payments are proceeds paid to a policyholder before death. Although accelerated payment plans vary from company to company, all of the plans involve early payout of some or all of the proceeds of the policy. Most accelerated payment plans fall into three basic types, depending on the circumstances that cause or “trigger” the payments to be accelerated. These are the:

- **long-term care model**, which allows policyholders to access their death benefits should they require extended confinement in a care facility or, in some instances, health care services at home;
- **dread disease or catastrophic illness model**, which allows policyholders to access their death benefits if they contract or acquire one of a number of specified covered conditions; and
- **terminal illness model**, which allows policyholders to access their death benefits following a diagnosis of terminal illness where death is likely to occur within a specified number of months.

Some companies refer to these types of payments as “living needs” or “accelerated death” payments.

Depending on the type of accelerated payment plan, receipt of accelerated payments may reduce the policy's face value (FV) by the amount of the payments and may reduce the cash surrender value (CSV) in a manner proportionate to the reduction in FV. In some cases, a lien may be attached to the policy in the amount of the accelerated payments and a proportionate reduction in CSV results. Since accelerated payments can be used to meet food or shelter needs, the payments are income in the month received and a resource if retained into the following month and not otherwise excludable. The receipt of an accelerated payment is not treated as a conversion of a resource for Medicaid purposes. This is because, under an accelerated arrangement, a person receives proceeds from the policy, not the policy's resource value, which is its CSV.

F-4225.1 Life Settlement

Revision 14-3; Effective September 1, 2014

A life settlement allows an individual to sell a life insurance policy for a lump-sum payment that is less than the expected death benefit but more than the available cash value. The Texas Department of Insurance regulates life

settlements. An individual may place proceeds from a life settlement contract into an irrevocable life settlement account. The irrevocable life settlement account can be designated to pay for the individual's long-term services and supports (LTSS), including, but not limited to, home health, assisted living and nursing home services.

A life settlement contract is an agreement between the owner of a life insurance policy and the life settlement provider or investor that is purchasing the life insurance policy.

A life settlement account is a bank account established with proceeds from a life settlement contract, which can be used to pay for the individual's long-term care services.

In order to be excluded for eligibility purposes, a life settlement contract must:

- direct the proceeds from the transaction into an irrevocable, state or federally insured account;
- specify that the proceeds be used for payment of LTSS expenses;
- specify the total amount payable for LTSS expenses; and
- indicate the amount of the reserved death benefit and the irrevocable beneficiary.

In order to be excluded for eligibility purposes, a life settlement account must:

- be irrevocable,
- be state or federally insured,
- allow payments for LTSS and/or medical expenses, and
- indicate the total amount payable for LTSS expenses.

If a life settlement account does not meet all of the above requirements:

- consider the proceeds from the transaction a countable resource; or
- if the proceeds are no longer accessible to the individual, explore transfer of assets.

Note: Consider any payments made from the life settlement account, such as bank fees, legal fees or other administrative costs, as income to the individual in the month the payment is made.

F-4226 Term and Burial Insurance

Revision 10-1; Effective March 1, 2010

Term insurance and burial insurance are not resources.

Burial insurance is a form of term insurance. By its terms, burial insurance can only be used to pay the burial expenses of the insured.

Term insurance is a contract of temporary protection. The insured pays relatively small premiums for a limited number of years, and the company agrees to pay the face amount of the policy only if the insured dies within the time specified in the policy. It has no cash surrender value.

If a term insurance policy has been purchased by a life insurance company and premiums are used to purchase separate whole life coverage, the whole life coverage is subject to the policy as described in Section F-4223, Life Insurance.

If the term insurance policy is a participating life insurance policy, any dividend accumulation at interest is a countable resource.

Appendix XXXV, Treatment of Insurance Dividends, indicates that dividends are used to purchase term insurance; disregard the dividends as income or a resource.

F-4226.1 Policy and Procedure

Revision 09-4; Effective December 1, 2009

Term Life Insurance — Life insurance with no cash or loan value or no potential for cash or loan value. The term life insurance policy is for temporary protection. The insured pays relatively small premiums for a limited number of years and the company agrees to pay the face amount of the policy only if the insured dies within the time specified in the policy. Term life insurance with HHSC while employed is an example of this type of life insurance. Some companies sell term insurance with the premiums to be paid for the insured's whole lifetime. If Form H1238, Verification of Insurance Policies, indicates that there is no potential for cash value and the Form H1238 indicates whole life, contact with the company will be needed to clarify this discrepancy.

Burial Insurance — A form of term insurance. By the terms of the burial insurance policy, burial insurance can only be used to pay the burial expenses of the insured.

The dividend accumulation is a countable resource, like the balance of a savings account.

The interest accrued on the dividends would be excluded from income when paid. Interest left to accumulate becomes part of the countable resource.

The following information must be included in the case record documentation:

- name of insurance company, policy number and face value(s);
- type of insurance coverage (that is, term or burial insurance); and
- source of verification.

Sources of verification include:

- copy of policy;
- letter from insurance company or organization, as appropriate;
- completed Form H1238; and
- documented telephone contact with representative of issuing company or organization.

F-4227 Burial Funds

Revision 13-4; Effective December 1, 2013

HHSC excludes up to $1,500 per person for funds that have been set aside and designated for the burial expenses of:

- an applicant or recipient;
- an applicant's or recipient's eligible or ineligible spouse; or
- the parent or parent's spouse when resources are deemed to a minor child (see Section F-1420, Deeming for Children).

Reductions in Maximum Exclusion

The burial fund exclusion allows a person to designate up to $1,500 of various kinds of resources as burial funds. The burial fund exclusion works in conjunction with the life insurance exclusion described in Section F-4223, Life Insurance, because the $1,500 set aside for burial must be reduced by the face value (FV) of:

- any life insurance policy that is already being excluded by the life insurance exclusion (see Section F-4223);
- any burial insurance policy for the burial expenses of the individual (see Section F-4226, Term and Burial Insurance);
- any amount held in an irrevocable trust, burial contract or other irrevocable arrangement for the individual's burial expenses, except to the extent that it represents excludable burial spaces (see Section F-4160, Prepaid Burial Contracts); or
- any life insurance policy for which a funeral provider has been made the irrevocable beneficiary, if the life insurance policy owner has irrevocably waived his right to, and cannot obtain, any cash surrender value (CSV) the life insurance policy may generate (see Section F-4170, Burial Contracts Funded by Life Insurance, and Section F-4172, Irrevocable Assignment).

To be excluded, the person's funds must be:

- liquid resources (see below),
- separately identifiable and not combined with other funds, and
- specifically designated for burial expenses.

How a Designation May Be Made

Burial funds may be designated as such by:

- an indication on the burial fund document (for example, the title on a bank account); or
- a signed statement.

Signed Statement Designating Burial Funds

A signed statement designating resources as set aside for burial must show the:

- value and owner of the resources;
- person for whose burial the resources are set aside;
- form(s) in which the resources are held (for example, burial contract, bank account, etc.); and
- date the individual first considered the funds set aside for the burial of the person specified.

Use Form H1252, Designation of Burial Funds, for resources owned by the applicant, recipient or spouse (or parent in a minor child deeming budget) for a signed statement of designation.

Date of Intent

Accept the person's allegation as to the date the person first considered the funds set aside for burial (even prior to application) unless there is evidence that the funds were used and replaced after that date.

Effective Date of Exclusion

Once the date that burial funds were considered set aside for burial has been established, the first month for which the exclusion affects the first-of-the-month resources determination is the latest of:

- the month following the month in which the funds were considered to have been set aside, subject to the rules of administrative finality; or
- the actual or effective month of filing if the funds were considered set aside before that month.

Note: The "separately identifiable" criteria above must be met before burial funds can be excluded. If the requirement is not met as of 12:01 a.m. on the first day of the "test" month, the exclusion cannot apply until the following month, even if the funds were considered as set aside for burial prior to the "test" month (see Section F-4227.3, Effective Date of Designation).

Designating Life Insurance as a Burial Fund

When designating a countable life insurance policy as a burial fund, the individual typically designates the policy itself rather than the CSV. This is the case because the CSV of a policy is payable only during the lifetime of the individual and thus cannot be used to bury the individual. However, since the CSV is the current resource value of the policy, it is the CSV which is applied toward the burial fund limit when determining countable resources.

When designating life insurance as a burial fund, the individual can also designate any dividend accumulations on the life insurance policy (see Section F-4224.1, Dividend Additions and Accumulations) as a burial fund. Dividend accumulations are a separate resource (that is, not considered as an increase in the value of the CSV) and must be designated as burial funds separate from the life insurance policy itself.

Note: A verbal designation is acceptable when the applicant/recipient or authorized representative is designating life insurance insuring the applicant/recipient (or spouse) and the case is due. A follow-up with a written statement from the recipient/authorized representative is required to continue the burial fund designation. The case also must reflect a special review to follow up for the written statement of designation.

Written documentation of the verbal statement from the applicant/recipient or authorized representative must contain the same information requested on Form H1252 for life insurance designation and must be in the case record documentation.

Burial Funds

Burial funds are:

- revocable burial contracts;
- revocable burial trusts;
- other revocable burial arrangements (including the value of certain installment sales contracts for burial spaces);
- cash;
- financial accounts (for example, savings or checking accounts); or
- other financial instruments with a definite cash value (for example, stocks, bonds, certificates of deposit and life insurance, including the cash value of life insurance the person owns on someone else).

These funds must be clearly designated for the person's or spouse's burial, cremation or other burial-related expenses. Property other than that listed in this section is not considered burial funds and may not be excluded under the burial funds provision. For example, a car, real property, livestock, etc., are not burial funds.

Expenses for Burial Funds Exclusion Purposes

Expenses Included — Generally, expenses related to preparing a body for burial and any services prior to burial. **Examples:** transportation of the body, embalming, cremation, flowers, clothing, services of the funeral director and staff, etc.

Expenses Not Included — Usually, expenses for items used for interment of the deceased's remains. Such items may be subject to the burial space exclusion (see Section F-4214, Burial Spaces). However, items that do not qualify for the burial space exclusion (for example, a space being purchased by installment contract) may be excluded under the burial fund exclusion.

Originally Designated Amount

The originally designated amount of a burial fund is the amount set aside for burial, including excluded and non-excluded funds, but exclusive of interest and appreciation at the time of the most recent designation. Any amount can be designated for burial, but only the amount established in Section F-4228, Burial Fund Calculation, Step 3, can be excluded.

Note: The person or his authorized representative meets requirements for excluding burial funds by:

- including a specific statement about the designation on a financial institution's records or on other ownership documents, or
- providing a written statement (or Form H1252) that the resource is designated for burial expenses. The person or his authorized representative must include in this statement the following information:
  - Type of resource set aside and designated
  - Name of the financial institution or company
  - Account or policy number
  - Amount of money in or value of the resource
  - Effective date of designation

Use Form H1276, Burial Fund Designation Worksheet, which provides a step-by-step worksheet for calculating the amount of excluded burial funds.

F-4227.1 Calculation of Available Burial Fund Exclusion

Revision 10-4; Effective December 1, 2010

From the $1,500-per person (for the person, spouse or deemor) allowance for burial fund exclusions:

1. deduct irrevocable arrangements owned by the person or someone else (for the person, spouse or deemor). This includes a revocable/irrevocable burial contract for the person's burial purchased by someone other than the person, including the spouse after the initial eligibility period in spousal cases (see Section F-4160, Prepaid Burial Contracts, Section F-4170, Burial Contracts Funded by Life Insurance, and Section F-4172, Irrevocable Assignment);

   Note: Burial insurance policies, generally ranging from $100 to $200, were issued by some funeral homes before 1965. These policies are not countable resources. However, they are considered irrevocable burial arrangements, which reduce the $1,500 maximum burial fund exclusion. If the policies have been purchased by life insurance companies and converted to term life insurance, they are treated as any other term life policy (see Section F-4226, Term and Burial Insurance).
2. deduct the face value of excluded life insurance on the individual (see Section F-4223, Life Insurance); and
3. use the remaining amount to reduce the countable amount of any liquid resource (see Section F-4100, Types of Liquid Resources) designated by the person (see Section F-4227.2, Opportunity to Designate).

Note: If the amount of the burial exclusion reduces the total countable resource amount below the resource limit, the person is resource eligible. If the amount of the exclusion is insufficient, the person is not eligible. If joint funds are being designated for more than one individual, calculate each individual's designation separately. For example, a couple with a $1,000 joint savings account could designate $500 for each spouse or $750 for one spouse and $250 for the other. Their statement of designation or Form H1252, Designation of Burial Funds, must be specific.

An exclusion of burial funds does not continue from one period of eligibility to another across a period of ineligibility. If a person reapplies after he has been denied, and there is a break in coverage, HHSC applies the burial fund exclusion as if it had never existed before. The exclusion is subject to the $1,500 maximum and the provisions of this item.

If a person designates a whole life policy (or policies) for burial expenses, he must designate the total cash value of each policy.

If an ineligible spouse/parent has designated funds for burial and then applies for benefits, it is not necessary to redesignate fund for burial.

F-4227.2 Opportunity to Designate

Revision 09-4; Effective December 1, 2009

If a person's resources exceed program limits, HHSC does not deny the case before determining if excess resources can be designated as burial funds and allowing the person the opportunity to do so. Use Form H1277, Notice of Opportunity to Designate Funds for Burial. A person may designate funds for burial at any time, not just at the point of ineligibility.

F-4227.3 Effective Date of Designation

Revision 10-3; Effective September 1, 2010

HHSC accepts the person's statement about the date he considered the funds set aside for burial, unless there is evidence of tampering. The effective date of designation can be retroactive to the month of application, or prior months, if all criteria for designation are met at that time. Once designated, the funds remain burial funds until eligibility terminates or until the funds are tampered with.

When an ineligible spouse/parent has designated funds for burial and then applies for benefits, the following applies:

- If resources have been deemed to the person from the ineligible spouse/parent, HHSC uses the value of the designated burial funds as of the original designation date.
- If resources have not been deemed to the person from the ineligible spouse/parent, HHSC uses the value of the designated burial fund as of the ineligible spouse's/parent's medical effective date (MED).

In spousal cases:

- If the ineligible spouse applies during the initial eligibility period, HHSC uses the value of the designated burial fund as of the original designation date.
- If the ineligible spouse applies after the initial eligibility period, HHSC uses the value of the designated burial fund as of the ineligible spouse's MED.

Notes:

- The 12:01 a.m. rule applies to the assessment of all resources. Use the value of the designated burial funds as of 12:01 a.m. for the month of the medical effective date in the calculation.
- The burial fund exclusion is only allowable for the person, the person's spouse (eligible or ineligible) or the parents of the person when the person is a minor child and deeming occurs.

- The burial fund exclusion is not allowed for the person's minor or adult children or any other individual. If the person purchases an asset that is a burial fund for a minor child or an adult child who is not disabled, treat as a transfer of assets. Deduct the value of the burial space items before calculating the penalty. If the person's child meets Social Security Administration disability criteria, regardless of age, treat as an exception to transfer.

F-4228 Burial Fund Calculation

Revision 10-4; Effective December 1, 2010

Procedure

Based on policy in Section F-4227, Burial Funds, Section F-4227.1, Calculation of Available Burial Fund Exclusion, Section F-4227.2, Opportunity to Designate, and Section F-4227.3, Effective Date of Designation, use the following for determination of the burial fund calculation.

Step	Procedure
1	Subtract from the $1,500 maximum burial fund exclusion the value of any irrevocable burial arrangement (for example, trust, contract, burial insurance) on the person whether the person owns it or not.
2	Also subtract from the $1,500-maximum burial fund exclusion the total face value of all excluded whole life insurance policies owned by the person.
3	The amount remaining is the amount available for burial fund exclusion.
4	Subtract the amount in Step 3 from the amount of burial funds designated by the person.
5	The remainder is a countable resource. If the remainder is a negative number, that amount can be designated as burial funds at a later date.

Examples:

- As of 12:01 a.m. on January 1 of this year, Carol Caswell owned the following resources:

  $2,200 – Savings account
  $1,200 – Cash value of a whole life insurance policy with a face value of $1,700

- The full $1,500 burial fund designation exclusion was available for designation.
- Ms. Caswell designated the cash value of the life insurance policy for burial effective 12:01 a.m. on January 1 of this year, but did not wish to designate the total savings account for burial. Therefore, she was ineligible January of this year.
- On January 1 of this year, Ms. Caswell withdrew $500 from her savings account and deposited the $500 into another savings account designated for burial. She provided a statement on Form H1252, Designation of Burial Funds, indicating that this account was designated for burial effective January 25 of this year. Funds that were not separately identifiable on the date of application but are subsequently separated and designated for burial are excluded effective at 12:01 a.m. of the first day of the following month.

Amount	Description
$ 1,500	Maximum allowable designation
– 1,200	Cash value of designated whole life insurance policy

Amount	Description
$ 300	Remaining available for burial fund designation
$ 500	Savings account designated for burial
$ 300	Available for burial fund designation
$ 200	Counted toward resource limit
$ 200	Countable value of designated savings account
+ 1,700	Original savings account
$ 1,900	**Total Countable Resources** as of 12:01 a.m. on February 1 of this year.

- The person has two life insurance policies with a total face value of $7,000 and total cash value of $1,100. The person also has an irrevocable, fully-paid burial arrangement which is owned by the community spouse. The face value is $3,770, which reduces the $1,500 burial fund designation dollar for dollar. Therefore, the $1,100 cash value of the life insurance is a countable resource.

F-4229 Annual Burial Fund Calculation

Revision 09-4; Effective December 1, 2009

HHSC excludes from income and resource determinations interest that accumulates and becomes a part of excludable burial funds or appreciation in the value of an excludable burial fund. Interest/appreciation on excluded burial funds is not included in determining if the $1,500-maximum has been reached. Also excluded is the increased cash value of life insurance policies excluded under this policy, but payments made on a prepaid burial contact that increases the value of the contract are not excluded as appreciation.

F-4229.1 Designated Amount is Less Than $1,500

Revision 09-4; Effective December 1, 2009

Example: The person became eligible in May 1988 with an original balance of $1,000 in the excluded burial fund account. The current balance is $1,166.40 in the designated savings account. The person now wants to increase the excludable burial fund balance by adding more money to this account. The person is not covered by any irrevocable trust and does not have any excluded whole life insurance. The person can add $500 to the burial fund without affecting resources. The $166.40 should be excluded as a resource. Any interest earned on this burial fund account is excluded.

F-4229.2 Designated Amount Exceeds $1,500

Revision 10-3; Effective September 1, 2010

If a designated resource exceeded $1,500 at the initial designation and that resource has increased in value at the next annual review from accrued interest, dividends or inflation, calculate the countable amount of the burial fund as follows:

1. Determine the percentage of total funds that were countable at the prior designation by dividing the countable amount of the designated resource by the total value of the designated resource.
2. Apply that percentage to the current total value of the designated resource. If a decimal number is used rather than a percent, take the decimal to three places. For example, 25.5 percent would be .255 in a decimal number.

At the next annual review (if designated funds increase in value again), multiply the total value at the review by the percent determined at the initial designation. The percentage used at each review remains the same unless major changes, such as tampering to the fund, occur.

Example: At the initial application, the person designated a $2,000 savings account for burial:

Amount	Description
$2,000	Savings designated for burial
–1,500	Designated burial fund allowance
$ 500	Countable resource

$500 ÷ $2,000 = 25% countable of the designated resource

At the annual review the following year:

Amount	Description
$2,100	Balance of designated savings (earned $100 in interest the first year)
× .250	Countable of the designated resource
$ 525	Total countable resources of the savings account

Twenty-five percent of the total interest earned is considered for income in the eligibility and co-payment budgets.

At the annual review the following year:

Amount	Description
Amount	Description
$ 2,225	Balance of designated savings (earned $100 in interest the first year and $125 the second year)
× .250	Twenty-five percent of the total interest earned
$556.25	Total countable resources of the savings account

Twenty-five percent of the total interest earned is considered for income in the eligibility and co-payment budgets.

F-4229.3 Increased Value from Person Action

Revision 09-4; Effective December 1, 2009

If the value of a resource previously excluded under burial designation fund exclusion was less than or equal to the allowable $1,500 at the time of designation, and the amount designated increased because of person action, such as additional payments, the increased amount which exceeds $1,500 is a countable resource.

If the amount designated exceeded $1,500 and increased in value due to person action, such as making monthly payments on a prepaid burial contract, the amount in excess of $1,500 is a countable resource.

F-4229.4 Increased Value from Person Action and Interest/Dividends

Revision 09-4; Effective December 1, 2009

HHSC excludes from income and resource determinations interest that accumulates and becomes part of excludable burial funds.

If the amount designated for burial funds increased to over $1,500 because of person action plus accrued interest, dividends or inflation, HHSC must first determine the date of the additional payment and the date interest or dividends were paid.

If the person made the additional payment before the interest was paid, determine the countable amount using the following steps:

1. Add the amount of the additional payment to the amount that was countable at the prior designation.
2. Divide this total by the value of the designated account after the additional payment was made (before the interest was paid). This yields the percentage of the fund that is now countable.
3. Multiply the current value of the designated fund (including interest) by the percentage from #2. This yields the countable value of the fund.

At the next review, if additional payments are made before interest is paid, the percentage changes again. Therefore, repeat the steps.

Example: At the initial application, Bill Brooks designated a $2,000 savings account for his burial. $1,500 (or 75.0%) was excluded and $500 (or 25.0%) was countable.

At the annual review, the savings account record shows:

Amount	Description
$ 2,000	Previous balance 12/31
100	Additional payment on 1/5
25	Interest on 3/1
25	Interest on 6/1
25	Interest on 9/1
25	Interest on 12/1
$ 2,200	Current value of account

Determine the countable value using the following steps:

Step 1.

Amount	Description
$ 500	Countable at prior designation
+ 100	Additional payment
$ 600	Total

Step 2.

$600 + $2,100 (value after payment, but before interest) = .286 or 28.6%

Step 3.

Amount	Description
$ 2,200	Current value of account
× .286	Percentage countable
$ 629.20	Countable resource of the designated savings account

If the person made the additional payment after the interest was paid:

1. Multiply the value of the resource after interest paid (before additional deposits) by the percent counted as determined at the previous designation. This yields the countable portion of the resource before the additional payments.
2. Add to the above figure the amount of the additional payments. The sum is the total countable resource value of the fund. Divide the countable amount by the total amount of the fund to determine the percentage to carry over to the next review.

At the next review, if additional payments are made after interest was paid, repeat the steps.

Example: At the initial application, Tom Taylor designated a $2,000 savings account for his burial. $1,500 (or 75.0%) was excluded and $500 (or 25.0%) was countable.

At the annual review, the savings account record shows the following:

Amount	Description
$ 2,000	Previous balance 12/31
100	Additional payment on 1/5
25	Interest on 3/1
25	Interest on 6/1
25	Interest on 9/1
25	Interest on 12/1
100	Additional payment on 12/5
$ 2,200	Current value of account

The eligibility specialist determined the countable value using the following steps:

Step 1:

Amount	Description
$2,000	Balance on savings
+ 100	Interest payments

Amount	Description
$2,100	Total Savings
×. 250	% previously determined
$ 525	Countable portion of the resource prior to additional payments

Step 2.

Amount	Description
$ 525	Countable portion of the resource prior to additional payments (total from Step 1)
+ 100	Additional Payment
$ 625	Countable resource value

Step 3.

Amount	Description
$625	Countable resource value (from Step 2)
+ $2,200	Current value of account
.284 or 28.4%	Total

F-4230 Treatment of Burial Fund Tampering

Revision 09-4; Effective December 1, 2009

If a person designates funds for burial, he is establishing that the funds will not be used for any other purpose. Therefore, if the designated funds are used for purposes other than the person's burial, they are really not designated for burial. The asset becomes a countable resource as of 12:01 a.m. of the first day of the month following the month the funds were used for other purposes.

HHSC does not consider that a person tampered with burial funds if he:

- adds funds to a resource that is designated for burial, or
- converts the total amount in a designated burial fund to another designated burial fund (for example, the person uses a savings account designated for burial expenses to purchase a prepaid funeral contract).

If funds are tampered with, they may be redesignated. Request restitution for months in which the designation was broken and the person's resources exceeded the appropriate resource limit. Redesignating may mean a different amount in the designated burial fund and possibly a new percentage of exclusion. It always means a new effective date of the designation.

F-4240 Safe Deposit Box

Revision 09-4; Effective December 1, 2009

If a person's application or redetermination form shows that he has a safe deposit box, ask him about its contents. If the contents indicate ownership of resources, refer to the appropriate handbook sections for handling these resources.

The following information must be included in the case record documentation:

- location of safe deposit box, and
- inventory of contents.

Sources of verification include:

- contact with financial institution, and
- statement by person or responsible person.

F-4250 Livestock

Revision 09-4; Effective December 1, 2009

Livestock maintained as part of a trade or business or exclusively for home consumption is not counted; otherwise, the livestock's current market value is a countable resource.

If the livestock meets the equity value and rate of return criteria for nonbusiness property, the livestock used to produce income may also be excluded.

If animals are maintained as part of a trade or business or exclusively for home consumption, do not verify the value. If the person's statement appears to be reasonable and the actual value could not affect eligibility, verification is also unnecessary. In all other cases, verify the current market value for the number and kind of animals reported.

The following information must be included in the case record documentation:

- kind and number of animals owned by person;
- whether animals are excluded as a resource;
- reason for exclusion, if excluded;
- current market value, if countable; and
- source of information or verification.

Sources of verification include:

- local knowledgeable source (for example, auction barn employee); and
- newspaper.

F-4260 Nonliquid Resources Converted to Cash

Revision 09-4; Effective December 1, 2009

See Section F-1260, Conversion of Resources.

If a person converts nonliquid resources to cash, subtract expenses from the gross amount for which the person sold the resource and count the net value of resources resulting from the sale. Examples of expenses are cost of advertising, legal fees and cost of repairs to make the resource salable.

Determine the type of resource sold and whether the person received the current market value. If he did not, use the transfer-of-resources policy.

Determine whether the person is eligible based on his total countable resources, including the net amount received from the sale.

If two or more resources are sold and the person incurs a loss in the sale of one of them, the person may not use this loss to lower the net proceeds from the sale of the other resources(s).

If the net value of all countable resources exceeds the applicable resource limitation, the person is not eligible unless the property can be excluded for another reason.

See Chapter J, Spousal Impoverishment; Section F-2000, Resource Exclusions – Limited and Related to Exempt Income; Section F-3000, Home; and Section F-5000, Potential Resource Exclusions.

If a person converts nonliquid resources to cash, subtract expenses from the gross amount for which the person sold the resource and count the net value of resources resulting from the sale. Examples of expenses are cost of advertising, legal fees and cost of repairs to make the resource salable.

Determine the type of resource sold and whether the person received the current market value. If he did not, use the transfer-of-resources policy.

Determine whether the person is eligible based on his total countable resources, including the net amount received from the sale.

Verify and document the gross amount that the person received from the sale of his resources and any expenses relating to the sale. Also verify the current market value of the resource.

Sources for verifying the amount received from the sale of a resource are:

- sales receipt or contract,
- note, and
- bank deposit slip.

Sources for verifying expenses related to the sale of a resource are:

- bill for repairs or services, and
- copy of a lien or note that had to be paid to effect the sale. The copy should show final settlement.

Sources for verifying the current market value of the resource are:

- statement from a knowledgeable source, depending on the type of resource;
- newspaper ads for the sale of similar items; and
- assessment or tax notices.

F-4300, Resources Essential to Self-Support

Body

Revision 09-4; Effective December 1, 2009

HHSC may exclude as a resource property essential to self-support, but count the income that the property produces.

Liquid resources do not qualify for exclusion as property essential to self-support unless they represent necessary assets of a trade or business. See Section F-4330, Business Property.

F-4310 Nonbusiness Property – $6000/6%

Revision 09-4; Effective December 1, 2009

A person (and spouse, if any) is allowed to have nonbusiness property that is producing income necessary to self-support, if the:

- equity value does not exceed $6,000; and
- person receives a net annual rate of return of at least 6% of the equity value.

If a person's equity in income-producing nonbusiness property exceeds $6,000, and the property is producing a net annual rate of return of at least 6%, the excess equity value is a countable resource. For example, total equity value minus $6,000 equals the amount to be counted, together with any other resources.

If the net annual rate of return is less than 6% of the equity value, the total equity value is a countable resource.

In some instances, a person may own more than one income-producing nonbusiness property. To be excludable, each property must separately produce a 6% rate of return. A maximum of $6,000 may be excluded from the combined equity value of all properties producing a 6% net annual rate of return. The combined equity value in excess of $6,000 is a resource.

Note: This exclusion does not apply to liquid assets. For example, a note cannot be excluded under the $6,000/6% policy.

Nonbusiness property that is essential to self-support includes, for example, rental property, leased farm property and income-producing mineral rights.

Confirm that the equity value of the resource does not exceed $6,000, and that the resource produces a net annual rate of return of at least 6% of the equity value. In determining equity value, deduct any encumbrances such as mortgages or liens.

Sources for verifying ownership include:

- copy of the deed,
- copy of the will, and
- copy of a current tax statement or assessment.

Sources for verifying income include:

- lease agreement;
- rent receipts;
- bank deposit slips;
- canceled checks and receipts from expense (to determine net income); and
- recent income tax return.

Sources for verifying the current market value include:

- copy of a mortgage or lien,
- copies of bills for repairs or services, and
- recent income tax return.

Reference: Verification procedures for mineral rights are explained in Section F-4213, Mineral Rights.

F-4311 Examples of $6000/6%

Revision 10-3; Effective September 1, 2010

Vernon Underwood owns farmland with a verified equity value of $4,500. Mr. Underwood has leased the land for $800 a year. Because the equity value of the property is less than $6,000, and the net annual rate of return exceeds the required minimum of 6%, Mr. Underwood's farmland is excluded as a resource.

George Best owns three lots, none of which is home property. A billboard company rents the lots from Mr. Best to use for advertising. The verified equity value of the lots and the amounts of rent received are:

Property	Equity Value	Annual Rent
Lot A	$ 800	$ 60
Lot B	600	50
Lot C	+ 5,000	+ 500
Total	$ 6,400	$ 610

Although each lot is worth less than $6,000, and each is producing a net annual rate of return of more than 6% of the equity value, the combined value of the three lots exceeds $6,000. Count the excess equity value of $400 as an available resource.

Ruby Markham has mineral rights with a verified equity value of $7,000. Her net annual income from the mineral rights at the time of redetermination was $450. She had no other countable resources.

Amount	Description
$7,000	Total equity value
–6,000	Excluded
1,000	Excess equity value
0	Other resources
$1,000	Total countable resources

Ms. Markham remained eligible because she was receiving more than 6% of the equity value of the mineral rights, and the excess equity, combined with any other resources, did not exceed the resource limit.

At a subsequent redetermination, verification received indicated that Ms. Markham's equity in the mineral rights remained at $7,000. The net annual rate of return, however, had changed to $280. An officer of the oil exploration company verified that production would continue to decrease during the next two years. Because the net annual rate of return was less than 6% of the equity value of $7,000, the mineral rights are a countable resource and Ms. Markham is no longer eligible for assistance.

F-4312 Rate of Return Less Than Reasonable

Revision 09-4; Effective December 1, 2009

A person's non-business property that is valued at $6,000 or less can be excluded even if it produces less than a 6% annual rate of return, if all of the following conditions are met:

- Unusual or adverse circumstances cause a temporary reduction in the rate of return.
- The property is used in an income-producing activity.

- The property usually has net annual rate of return of at least 6% of the equity value of the property.
- The person expects the property to resume producing a reasonable return within 18 months of the end of the calendar year in which the unusual incident caused the reduction in the rate of return. If, by the end of the time allowed, the property is not producing a net annual rate of return of at least 6% of the equity value, the resource cannot be excluded.

The person must send a convincing written explanation to exclude the property temporarily. Information from other knowledgeable sources may also be appropriate. Supervisory concurrence with the decision is recommended.

If granting an exclusion, review the case at each redetermination and again near the end of the time allowed (18 months from the end of the calendar year of the unusual incident).

Document in the case record the reason for the exclusion. Also show the rate of return that is temporarily being received.

F-4320 Employment-Related Personal Property

Revision 09-4; Effective December 1, 2009

HHSC excludes personal property that a person uses in connection with his employment. Also excluded is any resource that a person uses exclusively to produce items for home consumption and is a significant factor in his support and maintenance.

Resources used to produce items for home consumption include, but are not limited to:

- cows supplying milk,
- chickens supplying eggs, and
- garden plots for growing vegetables.

At application and at each redetermination, determine whether a resource used for producing items for home consumption is essential to the person's self support. If the resource, or the person's use of it for self-support, is questionable, obtain supervisory concurrence.

On the worksheet, record information about the resource owned and the reason for exclusion or nonexclusion.

F-4330 Business Property

Revision 09-4; Effective December 1, 2009

Property essential to self-support that is used in a person's trade or business is excluded from resources regardless of value or rate of return. Excludable business property is tangible business assets, including, but not limited to, land and buildings, equipment and supplies, inventory, livestock, motor vehicles and all liquid assets needed for the business.

Personal property used in a person's trade or business is also excluded from resources. Excluded personal property includes, but is not limited to, tools, safety equipment and uniforms.

To be considered as an excludable resource, business property (including personal, business-related property) must be in current use in the person's trade, business or employment. If the property is not in current use, HHSC

excludes the property only if it has been previously used by the person, and if it is reasonable to expect that it will be used again.

When a person alleges owning trade or business property, determine if a valid trade or business exists and if it is in current use. Obtain the following documentation:

1. a description of the trade or business,
2. a description of its assets,
3. the number of years it has been operating,
4. the identity of any co-owners, and
5. the estimated gross and net earnings for the current tax year. Business tax returns (IRS Form 1040 and appropriate schedules) can be used to determine earnings and the validity of the trade or business.

F-4400, Plan for Achieving Self-Support

Body

Revision 09-4; Effective December 1, 2009

If a blind or disabled person has an approved plan for achieving self-support (PASS), the MEPD Policy Section must approve the plan.

If the plan is approved, do not count the resources and income that are essential for accomplishing the objectives of the plan.

A counselor in the state agency for vocational rehabilitation formulates the majority of plans. However, the Veterans Administration, public or private social agencies or groups, anyone assisting the person, or the person himself may formulate plans.

Because an approved PASS is limited in duration, be sure to check the status of the plan at each redetermination and review the case again before the plan's termination date.

Keep in the case record a copy of the PASS. Record in the case record any additional information pertaining to the plan.

F-5000, Potential Resource Exclusions

F-5100, Reminders

Body
Revision 09-4; Effective December 1, 2009

See Section F-1000, General Principles of Resources, for consideration of ownership, accessibility and other treatment aspects of resources.

See Section F-1410, Deeming for Spouses, and Section F-1420, Deeming for Children, for exclusion of pensions when deeming resources from a spouse or parent.

See Section F-2000, Resource Exclusions – Limited and Related to Exempt Income.

See Section F-2100, Resources Exclusions – Limited, for treatment of certain resources that have a time limit on the exclusion or a dollar limit to the exclusion.

See Section F-2200, Resources Exclusions Related to Exempt Income, for treatment of certain resources that are associated with exempt income in Section Section E-2000, Exempt Income.

In Section F-4000, Liquid and Nonliquid Resources, the significance of distinction between liquid and nonliquid is necessary for the use of the exclusion for property essential to self-support. Liquid resources do not qualify for exclusion as property essential to self-support unless they represent necessary assets of a trade or business.

F-5200, Chart

Body

Revision 09-4; Effective December 1, 2009

A list of common resource exclusions follows. However, other exclusions, depending on the situation or on new federal regulations, could exist:

Exclusion	Section No.	No Limit on Value and /or Length of Time	Limit on Value and /or Length of Time
Home Serving as the principal place of residence, including the land on which the home stands and other buildings on that land	F-3000 F-3600		X
Funds from the sale of a home if reinvested timely in a replacement home	F-3400		X
Jointly-owned real property which cannot be sold without undue hardship (due to loss of housing) to the other owner(s)	F-1221	X	
Real property that was previously the home for so long as the owner's reasonable efforts to sell it are unsuccessful	F-4211 F-3130 F-3500	X	
Restricted, allotted Indian land if the Indian/owner cannot dispose of the land without permission of other individuals, his/her tribe or an agency of the federal government	F-2240 F-1220	X	
Automobile serving for transportation for medical	F-4221		
Life insurance, depending on its face value	F-4223		X
Burial space or plot	F-4214	X	
Burial funds for an applicant/recipient and/or his/her spouse	F-4227		X
Certain prepaid burial contracts	F-4160		X
Household goods and personal effects	F-4222		X
Property essential to self-support	F-4300		X
Resources of a blind or disabled person which are necessary to fulfill an approved plan for achieving self-support	F-4400		X
Retained retroactive SSI or RSDI benefits	F-2150		X
Radiation Exposure Compensation Trust Fund payments	F-2200	X	
German reparation payments made to World War II Holocaust survivors	F-2200	X	
Austrian social insurance payments	F-2200	X	
Japanese-American and Aleutian restitution payments	F-2200	X	

Exclusion	Section No.	No Limit on Value and /or Length of Time	Limit on Value and /or Length of Time
Federal disaster assistance received on account of a presidentially declared major disaster, including interest accumulated thereon	F-2200	X	
Cash (including accrued interest) and in-kind replacement received from any source at any time to replace or repair lost, damaged or stolen excluded resources	F-1270		X
Certain items excluded from both income and resources by other federal statutes	F-2260	Varies	
Agent Orange settlement payments to qualifying veterans and survivors	F-2260	X	
Victims' compensation payments	F-2210		X
State or local relocation assistance payments	F-2170		X
Tax refunds related to Earned Income Tax Credits	F-2130		X

F-6000, Types of Trusts

Body

Revision 20-3; Effective September 1, 2020

The trusts covered in this section are:

- Testamentary and Inter Vivos Trusts
- Medicaid-Qualifying Trust
- Trusts (Aug. 11, 1993, and After)
- Revocable Trusts
- Irrevocable
- Exception Trusts
- Qualified Income Trust (QIT)

F-6100 Testamentary and Inter Vivos Trusts

Revision 09-4; Effective December 1, 2009

A trust acts as an "account" created to hold assets. For example, trusts may hold assets for minors or adults who have been determined to be incompetent. Trusts also may be used to hold and distribute assets in such a way as to reduce income or estate taxes.

A trust includes any legal instrument, device or arrangement that may not be called a trust under state law, but that is similar to a trust. The characteristics of all trusts are primarily the same.

Elements such as trustees, trustors, beneficiaries, funding of the trust and whether or not the trust is revocable mean the same thing in any trust.

Resource and income eligibility treatment of trusts are different based on the terms of the trust.

The **trustee**, also known as the grantee, can be anyone — spouse, guardian, a financial institution or an individual holding a power of attorney.

If the person is the trustee and has the legal right to use the trust for the person's own benefit, then the trust is just like a bank account — all income and resources are available to that person.

A testamentary trust is established by will.

An inter vivos trust is established while the person creating the trust is still living.

There is a possibility that a person is a beneficiary of one of the above types of trusts when the person is a beneficiary of the trust, but his assets were not used to form the corpus of the trust.

Omnibus Budget Reconciliation Act (OBRA) of 1993 (Public Law 103-F-6F-6) made no changes in policy for testamentary and inter vivos trusts.

For trusts established using the person's assets, see Section F-6200, Medicaid-Qualifying Trust, and Section F-6300, Trusts (Aug. 11, 1993, and After).

Resources in a testamentary or inter vivos trust are countable if the person is the trustee and has the legal right to revoke the trust and use the money for his own benefit. If he does not have access to the trust, the trust is not counted as a resource. If a trust is not counted as a resource, payments (disbursements) from the trust made to or on behalf of the person are considered income (except payments [disbursements] used to purchase medical or social services for the person). If the person's access to a trust is restricted, that is, only the trustee (other than the person) or the court may withdraw the principal, then the value of the trust as a resource is not counted. This is true even if:

- the legal guardian is the trustee;
- the trust provides a regular, specified payment (disbursement) to the person; or
- the trust provides for discretionary withdrawals by the trustee.

Verification for a Testamentary or Inter Vivos Trust

Request the following:

- copy of the trust agreement;
- copy of the will, if the trust is a testamentary trust; and
- statement(s) from the financial institution, trust management company and attorney as to the following:
    - value of trust corpus (12:01 a.m. on the first day of the month(s)),
    - amount and frequency of income produced by the trust, and
    - amount of corpus and income available to the applicant/person.

Required Regional Legal Review and Documentation

A legal review of the trust document (or will) is necessary. Contact with regional legal staff is based on regionally established procedures. Check with your supervisor for regionally established procedures. Send a copy of the documents to the regional attorney for review. Ask the attorney to review the documents and determine if the trust:

- is a testamentary or inter vivos trust;
- is revocable or irrevocable;
- was established by someone other than the person such as a spouse, parent, grandparent, etc.;
- was established with someone else's money other than the person's money;

- restricts the person's access; or
- names the person as the trustee.

Resource Treatment

Based on the regional legal review, count the value of the corpus of the trust as an available resource if the:

- trust is a testamentary or inter vivos trust;
- trust is revocable; and
- person is named as the trustee and can use the money for the person's own benefit.

Based on the regional legal review, do not count the value of the corpus of the trust as an available resource if the:

- trust is a testamentary or inter vivos trust;
- person is not the trustee of the trust; and
- person's access to the trust is restricted — that is, only the trustee (other than the person) or the court may withdraw the principal.

In addition, the corpus of the trust is not counted as an available resource when the person is not the trustee, even if the:

- legal guardian is the trustee;
- trust provides a regular, specified payment/disbursement to the person; or
- trust provides for discretionary withdrawals by the trustee.

See Section E-3312, Testamentary and Inter Vivos Trusts Payments.

See Appendix XVI, Documentation and Verification Guide.

Note: Contact the regional attorney for help interpreting legal documents.

F-6200 Medicaid-Qualifying Trust

Revision 09-4; Effective December 1, 2009

A Medicaid-qualifying trust (MQT) is one that the person, his spouse, guardian or anyone holding his power of attorney establishes using the person's money. The person is the beneficiary of a Medicaid-qualifying trust. A Medicaid-qualifying trust is one that was established between June 1, 1986, and Aug. 10, 1993. Trusts which meet the MQT definition and were established prior to June 1, 1986, are treated as standard inter vivos trusts.

Note: Public Law 103-66 (OBRA '93) revised policy for trusts established using the person's money on or after Aug. 11, 1993.

For Medicaid-qualifying trusts established before that date, continue using the policy in this section. If provisions for a change in the trust were included in the document before Aug. 11, 1993, use the policy governing Medicaid-qualifying trusts for the change. If the trust was amended on or after Aug. 11, 1993, apply the policy in Section F-6300, Trusts (Aug. 11, 1993, and After).

Public Law 99-272 states that distributions from Medicaid-qualifying trusts are considered available to the person whether or not distributions are actually made. The amount available is the maximum amount the trustee could disburse if he used his full discretion under terms of the trust. If distribution is not made, the maximum amount the trustee may distribute if he used his full discretion under terms of the trust is considered an available resource. If trusts do not specify an amount for distribution, and if the trustee has access to and use of the principal or the income from the trust, then the entire amount is considered an available resource that may be used for the person's benefit.

Examples:

- The trustee has the discretion to distribute the corpus of the trust, which is property worth $6,000. The corpus, therefore, is a $6,000 countable resource.
- The person established an irrevocable Medicaid-qualifying trust before Aug. 11, 1993. The trustee has discretion only to distribute $100 monthly from the income earned by the trust but chooses not to do so. The corpus is not a countable resource; however, the person's other countable resources are increased by $100 every month. If necessary, schedule a special review to monitor eligibility.

F-6210 Zebley Cases

Revision 09-4; Effective December 1, 2009

A Medicaid-qualifying trust established for a minor child using the lump sum payment received in settlement of Zebley vs. Sullivan is excluded from all consideration of eligibility under undue hardship provisions. Undue hardship exists because the person would otherwise be forced to spend the settlement funds on services now covered by Medicaid when the funds will be needed once the person reaches majority. A trust established using Zebley settlement funds is excluded under undue hardship policy, even when the trust is set up on or after Aug. 11, 1993.

Zebley funds may be used to establish pooled trusts detailed in Section F-6700, Exception Trusts.

F-6300 Trusts (Aug. 11, 1993, and After)

Revision 09-4; Effective December 1, 2009

The Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66) revised policy concerning trusts established on or after Aug. 11, 1993, using the person's assets. The trust provisions apply to all MEPD applicants/recipients, whether in an institutionalized setting or not. However, the penalty period for transfers of assets into irrevocable trusts applies only to a person in an institutional setting.

A trust includes any legal instrument, device or arrangement which may not be called a trust under state law, but which is similar to a trust. That is, it involves a grantor who transfers property to an individual or entity with fiduciary obligations with the intention that it be held, managed or administered by the individual or entity for the benefit of the grantor or others. This can include (but is not limited to) escrow accounts, investment accounts, pension funds, irrevocable burial trusts, limited partnerships and other similar entities managed by an individual or entity with the fiduciary obligations.

Note: A legal review of the instrument, device or arrangement that establishes the trust is necessary. Contact with regional legal staff is based on regionally established procedures. Check with your supervisor for regionally established procedures. Send a copy of the documents to the regional attorney for review. See Appendix XVI, Documentation and Verification Guide.

The characteristics of the trust include the following:

- The trust was established on or after Aug. 11, 1993.
- The person's assets were used to form all or part of the corpus of the trust. The policy in this section does not apply to trusts established by a will in which the person is the beneficiary.
- The trust was established by:
  - the person;
  - the person's spouse;
  - any person, including a court or administrative body, with legal authority to act on behalf of or in place of the person or person's spouse; or
  - any person, including a court or administrative body, acting upon the direction or the request of the person or the person's spouse.

If the person's assets comprise only part of the corpus, the trust policies apply to that portion of corpus consisting of the person's former assets.

Example: The person established a trust on Aug. 15, 1993, with a corpus of $20,000. The person contributed $8,000 to the corpus and her adult children contributed $12,000. The trust policies apply to the $8,000 placed by the person into trust.

F-6310 Limited Partnerships

Revision 12-2; Effective June 1, 2012

A limited partnership is an investment arrangement often used as an estate-planning device. A limited partnership must be filed with the Secretary of State. There are general partners and limited partners. General partners manage and make all decisions pertaining to the partnership. Limited partners own a percentage of the partnership, but they are not active partners and have no voice in management. The ownership interest held by limited partners is not business property, but represents only an investment, much like stock shares in any corporation. As investors, they receive a share of the profits and losses. A "family limited partnership" is simply one that is restricted to family members.

A limited partnership is "similar legal device" to a trust.

Trust provisions of the Omnibus Budget Reconciliation Act of 1993 direct that the term "trust" includes any legal device similar to a trust.

The general partners act as trustee, and the limited partners are the equivalent of beneficiaries of an irrevocable trust. To the extent that the general partners can make each limited partner's ownership interest available to him, that interest is a countable resource and not a transfer of assets. However, a transfer of assets has occurred to the extent that:

- The value of the share of ownership purchased by the limited partner is less than the amount he invested.

Example: The individual originally owned 100% of the assets comprising the partnership. This 100% interest is exchanged for a 95% interest in the partnership. This represents a transfer of 5% of those assets.

- The general partners cannot make the limited partner's share available to him.

  Example: The limited partnership imposes restrictions on the sale of its property or the individual's interest in the partnership. A transfer of assets has occurred to the extent that the individual's right to sell his interest is restricted.

If transfer-of-assets provisions apply, the look-back period is 60 months.

Limited partnership agreements should be referred to the regional attorney. Medicaid eligibility specialists apply the appropriate policy based on the regional attorney's evaluation of the terms of the agreement.

See Chapter E, General Income, for treatment of income.

F-6400 Revocable Trusts

Revision 09-4; Effective December 1, 2009

A legal review of the instrument, device or arrangement that establishes the trust is necessary. Contact with regional legal staff is based on regionally established procedures. Check with your supervisor for regionally established procedures. Send a copy of the documents to the regional attorney for review. See Appendix XVI, Documentation and Verification Guide.

The corpus is an available resource.

Example: On Aug. 11, 1993, the person transferred $50,000 into a revocable trust. Terms of the trust do not permit the trustee to pay any portion of the corpus to or for the benefit of the person, but the person can revoke the trust. Since the trust is revocable, the entire $50,000 corpus is a countable resource.

Payments from the corpus or income generated by the corpus, to or for the benefit of the person, excluding payments for medical/social services, are income.

Payments from the corpus or income generated by the corpus for any other purpose are a transfer of assets.

Examples:

- A withdrawal from a trust account that is given to the person's brother is a transfer of assets.
- A withdrawal from a trust account that is given to a spouse does not incur a transfer of assets penalty because interspousal transfers are permitted.

When the home is in an irrevocable or revocable trust ("Living Trust"), see Section F-3300, The Home as a Countable Resource.

F-6500 Irrevocable Trusts

Revision 09-4; Effective December 1, 2009

A legal review of the instrument, device or arrangement that establishes the trust is necessary. Contact with regional legal staff is based on regionally established procedures. Check with your supervisor for regionally established procedures. Send a copy of the documents to the regional attorney for review. See Appendix XVI, Documentation and Verification Guide.

If there are any circumstances under which payment from an irrevocable trust could be made to or for the benefit of the person, then:

- the portion of the corpus, or income generated by the corpus, from which payment could be made is a countable resource;
- payments made to or for the benefit of the person, except medical and social services, are countable income; and
- payments for any other purpose are a transfer of assets.

Although termed irrevocable, a trust which provides that the trust can only be modified or terminated by a court is a revocable trust because the person or his responsible party can petition the court to amend or terminate the trust.

Although termed irrevocable, a trust that will terminate if a certain circumstance occurs during the lifetime of the person, such as the person leaving the nursing facility and returning home, is a revocable trust.

If there are no circumstances under which payments from some portion or all of an irrevocable trust, or income generated by the trust, could be made available to a person, then the corpus, or portion of the corpus, and the generated income are considered a transfer of assets.

The date of transfer is the date the trust was established, or if terms of the trust foreclose payment to the person at a later date, the date payment is foreclosed to the person. The value of the trust, for calculating the penalty period, includes any payments made from the trust for whatever purpose after the date the trust was established or, if later, the date payment to the person was foreclosed. If funds were added to that portion of the trust after these dates, including interest earned by the trust, the addition of those funds is considered to be a new transfer of assets, effective on the date the funds are added to the trust. Thus, in treating portions of a trust which cannot be paid to a person, the value of the transferred amount is no less than its value on the date of establishment or foreclosure, and may be greater if funds were added to the trust after that date.

F-6600 Treatment of Trusts

Revision 09-4; Effective December 1, 2009

A legal review of the instrument, device or arrangement that establishes the trust is required. Contact with regional legal staff is based on regionally established procedures. Check with your supervisor for regionally established procedures. Send a copy of the documents to the regional attorney for review. See Appendix XVI, Documentation and Verification Guide.

The following policy applies to trusts without regard to:

- the purpose for which the trust is established;
- whether the trustee, or similar person or entity, has or exercises any discretion under the trust;
- any restrictions on when or whether distributions can be made from the trust; or
- any restrictions on the use of distributions from the trust.

This means that any trust which meets the basic requirements outlined in previous sections can be counted in determining eligibility for Medicaid. No clause or requirement in the trust, no matter how specifically it applies to Medicaid, or other federal or state programs (that is, an exculpatory clause), precludes a trust from being considered under the rules of this section. While exculpatory clauses, use clauses, trustee discretion or restrictions on distributions do not affect a trust's countability, they do have an impact on how the various components of specific trusts are treated.

F-6610 Payments from a Trust

Revision 09-4; Effective December 1, 2009

A legal review of the instrument, device or arrangement that establishes the trust is necessary. Contact with regional legal staff is based on regionally established procedures. Check with your supervisor for regionally established procedures. Send a copy of the documents to the regional attorney for review. See Appendix XVI, Documentation and Verification Guide.

Payments to or on behalf of the person:

Payments are considered to be made to the person when any amount from the trust, including an amount from the corpus or income produced by the corpus, is paid directly to the person, or to someone acting on his behalf, such as a guardian or legal representative.

Payments made for the benefit of the person are payments of any sort, including an amount from the corpus or income produced by the corpus, paid to another entity so that the person derives some benefit from the payment. For example, such payments could include purchase of clothing or other items, such as a radio or television for the person. Such payments could also include payment for services the person may require, or care, whether medical or personal, that the person may need. Payments to maintain a home would also be payments for the benefit of the person.

A payment to or for the benefit of the person is counted under trust provisions only if such a payment is ordinarily counted as income. For example, payments made on behalf of a person for medical care are not counted in determining income eligibility. Thus, such payments are not counted as income under the trust provision.

Circumstances under which payments can or cannot be made:

In determining whether payments can or cannot be made from a trust, any restrictions on payments, such as use restrictions, exculpatory clauses or limits on trustee discretion that may be included in the trust, must be considered.

Example: If the trust provides that the trustee can disburse only $1,000 out of a $20,000 trust, only the $1,000 would be treated as a payment (disbursement) that could be made. The remaining $19,000 would be treated as an amount that cannot, under any circumstances, be paid to or for the benefit of the person.

When a trust provides, in some manner, that a payment (disbursement) can be made, even though that payment (disbursement) may be sometime in the future, the trust is treated as providing that the payment (disbursement) can be made from the trust.

Example: If a trust contains $50,000 that the trustee can pay to the person only in the event that the person needs, for example, a heart transplant, the full amount would be considered as payment (disbursement) that could be made under some circumstances, even though the likelihood of payment (disbursement) is remote.

F-6700 Exception Trusts

Revision 09-4; Effective December 1, 2009

A legal review of the instrument, device or arrangement that establishes the trust is necessary. Contact with regional legal staff is based on regionally established procedures. Check with your supervisor for regionally established procedures. Send a copy of the documents to the regional attorney for review. See Appendix XVI, Documentation and Verification Guide.

The Omnibus Budget Reconciliation Act of 1993 identifies several types of trusts which are exceptions to the trust provisions stated in Section F-6300, Trusts (Aug. 11, 1993, and After). These exceptions apply only to trusts established on or after Aug. 11, 1993.

F-6710 Special Needs Trust

Revision 20-3; Effective September 1, 2020

A legal review of the instrument, device or arrangement that establishes the trust is necessary. Contact with regional legal staff is based on regionally established procedures. Check with your supervisor for regionally established procedures. Send a copy of the documents to the regional attorney for review.

Special needs trust:

A special needs trust is a revocable or irrevocable trust established with the assets (income or resources) of a person under age 65 who meets the SSI program's disability criteria. The trust must be established for the person's benefit by a parent, grandparent, legal guardian, a court or the person. Beginning Dec. 13, 2016, people under age 65 who meet the SSI program's disability criteria may establish a special needs trust for their own benefit. The trust must include a provision that the state is designated as the residuary beneficiary to receive, at the person's death, funds remaining in the trust equal to the total amount of Medicaid paid on their behalf.

Use Form H1210, Subrogation (Trusts/Annuities/Court Settlements), to report to the Provider Claims Payment Section any potential paybacks to the state as the residuary beneficiary of special needs trusts.

This trust exception continues even after a person becomes age 65 if the individual continues to meet the disability criteria for the SSI program. However, additions or augmentations to the trust after the person becomes age 65 are a transfer of assets.

If a person is receiving disability benefits from SSI, RSDI or Railroad Retirement (RR), their disability is automatically established. Verify that the SSI, RSDI or RR benefit is a disability benefit. Otherwise, disability must be established.

Related Policy
Documentation and Verification Guide, Appendix XVI

F-6711 Treatment as Resource

Revision 09-4; Effective December 1, 2009

The trust is not counted as a resource.

F-6712 Treatment as Income

Revision 18-1; Effective March 1, 2018

Any distribution paid directly from a trust to the individual or to a third party for the benefit of the individual is unearned income to the individual in the month of receipt, except:

- payments for medical or social services for the trust beneficiary (Section E-1000, General Income, for an explanation of medical and social services); and
- payments to the trust beneficiary's Achieving a Better Life Experience account (Section E-3331.4, Treatment of Interest and Dividends Earned on an Achieving a Better Life Experience (ABLE) Account).

A payment to or for the benefit of the individual is counted under trust provisions only if such payment is ordinarily counted as income.

F-6713 Transfer of Assets

Revision 09-4; Effective December 1, 2009

Transfer-of-assets provisions do not apply when such a trust is established. However, if assets are transferred to another party from the corpus or income generated by the corpus, then the policy in Chapter I, Transfer of Assets, applies.

F-6720 Pooled Trust

Revision 09-4; Effective December 1, 2009

A legal review of the instrument, device or arrangement that establishes the trust is necessary. Contact with regional legal staff is based on regionally established procedures. Check with your supervisor for regionally established procedures. Send a copy of the documents to the regional attorney for review. See Appendix XVI, Documentation and Verification Guide.

Pooled trust:

Note: Zebley funds may be used to establish pooled trusts.

A pooled trust is a revocable or irrevocable trust containing the assets of a person who meets SSI's definition of disability and which satisfies the following conditions:

- It was established and is managed by a non-profit association.
- A separate account is maintained for each beneficiary but, for investment and management purposes, the accounts may be pooled.
- Accounts in the trust are established solely for the benefit of persons who meet SSI's disability criteria, and the trusts are established by a parent, grandparent or legal guardian of such individuals by a court, or by the disabled individuals themselves.
- The trust must include a provision that, to the extent that amounts remaining in a person's account at his death are not retained by the trust, the state is reimbursed in an amount equal to the total amount Medicaid paid on the person's behalf.

Note: Use Form H1210 to report to the Provider Claims Payment Section any potential paybacks to the state as the residuary beneficiary of pooled trusts.

Examples of pooled trusts are:

- The ARC of Texas Master Pooled Trust, established in 1997.
- Declaration of Trust for the Travis County Master Trust; Founders Trust Company, Trustee, adopted by decree of the District Court of Travis County, Texas, 201st Judicial District, effective Aug. 1, 1993.
- Declaration of Trust for Children for Whom the Texas Department of Protective and Regulatory Services is Managing Conservator or Who Are or Have Been Under its Jurisdiction; Boatmen's National Bank of Austin, Trustee, adopted by decree of the District Court of Travis County, Texas, 98th Judicial District, effective June 1, 1993.

F-6721 Treatment as Resource

Revision 09-4; Effective December 1, 2009

The trust is not counted as a resource.

F-6722 Treatment as Income

Revision 18-1; Effective March 1, 2018

Any distribution to or for the benefit of the person from corpus or income generated by the trust is countable income, except the following distributions:

- payments for medical or social services (See Section E-1000, General Income, for an explanation of medical and social services); and

- payments to an Achieving a Better Life Experience account (E-3331.4, Treatment of Interest and Dividends Earned on an Achieving a Better Life Experience (ABLE) Account.).

A payment to or for the benefit of the person is counted under trust provisions only if such payment is ordinarily counted as income.

F-6723 Transfer of Assets

Revision 09-4; Effective December 1, 2009

Transfer-of-assets provisions do not apply when a pooled trust is established for the benefit of a person under age 65. If the person is age 65 or older, or if the person's portion of the assets in the trust are transferred to another party, then the policy in Chapter I, Transfer of Assets, applies.

F-6800 Qualified Income Trust (QIT)

Revision 16-4; Effective December 1, 2016

When an applicant is income ineligible in an institutional setting, see Section B-2500, Explaining Policy vs. Giving Advice, to determine the appropriate actions to take and the actions to avoid. See Appendix XXXVI, Qualified Income Trusts (QITs) and Medicaid for the Elderly and People with Disabilities (MEPD), for more information concerning a QIT and a sample QIT document.

Although the use of a QIT can overcome the special income limit for MEPD eligibility for institutional or Home and Community-Based Services waiver programs, it is not available to individuals in Community Attendant Services (CAS) who are income ineligible.

If a QIT is received, a legal review of the instrument, device, or arrangement that establishes the trust is necessary. Contact with regional legal staff is based on regionally established procedures. Check with your supervisor for regionally established procedures. Send a copy of the QIT documents to the regional attorney for review. See Appendix XVI, Documentation and Verification Guide.

Qualified income trust (QIT):

A QIT is an irrevocable trust established for the benefit of an individual and/or the individual's spouse, the corpus of which is composed only of the individual's income (including accumulated income). The trust must include a provision that the state is designated as the residuary beneficiary to receive, at the individual's death, funds remaining in the trust equal to the total amount of funds Medicaid paid on the individual's behalf. Use Form H1210, Subrogation (Trusts/Annuities/Court Settlements), to report to the Provider Holds and Recoupment Unit any potential paybacks to the state as the residuary beneficiary of QITs.

The following lists the characteristics of a QIT.

- The trust must be irrevocable.
- The trust must contain only the individual's income.
    - If resources are placed in the trust, it is not a QIT.

  - Some banks may require nominal deposits, $10 to $20, to establish a financial account to fund the trust.
  - Nominal amounts of an individual's resources, or another party's funds, may be used to establish the account without invalidating the trust or being counted as gift income to the individual. Once the trust account is established, however, only the individual's income can be directed to the trust account.
- The income does not have to be directly deposited into the trust.
- The income for which the trust is established must be deposited into the trust during the month it is received by the individual.
- The trust may be established with any or all sources of an individual's income, but an entire income source must be deposited. For example, the trust may be established for an individual's private pension income, but not the individual's Social Security income. If the trust document indicates only half of the pension income must be deposited, it is not a valid QIT.

F-6810 Treatment as Resource

Revision 09-4; Effective December 1, 2009

The trust is not counted as a resource.

F-6820 Treatment as Income

Revision 16-4; Effective December 1, 2016

Income directed to the trust is disregarded from countable income when testing eligibility for institutional or Home and Community-Based Services (HCBS) waiver programs. Income must be directed to the trust account during the calendar month in which it is received. Any source of non-exempt/non-excludable income which is not directed to the QIT account during the calendar month of receipt is countable income for that month.

For the initial month that a QIT is established, a partial deposit of the income for which the trust is established will not invalidate the trust and the entire amount of the income source(s) will be disregarded from countable income for that month. An individual may have used some of the monthly income to pay expenses prior to the date the QIT is established so the entire source(s) may not be available to open the QIT account. If only a partial deposit is made in the initial month, prior to certification, staff must verify that the entire amount of the income source(s) for which the QIT is established is being deposited into the QIT account subsequent month or the QIT is considered invalidated.

If countable income exceeds the institutional income limit, the individual is income-ineligible for the month. Applicants may not be certified for any calendar month(s) in which they are income-ineligible. For active individuals, restitution is requested in the amount of the vendor payment for any calendar month(s) in which they are income-ineligible.

Notes:

- When an individual does not pay a full month's co-payment due to hospitalization or because Medicare covered 100% of the cost of a partial month, the accumulated funds in the QIT trust are not a countable

resource, and transfer of assets is not involved.

- An individual receiving HCBS waiver services who establishes a QIT covering all waiver costs is not denied. In a waiver program, the applicant with a QIT is receiving the benefit of the contracted Medicaid rates for waiver services as opposed to the private rates.

Examples:

- The applicant entered the nursing facility and applied for Medicaid in July. Income totals $3,600. The QIT calls for all income to be directed to the trust account. However, the trustee did not deposit the July income checks to the trust account until August 23. The entire $3,600 is countable income for July, and the applicant is ineligible for that month.

- The individual was certified for Medicaid in September. The QIT calls for all income (totaling $3,600) to be directed to the trust account. During the redetermination in August of the following year, the eligibility specialist learns that income checks for June were not deposited to the trust account until July. Because the person was ineligible for June, the eligibility specialist requests restitution for that month in the amount of the vendor payment.

Income directed to the trust is not disregarded in determining eligibility for SSI or non-institutional medical assistance programs: Qualified Medicare Beneficiaries, Special Low-Income Medicare Beneficiaries, or Community Attendant Services.

Income paid from the trust for co-payment for institutional or Home and Community-Based Services waiver services or to purchase other medical services for the person is not countable income for eligibility purposes. Income paid from the trust directly to the person or otherwise spent for his benefit is countable income for eligibility purposes.

Examples of countable income include cash distributions directly to the individual and direct payments (disbursements) from the trust for the individual's hair salon services. These distributions do not invalidate the trust; however, they are countable income in the month of distribution. If countable income exceeds the institutional limit, the individual is income ineligible for that month. Eligibility specialists may not certify applicants for any month(s) in which they are income ineligible. For active individuals, the eligibility specialist requests restitution for any month(s) in which the individual was ineligible. The eligibility specialist must test for ongoing eligibility.

The individual cannot use income from the trust to purchase eligibility for any HCBS waiver program. If the trustee directs to the trust account different sources of income other than those identified in the QIT document, but the entire income source(s) is deposited and countable income remains within the institutional income limit, eligibility is not affected.

Example: The individual's income totals $3,600, consisting of $600 Social Security and $3,000 private pension. The QIT calls for all income to be directed to the trust account. At redetermination, the eligibility specialist learns that the trustee is directing only the private pension to the trust account. Since the individual's countable income totals $600, the individual remains income-eligible.

If the trust instrument requires that the income placed in the trust must be paid out of the trust for institutional or HCBS waiver services provided to the individual, there is no transfer of assets because the individual receives fair market value for the income that was placed into the trust. However, if there is no such requirement or the income is not used for the individual's care, transfer of assets provisions apply. The income must be paid out by the end of the month following the month funds were placed in the trust to avoid transfer provisions. Because transfer of assets is not imposed for transfers of assets between spouses, QIT provisions that allow payments to or for the benefit of the individual's spouse do not result in a transfer of assets penalty.

Institutional care co-payment and community-based care co-payment calculations are based on the individual's total income (income directed to the trust as well as income not directed to the trust), less the standard co-

payment deductions. Costs of trust administration are not deducted in the co-payment calculation; however, legal and accounting fees necessary to maintain the trust can be paid from the trust without incurring a transfer penalty.

VA aid-and-attendance benefits, housebound allowances and reimbursements for unusual or continuing medical expenses are exempt from both eligibility and co-payment calculations. However, if an individual deposits these payments into a QIT account, they are countable for co-payment calculations. If an individual receives a VA pension that includes aid-and-attendance benefits, housebound allowances or reimbursements for unusual or continuing medical expenses, the individual may separate the aid-and-attendance benefits, household allowances or reimbursements for unusual or continuing medical expenses from the VA pension before depositing the VA pension into the QIT account. Aid-and-attendance benefits, housebound allowances or reimbursements for unusual or continuing medical expenses are not income for Medicaid eligibility determinations.

The income placed in a QIT will be disregarded for eligibility purposes for the first month that the individual has a valid signed trust and enough income is placed in the account to reduce the remaining income below the eligibility limit. For the initial month that a QIT is established, even if only a partial payment of the income for which the trust is established is deposited, the entire income source is disregarded for that month.

F-6900 Undue Hardship

Revision 09-4; Effective December 1, 2009

When application of the trust provisions would create an undue hardship, those provisions do not apply. Undue hardship exists when application of the trust provisions would deprive the person of medical care so that his health or his life would be endangered. Undue hardship also exists when application of the trust provisions would deprive the person of food, clothing, shelter or other necessities of life.

Undue hardship does not exist if a person is inconvenienced or must restrict his lifestyle, but is not at risk of serious deprivation. Undue hardship relates to hardship to the person, not relatives or responsible parties of the person.

Before requesting a waiver of the trust provisions on the grounds of undue hardship, the person must make reasonable efforts to recover assets placed in trust, such as petitioning the court to dissolve the trust. If a person claims undue hardship, HHSC must make a decision on the situation as soon as possible, but within 30 days of receipt of the request for a waiver of the trust policy. The person has the right to appeal an adverse decision on undue hardship.

Minimum case documentation includes a written statement explaining the person's or grantor's reasons for establishing the trust, why the person's needs cannot be met and why there is undue hardship for the person.

The supervisor must sign off on all undue hardship cases.

F-6100, Testamentary and Inter Vivos Trusts

Body

Revision 09-4; Effective December 1, 2009

A trust acts as an "account" created to hold assets. For example, trusts may hold assets for minors or adults who have been determined to be incompetent. Trusts also may be used to hold and distribute assets in such a way as

to reduce income or estate taxes.

A trust includes any legal instrument, device or arrangement that may not be called a trust under state law, but that is similar to a trust. The characteristics of all trusts are primarily the same.

Elements such as trustees, trustors, beneficiaries, funding of the trust and whether or not the trust is revocable mean the same thing in any trust.

Resource and income eligibility treatment of trusts are different based on the terms of the trust.

The **trustee**, also known as the grantee, can be anyone — spouse, guardian, a financial institution or an individual holding a power of attorney.

If the person is the trustee and has the legal right to use the trust for the person's own benefit, then the trust is just like a bank account — all income and resources are available to that person.

A testamentary trust is established by will.

An inter vivos trust is established while the person creating the trust is still living.

There is a possibility that a person is a beneficiary of one of the above types of trusts when the person is a beneficiary of the trust, but his assets were not used to form the corpus of the trust.

Omnibus Budget Reconciliation Act (OBRA) of 1993 (Public Law 103-F-6F-6) made no changes in policy for testamentary and inter vivos trusts.

For trusts established using the person's assets, see Section F-6200, Medicaid-Qualifying Trust, and Section F-6300, Trusts (Aug. 11, 1993, and After).

Resources in a testamentary or inter vivos trust are countable if the person is the trustee and has the legal right to revoke the trust and use the money for his own benefit. If he does not have access to the trust, the trust is not counted as a resource. If a trust is not counted as a resource, payments (disbursements) from the trust made to or on behalf of the person are considered income (except payments [disbursements] used to purchase medical or social services for the person). If the person's access to a trust is restricted, that is, only the trustee (other than the person) or the court may withdraw the principal, then the value of the trust as a resource is not counted. This is true even if:

- the legal guardian is the trustee;
- the trust provides a regular, specified payment (disbursement) to the person; or
- the trust provides for discretionary withdrawals by the trustee.

Verification for a Testamentary or Inter Vivos Trust

Request the following:

- copy of the trust agreement;
- copy of the will, if the trust is a testamentary trust; and
- statement(s) from the financial institution, trust management company and attorney as to the following:
    - value of trust corpus (12:01 a.m. on the first day of the month(s)),
    - amount and frequency of income produced by the trust, and
    - amount of corpus and income available to the applicant/person.

Required Regional Legal Review and Documentation

A legal review of the trust document (or will) is necessary. Contact with regional legal staff is based on regionally established procedures. Check with your supervisor for regionally established procedures. Send a copy of the documents to the regional attorney for review. Ask the attorney to review the documents and determine if the trust:

- is a testamentary or inter vivos trust;
- is revocable or irrevocable;
- was established by someone other than the person such as a spouse, parent, grandparent, etc.;
- was established with someone else's money other than the person's money;
- restricts the person's access; or
- names the person as the trustee.

Resource Treatment

Based on the regional legal review, count the value of the corpus of the trust as an available resource if the:

- trust is a testamentary or inter vivos trust;
- trust is revocable; and
- person is named as the trustee and can use the money for the person's own benefit.

Based on the regional legal review, do not count the value of the corpus of the trust as an available resource if the:

- trust is a testamentary or inter vivos trust;
- person is not the trustee of the trust; and
- person's access to the trust is restricted — that is, only the trustee (other than the person) or the court may withdraw the principal.

In addition, the corpus of the trust is not counted as an available resource when the person is not the trustee, even if the:

- legal guardian is the trustee;
- trust provides a regular, specified payment/disbursement to the person; or
- trust provides for discretionary withdrawals by the trustee.

See Section E-3312, Testamentary and Inter Vivos Trusts Payments.

See Appendix XVI, Documentation and Verification Guide.

Note: Contact the regional attorney for help interpreting legal documents.

F-6200, Medicaid-Qualifying Trust

Body

Revision 09-4; Effective December 1, 2009

A Medicaid-qualifying trust (MQT) is one that the person, his spouse, guardian or anyone holding his power of attorney establishes using the person's money. The person is the beneficiary of a Medicaid-qualifying trust. A Medicaid-qualifying trust is one that was established between June 1, 1986, and Aug. 10, 1993. Trusts which meet the MQT definition and were established prior to June 1, 1986, are treated as standard inter vivos trusts.

Note: Public Law 103-66 (OBRA '93) revised policy for trusts established using the person's money on or after Aug. 11, 1993.

For Medicaid-qualifying trusts established before that date, continue using the policy in this section. If provisions for a change in the trust were included in the document before Aug. 11, 1993, use the policy governing Medicaid-qualifying trusts for the change. If the trust was amended on or after Aug. 11, 1993, apply the policy in Section F-6300, Trusts (Aug. 11, 1993, and After).

Public Law 99-272 states that distributions from Medicaid-qualifying trusts are considered available to the person whether or not distributions are actually made. The amount available is the maximum amount the trustee could disburse if he used his full discretion under terms of the trust. If distribution is not made, the maximum amount the trustee may distribute if he used his full discretion under terms of the trust is considered an available resource. If trusts do not specify an amount for distribution, and if the trustee has access to and use of the principal or the income from the trust, then the entire amount is considered an available resource that may be used for the person's benefit.

Examples:

- The trustee has the discretion to distribute the corpus of the trust, which is property worth $6,000. The corpus, therefore, is a $6,000 countable resource.
- The person established an irrevocable Medicaid-qualifying trust before Aug. 11, 1993. The trustee has discretion only to distribute $100 monthly from the income earned by the trust but chooses not to do so. The corpus is not a countable resource; however, the person's other countable resources are increased by $100 every month. If necessary, schedule a special review to monitor eligibility.

F-6210 Zebley Cases

Revision 09-4; Effective December 1, 2009

A Medicaid-qualifying trust established for a minor child using the lump sum payment received in settlement of Zebley vs. Sullivan is excluded from all consideration of eligibility under undue hardship provisions. Undue hardship exists because the person would otherwise be forced to spend the settlement funds on services now covered by Medicaid when the funds will be needed once the person reaches majority. A trust established using Zebley settlement funds is excluded under undue hardship policy, even when the trust is set up on or after Aug. 11, 1993.

Zebley funds may be used to establish pooled trusts detailed in Section F-6700, Exception Trusts.

F-6300, Trusts (August 11, 1993 and After)

Body

Revision 09-4; Effective December 1, 2009

The Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66) revised policy concerning trusts established on or after Aug. 11, 1993, using the person's assets. The trust provisions apply to all MEPD applicants/recipients, whether in an institutionalized setting or not. However, the penalty period for transfers of assets into irrevocable trusts applies only to a person in an institutional setting.

A trust includes any legal instrument, device or arrangement which may not be called a trust under state law, but which is similar to a trust. That is, it involves a grantor who transfers property to an individual or entity with fiduciary obligations with the intention that it be held, managed or administered by the individual or entity for the benefit of the grantor or others. This can include (but is not limited to) escrow accounts, investment accounts, pension funds, irrevocable burial trusts, limited partnerships and other similar entities managed by an individual or entity with the fiduciary obligations.

Note: A legal review of the instrument, device or arrangement that establishes the trust is necessary. Contact with regional legal staff is based on regionally established procedures. Check with your supervisor for regionally established procedures. Send a copy of the documents to the regional attorney for review. See Appendix XVI, Documentation and Verification Guide.

The characteristics of the trust include the following:

- The trust was established on or after Aug. 11, 1993.
- The person's assets were used to form all or part of the corpus of the trust. The policy in this section does not apply to trusts established by a will in which the person is the beneficiary.
- The trust was established by:
  - the person;
  - the person's spouse;
  - any person, including a court or administrative body, with legal authority to act on behalf of or in place of the person or person's spouse; or
  - any person, including a court or administrative body, acting upon the direction or the request of the person or the person's spouse.

If the person's assets comprise only part of the corpus, the trust policies apply to that portion of corpus consisting of the person's former assets.

Example: The person established a trust on Aug. 15, 1993, with a corpus of $20,000. The person contributed $8,000 to the corpus and her adult children contributed $12,000. The trust policies apply to the $8,000 placed by the person into trust.

F-6310 Limited Partnerships

Revision 12-2; Effective June 1, 2012

A limited partnership is an investment arrangement often used as an estate-planning device. A limited partnership must be filed with the Secretary of State. There are general partners and limited partners. General partners manage and make all decisions pertaining to the partnership. Limited partners own a percentage of the partnership, but they are not active partners and have no voice in management. The ownership interest held by limited partners is not business property, but represents only an investment, much like stock shares in any corporation. As investors, they receive a share of the profits and losses. A "family limited partnership" is simply one that is restricted to family members.

A limited partnership is "similar legal device" to a trust.

Trust provisions of the Omnibus Budget Reconciliation Act of 1993 direct that the term "trust" includes any legal device similar to a trust.

The general partners act as trustee, and the limited partners are the equivalent of beneficiaries of an irrevocable trust. To the extent that the general partners can make each limited partner's ownership interest available to him, that interest is a countable resource and not a transfer of assets. However, a transfer of assets has occurred to the extent that:

- The value of the share of ownership purchased by the limited partner is less than the amount he invested.

  Example: The individual originally owned 100% of the assets comprising the partnership. This 100% interest is exchanged for a 95% interest in the partnership. This represents a transfer of 5% of those assets.

- The general partners cannot make the limited partner's share available to him.

  Example: The limited partnership imposes restrictions on the sale of its property or the individual's interest in the partnership. A transfer of assets has occurred to the extent that the individual's right to sell his interest is restricted.

If transfer-of-assets provisions apply, the look-back period is 60 months.

Limited partnership agreements should be referred to the regional attorney. Medicaid eligibility specialists apply the appropriate policy based on the regional attorney's evaluation of the terms of the agreement.

See Chapter E, General Income, for treatment of income.

F-6400, Revocable Trusts

Body

Revision 09-4; Effective December 1, 2009

A legal review of the instrument, device or arrangement that establishes the trust is necessary. Contact with regional legal staff is based on regionally established procedures. Check with your supervisor for regionally established procedures. Send a copy of the documents to the regional attorney for review. See Appendix XVI, Documentation and Verification Guide.

The corpus is an available resource.

Example: On Aug. 11, 1993, the person transferred $50,000 into a revocable trust. Terms of the trust do not permit the trustee to pay any portion of the corpus to or for the benefit of the person, but the person can revoke the trust. Since the trust is revocable, the entire $50,000 corpus is a countable resource.

Payments from the corpus or income generated by the corpus, to or for the benefit of the person, excluding payments for medical/social services, are income.

Payments from the corpus or income generated by the corpus for any other purpose are a transfer of assets.

Examples:

- A withdrawal from a trust account that is given to the person's brother is a transfer of assets.
- A withdrawal from a trust account that is given to a spouse does not incur a transfer of assets penalty because interspousal transfers are permitted.

When the home is in an irrevocable or revocable trust ("Living Trust"), see Section F-3300, The Home as a Countable Resource.

F-6500, Irrevocable Trusts

Body

Revision 09-4; Effective December 1, 2009

A legal review of the instrument, device or arrangement that establishes the trust is necessary. Contact with regional legal staff is based on regionally established procedures. Check with your supervisor for regionally established procedures. Send a copy of the documents to the regional attorney for review. See Appendix XVI, Documentation and Verification Guide.

If there are any circumstances under which payment from an irrevocable trust could be made to or for the benefit of the person, then:

- the portion of the corpus, or income generated by the corpus, from which payment could be made is a countable resource;
- payments made to or for the benefit of the person, except medical and social services, are countable income; and
- payments for any other purpose are a transfer of assets.

Although termed irrevocable, a trust which provides that the trust can only be modified or terminated by a court is a revocable trust because the person or his responsible party can petition the court to amend or terminate the trust.

Although termed irrevocable, a trust that will terminate if a certain circumstance occurs during the lifetime of the person, such as the person leaving the nursing facility and returning home, is a revocable trust.

If there are no circumstances under which payments from some portion or all of an irrevocable trust, or income generated by the trust, could be made available to a person, then the corpus, or portion of the corpus, and the generated income are considered a transfer of assets.

The date of transfer is the date the trust was established, or if terms of the trust foreclose payment to the person at a later date, the date payment is foreclosed to the person. The value of the trust, for calculating the penalty period, includes any payments made from the trust for whatever purpose after the date the trust was established or, if later, the date payment to the person was foreclosed. If funds were added to that portion of the trust after these dates, including interest earned by the trust, the addition of those funds is considered to be a new transfer of assets, effective on the date the funds are added to the trust. Thus, in treating portions of a trust which cannot be paid to a person, the value of the transferred amount is no less than its value on the date of establishment or foreclosure, and may be greater if funds were added to the trust after that date.

F-6600, Treatment of Trusts

Body

Revision 09-4; Effective December 1, 2009

A legal review of the instrument, device or arrangement that establishes the trust is required. Contact with regional legal staff is based on regionally established procedures. Check with your supervisor for regionally established procedures. Send a copy of the documents to the regional attorney for review. See Appendix XVI, Documentation and Verification Guide.

The following policy applies to trusts without regard to:

- the purpose for which the trust is established;
- whether the trustee, or similar person or entity, has or exercises any discretion under the trust;
- any restrictions on when or whether distributions can be made from the trust; or
- any restrictions on the use of distributions from the trust.

This means that any trust which meets the basic requirements outlined in previous sections can be counted in determining eligibility for Medicaid. No clause or requirement in the trust, no matter how specifically it applies to Medicaid, or other federal or state programs (that is, an exculpatory clause), precludes a trust from being considered under the rules of this section. While exculpatory clauses, use clauses, trustee discretion or restrictions on distributions do not affect a trust's countability, they do have an impact on how the various components of specific trusts are treated.

F-6610 Payments from a Trust

Revision 09-4; Effective December 1, 2009

A legal review of the instrument, device or arrangement that establishes the trust is necessary. Contact with regional legal staff is based on regionally established procedures. Check with your supervisor for regionally established procedures. Send a copy of the documents to the regional attorney for review. See Appendix XVI, Documentation and Verification Guide.

Payments to or on behalf of the person:

Payments are considered to be made to the person when any amount from the trust, including an amount from the corpus or income produced by the corpus, is paid directly to the person, or to someone acting on his behalf, such as a guardian or legal representative.

Payments made for the benefit of the person are payments of any sort, including an amount from the corpus or income produced by the corpus, paid to another entity so that the person derives some benefit from the payment. For example, such payments could include purchase of clothing or other items, such as a radio or television for the person. Such payments could also include payment for services the person may require, or care, whether medical or personal, that the person may need. Payments to maintain a home would also be payments for the benefit of the person.

A payment to or for the benefit of the person is counted under trust provisions only if such a payment is ordinarily counted as income. For example, payments made on behalf of a person for medical care are not counted in determining income eligibility. Thus, such payments are not counted as income under the trust provision.

Circumstances under which payments can or cannot be made:

In determining whether payments can or cannot be made from a trust, any restrictions on payments, such as use restrictions, exculpatory clauses or limits on trustee discretion that may be included in the trust, must be considered.

Example: If the trust provides that the trustee can disburse only $1,000 out of a $20,000 trust, only the $1,000 would be treated as a payment (disbursement) that could be made. The remaining $19,000 would be treated as an amount that cannot, under any circumstances, be paid to or for the benefit of the person.

When a trust provides, in some manner, that a payment (disbursement) can be made, even though that payment (disbursement) may be sometime in the future, the trust is treated as providing that the payment (disbursement) can be made from the trust.

Example: If a trust contains $50,000 that the trustee can pay to the person only in the event that the person needs, for example, a heart transplant, the full amount would be considered as payment (disbursement) that could be made under some circumstances, even though the likelihood of payment (disbursement) is remote.

F-6700, Exception Trusts

Body

Revision 09-4; Effective December 1, 2009

A legal review of the instrument, device or arrangement that establishes the trust is necessary. Contact with regional legal staff is based on regionally established procedures. Check with your supervisor for regionally established procedures. Send a copy of the documents to the regional attorney for review. See Appendix XVI, Documentation and Verification Guide.

The Omnibus Budget Reconciliation Act of 1993 identifies several types of trusts which are exceptions to the trust provisions stated in Section F-6300, Trusts (Aug. 11, 1993, and After). These exceptions apply only to trusts established on or after Aug. 11, 1993.

F-6710 Special Needs Trust

Revision 20-3; Effective September 1, 2020

A legal review of the instrument, device or arrangement that establishes the trust is necessary. Contact with regional legal staff is based on regionally established procedures. Check with your supervisor for regionally established procedures. Send a copy of the documents to the regional attorney for review.

Special needs trust:

A special needs trust is a revocable or irrevocable trust established with the assets (income or resources) of a person under age 65 who meets the SSI program's disability criteria. The trust must be established for the person’s benefit by a parent, grandparent, legal guardian, a court or the person. Beginning Dec. 13, 2016, people under age 65 who meet the SSI program's disability criteria may establish a special needs trust for their own benefit. The trust must include a provision that the state is designated as the residuary beneficiary to receive, at the person's death, funds remaining in the trust equal to the total amount of Medicaid paid on their behalf.

Use Form H1210, Subrogation (Trusts/Annuities/Court Settlements), to report to the Provider Claims Payment Section any potential paybacks to the state as the residuary beneficiary of special needs trusts.

This trust exception continues even after a person becomes age 65 if the individual continues to meet the disability criteria for the SSI program. However, additions or augmentations to the trust after the person becomes age 65 are a transfer of assets.

If a person is receiving disability benefits from SSI, RSDI or Railroad Retirement (RR), their disability is automatically established. Verify that the SSI, RSDI or RR benefit is a disability benefit. Otherwise, disability must be established.

Related Policy

Documentation and Verification Guide, Appendix XVI

F-6711 Treatment as Resource

Revision 09-4; Effective December 1, 2009

The trust is not counted as a resource.

F-6712 Treatment as Income

Revision 18-1; Effective March 1, 2018

Any distribution paid directly from a trust to the individual or to a third party for the benefit of the individual is unearned income to the individual in the month of receipt, except:

- payments for medical or social services for the trust beneficiary (Section E-1000, General Income, for an explanation of medical and social services); and
- payments to the trust beneficiary's Achieving a Better Life Experience account (Section E-3331.4, Treatment of Interest and Dividends Earned on an Achieving a Better Life Experience (ABLE) Account).

A payment to or for the benefit of the individual is counted under trust provisions only if such payment is ordinarily counted as income.

F-6713 Transfer of Assets

Revision 09-4; Effective December 1, 2009

Transfer-of-assets provisions do not apply when such a trust is established. However, if assets are transferred to another party from the corpus or income generated by the corpus, then the policy in Chapter I, Transfer of Assets, applies.

F-6720 Pooled Trust

Revision 09-4; Effective December 1, 2009

A legal review of the instrument, device or arrangement that establishes the trust is necessary. Contact with regional legal staff is based on regionally established procedures. Check with your supervisor for regionally established procedures. Send a copy of the documents to the regional attorney for review. See Appendix XVI, Documentation and Verification Guide.

Pooled trust:

Note: Zebley funds may be used to establish pooled trusts.

A pooled trust is a revocable or irrevocable trust containing the assets of a person who meets SSI's definition of disability and which satisfies the following conditions:

- It was established and is managed by a non-profit association.
- A separate account is maintained for each beneficiary but, for investment and management purposes, the accounts may be pooled.
- Accounts in the trust are established solely for the benefit of persons who meet SSI's disability criteria, and the trusts are established by a parent, grandparent or legal guardian of such individuals by a court, or by the disabled individuals themselves.
- The trust must include a provision that, to the extent that amounts remaining in a person's account at his death are not retained by the trust, the state is reimbursed in an amount equal to the total amount Medicaid paid on the person's behalf.

Note: Use Form H1210 to report to the Provider Claims Payment Section any potential paybacks to the state as the residuary beneficiary of pooled trusts.

Examples of pooled trusts are:

- The ARC of Texas Master Pooled Trust, established in 1997.
- Declaration of Trust for the Travis County Master Trust; Founders Trust Company, Trustee, adopted by decree of the District Court of Travis County, Texas, 201st Judicial District, effective Aug. 1, 1993.
- Declaration of Trust for Children for Whom the Texas Department of Protective and Regulatory Services is Managing Conservator or Who Are or Have Been Under its Jurisdiction; Boatmen's National Bank of Austin, Trustee, adopted by decree of the District Court of Travis County, Texas, 98th Judicial District, effective June 1, 1993.

F-6721 Treatment as Resource

Revision 09-4; Effective December 1, 2009

The trust is not counted as a resource.

F-6722 Treatment as Income

Revision 18-1; Effective March 1, 2018

Any distribution to or for the benefit of the person from corpus or income generated by the trust is countable income, except the following distributions:

- payments for medical or social services (See Section E-1000, General Income, for an explanation of medical and social services); and
- payments to an Achieving a Better Life Experience account (E-3331.4, Treatment of Interest and Dividends Earned on an Achieving a Better Life Experience (ABLE) Account.).

A payment to or for the benefit of the person is counted under trust provisions only if such payment is ordinarily counted as income.

F-6723 Transfer of Assets

Revision 09-4; Effective December 1, 2009

Transfer-of-assets provisions do not apply when a pooled trust is established for the benefit of a person under age 65. If the person is age 65 or older, or if the person's portion of the assets in the trust are transferred to another party, then the policy in Chapter I, Transfer of Assets, applies.

F-6800, Qualified Income Trust

Body

Revision 16-4; Effective December 1, 2016

When an applicant is income ineligible in an institutional setting, see Section B-2500, Explaining Policy vs. Giving Advice, to determine the appropriate actions to take and the actions to avoid. See Appendix XXXVI, Qualified Income Trusts (QITs) and Medicaid for the Elderly and People with Disabilities (MEPD), for more information concerning a QIT and a sample QIT document.

Although the use of a QIT can overcome the special income limit for MEPD eligibility for institutional or Home and Community-Based Services waiver programs, it is not available to individuals in Community Attendant Services (CAS) who are income ineligible.

If a QIT is received, a legal review of the instrument, device, or arrangement that establishes the trust is necessary. Contact with regional legal staff is based on regionally established procedures. Check with your supervisor for regionally established procedures. Send a copy of the QIT documents to the regional attorney for review. See Appendix XVI, Documentation and Verification Guide.

Qualified income trust (QIT):

A QIT is an irrevocable trust established for the benefit of an individual and/or the individual's spouse, the corpus of which is composed only of the individual's income (including accumulated income). The trust must include a provision that the state is designated as the residuary beneficiary to receive, at the individual's death, funds remaining in the trust equal to the total amount of funds Medicaid paid on the individual's behalf.
Use Form H1210, Subrogation (Trusts/Annuities/Court Settlements), to report to the Provider Holds and Recoupment Unit any potential paybacks to the state as the residuary beneficiary of QITs.

The following lists the characteristics of a QIT.

- The trust must be irrevocable.
- The trust must contain only the individual's income.
  - If resources are placed in the trust, it is not a QIT.
  - Some banks may require nominal deposits, $10 to $20, to establish a financial account to fund the trust.
  - Nominal amounts of an individual's resources, or another party's funds, may be used to establish the account without invalidating the trust or being counted as gift income to the individual. Once the trust account is established, however, only the individual's income can be directed to the trust account.
- The income does not have to be directly deposited into the trust.
- The income for which the trust is established must be deposited into the trust during the month it is received by the individual.
- The trust may be established with any or all sources of an individual's income, but an entire income source must be deposited. For example, the trust may be established for an individual's private pension income, but not the individual's Social Security income. If the trust document indicates only half of the pension income must be deposited, it is not a valid QIT.

F-6810 Treatment as Resource

Revision 09-4; Effective December 1, 2009

The trust is not counted as a resource.

F-6820 Treatment as Income

Revision 16-4; Effective December 1, 2016

Income directed to the trust is disregarded from countable income when testing eligibility for institutional or Home and Community-Based Services (HCBS) waiver programs. Income must be directed to the trust account during the calendar month in which it is received. Any source of non-exempt/non-excludable income which is not directed to the QIT account during the calendar month of receipt is countable income for that month.

For the initial month that a QIT is established, a partial deposit of the income for which the trust is established will not invalidate the trust and the entire amount of the income source(s) will be disregarded from countable income for that month. An individual may have used some of the monthly income to pay expenses prior to the date the QIT is established so the entire source(s) may not be available to open the QIT account. If only a partial deposit is made in the initial month, prior to certification, staff must verify that the entire amount of the income source(s) for which the QIT is established is being deposited into the QIT account subsequent month or the QIT is considered invalidated.

If countable income exceeds the institutional income limit, the individual is income-ineligible for the month. Applicants may not be certified for any calendar month(s) in which they are income-ineligible. For active individuals, restitution is requested in the amount of the vendor payment for any calendar month(s) in which they are income-ineligible.

Notes:

- When an individual does not pay a full month's co-payment due to hospitalization or because Medicare covered 100% of the cost of a partial month, the accumulated funds in the QIT trust are not a countable resource, and transfer of assets is not involved.
- An individual receiving HCBS waiver services who establishes a QIT covering all waiver costs is not denied. In a waiver program, the applicant with a QIT is receiving the benefit of the contracted Medicaid rates for waiver services as opposed to the private rates.

Examples:

- The applicant entered the nursing facility and applied for Medicaid in July. Income totals $3,600. The QIT calls for all income to be directed to the trust account. However, the trustee did not deposit the July income checks to the trust account until August 23. The entire $3,600 is countable income for July, and the applicant is ineligible for that month.

- The individual was certified for Medicaid in September. The QIT calls for all income (totaling $3,600) to be directed to the trust account. During the redetermination in August of the following year, the eligibility specialist learns that income checks for June were not deposited to the trust account until July. Because the person was ineligible for June, the eligibility specialist requests restitution for that month in the amount of the vendor payment.

Income directed to the trust is not disregarded in determining eligibility for SSI or non-institutional medical assistance programs: Qualified Medicare Beneficiaries, Special Low-Income Medicare Beneficiaries, or Community Attendant Services.

Income paid from the trust for co-payment for institutional or Home and Community-Based Services waiver services or to purchase other medical services for the person is not countable income for eligibility purposes. Income paid from the trust directly to the person or otherwise spent for his benefit is countable income for eligibility purposes.

Examples of countable income include cash distributions directly to the individual and direct payments (disbursements) from the trust for the individual's hair salon services. These distributions do not invalidate the

trust; however, they are countable income in the month of distribution. If countable income exceeds the institutional limit, the individual is income ineligible for that month. Eligibility specialists may not certify applicants for any month(s) in which they are income ineligible. For active individuals, the eligibility specialist requests restitution for any month(s) in which the individual was ineligible. The eligibility specialist must test for ongoing eligibility.

The individual cannot use income from the trust to purchase eligibility for any HCBS waiver program. If the trustee directs to the trust account different sources of income other than those identified in the QIT document, but the entire income source(s) is deposited and countable income remains within the institutional income limit, eligibility is not affected.

Example: The individual's income totals $3,600, consisting of $600 Social Security and $3,000 private pension. The QIT calls for all income to be directed to the trust account. At redetermination, the eligibility specialist learns that the trustee is directing only the private pension to the trust account. Since the individual's countable income totals $600, the individual remains income-eligible.

If the trust instrument requires that the income placed in the trust must be paid out of the trust for institutional or HCBS waiver services provided to the individual, there is no transfer of assets because the individual receives fair market value for the income that was placed into the trust. However, if there is no such requirement or the income is not used for the individual's care, transfer of assets provisions apply. The income must be paid out by the end of the month following the month funds were placed in the trust to avoid transfer provisions. Because transfer of assets is not imposed for transfers of assets between spouses, QIT provisions that allow payments to or for the benefit of the individual's spouse do not result in a transfer of assets penalty.

Institutional care co-payment and community-based care co-payment calculations are based on the individual's total income (income directed to the trust as well as income not directed to the trust), less the standard co-payment deductions. Costs of trust administration are not deducted in the co-payment calculation; however, legal and accounting fees necessary to maintain the trust can be paid from the trust without incurring a transfer penalty.

VA aid-and-attendance benefits, housebound allowances and reimbursements for unusual or continuing medical expenses are exempt from both eligibility and co-payment calculations. However, if an individual deposits these payments into a QIT account, they are countable for co-payment calculations. If an individual receives a VA pension that includes aid-and-attendance benefits, housebound allowances or reimbursements for unusual or continuing medical expenses, the individual may separate the aid-and-attendance benefits, household allowances or reimbursements for unusual or continuing medical expenses from the VA pension before depositing the VA pension into the QIT account. Aid-and-attendance benefits, housebound allowances or reimbursements for unusual or continuing medical expenses are not income for Medicaid eligibility determinations.

The income placed in a QIT will be disregarded for eligibility purposes for the first month that the individual has a valid signed trust and enough income is placed in the account to reduce the remaining income below the eligibility limit. For the initial month that a QIT is established, even if only a partial payment of the income for which the trust is established is deposited, the entire income source is disregarded for that month.

F-6900, Undue Hardship

Body

Revision 09-4; Effective December 1, 2009

When application of the trust provisions would create an undue hardship, those provisions do not apply. Undue hardship exists when application of the trust provisions would deprive the person of medical care so that his health or his life would be endangered. Undue hardship also exists when application of the trust provisions would deprive the person of food, clothing, shelter or other necessities of life.

Undue hardship does not exist if a person is inconvenienced or must restrict his lifestyle, but is not at risk of serious deprivation. Undue hardship relates to hardship to the person, not relatives or responsible parties of the person.

Before requesting a waiver of the trust provisions on the grounds of undue hardship, the person must make reasonable efforts to recover assets placed in trust, such as petitioning the court to dissolve the trust. If a person claims undue hardship, HHSC must make a decision on the situation as soon as possible, but within 30 days of receipt of the request for a waiver of the trust policy. The person has the right to appeal an adverse decision on undue hardship.

Minimum case documentation includes a written statement explaining the person's or grantor's reasons for establishing the trust, why the person's needs cannot be met and why there is undue hardship for the person.

The supervisor must sign off on all undue hardship cases.

F-7000, Annuities

Body

Revision 21-4; Effective December 1, 2021

§358.333. Treatment of Employment- and Retirement-Related Annuities

(a) In this section:

(1) an employment-related annuity means an annuity that provides a return on prior services, as part of or in a similar manner to a pension or retirement plan; and

(2) a retirement-related annuity means an annuity purchased by or on behalf of an annuitant in an institutional setting.

(b) An employment-related annuity or a retirement-related annuity established before February 8, 2006, is not a countable resource. Income from such an annuity is treated in accordance with 20 CFR §§416.1120-416.1124.

(c) An employment-related annuity established or having a transaction on or after February 8, 2006, is not a countable resource. Income from such an annuity is treated in accordance with 20 CFR §§416.1120-416.1124.

(d) A retirement-related annuity with a purchase or transaction date on or after February 8, 2006, is not a countable resource, if the annuitant's income eligibility is determined under the special income limit. Income from such an annuity is treated in accordance with 20 CFR §§416.1120-416.1124, if the annuity:

(1) is an annuity described in subsection (b) or (q) of §408 of the Internal Revenue Code of 1986; or

(2) is purchased with proceeds from:

(A) an account or trust described in subsection (a), (c), or (p) of §408 of the Internal Revenue Code of 1986;

(B) a simplified employee pension (within the meaning of §408(k) of the Internal Revenue Code of 1986; or

(C) a Roth IRA described in §408A of the Internal Revenue Code of 1986.

§358.334. Treatment of a Nonemployment-Related Annuity with a Purchase or Transaction Date before February 8, 2006

(a) This section describes the Texas Health and Human Services Commission's (HHSC's) treatment of nonemployment-related annuities purchased or having a transaction date before February 8, 2006. In this section, a nonemployment-related annuity means a revocable or irrevocable annuity a person may purchase to provide income.

(b) A nonemployment-related annuity is not a countable resource if the annuity:

(1) is irrevocable;

(2) pays out principal in equal monthly installments and pays out interest in either equal monthly installments or in amounts that result in increases of the monthly installments at least annually;

(3) is guaranteed to return within the person's life expectancy at least the person's principal investment plus a reasonable amount of interest (based on prevailing market interest rates at the time of the annuity purchase, as determined by HHSC);

(4) names the state of Texas or HHSC as the residual beneficiary of amounts payable under the annuity contract, not to exceed any Medicaid funds expended on the person during the person's lifetime, except as described in subsection (c) of this section; and

(5) is issued by an insurance company licensed and approved to do business in the state of Texas.

(c) If a person in an institutional setting is married and the spousal impoverishment provisions of §358.413 of this subchapter (relating to Spousal Impoverishment Treatment of Income and Resources) apply, the requirement in subsection (b)(4) of this section does not apply to a nonemployment-related annuity purchased by or for a community spouse.

(d) A nonemployment-related annuity that does not meet the requirements of subsection (b) or (c) of this section is a countable resource.

(1) HHSC applies transfer-of-assets provisions in Division 4 of this subchapter (relating to Transfer of Assets) to an annuity that is a countable resource and does not meet the criterion in subsection (b)(3) of this section. The date of the transfer of assets is the date of the annuity purchase or, if applicable, the date the annuity contract was last amended in exchange for consideration. HHSC determines the amount of the transfer by assessing the difference between the life expectancy of the person and the number of years remaining until the annuity is paid out. The amount payable during that period is the amount of the transfer of assets.

(2) If the annuity is a countable resource and is revocable, HHSC:

(A) counts the amount refundable upon revocation of the annuity as the value of the resource; and

(B) applies transfer-of-assets provisions in Division 4 of this subchapter if the person sells the annuity for less than the amount refundable upon revocation.

(3) If the annuity is a countable resource and is irrevocable, HHSC:

(A) counts fair market value as the value of the resource and presumes fair market value is 80% of the annuity's total remaining payout;

(B) applies transfer-of-assets provisions in Division 4 of this subchapter if the annuity is sold for less than the purchase price minus the amount of principal already paid; and

(C) if the terms of the annuity contract are non-negotiable, applies transfer-of-assets provisions in Division 4 of this subchapter to the total remaining payout.

(e) Income from a nonemployment-related annuity that is not a countable resource under subsection (c) of this section is treated in accordance with 20 CFR §§416.1120-416.1124.

§358.335. Treatment of Annuities with a Purchase or Transaction Date on or after February 8, 2006

(a) This section describes the Texas Health and Human Services Commission's (HHSC's) treatment of nonemployment-related annuities purchased or having a transaction date on or after February 8, 2006. In this section, a nonemployment-related annuity means a revocable or irrevocable annuity a person may purchase to provide income.

(b) A nonemployment-related annuity is not a countable resource if the annuity:

(1) is irrevocable;

(2) is nonassignable;

(3) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made;

(4) is guaranteed to return within the person's life expectancy at least the person's principal investment (that is, it is actuarially sound, as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Department of Health and Human Services); and

(5) names the state of Texas as the remainder beneficiary in the first position for at least the total amount of Medicaid paid on behalf of a person in an institutionalized setting.

(c) If a person in an institutionalized setting is married and the spousal impoverishment provisions of §358.413 of this subchapter (relating to Spousal Impoverishment Treatment of Income and Resources) apply, a nonemployment-related annuity is not a countable resource if the annuity meets the requirements of subsection (b)(1) - (4) of this section and the annuity:

(1) names the state of Texas as the remainder beneficiary in the first position for at least the total amount of Medicaid paid on behalf of the person in an institutional setting; or

(2) names the state of Texas in the second position if the community spouse or a minor or disabled child is named in the first position.

(d) A nonemployment-related annuity that is revocable is a countable resource. For a revocable nonemployment-related annuity, HHSC:

(1) uses fair market value to determine the value of the resource; and

(2) applies transfer-of-assets provisions in Division 4 of this subchapter (relating to Transfer of Assets) based on the amount already paid out of the annuity.

(e) A nonemployment-related annuity that is irrevocable is not a countable resource. For an irrevocable nonemployment-related annuity, HHSC:

(1) applies transfer-of-assets provisions in Division 4 of this subchapter to the purchase price of the annuity; and

(2) for a transaction involving an existing annuity, applies transfer-of-assets provisions to the remaining payout value at the time of the transaction.

(f) Income from an annuity that is not a countable resource is treated in accordance with 20 CFR §§416.1120 - 416.1124.

F-7100 Determining Annuity Policy

Revision 09-4; Effective December 1, 2009

F-7110 Persons Impacted by Post-Deficit Reduction Act (DRA) Annuity Policy

Revision 09-4; Effective December 1, 2009

Post-DRA annuity policy impacts any person who applies for Medicaid in an institutional setting on or after Oct. 1, 2006. Post-DRA annuity policy would also impact any person who is Medicaid eligible in the community and requests a program transfer to a Medicaid program in an institutional setting on or after Oct. 1, 2006. This includes:

- **Applicants** — For applications filed on or after Oct. 1, 2006, consider both pre-DRA and post-DRA annuity policies.
- **Program transfer requests** — For program transfer requests from any Medicaid program to an institutional program or waiver services requested on or after Oct. 1, 2006, consider both pre-DRA and post-DRA annuity policies.
- **Redeterminations** — For redeterminations of institutional or waiver services worked on or after Oct. 1, 2006, consider both pre-DRA and post-DRA annuity policies.
- **Reported changes** — For reported changes in annuities worked on or after Oct. 1, 2006, consider both pre-DRA and post-DRA annuity policies. This includes all annuities, regardless of purchase date.

Note: Neither pre-DRA or post-DRA transfer of asset policies regarding annuities apply to a person who has had continuous Medicaid coverage before March 1, 1981. This includes any person who is Medicaid eligible in the community and requests a program transfer to an institutional program or waiver services and who has had continuous Medicaid coverage before March 1, 1981.

F-7120 Application File Date or Program Transfer Request Date

Revision 21-4; Effective December 1, 2021

If the application file date or program transfer request date is:

- before Oct. 1, 2006, use pre-DRA annuity policy;
- on or after Oct. 1, 2006 and the annuity was purchased or the last annuity transaction date was before Feb. 8, 2006, use pre-DRA annuity policy; or
- on or after Oct. 1, 2006 and the annuity was purchased or the last annuity transaction date was on or after Feb. 8, 2006, use post-DRA annuity policy.

The application file date is the date the Texas Health and Human Services Commission (HHSC) receives an application form containing the applicant's name, address and appropriate signature.

The program transfer request date is:

- the date a Medicaid recipient is admitted to a long-term care facility; or
- the date a request (Form H1746-A) is received to test a Medicaid recipient for waiver Medicaid.

F-7130 Annuity Transaction

Revision 09-4; Effective December 1, 2009

Transactions other than purchases that would make an annuity subject to the DRA policy include any action taken by the person that changes the course of payment from the annuity or that changes the treatment of the income or principal of the annuity. These transactions include additions of principal, elective withdrawals, requests to change the distribution of the annuity, elections to annuitize the contract and similar actions.

F-7140 Annuity Purchase or Transaction Date

Revision 09-4; Effective December 1, 2009

If the annuity purchase or transaction date is:

- before Feb. 8, 2006, use pre-DRA annuity policy regardless of the application file date/program transfer request date or the date of the case manager action for an existing case; or
- on or after Feb. 8, 2006, use pre-DRA and post-DRA policy in determining annuity treatment based on the application file date or program transfer request date or the date of the case manager action for an existing case.

F-7200 Post-Deficit Reduction Act (DRA) Annuity Policy

Revision 09-4; Effective December 1, 2009

F-7210 Employment and Retirement-Related Annuities

Revision 09-4; Effective December 1, 2009

An annuity that meets the following guidelines is not a resource or transfer of asset:

- An annuity described in subsection (b) or (q) of Section 408 of the Internal Revenue Code of 1986; or
- An annuity purchased with proceeds from:
  - an account or trust described in subsection (a), (c) or (p) of Section 408 of the Code;
  - a simplified employee pension (within the meaning of Section 408(k) of the Code); or
  - a Roth Personal Retirement Account described in Section 408A of the Code.

F-7220 Post-Deficit Reduction Act (DRA) Treatment of an Annuity

Revision 09-4; Effective December 1, 2009

When an annuity meets the post-DRA terms and conditions:

- do not count the annuity as a resource;
- do not consider the annuity as a transfer of asset; and
- consider the monthly payments as unearned income.

F-7230 Post-Deficit Reduction Act (DRA) Terms and Conditions

Revision 13-2; Effective June 1, 2013

The annuity meets the post-DRA terms and conditions if the annuity is irrevocable and non-assignable. The irrevocable and non-assignable annuity must also:

- be in the institutionalized person's name;
- provide for payments in equal amounts during the term of the annuity;
- not have any provision for deferral of payments or balloon payments;
- guarantee to return within the person's life expectancy at least the person's principal investment (life expectancy is calculated using life expectancy tables available from the Social Security Administration's (SSA) online Period Life Table); and
- name the state of Texas as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized person.

The annuity meets the post-DRA terms and conditions when the institutionalized person is married and the annuity:

- is in the institutionalized person's name;
- is irrevocable and non-assignable;
- provides for payments in equal amounts during the term of the annuity;
- has no provision for deferral of payments or balloon payments;

- guarantees to return within the person's life expectancy at least the person's principal investment (life expectancy is calculated using life expectancy tables available from the SSA's online Period Life Table); and
- names the state of Texas as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized person, or names the state of Texas in the second position if the community spouse or minor or disabled child is named in the first position.

The annuity meets the post-DRA terms and conditions when the institutionalized person is married and the annuity:

- is in the ineligible community spouse's name;
- is irrevocable and non-assignable;
- provides for payments in equal amounts during the term of the annuity;
- has no provision for deferral of payments or balloon payments;
- guarantees to return within the ineligible community spouse's life expectancy at least the ineligible community spouse's principal investment (life expectancy is calculated using life expectancy tables available from the SSA's online Period Life Table); and
- names the state of Texas as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized person or names the state of Texas in the second position if the institutionalized person or minor or disabled child is named in the first position.

F-7240 Treatment of an Annuity When Terms and Conditions Are Not Met

Revision 09-4; Effective December 1, 2009

When an annuity does not meet the post-DRA terms and conditions, first determine if the annuity is either revocable or irrevocable.

If the annuity is revocable:

- Consider the annuity as a countable asset based on the current fair market value.
- Consider a transfer of assets depending on how much has been paid out of the annuity.

Example:

Annuity	Amount	Consideration
Purchase Price	$ 60,000	
Refund Value	$ 40,000	Countable Resource
Paid Out	+$10,000	Person Received
	$ 50,000	
Purchase Price	$ 60,000	
	–$50,000	
Difference	$ 10,000	Transfer of asset

If the annuity is irrevocable:

- For an application, consider the purchase price as a transfer of asset.

- For an action to an existing annuity that does not meet post-DRA policy, consider the remaining payout value at the time of the action as a transfer of asset.

When considering transfer of assets policy, refer to the look-back period policy for penalty start date and the calculation of penalty period.

Note: Annuities purchased on or after Oct. 1, 2006, are not subject to interest payout comparison with another company's products.

Follow regional procedures to request assistance from HHSC Legal regarding the terms and conditions of an annuity and in determining the appropriate treatment of the annuity.

F-7250 Notice Requirements for Application and Redeterminations

Revision 09-4; Effective December 1, 2009

To meet post-DRA annuity requirements, revised Form H1200, Application for Assistance – Your Texas Benefits; Form H1200-EZ, Application for Assistance – Aged and Disabled; Form H1200-PFS, Medicaid Application for Assistance (for Residents of State Facilities) Property and Financial Statement; Form H1200-A, Medical Assistance Only (MAO) Recertification; and Form H1010, Integrated Application, include the following statement:

"You must disclose if you and/or your spouse have an interest in an annuity or similar instrument. If you are determined eligible for Medicaid, the state becomes the remainder beneficiary of the instrument."

In addition, if using a streamline redetermination process, notices sent to the recipient must include the following statement:

"The DRA requires that the issuer (company) of an annuity owned by a recipient must be notified that the state is the remainder beneficiary."

F-7300 Pre-Deficit Reduction Act (DRA) Annuity Policy

Revision 09-4; Effective December 1, 2009

F-7310 General Treatment of Annuities and the Five Criteria Test

Revision 09-4; Effective December 1, 2009

When the annuity meets the five criteria in §358.334, Treatment of a Nonemployment-Related Annuity with a Purchase or Transaction Date before Feb. 8, 2006:

- it is not counted as a resource; and
- payments are counted as unearned income.

When an annuity does not meet the criteria:

- It is counted as a resource and the countable value is presumed to be 80% of the remaining payout.
- It is a transfer of assets only when it does not pay out the principal, plus a reasonable amount of interest within the annuitant's life expectancy.
- The date of the transfer is the date of the annuity purchase or, if applicable, the date that the annuity contract was last amended in exchange for consideration. If the annuity contract has been amended, refer to agency legal counsel to determine if amendment has affected the date of the transfer.

Use the life expectancy table to determine the amount payable during the client's life expectancy. The remaining payout is the amount of the transfer. **Example:** If the life expectancy is six years and the payout is eight years, the amount payable the last two years is the amount of the transfer.

To determine life expectancy, use the available online actuarial publication from the Social Security Administration's Period Life Table.

F-7320 Determining a Reasonable Amount of Interest

Revision 09-4; Effective December 1, 2009

F-7321 Treatment of Annuities That Return the Principal Within the Life Expectancy But Pay No Interest

Revision 09-4; Effective December 1, 2009

If the annuity in question is guaranteed to pay out only the principal investment within the annuitant's life expectancy, then it does not meet the requirement to return a reasonable amount of interest. If this is the case, then the annuity is a countable resource.

HHSC presumes that the fair market value of such an annuity is 80% of its total remaining payout. This presumption may be overcome only if the client provides credible evidence to the contrary. This may be done only by providing a written appraisal of the annuity's value obtained from at least two reputable companies that are in the business of purchasing annuities.

If the countable value of the annuity does not render the client resource ineligible, determine whether there is any penalty resulting from a transfer of assets. Transfer of asset policy applies because, by purchasing an annuity that pays out no interest, the purchaser does not receive fair market value on the principal investment. To determine the amount of the transfer, first determine the interest percentage that a one-year CD in the local marketplace was paying at the time of the annuity purchase. Obtain this information from a local bank or financial institution. After obtaining this information, use the following formula:

- Purchase Price
- x One-Year CD Interest Rate
- = Uncompensated Transfer

Example: If the purchase price of the annuity in question is $10,000 and the one-year CD rate is 3%, the amount of the uncompensated transfer is $300 ($10,000 x .03 = $300). The date of the transfer is the date of the annuity purchase. Follow current policy to determine if the uncompensated transfer results in any penalty.

F-7322 Treatment of Annuities That Return the Principal Within the Life Expectancy and Pay Interest

Revision 09-4; Effective December 1, 2009

If the annuity in question is guaranteed to pay out the principal investment, plus at least some interest within the annuitant's life expectancy, the following standard applies for determining whether the interest is reasonable: the interest returned is comparable to at least two similar annuities.

The client must furnish these comparisons, which the client may obtain from the person who sold the client the annuity or from any other reputable source. Each market comparison provided must be a similar product from a company licensed to sell annuities in Texas. For example, if the annuity in question is a single premium annuity with a five-year payout, the comparisons provided must be for a single premium annuity with a five-year payout based on the same principal investment as the annuity in question. Copies of the market comparisons must be filed in the case record. The annuity being reviewed must pay out interest in an amount at least equal to or greater than the furnished comparisons.

If the client does not provide comparisons or the comparisons do not meet the standard, the annuity in question does not return a reasonable amount of interest, so it is a countable resource.

HHSC presumes that the fair market value of such an annuity is 80% of its total remaining payout. This presumption may be overcome only if the client provides credible evidence to the contrary. This may be done only by providing a written appraisal of the annuity's value obtained from at least two reputable companies that are in the business of purchasing annuities.

If the countable value of the annuity does not render the client resource ineligible, determine whether there is any penalty resulting from a transfer of assets. To determine the amount of the transfer, first determine the interest percentage that a one-year CD in the local marketplace was paying at the time of the annuity purchase. Obtain this information from a local bank or financial institution. After obtaining this information, use the following formula:

- Purchase Price
- x One-Year CD Interest Rate
- = Amount Transferred
- − Actual Guaranteed Interest Payout
- = Uncompensated Transfer

Example: If the purchase price of the annuity in question is $10,000 and the one-year CD rate is 3%, the amount transferred is $300 ($10,000 x .03 = $300). If the actual guaranteed interest payout of the annuity in question is $200, the uncompensated transfer is $100 ($300 - $200 = $100). The date of the transfer is the date of the annuity purchase. Follow current policy to determine if the uncompensated transfer results in any penalty.

Note: All annuity documents must be referred to agency legal counsel. Legal counsel will provide a written opinion on terms and conditions that impact eligibility.

Use Form H1210, Subrogation (Trusts/Annuities/Court Settlements), to report to the Provider Claims area any potential paybacks to the state as the residuary beneficiary of irrevocable annuities.

F-7100, Determining Annuity Policy

Body

F-7110 Persons Impacted by Post-Deficit Reduction Act (DRA) Annuity Policy

Revision 09-4; Effective December 1, 2009

Post-DRA annuity policy impacts any person who applies for Medicaid in an institutional setting on or after Oct. 1, 2006. Post-DRA annuity policy would also impact any person who is Medicaid eligible in the community and requests a program transfer to a Medicaid program in an institutional setting on or after Oct. 1, 2006. This includes:

- **Applicants** — For applications filed on or after Oct. 1, 2006, consider both pre-DRA and post-DRA annuity policies.
- **Program transfer requests** — For program transfer requests from any Medicaid program to an institutional program or waiver services requested on or after Oct. 1, 2006, consider both pre-DRA and post-DRA annuity policies.
- **Redeterminations** — For redeterminations of institutional or waiver services worked on or after Oct. 1, 2006, consider both pre-DRA and post-DRA annuity policies.
- **Reported changes** — For reported changes in annuities worked on or after Oct. 1, 2006, consider both pre-DRA and post-DRA annuity policies. This includes all annuities, regardless of purchase date.

Note: Neither pre-DRA or post-DRA transfer of asset policies regarding annuities apply to a person who has had continuous Medicaid coverage before March 1, 1981. This includes any person who is Medicaid eligible in the community and requests a program transfer to an institutional program or waiver services and who has had continuous Medicaid coverage before March 1, 1981.

F-7120 Application File Date or Program Transfer Request Date

Revision 21-4; Effective December 1, 2021

If the application file date or program transfer request date is:

- before Oct. 1, 2006, use pre-DRA annuity policy;
- on or after Oct. 1, 2006 and the annuity was purchased or the last annuity transaction date was before Feb. 8, 2006, use pre-DRA annuity policy; or
- on or after Oct. 1, 2006 and the annuity was purchased or the last annuity transaction date was on or after Feb. 8, 2006, use post-DRA annuity policy.

The application file date is the date the Texas Health and Human Services Commission (HHSC) receives an application form containing the applicant's name, address and appropriate signature.

The program transfer request date is:

- the date a Medicaid recipient is admitted to a long-term care facility; or
- he date a request (Form H1746-A) is received to test a Medicaid recipient for waiver Medicaid.

F-7130 Annuity Transaction

Revision 09-4; Effective December 1, 2009

Transactions other than purchases that would make an annuity subject to the DRA policy include any action taken by the person that changes the course of payment from the annuity or that changes the treatment of the income or principal of the annuity. These transactions include additions of principal, elective withdrawals, requests to change the distribution of the annuity, elections to annuitize the contract and similar actions.

F-7140 Annuity Purchase or Transaction Date

Revision 09-4; Effective December 1, 2009

If the annuity purchase or transaction date is:

- before Feb. 8, 2006, use pre-DRA annuity policy regardless of the application file date/program transfer request date or the date of the case manager action for an existing case; or
- on or after Feb. 8, 2006, use pre-DRA and post-DRA policy in determining annuity treatment based on the application file date or program transfer request date or the date of the case manager action for an existing case.

F-7200, Post-DRA Annuity Policy

Body

F-7210 Employment and Retirement-Related Annuities

Revision 09-4; Effective December 1, 2009

An annuity that meets the following guidelines is not a resource or transfer of asset:

- An annuity described in subsection (b) or (q) of Section 408 of the Internal Revenue Code of 1986; or
- An annuity purchased with proceeds from:
  - an account or trust described in subsection (a), (c) or (p) of Section 408 of the Code;
  - a simplified employee pension (within the meaning of Section 408(k) of the Code); or
  - a Roth Personal Retirement Account described in Section 408A of the Code.

F-7220 Post-Deficit Reduction Act (DRA) Treatment of an Annuity

Revision 09-4; Effective December 1, 2009

When an annuity meets the post-DRA terms and conditions:

- do not count the annuity as a resource;
- do not consider the annuity as a transfer of asset; and
- consider the monthly payments as unearned income.

F-7230 Post-Deficit Reduction Act (DRA) Terms and Conditions

Revision 13-2; Effective June 1, 2013

The annuity meets the post-DRA terms and conditions if the annuity is irrevocable and non-assignable. The irrevocable and non-assignable annuity must also:

- be in the institutionalized person's name;
- provide for payments in equal amounts during the term of the annuity;
- not have any provision for deferral of payments or balloon payments;
- guarantee to return within the person's life expectancy at least the person's principal investment (life expectancy is calculated using life expectancy tables available from the Social Security Administration's (SSA) online Period Life Table); and
- name the state of Texas as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized person.

The annuity meets the post-DRA terms and conditions when the institutionalized person is married and the annuity:

- is in the institutionalized person's name;
- is irrevocable and non-assignable;
- provides for payments in equal amounts during the term of the annuity;
- has no provision for deferral of payments or balloon payments;
- guarantees to return within the person's life expectancy at least the person's principal investment (life expectancy is calculated using life expectancy tables available from the SSA's online Period Life Table); and
- names the state of Texas as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized person, or names the state of Texas in the second position if the community spouse or minor or disabled child is named in the first position.

The annuity meets the post-DRA terms and conditions when the institutionalized person is married and the annuity:

- is in the ineligible community spouse's name;
- is irrevocable and non-assignable;
- provides for payments in equal amounts during the term of the annuity;
- has no provision for deferral of payments or balloon payments;
- guarantees to return within the ineligible community spouse's life expectancy at least the ineligible community spouse's principal investment (life expectancy is calculated using life expectancy tables available from the SSA's online Period Life Table); and
- names the state of Texas as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized person or names the state of Texas in the second position if the institutionalized person or minor or disabled child is named in the first position.

F-7240 Treatment of an Annuity When Terms and Conditions Are Not Met

Revision 09-4; Effective December 1, 2009

When an annuity does not meet the post-DRA terms and conditions, first determine if the annuity is either revocable or irrevocable.

If the annuity is revocable:

- Consider the annuity as a countable asset based on the current fair market value.
- Consider a transfer of assets depending on how much has been paid out of the annuity.

Example:

Annuity	Amount	Consideration
Purchase Price	$ 60,000	
Refund Value	$ 40,000	Countable Resource
Paid Out	+$10,000	Person Received
	$ 50,000	
Purchase Price	$ 60,000	
	–$50,000	
Difference	$ 10,000	Transfer of asset

If the annuity is irrevocable:

- For an application, consider the purchase price as a transfer of asset.
- For an action to an existing annuity that does not meet post-DRA policy, consider the remaining payout value at the time of the action as a transfer of asset.

When considering transfer of assets policy, refer to the look-back period policy for penalty start date and the calculation of penalty period.

Note: Annuities purchased on or after Oct. 1, 2006, are not subject to interest payout comparison with another company's products.

Follow regional procedures to request assistance from HHSC Legal regarding the terms and conditions of an annuity and in determining the appropriate treatment of the annuity.

F-7250 Notice Requirements for Application and Redeterminations

Revision 09-4; Effective December 1, 2009

To meet post-DRA annuity requirements, revised Form H1200, Application for Assistance – Your Texas Benefits; Form H1200-EZ, Application for Assistance – Aged and Disabled; Form H1200-PFS, Medicaid Application for Assistance (for Residents of State Facilities) Property and Financial Statement; Form H1200-A,

Medical Assistance Only (MAO) Recertification; and Form H1010, Integrated Application, include the following statement:

"You must disclose if you and/or your spouse have an interest in an annuity or similar instrument. If you are determined eligible for Medicaid, the state becomes the remainder beneficiary of the instrument."

In addition, if using a streamline redetermination process, notices sent to the recipient must include the following statement:

"The DRA requires that the issuer (company) of an annuity owned by a recipient must be notified that the state is the remainder beneficiary."

F-7300, Pre-DRA Annuity Policy

Body

F-7310 General Treatment of Annuities and the Five Criteria Test

Revision 09-4; Effective December 1, 2009

When the annuity meets the five criteria in §358.334, Treatment of a Nonemployment-Related Annuity with a Purchase or Transaction Date before Feb. 8, 2006:

- it is not counted as a resource; and
- payments are counted as unearned income.

When an annuity does not meet the criteria:

- It is counted as a resource and the countable value is presumed to be 80% of the remaining payout.
- It is a transfer of assets only when it does not pay out the principal, plus a reasonable amount of interest within the annuitant's life expectancy.
- The date of the transfer is the date of the annuity purchase or, if applicable, the date that the annuity contract was last amended in exchange for consideration. If the annuity contract has been amended, refer to agency legal counsel to determine if amendment has affected the date of the transfer.

Use the life expectancy table to determine the amount payable during the client's life expectancy. The remaining payout is the amount of the transfer. **Example:** If the life expectancy is six years and the payout is eight years, the amount payable the last two years is the amount of the transfer.

To determine life expectancy, use the available online actuarial publication from the Social Security Administration's Period Life Table.

F-7320 Determining a Reasonable Amount of Interest

Revision 09-4; Effective December 1, 2009

F-7321 Treatment of Annuities That Return the Principal Within the Life Expectancy But Pay No Interest

Revision 09-4; Effective December 1, 2009

If the annuity in question is guaranteed to pay out only the principal investment within the annuitant's life expectancy, then it does not meet the requirement to return a reasonable amount of interest. If this is the case, then the annuity is a countable resource.

HHSC presumes that the fair market value of such an annuity is 80% of its total remaining payout. This presumption may be overcome only if the client provides credible evidence to the contrary. This may be done only by providing a written appraisal of the annuity's value obtained from at least two reputable companies that are in the business of purchasing annuities.

If the countable value of the annuity does not render the client resource ineligible, determine whether there is any penalty resulting from a transfer of assets. Transfer of asset policy applies because, by purchasing an annuity that pays out no interest, the purchaser does not receive fair market value on the principal investment. To determine the amount of the transfer, first determine the interest percentage that a one-year CD in the local marketplace was paying at the time of the annuity purchase. Obtain this information from a local bank or financial institution. After obtaining this information, use the following formula:

- Purchase Price
- x One-Year CD Interest Rate
- = Uncompensated Transfer

Example: If the purchase price of the annuity in question is $10,000 and the one-year CD rate is 3%, the amount of the uncompensated transfer is $300 ($10,000 x .03 = $300). The date of the transfer is the date of the annuity purchase. Follow current policy to determine if the uncompensated transfer results in any penalty.

F-7322 Treatment of Annuities That Return the Principal Within the Life Expectancy and Pay Interest

Revision 09-4; Effective December 1, 2009

If the annuity in question is guaranteed to pay out the principal investment, plus at least some interest within the annuitant's life expectancy, the following standard applies for determining whether the interest is reasonable: the interest returned is comparable to at least two similar annuities.

The client must furnish these comparisons, which the client may obtain from the person who sold the client the annuity or from any other reputable source. Each market comparison provided must be a similar product from a company licensed to sell annuities in Texas. For example, if the annuity in question is a single premium annuity with a five-year payout, the comparisons provided must be for a single premium annuity with a five-year payout based on the same principal investment as the annuity in question. Copies of the market comparisons must be filed in the case record. The annuity being reviewed must pay out interest in an amount at least equal to or greater than the furnished comparisons.

If the client does not provide comparisons or the comparisons do not meet the standard, the annuity in question does not return a reasonable amount of interest, so it is a countable resource.

HHSC presumes that the fair market value of such an annuity is 80% of its total remaining payout. This presumption may be overcome only if the client provides credible evidence to the contrary. This may be done only by providing a written appraisal of the annuity's value obtained from at least two reputable companies that are in the business of purchasing annuities.

If the countable value of the annuity does not render the client resource ineligible, determine whether there is any penalty resulting from a transfer of assets. To determine the amount of the transfer, first determine the interest percentage that a one-year CD in the local marketplace was paying at the time of the annuity purchase. Obtain this information from a local bank or financial institution. After obtaining this information, use the following formula:

- Purchase Price
- x One-Year CD Interest Rate
- = Amount Transferred
- − Actual Guaranteed Interest Payout
- = Uncompensated Transfer

Example: If the purchase price of the annuity in question is $10,000 and the one-year CD rate is 3%, the amount transferred is $300 ($10,000 x .03 = $300). If the actual guaranteed interest payout of the annuity in question is $200, the uncompensated transfer is $100 ($300 - $200 = $100). The date of the transfer is the date of the annuity purchase. Follow current policy to determine if the uncompensated transfer results in any penalty.

Note: All annuity documents must be referred to agency legal counsel. Legal counsel will provide a written opinion on terms and conditions that impact eligibility.

Use Form H1210, Subrogation (Trusts/Annuities/Court Settlements), to report to the Provider Claims area any potential paybacks to the state as the residuary beneficiary of irrevocable annuities.

F-8000, Educational Funds

Body

Revision 16-4; Effective December 1, 2016

F-8100 Educational Assistance

Revision 13-3; Effective September 1, 2013

Educational assistance may be provided in many forms including:

- Grants, scholarships, fellowships, and gifts
- Assistance under Title IV of the Higher Education Act of 1965 (HEA) or the Bureau of Indian Affairs (BIA)
- Department of Veterans Affairs (VA) Educational Benefits
- Educational payments under AmeriCorps and the National Civilian Community Corps

F-8110 Grants, Scholarships and Fellowships

Revision 13-3; Effective September 1,2013

- Any portion of a grant, scholarship, fellowship or gift used for paying educational expenses is excluded from income.
- Any portion of a grant, scholarship, fellowship or gift that is not used to pay current educational expenses, but will be used for paying this type of educational expense at a future date, is excluded from income in the month of receipt.
- Any portion not used for current educational expenses or set aside for future educational expenses is countable income in the month received and a countable resource the month after, if retained.

F-8120 Title IV of the Higher Education Act of 1965 or Bureau of Indian Affairs

Revision 13-3; Effective September 1, 2013

All financial assistance received under HEA or BIA is excluded from income and resources regardless of use. Interest and dividends earned on any unspent educational assistance under Title IV of HEA or under BIA also are excluded from income.
Examples of HEA Title IV Programs:

- Pell grants
- Academic Achievement Incentive Scholarships
- Federal Supplemental Educational Opportunities Grants (FSEOG)
- Federal Educational Loans (Federal PLUS Loans, Perkins Loans, Stafford Loans, Ford Loans, etc.)
- Upward Bound
- LEAP (Leveraging Educational Assistance Partnership)
- SLEAP (Special Leveraging Educational Assistance Partnership)
- Work-study programs

NOTE: State educational assistance programs, including work-study, funded by LEAP or SLEAP are programs under Title IV of HEA.

F-8130 Department of Veterans Affairs Educational Benefits

Revision 13-3; Effective September 1, 2013

Payments made by VA to pay for tuition, books, fees, tutorial services or any other necessary educational expenses are excluded from income.

F-8140 AmeriCorps and the National Civilian Community Corps

Revision 13-3; Effective September 1, 2013

Effective with benefits payable on or after Sept. 1, 2008, cash or in-kind payments provided by AmeriCorps State and National or AmeriCorps NCCC are excluded from income, even if they meet the definition of wages.

Such payments include, but are not limited to:

- Living allowance payments
- Stipends
- Food and shelter
- Clothing allowance
- Educational awards
- Payments in lieu of educational awards.

F-8200 Tuition Savings Programs (Qualified Tuition Programs)

Revision 13-3; Effective September 1, 2013

Tuition savings programs allow individuals to prepay or contribute to an account established for paying a designated beneficiary's education expenses beyond high school. Prepaid tuition plans and higher education savings plans authorized under Chapter 54, Subchapter G, H, or I of the Texas Education Code will be collectively called tuition savings programs.
Tuition savings programs include:

- Prepaid tuition plans such as the Texas Tuition Promise Fund or the Texas Tomorrow Fund II.
- Higher education savings plans such as the Texas College Savings Plan.
- 529 Plans or Qualified Tuition Plans authorized under Section 529 of the Internal Revenue Code.

Note: The Texas Guaranteed Tuition Plan (formerly the Texas Tomorrow Fund) is closed to new enrollment but contracts will continue to be honored by the state.

F-8210 Resource Treatment

Revision 13-3; Effective September 1, 2013

Whether the applicant/recipient is the account holder, contributor, or beneficiary, exclude any funds used to establish a tuition savings program from countable resources if the tuition savings program was established:

1. before the beneficiary's 21st birthday; **and**
2. by the beneficiary's parent, stepparent, spouse, grandparent, brother, sister, uncle, or aunt, whether related by whole blood, half blood, or adoption.

Note: The designated beneficiary can be changed to another member of the contributor's family as long as the new beneficiary meets the above criteria at the time of the change.

Funds used to establish a tuition savings program are not considered a transfer of resources.

F-8220 Income Treatment

Revision 16-4; Effective December 1, 2016

Payments made from or interest earned on a tuition savings program are excluded from countable income.

This exclusion does not apply to groups whose eligibility is determined using the Special Income Limit. The Special Income Limit groups are as follows:

- institutional programs:
  - state group home (TA 12 ME);
  - state school (TP 10 ME);
  - non-state group home (TP 15 ME);
  - state supported living center (TA 16 ME); and
  - nursing facility (TP 17 ME);
- waiver programs (TA 10 ME);
- Community Attendant Services (CAS) (TP 14 ME); and
- Program of All-Inclusive Care for the Elderly (PACE) (TA 10 ME).

This exclusion does not apply if a withdrawal from the tuition savings program is made for any purpose other than paying the qualified educational expenses of the beneficiary or if the tuition savings program is cancelled. Distributions from the account not used for the educational expenses of the beneficiary are considered income to the individual receiving the funds in the month received. If the individual is the account owner, distributions from the account to the beneficiary which are not used to pay educational expenses should be explored as a possible transfer of resources.

Note: A prepaid tuition contract terminates on the 10th anniversary of the date the beneficiary is projected to graduate from high school.

F-8300 Uniform Transfers to Minors

Revision 13-3; Effective September 1, 2013

Under the Uniform Transfers to Minors Act (UTMA), a person may establish a qualifying UTMA account in the name of a minor child. To set up the account, the person irrevocably gifts cash or other resources, such as stocks and bonds, to the account. The person names a custodian to the account, who frequently is the person who set up the account. The person does not incur a transfer of asset penalty by setting up a UTMA account.

The custodian on the account has a fiduciary duty to manage the account on behalf of the minor child. The custodian of the UTMA account may use UTMA account funds to purchase an education fund somewhat similar to the Texas Tomorrow Fund for a minor child who is qualified under state law.

The minor child must be under age 21 at the time the education fund is purchased. The qualified minor child would have to remain the named beneficiary of the education fund and the education fund must remain part of

the holdings of the UTMA account.

State laws regulating the UTMA account establish appropriate expenditures of the education fund on behalf of the beneficiary, the minor child. The beneficiary takes control of the education fund from the custodian once the beneficiary obtains majority.

Consult with your regional attorney regarding state law governing UTMA accounts.

F-8400 Coverdell Educational Savings Accounts (ESAs)

Revision 13-3; Effective September 1, 2013

Coverdell Educational Savings Accounts (ESAs) are trusts or custodial accounts created by a donor for the benefit of a child under age 18 or someone with special needs. The funds put into the ESA are for educational use only. The ESAs are authorized and governed by Section 530 of the Internal Revenue Code. They are similar to college savings plans, commonly called 529 plans, authorized and governed by Section 529 of the Internal Revenue Code. ESAs differ from 529 plans in several ways, but the most important difference is that, unlike a 529 plan, once the person gives the money to set up the ESA, the donor may not withdraw the funds for personal use. The funds may only be used for the beneficiary, a student, and then only for expenses that meet the ESA guidelines. Consult with your regional attorney regarding an ESA.

F-8100, Educational Assistance

Body

Revision 13-3; Effective September 1, 2013

Educational assistance may be provided in many forms including:

- Grants, scholarships, fellowships, and gifts
- Assistance under Title IV of the Higher Education Act of 1965 (HEA) or the Bureau of Indian Affairs (BIA)
- Department of Veterans Affairs (VA) Educational Benefits
- Educational payments under AmeriCorps and the National Civilian Community Corps

F-8110 Grants, Scholarships and Fellowships

Revision 13-3; Effective September 1,2013

- Any portion of a grant, scholarship, fellowship or gift used for paying educational expenses is excluded from income.
- Any portion of a grant, scholarship, fellowship or gift that is not used to pay current educational expenses, but will be used for paying this type of educational expense at a future date, is excluded from income in the month of receipt.

- Any portion not used for current educational expenses or set aside for future educational expenses is countable income in the month received and a countable resource the month after, if retained.

F-8120 Title IV of the Higher Education Act of 1965 or Bureau of Indian Affairs

Revision 13-3; Effective September 1, 2013

All financial assistance received under HEA or BIA is excluded from income and resources regardless of use. Interest and dividends earned on any unspent educational assistance under Title IV of HEA or under BIA also are excluded from income.
Examples of HEA Title IV Programs:

- Pell grants
- Academic Achievement Incentive Scholarships
- Federal Supplemental Educational Opportunities Grants (FSEOG)
- Federal Educational Loans (Federal PLUS Loans, Perkins Loans, Stafford Loans, Ford Loans, etc.)
- Upward Bound
- LEAP (Leveraging Educational Assistance Partnership)
- SLEAP (Special Leveraging Educational Assistance Partnership)
- Work-study programs

Note: State educational assistance programs, including work-study, funded by LEAP or SLEAP are programs under Title IV of HEA.

F-8130 Department of Veterans Affairs Educational Benefits

Revision 13-3; Effective September 1, 2013

Payments made by VA to pay for tuition, books, fees, tutorial services or any other necessary educational expenses are excluded from income.

F-8140 AmeriCorps and the National Civilian Community Corps

Revision 13-3; Effective September 1, 2013

Effective with benefits payable on or after Sept. 1, 2008, cash or in-kind payments provided by AmeriCorps State and National or AmeriCorps NCCC are excluded from income, even if they meet the definition of wages.

Such payments include, but are not limited to:

- Living allowance payments
- Stipends
- Food and shelter
- Clothing allowance
- Educational awards

- Payments in lieu of educational awards.

F-8200, Tuition Savings Programs (Qualified Tuition Programs)

Body

Revision 13-3; Effective September 1, 2013

Tuition savings programs allow individuals to prepay or contribute to an account established for paying a designated beneficiary's education expenses beyond high school. Prepaid tuition plans and higher education savings plans authorized under Chapter 54, Subchapter G, H, or I of the Texas Education Code will be collectively called tuition savings programs.
Tuition savings programs include:

- Prepaid tuition plans such as the Texas Tuition Promise Fund or the Texas Tomorrow Fund II.
- Higher education savings plans such as the Texas College Savings Plan.
- 529 Plans or Qualified Tuition Plans authorized under Section 529 of the Internal Revenue Code.

Note: The Texas Guaranteed Tuition Plan (formerly the Texas Tomorrow Fund) is closed to new enrollment but contracts will continue to be honored by the state.

F-8210 Resource Treatment

Revision 13-3; Effective September 1, 2013

Whether the applicant/recipient is the account holder, contributor, or beneficiary, exclude any funds used to establish a tuition savings program from countable resources if the tuition savings program was established:

1. before the beneficiary's 21st birthday; **and**
2. by the beneficiary's parent, stepparent, spouse, grandparent, brother, sister, uncle, or aunt, whether related by whole blood, half blood, or adoption.

Note: The designated beneficiary can be changed to another member of the contributor's family as long as the new beneficiary meets the above criteria at the time of the change.

Funds used to establish a tuition savings program are not considered a transfer of resources.

F-8220 Income Treatment

Revision 16-4; Effective December 1, 2016

Payments made from or interest earned on a tuition savings program are excluded from countable income.

This exclusion does not apply to groups whose eligibility is determined using the Special Income Limit. The Special Income Limit groups are as follows:

- institutional programs:
  - state group home (TA 12 ME);
  - state school (TP 10 ME);

    - non-state group home (TP 15 ME);
    - state supported living center (TA 16 ME); and
    - nursing facility (TP 17 ME);
- waiver programs (TA 10 ME);
- Community Attendant Services (CAS) (TP 14 ME); and
- Program of All-Inclusive Care for the Elderly (PACE) (TA 10 ME).

This exclusion does not apply if a withdrawal from the tuition savings program is made for any purpose other than paying the qualified educational expenses of the beneficiary or if the tuition savings program is cancelled. Distributions from the account not used for the educational expenses of the beneficiary are considered income to the individual receiving the funds in the month received. If the individual is the account owner, distributions from the account to the beneficiary which are not used to pay educational expenses should be explored as a possible transfer of resources.

Note: A prepaid tuition contract terminates on the 10th anniversary of the date the beneficiary is projected to graduate from high school.

F-8300, Uniform Transfers to Minors

Body

Revision 13-3; Effective September 1, 2013

Under the Uniform Transfers to Minors Act (UTMA), a person may establish a qualifying UTMA account in the name of a minor child. To set up the account, the person irrevocably gifts cash or other resources, such as stocks and bonds, to the account. The person names a custodian to the account, who frequently is the person who set up the account. The person does not incur a transfer of asset penalty by setting up a UTMA account.

The custodian on the account has a fiduciary duty to manage the account on behalf of the minor child. The custodian of the UTMA account may use UTMA account funds to purchase an education fund somewhat similar to the Texas Tomorrow Fund for a minor child who is qualified under state law.

The minor child must be under age 21 at the time the education fund is purchased. The qualified minor child would have to remain the named beneficiary of the education fund and the education fund must remain part of the holdings of the UTMA account.

State laws regulating the UTMA account establish appropriate expenditures of the education fund on behalf of the beneficiary, the minor child. The beneficiary takes control of the education fund from the custodian once the beneficiary obtains majority.

Consult with your regional attorney regarding state law governing UTMA accounts.

F-8400, Coverdell Educational Savings Accounts

Body

Revision 13-3; Effective September 1, 2013

Coverdell Educational Savings Accounts (ESAs) are trusts or custodial accounts created by a donor for the benefit of a child under age 18 or someone with special needs. The funds put into the ESA are for educational use only. The ESAs are authorized and governed by Section 530 of the Internal Revenue Code. They are similar to college savings plans, commonly called 529 plans, authorized and governed by Section 529 of the Internal Revenue Code. ESAs differ from 529 plans in several ways, but the most important difference is that, unlike a 529 plan, once the person gives the money to set up the ESA, the donor may not withdraw the funds for personal

use. The funds may only be used for the beneficiary, a student, and then only for expenses that meet the ESA guidelines. Consult with your regional attorney regarding an ESA.

Chapter G, Eligibility Budgets

G-1000, Eligibility Budgets Overview

Body

Revision 21-1; Effective March 1, 2021

An eligibility budget is used to determine a person's financial eligibility for Medicaid. Base the type of eligibility budget on:

- where the person lives and whether a person is married or not married at the beginning of each month;
- whether a person is considered a child; and
- whether a person is considered another person's parent.

The setting where a person lives, in part, determines whether an eligibility budget will be:

- noninstitutional; or
- institutional.

Examples of an institutional setting are a nursing facility or a waiver. Even though the person receiving services though a waiver is living in the community, eligibility factors are based on that person living in an institution.

This chapter will focus on the financial income eligibility budget. However, the person must meet all other requirements to be eligible for Medicaid. The financial resource budget is discussed under Chapter F, Resources.

G-1100, Texas Administrative Code Rules

Body

Revision 09-4; Effective December 1, 2009

Subchapter C, Division 6, Budgeting for Eligibility and Co-payment

§358.431. Definitions.

In this division, the following words and terms have the following meanings, unless the context clearly indicates otherwise.

(1) Child--Has the meaning given in 20 CFR §416.1856.

(2) Couple--Two persons who live together and:

(A) present themselves to the community as husband and wife, intend to be married, and are considered to be married under state law;

(B) are determined to be husband and wife for purposes of receiving Social Security benefits; or

(C) are recognized as husband and wife under state law.

(3) Dependent relative--A relative who was living in the home of an applicant or recipient before the applicant's or recipient's absence and who is unable to support himself or herself outside of the person's home due to medical, social, or other reasons.

(4) Parent--Has the meaning given in 20 CFR §416.1881.

§358.432. Eligibility Budgets.

The Texas Health and Human Services Commission (HHSC) prepares an eligibility budget to determine a person's financial eligibility for Medicaid. The type of eligibility budget HHSC prepares depends on:

(1) where the person lives and whether a person is married or not married at the beginning of each month;

(2) whether a person is considered a child; and

(3) whether a person is considered another person's parent.

§358.433. Special Income Limit.

The Texas Health and Human Services Commission uses a special income limit to determine income eligibility under circumstances established in this section. The special income limit for a person is equal to or less than 300 percent of the full individual Supplemental Security Income (SSI) federal benefit rate. The special income limit for a couple is twice the special income limit for an individual.

(1) To qualify for the special income limit, a person or couple must have countable income that exceeds the reduced SSI federal benefit rate; and:

(A) must:

(i) reside in:

(I) a Medicaid-certified long-term care facility for 30 consecutive days; or

(II) a Medicaid-certified institution for mental diseases for 30 consecutive days, if the person is 65 years of age or older; and

(ii) receive a level of care or medical necessity determination that qualifies the person or couple for Medicaid; or

(B) must be approved by a Texas health and human services agency to receive services under a §1915(c) waiver program and receive the services within one month after approval.

(2) The 30 consecutive days described in paragraph (1)(A) of this section are not disrupted if the person:

(A) makes a three-day therapeutic home visit with a planned return to the facility;

(B) is admitted to a hospital with a planned return to the facility; or

(C) moves from a facility described in paragraph (1)(A)(i) of this section:

(i) to a §1915(c) waiver program; or

(ii) to another Medicaid-certified facility.

(3) If a person dies before meeting the 30-consecutive-day requirement without moving to a noninstitutional setting, the person is considered to have met the requirement for application of the special income limit.

§358.434. Budget Types for a Noninstitutional Setting.

(a) Individual budget. The Texas Health and Human Services Commission (HHSC) prepares an individual budget for a person in a noninstitutional setting if the person is:

(1) single;

(2) widowed;

(3) divorced; or

(4) married and is:

(A) an applicant separated from his or her spouse at the time of application; or

(B) a recipient separated from his or her spouse during the previous month.

(b) Couple budget. HHSC prepares a couple budget for a couple in a noninstitutional setting if:

(1) the couple meets the definition of a couple in §358.431 of this division (relating to Definitions);

(2) each spouse is an applicant or a recipient; and

(3) both spouses are in the same coverage group.

(c) Companion budget. HHSC prepares a companion budget for a person in a noninstitutional setting who has an ineligible spouse if:

(1) the couple meets the definition of a couple in §358.431 of this division; and

(2) the person lives with the ineligible spouse during any part of a calendar month.

§358.435. Noninstitutional Eligibility Budgets.

(a) Scope. The Texas Health and Human Services Commission (HHSC) prepares a noninstitutional eligibility budget to determine financial eligibility for a person or couple in a noninstitutional setting, if the person or couple:

(1) applies for retroactive coverage;

(2) applies for or has eligibility redetermined under a federally mandated Medicaid-funded program for the elderly and people with disabilities as described in §358.107 of this chapter (relating to Coverage Groups); or

(3) applies for or has eligibility redetermined under §1929(b)(2)(B) of the Social Security Act.

(b) Individual budget. In preparing an eligibility budget for a person who meets the criteria in §358.434(a) of this division (relating to Budget Types for a Noninstitutional Setting), HHSC:

(1) counts the person's income in accordance with §1612 of the Social Security Act (42 U.S.C. §1382a);

(2) counts the person's resources in accordance with §1613 of the Social Security Act (42 U.S.C. §1382b);

(3) applies the individual resource limit in accordance with 20 CFR §416.1205; and

(4) applies the appropriate income limit, effective the month of eligibility determination, as follows:

(A) for a person who meets the criterion in subsection (a)(1) or (2) of this section, the income limit is the full individual Supplemental Security Income (SSI) federal benefit rate; and

(B) for a person who meets the criterion in subsection (a)(3) of this section, the income limit is the special income limit based on 300 percent of the full individual SSI federal benefit rate.

(c) Couple budget. In preparing an eligibility budget for a couple who meets the criteria in §358.434(b) of this division, HHSC:

(1) counts the income of both spouses in accordance with §1612 of the Social Security Act;

(2) counts the resources of both spouses in accordance with §1613 of the Social Security Act;

(3) applies the couple resource limit in accordance with 20 CFR §416.1205; and

(4) applies the appropriate income limit, effective the month of eligibility determination, as follows:

(A) for a couple who meets the criterion in subsection (a)(1) or (2) of this section, the income limit is the full couple SSI federal benefit rate; and

(B) for a couple who meets the criterion in subsection (a)(3) of this section, the income limit is twice the special income limit based on 300 percent of the full individual SSI federal benefit rate.

(d) Companion budget. In preparing an eligibility budget for a person who meets the criteria in §358.434(c) of this division, HHSC:

(1) counts the income of both spouses in accordance with §1612 of the Social Security Act;

(2) counts the resources of both spouses in accordance with §1613 of the Social Security Act;

(3) deems the ineligible spouse's income and resources;

(4) applies the couple resource limit in accordance with 20 CFR §416.1205; and

(5) applies the appropriate income limit, effective the month of eligibility determination, as follows:

(A) for a person who meets the criterion in subsection (a)(1) or (2) of this section, the income limit is the full individual SSI federal benefit rate; and

(B) for a person who meets the criterion in subsection (a)(3) of this section, the income limit is the special income limit based on 300 percent of the full individual SSI federal benefit rate.

§358.436. Budget Types for an Institutional Setting.

(a) Individual budget. The Texas Health and Human Services Commission (HHSC) prepares an individual budget for a person in an institutional setting if the person is:

(1) single;

(2) widowed;

(3) divorced; or

(4) married and meets the criteria in subsection (c) of this section, but the community spouse refuses to cooperate in providing information and circumstances indicate possible abuse or neglect by the community spouse.

(b) Couple budget. HHSC prepares a couple budget for a couple in an institutional setting if:

(1) the couple meets the definition of a couple in §358.431 of this division (relating to Definitions);

(2) each spouse is an applicant or a recipient; and

(3) both spouses are in the same coverage group.

(c) Institutional companion budget. HHSC prepares an institutional companion budget for a person in an institutional setting if:

(1) the person has a community spouse; and

(2) the couple meets the definition of a couple in §358.431 of this division, except the criterion that the couple live together does not apply.

§358.437. Institutional Eligibility Budgets.

(a) Scope. The Texas Health and Human Services Commission (HHSC) prepares an institutional eligibility budget to determine financial eligibility for a person or couple in an institutional setting, if the person or couple:

(1) applies for retroactive coverage; or

(2) applies for or has eligibility redetermined under a federally optional Medicaid-funded program for the elderly and people with disabilities as described in §358.107 of this chapter (relating to Coverage Groups).

(b) Individual budget. In preparing an eligibility budget for a person who meets the criteria in §358.433 of this division (relating to Special Income Limit) and §358.436(a) of this division (relating to Budget Types for an Institutional Setting), HHSC:

(1) counts the person's income in accordance with §1612 of the Social Security Act (42 U.S.C. §1382a);

(2) counts the person's resources in accordance with §1613 of the Social Security Act (42 U.S.C. §1382b);

(3) applies the individual resource limit in accordance with 20 CFR §416.1205; and

(4) applies the special income limit effective the month of eligibility determination.

(c) Couple budget. In preparing an eligibility budget for a couple who meets the criteria in §358.433 of this division and §358.436(b) of this division, HHSC:

(1) counts the income of both spouses in accordance with §1612 of the Social Security Act;

(2) counts the resources of both spouses in accordance with §1613 of the Social Security Act;

(3) applies the couple resource limit in accordance with 20 CFR §416.1205; and

(4) applies the special income limit, effective the month of eligibility determination.

(d) Institutional companion budget. In preparing an eligibility budget for a person who meets the criteria in §358.433 of this division and §358.436(c) of this division, HHSC:

(1) applies spousal impoverishment treatment of income and resources under 42 U.S.C. §1936r-5, counting income of both spouses in accordance with §1612 of the Social Security Act and resources of both spouses in accordance with §1613 of the Social Security Act;

(2) follows resource eligibility in accordance with 42 U.S.C. §1396r-5;

(3) bases income eligibility on the income of the person in the institutional setting; and

(4) applies the special income limit effective the month of determination.

(e) Less than 30 consecutive days. In preparing an eligibility budget for a person or couple in an institutional setting who does not meet the criteria in §358.433 of this division, HHSC applies the criteria in §358.435 of this division (relating to Noninstitutional Eligibility Budgets).

G-1200, Definitions

Body

Revision 15-4; Effective December 1, 2015

A child is neither married nor a head of a household and is either:

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

See Section D-1210, Definition of a Child, for more information.

A couple is two people who live together and:

- present themselves to the community as a married couple, intend to be married and are considered to be married under state law;
- are determined to be married for purposes of receiving Social Security benefits; or
- are recognized as married under state law.

A dependent relative is a relative who was living in the home of an applicant or recipient before the applicant's or recipient's absence and who is unable to support himself or herself outside of the person's home due to medical, social or other reasons.

A parent is:

- a natural or adoptive parent of the child, or
- the spouse of the natural or adoptive parent ("stepparent").

The stepparent must be the present spouse of the natural or adoptive parent. A person is not a stepparent if the natural or adoptive parent to whom the stepparent was married has died, or if the parent and stepparent have been divorced or their marriage has been annulled. See Section D-4213, Parent, for more information on the definition of a parent.

G-1300, Income Limits

Body

Revision 12-4; Effective December 1, 2012

The MEPD programs use income limits based on the Supplementary Security Income (SSI) limit up to the 300% of the federal poverty level. For a detailed list of the various income limits for the different programs, see Appendix XXXI, Budget Reference Chart.

G-1310 Community-Based Programs Using SSI Limits

Revision 21-1; Effective March 1, 2021

For those programs being tested using the SSI federal benefit rate (FBR), use the following figures.

Income Limits

The monthly income limits for initial certification are:

Date Range	Individual	Couple
Jan. 1, 2021 to present	$794	$1,191
Jan. 1, 2020 to Dec. 31, 2020	$783	$1,175
Jan. 1, 2019 to Dec. 31, 2019	$771	$1,157
Jan. 1, 2018 to Dec. 31, 2018	$750	$1,125
Jan. 1, 2017 to Dec. 31, 2017	$735	$1,103
Jan. 1, 2016 to Dec. 31, 2016	$733	$1,100
Jan. 1, 2015 to Dec. 31, 2015	$733	$1,100
Jan. 1, 2014 to Dec. 31, 2014	$721	$1,082
Jan. 1, 2013 to Dec. 31, 2013	$710	$1,066
Jan. 1, 2012 to Dec. 31, 2012	$698	$1,048
Jan. 1, 2011 to Dec. 31, 2011	$674	$1,011
Jan. 1, 2010 to Dec. 31, 2010	$674	$1,011

G-1320 Special Income Limits

Revision 21-1; Effective March 1, 2021

For those programs being tested using the special income limit of 300 percent of the SSI-FBR, use the following figures.

Income Limits

The monthly income limits for initial certification are:

Date Range	Individual	Couple
Jan. 1, 2021 to present	$2,382	$4,764
Jan. 1, 2020 to Dec. 31, 2020	$2,349	$4,698
Jan. 1, 2019 to Dec. 31, 2019	$2,313	$4,626
Jan. 1, 2018 to Dec. 31, 2018	$2,250	$4,500
Jan. 1, 2017 to Dec. 31, 2017	$2,205	$4,410
Jan. 1, 2016 to Dec. 31, 2016	$2,199	$4,398
Jan. 1, 2015 to Dec. 31, 2015	$2,199	$4,398

Date Range	Individual	Couple
Jan. 1, 2014 to Dec. 31, 2014	$2,163	$4,326
Jan. 1, 2013 to Dec. 31, 2013	$2,130	$4,260
Jan. 1, 2012 to Dec. 31, 2012	$2,094	$4,188
Jan. 1, 2011 to Dec. 31, 2011	$2,022	$4,044
Jan. 1, 2010 to Dec. 31, 2010	$2,022	$4,044

G-2000, Income Treatment

G-2100, Eligibility Exceptions

Body

Revision 09-4; Effective December 1, 2009

For the income eligibility budget, treatment of the following income exceptions is the same whether the person is in a noninstitutional or an institutional setting.

When calculating the total income for the income eligibility budget, do not consider receipt of those items detailed in Section E-1700, Things That Are Not Income. Some examples of things that are not income are:

- medical care and services that are not income;
- social services that are not income;
- sale of a resource;
- proceeds of a loan;
- mandatory payroll deductions; and
- cafeteria plan.

When calculating the total income for the income eligibility budget, do not consider receipt of those items detailed in Section E-2000, Exempt Income. Some examples of exempt income are:

- income exempt under federal laws;
- exempt income for Native Americans;
- earned income tax credits; and
- certain educational assistance.

When calculating the total income for the income eligibility budget, do not consider receipt of income that meets the definition of irregular or infrequent detailed in Section E-9000, Infrequent or Irregular Income. Take special note of interest and dividend treatment detailed in:

- Section E-3331, Interest and Dividends
- Section E-3331.1, Treatment of Interest/Dividends on Fully Countable Resources
- Section E-3331.2, Treatment of Interest/Dividends on Certain Excluded or Partially Excluded Resources
- Section E-3331.3, Treatment of Interest/Dividends on All Other Resources

G-2200, Variable Income

Body

Revision 09-4; Effective December 1, 2009

For the income eligibility budget, treatment of variable income is the same whether the person is in a noninstitutional or an institutional setting.

Average monthly income that is predictable but varies in amounts from month to month as detailed in Section E-5000, Variable Income.

G-2300, Special Income for Noninstitutional Budgets

Body

Revision 09-4; Effective December 1, 2009

When the living arrangement is noninstitutional, income from support and maintenance and from deeming are considered in the eligibility budget. Refer to information in:

- Section E-8000, Support and Maintenance
- Section E-7000, Deeming Income

G-2310 Noninstitutional Deeming

Revision 09-4; Effective December 1, 2009

The term "deeming" identifies the process of considering another person's income and resources to determine available funds for meeting a person's basic needs of food and shelter.

G-2311 Spouse-to-Spouse Noninstitutional Deeming

Revision 09-4; Effective December 1, 2009

Use the following steps to prepare a budget for an individual when the person lives with an ineligible spouse in a non-institutional living arrangement.

G-2311.1 Pretest to Deeming

Revision 11-4; Effective December 1, 2011

For spouse-to-spouse deeming policy to apply, the person must first be eligible based on the person's own income in the pretest. To determine if the person meets the pretest, use the steps in Section G-5000, Noninstitutional Budget Steps, to determine the person's countable income and compare the person's countable income to the program's income limit for an individual.

If the individual is eligible in the pretest, Appendix XXIX, Special Deeming Eligibility Test for Spouse to Spouse, provides the manual steps used to calculate eligibility with deeming.

- Allocations — An allocation is an amount deducted from income that is subject to deeming, which is considered to be set aside for the support of certain individuals other than the eligible individual.

Normally, the allocation amounts are based on the difference between the eligible couple and individual income limits for the program being tested.

Example: The allocation for a Medicaid program that uses the SSI federal benefit rate (FBR) limit is the difference between the SSI FBR couple and SSI FBR individual income limits. See Appendix XXXI, Budget Reference Chart.

- The allocation for Qualified Medicare Beneficiaries (QMB) is the difference between the QMB couple and QMB individual income limits.
- The allocation amount when the Special Income Limit is used is the difference between the SSI FBR couple and SSI FBR individual income limits.
- When the Special Income Limit is used, the general income exclusion and the earned income exclusion are not allowed.

G-2311.2 Examples of Spouse-to-Spouse Deeming

Revision 21-1; Effective March 1, 2021

A couple lives together in their own home. Only one spouse is applying for Community Attendant Services (CAS). The applicant's only income is gross monthly Retirement, Survivors, and Disability Insurance (RSDI) benefits of $675. The non-applicant spouse is working and earns $800 gross monthly wages. The non-applicant spouse also gets RSDI of $200, and their 16-year-old son gets RSDI of $211.

Deeming Pretest — Person must be eligible as an individual first.

Applicant's income:

Step	Description	Amount
Step 1:	Appropriate income limit	$2,382
Step 2:	Gross earned income	$0
Step 3:	Monthly unearned income	$675
Step 4:	Earned or unearned income exclusions	NA
Step 5:	Pickle RSDI COLA disregards	NA
Step 6:	Disabled Adult Child (DAC) RSDI exclusions	NA
Step 7:	Early Age Widow/Widower (W/W) RSDI exclusions	NA
Step 8:	Disabled W/W RSDI exclusions	NA
Step 9:	Remainder	$675

Remainder is less than the individual income limit for CAS. Continue with the deeming process.

Determining the ineligible spouse's income (this section and Appendix XXIX, Special Deeming Eligibility Test for Spouse to Spouse):

Step 1:	Appropriate income limit for couple	$4,764
Step 2:	Gross earned income	$800
	Gross unearned income	$200

Step 3:	$397 Allocation for ineligible child	$397	
	Son's RSDI	– $211	
	Allocation for ineligible child	$186	
	Unearned income	$200	
	Allocation for ineligible child	– $186	
	Remaining unearned	$14	
Step 4:	Remaining unearned	$14	
	Remaining earned	+ $800	
		$814	> $397 Deeming allowance
			Proceed to Step 5
Step 5:	Non-applicant spouse's remaining unearned	$14	
	Applicant's unearned	+$675	
	Combined unearned	$689	
	Non-applicant spouse's earned income	$800	
	Applicant's earned income	+$0	
	Combined earned	$800	
Step 6:	No $20 general exclusion since the applicant is applying for CAS.		
Step 7:	No earned income exclusions since the applicant is applying for CAS.		
Step 8:	Remaining income =	$689	Unearned
		+ $800	Earned
		$1,489	< $4,764
	Eligible for CAS		

A couple lives together in their own home. Only one spouse is applying for QMB. The applicant's only income is gross monthly RSDI of $780. The non-applicant spouse's gross monthly wages are $800. They have no children.

Deeming Pretest — Person must be eligible as an individual first.

Step	Description	Amount
Step 1:	Appropriate income limit	$1,064
Step 2:	Gross earned income	$0
Step 3:	Monthly unearned income	$780
Step 4:	Earned or unearned exclusions	− $20
Step 5:	Pickle RSDI COLA disregards	NA
Step 6:	DAC RSDI disregards	NA

Step	Description	Amount
Step 7:	Early Age W/W RSDI exclusions	NA
Step 8:	Disabled W/W RSDI disregards	NA
Step 9:	Remainder	$760

Remainder is less than the individual income limit for QMB. Continue with the deeming process.

Determining the ineligible spouse's income (this section and Appendix XXIX, Special Deeming Eligibility Test for Spouse to Spouse)

Step 1:	Appropriate income limit for couple	$1,437	
Step 2:	Earned	$800	
	Unearned	+ $0	
	Total	$800	
Step 3:	No ineligible children.		
	Allocation for ineligible children	$0	
	Remaining earned	$800	
Step 4:	Remaining income (earned and unearned)	$800 >	$373 Deeming allowance Proceed to Step 5
Step 5:	Non-applicant spouse's remaining unearned	$0	
	Applicant's remaining unearned	+$780	
	Combined remaining unearned	$780	
	Non-applicant spouse's remaining earned	$800	
	Applicant's remaining earned	+$0	
	Combined remaining earned	$800	
Step 6:	Combined unearned =	$780 − $20	general exclusion = $760
Step 7:	Combined earned =	$800 − $65 = $735	divided by 2 = $367.50
Step 8:	Remaining unearned	$760	
	Remaining earned	+ $367.50	
	Total	$1,127.50	< $1,437
	Eligible for QMB		

G-2312 Parent-to-Child Noninstitutional Deeming

Revision 11-3; Effective September 1, 2011

The term deeming identifies the process of considering another person's income and resources to be available for meeting a person's basic needs of food and shelter.

Allocations — To consider that a portion of an ineligible parent's income is used to provide for the ineligible parent's own living expenses and those of any ineligible child/children living in the household. Based on this consideration, apply allocations for:

- ineligible parents; and
- ineligible children in the household.

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

Deem a parent's income to an eligible child beginning the month:

- after the month the child comes home to live with the parent(s) (for example, the month following the month the child comes home from the hospital); or
- of birth when a child is born in the parent's home; or
- after the month of adoption (the month of adoption is the month the adoption becomes final); or
- after the month of marriage (for example, when a natural or adoptive parent marries) or the month after the month a parent begins living in a relationship in which they hold themselves out as married.

Deeming applies from a parent to a child when they live together in the same household.

Exceptions:

An ineligible spouse or parent who is absent from a deeming household due solely to a duty assignment as a member of the Armed Forces on active duty will, in the absence of evidence to the contrary, be considered to be living in the same household as the Supplemental Security Income (SSI) claimant/recipient for income and resources deeming purposes.

This policy applies regardless of how long the deemor is absent from the household due to a duty assignment and regardless of when such absence began.

If a natural or adoptive parent is deceased or is divorced from the stepparent, and the child is living with the stepparent, the stepparent is not considered a parent or spouse of a parent of the eligible child for deeming purposes.

Deeming does not apply if one or both of the parents are eligible for Medicaid.

This deeming process does not apply to the Medicaid Buy-In for Children (MBIC) program. See Section N-6000, Budgeting, for consideration of parents' income in the eligibility budget for MBIC.

To determine the amount of a parent's (and the parent's spouse's, if any) income to be deemed to a disabled child under 18, use the following steps.

Step	Procedure
1.	Determine the gross earned and unearned nonexempt and nonexcludable income of the parent(s).
2.	Determine the total amount of allocations for ineligible children under 21 who live in the same household. The amount of a child's allocation is the difference between the couple and the individual limits for the program being tested, except when the Special Income Limit is used, less the amount of the child's own nonexempt income. When the Special Income Limit is used, the allocation equals the difference between the SSI federal benefit rate (FBR) couple and SSI FBR individual income limits, less the child's own nonexempt income.
3.	Subtract the total amount of allocations for ineligible children in the household from the unearned income of the parent(s). Any unmet remainder of the allocation is deducted from the earned income of the parent(s).
4.	If remaining income includes both earned and unearned income, deduct $20 from unearned income and then from earned income if unearned income is less than $20. From the remaining earned income, deduct $65 plus one-half of the remainder. Then, from the sum of remaining earned and unearned income, subtract an amount equal to the SSI FBR for an individual or a couple, as appropriate.
5.	Divide any remaining income from the calculation in Step 4 equally among all eligible children in the household to establish each child's deemed income.

G-2312.1 Examples of Parent-to-Child Deeming

Revision 21-1; Effective March 1, 2021

Example 1:

A child is 14 years old and is applying for Prior Medical for SSI (ME-SSI Prior). He lives with his ineligible parents. He has one ineligible sibling, age 16. Neither child has any income. The parents' gross monthly earnings total $1,500 and their gross unearned income is $100.

Parent-to-Child Deeming

Step 1:	Parents' gross earned =	$1,500
	Parents' gross unearned =	$100
Step 2:	Allocation for ineligible child	$397
	Sibling's income	- $0
	Allocation for ineleigible child	$397
Step 3:	Parents' unearned income	$100
	Allocation for ineligible child	− $397
	Unmet remainder of the allocation	− $297
	Parents' earned income	$1,500
	Unmet remainder of the allocation	− $297
	Remaining earned	$1,203
Step 4:	− $20 general exclusion =	$1,183
	− $65 =	$1,118
	divided by 2 =	$559
	Remaining earned	$559
	Remaining unearned	+ $0
	Total	$559
	SSI FBR for couple	− $1,191
	Income deemed to applicant	$0

Determining the Applicant's Income

Step 1:	Appropriate income limit =	$794
Step 2:	Gross earned income =	$0
Step 3:	Monthly unearned income =	$0
Step 4:	$20 general exclusion =	− $20
Step 5:	Pickle RSDI COLA disregards =	NA
Step 6:	DAC RSDI disregards =	NA
Step 7:	Early Age W/W RSDI exclusions =	NA
Step 8:	Disabled W/W RSDI disregards =	NA
Step 9:	Remainder =	$774 < $794

Eligible for Prior Medical for SSI (ME-SSI Prior)

Example 2:

A different child is 13 years old and is applying for Community Attendant Services (CAS). She lives with her ineligible parents. She has two ineligible brothers, ages 15 and 16. She gets $700 per month in RSDI disability benefits. Her brothers have no income. The parents' gross monthly earned income is $2,000 and their gross monthly unearned income is $200.

Parent-to-Child Deeming

Step 1:	Parents' gross earned =	$2,000	
	Parents' gross unearned =	$200	
Step 2:	Allocation for ineligible child	$397	
	First brother's income	− $0	
	Allocation for first brother	$397	
	Allocation for ineligible child	$397	
	Second brother's income	− $0	
	Allocation for second brother	$397	
	Total allocation for ineligible children =	$397 x 2	= $794
Step 3:	Parents' unearned income =	$200	
	Allocation for ineligible children =	− $794	
		− $594	Unmet remainder
	Parents' earned income =	$2,000	
	Unmet remainder of allocation =	− $594	
		$1,406	Remaining earned
Step 4:	Remaining unearned	$0	
	Remaining earned	$1,406	
	General exclusion	− $20	
		$1,386	
		− $65	
		$1,321	divided by 2 = $660.50
	Remaining earned and unearned	$660.50	
	SSI FBR for couple	− $1,191	
	Remainder	$0	
Step 5:	Income deemed to applicant	$0	

When parent-to-child deeming occurs for CAS, the $20 and the $65 plus one-half earnings exclusions are given to the parents in determining the amount to be deemed to the child. CAS does not allow these exclusions for the child who is the applicant or recipient.

Determining the Applicant's Income

Step 1:	Appropriate income limit =	$2,382
Step 2:	Gross earned income =	$0
Step 3:	RSDI	$700
	Deemed income	+ $0
	Total unearned income	$700
Step 4:	No $20 general exclusion since applicant is applying for CAS	NA
Step 5:	Pickle RSDI COLA disregards =	NA
Step 6:	DAC RSDI exclusions =	NA
Step 7:	Early Age W/W RSDI exclusions =	NA
Step 8:	Disabled W/W RSDI exclusions =	NA
Step 9:	Remainder =	$700 < $2,382
	Eligible for CAS	

G-3000, Noninstitutional Budget Types

G-3110, Individual Noninstitutional Budget

Body

Revision 09-4; Effective December 1, 2009

Eligibility is determined for individuals and couples (in noninstitutional living arrangements) who:

- apply for retroactive Medicaid coverage;
- apply for or have eligibility redetermined under various federally-mandated MEPD programs; or
- apply for or have eligibility redetermined under the Community Attendant Services (CAS) program formerly known as 1929(b).

The income standard used and the income counted depend on whether the budget is for an individual, companion or couple case.

G-3110 Individual Noninstitutional Budget

Revision 09-4; Effective December 1, 2009

The full SSI federal benefit rate for an individual is the income standard or limit used for a person. Only the person's income is considered. An individual budget is prepared if the person is single, widowed or divorced, or a married person who is:

- a person separated from his spouse at the time of application, or
- a person separated from his spouse during the previous month.

If the person is an individual and the MEPD program is Community Attendant Services (CAS), the institutional special income limit for an individual is the income standard or limit used.

See Appendix XXXI, Budget Reference Chart

G-3120 Companion Noninstitutional Budget (Person with Ineligible Spouse)

Revision 09-4; Effective December 1, 2009

The full SSI federal benefit rate for an individual is the income standard or limit used for a person, if a person lives with his ineligible spouse during any part of a calendar month. The income of the ineligible spouse may be deemed available to the person. See Section E-7000, Deeming Income, and Section G-2311, Spouse-to-Spouse Noninstitutional Deeming.

The institutional special income limit for an individual is the income standard or limit used for a person, if a person lives with his ineligible spouse during any part of a calendar month and the MEPD program is Community Attendant Services (CAS).

G-3130 Couple Noninstitutional Budget

Revision 15-4; Effective December 1, 2015

The following applies to couple budgets:

MEPD programs consider the income of both spouses against the full SSI payment standard for a couple (or the appropriate income limit for a couple if both spouses are clients in the same coverage group). A couple budget is prepared if an individual is living with an eligible spouse (i.e., a spouse who is aged or has a disability) and they are:

- presenting themselves to the community as a married couple,
- determined to be married for purposes of receiving Social Security benefits, or
- recognized as married under state law.

The institutional special income limit for a couple is the income standard or limit used for a couple, if the person lives with the eligible spouse during any part of a calendar month and the MEPD program is CAS.

Note: A couple budget is not prepared when only one member of an eligible couple enters a Title XIX long-term care facility and is entitled to vendor payment.

G-3131 Couple Budget Policy

Revision 09-4; Effective December 1, 2009

If both spouses are ineligible as a couple, redetermine the eligibility for each person on an individual basis. Use deeming procedures if appropriate. See Section E-7000, Deeming Income, and Section G-2311, Spouse-to-Spouse Noninstitutional Deeming.

Prepare an individual deeming budget for each spouse.

Perform the deeming pre-test for each member of the couple. Allow the exclusions, including the $20 dollar general exclusion, for each member of the couple during the deeming pre-test.

If only one member of the couple is eligible based on the deeming pre-test, complete a special deeming eligibility test worksheet using the steps found in Appendix XXIX, Special Deeming Eligibility Test for Spouse to Spouse, for the member found eligible in the pre-test.

If both members of the couple are eligible based on the deeming pre-test, complete a special deeming eligibility test worksheet using the steps in Appendix XXIX. Complete a worksheet for each member of the couple and follow the steps for each member as if one member of the couple was ineligible.

G-4000, Noninstitutional Exclusions

G-4100, Income Exclusions

Body

Revision 09-4; Effective December 1, 2009

After granting the applicable exemptions, apply appropriate exclusions to the remaining income of the person, including any income that is deemed as unearned income. See Section G-2000, Income Treatment, for exempt, variable and deemed income treatment.

An exclusion is not an exemption. An exclusion is applied to a type of income that would otherwise be counted in the eligibility determination. Income that is excluded in the eligibility test generally is considered when determining the amount that the person must pay for his care in a medical facility (see Chapter H, Co-Payment Budget.

G-4110 Twenty-Dollar General Exclusion

Revision 11-3; Effective September 1, 2011

For each month, the first $20 of unearned or earned income is excluded. This exclusion is applied first to unearned income, then to earned income if the unearned income is less than $20.

If no unearned income exists, the entire $20-exclusion is applied to the earned income.

See Section E-3000, Earned and Unearned Income.

Exceptions are as follows:

- Although this exclusion does not apply to VA pensions and parents' dependency and indemnity compensation (DIC), it does apply to VA compensation and insurance. If, however, a person receives income from a VA pension and another source, he retains the general exclusion.
- In the case of an eligible couple, only one $20-general exclusion is applied to the couple's combined income.
- The $20-general exclusion does not apply when determining eligibility for Community Attendant Services.
- The $20-general exclusion does not apply when determining eligibility for Medicaid Buy-In for Children (MBIC). See Section N-6320, MBIC Income Exclusion.

Example: The person receives $15 a month as a contribution from a relative. He also has $80 a month as gross earned income. The entire amount of the contribution is excluded because it is less than $20. The remaining $5 is then subtracted from the $80 gross earned income.

See Section E-4315, VA Aid and Attendance and Housebound Payments. Do not consider these payments in the eligibility budget.

G-4120 Earned Income Exclusion

Revision 18-4; Effective December 1, 2018

After applying the $20 general exclusion, exclude $65 of the remaining earned income plus one-half of the remaining earnings. In the case of an eligible couple, allow only one earned income exclusion for the couple's combined earned income.

Exceptions:

- The earned income exclusion does not apply when determining eligibility for Community Attendant Services.
- The earned income exclusion does not apply when determining eligibility for the Medicaid Buy-In for Children (MBIC) program.

Note: Do not apply the earned income exclusion when eligibility is determined using the special income limit.

Related Policy

MBIC Income Exclusion, N-6320
Institutional Eligibility Budget Steps, G-6300

G-4121 Examples of the Earned Income Exclusion

Revision 09-4; Effective December 1, 2009

- Bob Evans' monthly income is $350 in wages and $100 in pension payments.

Description	Amount
Unearned income	$100.00
General income exclusion	– $20.00
Remaining unearned income	$80.00
Earned income exclusion:	
Gross earned income	$350.00
First $65.00	– $65.00
Remaining	$285.00
One-half of remaining	$142.50
Countable unearned income	$80.00
Countable earned income	+ $142.50
Total countable income	$222.50

- Ralph and Mary Teague are both receiving disability Social Security and SSI benefits. They were in an automobile accident in June, the month before they applied for SSI. Mr. and Mrs. Teague have applied for

retroactive Medicaid to help with the payment of their hospital bills in June. In the month under consideration, Ralph received wages from the Senior Citizens' Center for preparing meals. Mary did part-time piecework sewing by hand at home for a local clothing manufacturer. She had no work-related expenses because the company supplied the materials.

Description	Amount
Unearned income	
Ralph's Social Security benefits	$200.00
Mary's Social Security benefits	+ $100.00
Gross unearned benefits for the couple	$300.00
General income exclusion (only one allowed)	– $20.00
Remaining unearned income	$280.00
Earned income:	
Ralph's wages	$306.40
Mary's wages	+ $109.90
Total gross earned income	$416.30
Earned income exclusion (only one allowed):	
First $65.00	$65.00
Remaining	$351.30
One-half of remaining	$175.65
Countable unearned income	$280.00
Countable earned income	+ $175.65
Total countable income for the couple	$455.65

G-4200, Special Exclusion for Medicare Savings Programs – Census Bureau Wages

Body

Revision 09-4; Effective December 1, 2009

The census is a count of everyone living in the United States and is mandated by the U.S. Constitution. The U.S. Census Bureau conducts the census every 10 years.

Wages paid by the Census Bureau for temporary employment related to census activities are excluded income for the Medicare Savings Programs (MSP). Do not include these wages in the eligibility budget for MSP.

These wages for temporary employment are not countable income in the month of receipt, but are considered a resource thereafter.

Wages paid by the Census Bureau for temporary employment related to census activities **are included** in eligibility or co-payment budgets for any other Medicaid for the Elderly and People with Disabilities (MEPD) program that is not an MSP.

Wages received from the Census Bureau for full-time employment are considered earned income and treated according to policy in Section E-3000, Earned and Unearned Income.

For cases with a combination of regular Medicaid benefits and an MSP, the wages are countable in the eligibility budget (and co-payment, if applicable) for the regular Medicaid program, but are excluded in the eligibility

budget for MSP.

Example: Individual is being considered for Pickle with Qualified Medicare Beneficiary (QMB) benefits. The wages paid by the Census Bureau for temporary employment related to census activities are included in the eligibility budget for Pickle, but are excluded in the eligibility budget for QMB.

G-4300, Special Income Exclusion for COLA Disregard

Body

G-4310 Computing Social Security Cost-of-Living Increases

Revision 21-1; Effective March 1, 2021

The following chart shows the Pickle (ME-Pickle) multiplier for Social Security cost-of-living adjustments since April 1977.

Last Check Received	Multiplier
Jan. 2020 to Dec. 2020	0.0128
Jan. 2019 to Dec. 2019	0.0284
Jan. 2018 to Dec. 2018	0.0548
Jan. 2017 to Dec. 2017	0.0734
Jan. 2016 to Dec. 2016	0.0761
Jan. 2015 to Dec. 2015	0.0853
Jan. 2014 to Dec. 2014	0.1006
Jan. 2013 to Dec. 2013	0.1139
Jan. 2012 to Dec. 2012	0.1287
Jan. 2011 to Dec. 2011	0.159
Jan. 2010 to Dec. 2010	0.1673
Jan. 2009 to Dec. 2009	0.1755
Jan. 2008 to Dec. 2008	0.2207
Jan. 2007 to Dec. 2007	0.2383
Jan. 2006 to Dec. 2006	0.2626
Jan. 2005 to Dec. 2005	0.2916
Jan. 2004 to Dec. 2004	0.3103
Jan. 2003 to Dec. 2003	0.3244
Jan. 2002 to Dec. 2002	0.3338
Jan. 2001 to Dec. 2001	0.3507
Jan. 2000 to Dec. 2000	0.3726
Jan. 1999 to Dec. 1999	0.3873
Jan. 1998 to Dec. 1998	0.3952
Jan. 1997 to Dec. 1997	0.4076
Jan. 1996 to Dec. 1996	0.4243
Jan. 1995 to Dec. 1995	0.4389
Jan. 1994 to Dec. 1994	0.4542
Jan. 1993 to Dec. 1993	0.468

Last Check Received	Multiplier
Jan. 1992 to Dec. 1992	0.4835
Jan. 1991 to Dec. 1991	0.5019
Jan. 1990 to Dec. 1990	0.5275
Jan. 1989 to Dec. 1989	0.5487
Jan. 1988 to Dec. 1988	0.566
Jan. 1987 to Dec. 1987	0.5835
Jan. 1986 to Dec. 1986	0.5889
Jan. 1985 to Dec. 1985	0.6012
Jan. 1984 to Dec. 1984	0.6147
July 1982 to Dec. 1983	0.6277
July 1981 to June 1982	0.6534
July 1980 to June 1981	0.6883
July 1979 to June 1980	0.7273
July 1978 to June 1979	0.7519
July 1977 to June 1978	0.767
April 1977 to June 1977	0.78

To calculate the Pickle (ME-Pickle) disregard, use the multiplier for the date the person received the last Supplemental Security Income check, and multiply by the current Retirement, Survivors and Disability Insurance benefit amount. Round the result to the nearest dollar amount. Subtract this disregard amount and all other available exclusions from the person's available income to determine the person's countable income.

Reference: For calculating manual budgets, see step 5 in Section G-5100, Individual and Couple Noninstitutional Budgets, or use Appendix XXXVIII, Pickle Disregard Computation Worksheet.

Also follow this procedure for any family member whose income is considered in the eligibility determination.

G-4311 Pickle

Revision 13-1; Effective March 1, 2013

For persons who qualify for Pickle (ME-Pickle) and who received a 20% Social Security cost-of-living adjustment (COLA) increase in October 1972, exclude the amount of that increase in determining the person's eligibility.

For persons who qualify for Pickle (ME-Pickle) because of an SSI denial after April 1977, exclude Social Security COLAs received since the person last received both SSI and Social Security benefits in the same month. The person must have been entitled to both benefits in the same month. Because SSA processing procedures can be unpredictable, the person may not actually have received both checks/direct deposits in the same calendar month.

Note: Also exclude Social Security COLAs for the same period from the income of any family member whose income is deemed to the individual. The earliest increase that can be excluded is the July 1977 increase.

When an application for Pickle (ME-Pickle) assistance is received, verify the SSI denial date and current benefit and use the appropriate multiplier to calculate the disregard amount. Do not contact the Social Security office for this information.

Allow the COLA disregard after the date of denial. If the denial was sometime after the normal yearly December/January COLA, then the next available COLA would be available as the disregard.

Example: If denial is in May 2007, the next COLA disregard available to the person would be in January 2008 using Appendix XXXVIII, Pickle Disregard Computation Worksheet.

A variance to this may occur when a decision from SSA is delayed. Address entitlement, date of denial, and date of receipt of notice of denial when dealing with this.

Do not certify the person for Pickle (ME-Pickle) if the income before the COLA disregards is less than the SSI federal benefit rate (FBR). A person whose income, before the COLA exclusion, is less than the SSI FBR cannot be certified for the Social Security COLA programs.

- An SSI person who goes on and off SSI because of Social Security rounding is not eligible for Pickle (ME-Pickle) until he has been denied SSI because of a COLA increase.
- Persons who lose SSI eligibility because of a transfer of assets penalty do not qualify for Pickle (ME-Pickle) while the penalty period is in force. These individuals should be tested for potential eligibility under other MEPD programs, including Qualified Medicare Beneficiary.

Except in certain situations, a person cannot be eligible for the Pickle program.

G-4312 Ping-Pong

Revision 11-4; Effective December 1, 2011

In certain situations, a person whose income is less than the SSI federal benefit rate can be certified for the Social Security COLA programs.

In "ping-pong" cases, when a Pickle (ME-Pickle) person goes on and off SSI with a $1 check, maintain the case as an ongoing Pickle (ME-Pickle). This will stabilize receipt of Medicaid benefits.

G-4320 Special Income Exclusion for Disabled Adult Children

Revision 11-4; Effective December 1, 2011

ME-Disabled Adult Child. Individuals 18 and older who were denied SSI benefits on or after July 1, 1987, because of entitlement to or an increase in RSDI disabled adult children's benefits may be eligible for Medicaid if they otherwise would meet all current SSI eligibility criteria in the absence of those disabled adult children's benefits. Eligible individuals are also entitled to the exclusion of subsequent increase in those benefits.

After receiving an application for ME-Disabled Adult Child assistance, verify the amount of the appropriate disabled adult children's benefit or increase in order to determine the appropriate disabled adult children exclusion. If the person is in a vendor living arrangement, develop the case under the institutional guidelines.

G-4330 Special Income Exclusion for Widow/Widower

Revision 11-4; Effective December 1, 2011

ME-Early Aged Widow(er). Disabled individuals 60 and older who were denied SSI benefits because of entitlement to early aged widow's or widower's benefits may be eligible for Medicaid if they meet all current SSI eligibility criteria in the absence of those early aged widow's or widower's benefits.

Eligible individuals are also entitled to the exclusion of subsequent increases in these benefits. They may continue to receive Medicaid until they are eligible for Medicare. Medicaid benefits under Widow/Widower (ME-Early Aged Widow(er)) cannot begin before July 1, 1988, regardless of when an individual became eligible for or was denied SSI.

ME-Disabled Widow(er). Disabled individuals who were denied SSI benefits because of an increase in widow's or widower's disability benefits as a result of the relaxing of disability criteria may be eligible for Medicaid if they meet all SSI eligibility criteria in the absence of those widow's or widower's disability benefits.

Eligible individuals are also entitled to the exclusion of subsequent increases in these benefits. They may continue to receive Medicaid until they are entitled to Medicare. Medicaid benefits under this coverage group were not available before Jan. 1, 1991, regardless of when an individual became eligible for or was denied SSI.

Note: The widow's or widower's disability benefits under Social Security begin at age 50. ME-Disabled Widow(er).

After receiving an application for Widow/Widower (ME-Early Aged Widow(er), ME-Disabled Widower) assistance, verify the amount of the early aged/disabled widow's or widower's benefit. If the applicant/person is in a institutional living arrangement, develop the case as under the institutional guidelines.

G-4400, Other Income Exclusions Related to Work

Body

Revision 11-1; Effective March 1, 2011

The development of other income exclusions related to work may be necessary when earned income is over the $65 per month earned income exclusion (or up to $85 per month if the $20 general exclusion has not been used up on unearned income) and the person is ineligible for Medicaid.

G-4410 Exclusion for Work Expenses for the Blind

Revision 09-1; Effective December 1, 2009

In addition to the earned income exclusion, a blind person's earned income is reduced by the amount of expenses that he can reasonably attribute to the earnings of the income.

G-4420 Exclusion for Impairment-Related Work Expenses

Revision 11-1; Effective March 1, 2011

In addition to the earned income exclusion, a disabled person's earned income is reduced by the amount of expenses that the person can reasonably attribute to the earnings of the income.

G-4430 Income Needed to Fulfill a Plan for Self-Support (Blind or Disabled)

Revision 11-1; Effective March 1, 2011

Earned or unearned income not excluded from consideration by the previous exclusions may be reduced to the extent that it is needed to fulfill an approved plan of a blind or disabled person for attaining self-support.

The plan must be submitted to MEPD, State Office, Mail Code 2090, for approval. The objectives of the plan and a time limit for achieving the objectives also must be designated. Each plan must describe the income that would be excluded in the case in addition to the previous income exclusions. Check the MEPD website for current MEPD staff contacts.

G-4500, Medicaid Buy-In for Children Income Exclusions

Body

Revision 11-3; Effective September 1, 2011

In determining eligibility for the Medicaid Buy-In for Children (MBIC) program, allow a general income exclusion of $65 plus one-half of the remaining income. Deduct this exclusion at the end of the budget calculation. See Section N-6320, MBIC Income Exclusion.

Ineligible Siblings

Allow an exclusion from an ineligible sibling's income before counting the ineligible sibling's income in the budget. This exclusion is allowed for each ineligible sibling in the family unit. See Section N-6330, Ineligible Sibling Exclusion.

G-5000, Noninstitutional Budget Steps

G-5100, Individual and Couple Noninstitutional Budgets

Body

Revision 09-4; Effective December 1, 2009

Reminders:

- Monitor eligibility at least every three months if the client's total countable income is within $10 of the income limit.
- When income tax is withheld from retirement, pensions and disability benefits, use the gross amount for the eligibility calculation.
- If the person has VA, see Section E-4311.2, $90 VA Pension and Institutional Setting.

G-5110 COLA Disregard Programs

Revision 11-4; Effective December 1, 2011

Use the following steps to prepare a budget for an individual or an eligible couple in a noninstitutional living arrangement. Follow this procedure at application and for every redetermination.

Step	Procedure
1	Determine the appropriate income limit for either an individual or couple using the SSI federal benefit rate (FBR). See Appendix XXXI, Budget Reference Chart.
2	Determine monthly earned income. See the following: Section G-2000, Income Treatment Section E-3000, Earned and Unearned Income Section E-2000, Exempt Income Section E-2200, Earned Income Exemption Section E-1700, Things That Are Not Income Section E-1770, Mandatory Payroll Deductions
3	Determine monthly unearned income, including income from support and maintenance, if appropriate. See the following: Section G-2000, Income Treatment Section E-3000, Earned and Unearned Income Section E-1700, Things That Are Not Income Section E-2000, Exempt Income Section E-4000, Fixed Income Section E-5000, Variable Section E-7000, Deeming Income Section G-2310, Noninstitutional Deeming Section E-8000, Support and Maintenance Section E-9000, Infrequent or Irregular
4	Deduct earned and unearned income exclusions, as appropriate. See Section G-4000, Noninstitutional Exclusions. Compare the remainder to the appropriate SSI FBR to test for the income element of eligibility. **Note:** If the remainder is less than the SSI income limit, refer the person to SSA. See Section G-4312, Ping-Pong, for this exception.
5	Determine the amount of COLA disregard. See Section G-4300, Special Income Exclusion for COLA Disregard, for the MEPD group. See Chapter A, General Information and MEPD Groups, for the descriptions of the MEPD groups. For Pickle (ME-Pickle) type of assistance, deduct the amount of the RSDI increases received since the person last was eligible for and entitled to both SSI and Social Security in the same month. **Reference:** See Section G-4310, Computing Social Security Cost-of-Living Increases. For the Disabled Adult Children's (DAC) benefits type of assistance (ME-Disabled Adult Child), the amount of the appropriate RSDI disabled children's entitlement/increase(s) and any subsequent DAC increase. **Reference:** See Section G-4320, Special Income Exclusion for Disabled Adult Children.

Step	Procedure
	For Receipt of Early Aged Widow's or Widower's benefits type of assistance (ME-Early Aged Widow(er)), the amount of the appropriate Social Security early aged widow's or widower's benefits that resulted in SSI denial, and any subsequent RSDI COLAs. **Reference:** See Section G-4330, Special Income Exclusion for Widow/Widower. For Receipt of Disabled Widow's or Widower's benefits type of assistance (ME-Disabled Widow(er)), the full RSDI amount, including the appropriate amount of the disabled widow's or widower's benefits or surviving divorced spouse's benefits that resulted in SSI denial and any subsequent increases (whether COLA or not). **Reference:** See Section G-4330, Special Income Exclusion for Widow/Widower. Deduct the COLA disregard amount of the appropriate MEPD program.
9	The remainder is countable income. Compare the remainder to the appropriate income limit to test for the income element of eligibility. The remainder must be at least 1 cent less than SSI FBR.

G-5120 Community Attendant Services

Revision 09-4; Effective December 1, 2009

Use the following steps to prepare a budget for an individual or an eligible couple in a noninstitutional living arrangement. Follow this procedure at application and for every redetermination.

Step	Procedure
1	Determine the appropriate income limit for either an individual or couple using the special income limit. See Appendix XXXI, Budget Reference Chart.
2	Determine monthly earned income. See the following: Section G-2000, Income Treatment Section E-3000, Earned and Unearned Income Section E-2000, Exempt Income Section E-2200, Earned Income Exemption Section E-1700, Things That Are Not Income Section E-1770, Mandatory Payroll Deductions

Step	Procedure
3	Determine monthly unearned income, including income from support and maintenance, if appropriate. See the following: Section G-2000, Income Treatment Section E-3000, Earned and Unearned Income Section E-1770, Things That Are Not Income Section E-2000, Exempt Income Section E-4000, Fixed Income Section E-5000, Variable Section E-7000, Deeming Income Section G-2310, Noninstitutional Deeming Section E-8000, Support and Maintenance Section E-9000, Infrequent or Irregular
4	Do **not** subtract either the: • $20-general exclusion, or • earned income exclusion. See Section G-4000, Noninstitutional Exclusions. Compare the remainder to the appropriate SSI FBR to test for the income element of eligibility. **Note:** If the remainder is less than the SSI income limit, refer the person to SSA.
5	The remainder is countable income. Compare the remainder to the appropriate income limit to test for the income element of eligibility. The remainder must be equal to or less than the Special Income Limit.

G-5130 Medicare Savings Programs (MSP)

Revision 09-4; Effective December 1, 2009

Use the following steps to prepare a budget for an individual or an eligible couple in a noninstitutional living arrangement. Follow this procedure at application and for every redetermination.

Step	Procedure
1	Determine the appropriate income limit for either an individual or couple using the MSP income limits. See Appendix XXXI, Budget Reference Chart.
2	Determine monthly earned income. See the following: Section G-2000, Income Treatment Section E-3000, Earned and Unearned Income Section E-2000, Exempt Income Section E-2200, Earned Income Exemption Section E-1700, Things That Are Not Income Section E-1770, Mandatory Payroll Deductions

Step	Procedure
3	Determine monthly unearned income, including income from support and maintenance, if appropriate. See the following: Section G-2000, Income Treatment Section E-3000, Earned and Unearned Income Section E-1700, Things That Are Not Income Section E-2000, Exempt Income Section E-4000, Fixed Income Section E-5000, Variable Section E-7000, Deeming Income Section G-2310, Noninstitutional Deeming Section E-8000, Support and Maintenance Section E-9000, Infrequent or Irregular
4	Deduct earned and unearned income exclusions, as appropriate: • $20-general income exclusion • earned income exclusion See Section G-4000, Noninstitutional Exclusions. Compare the remainder to the appropriate SSI FBR to test for the income element of eligibility. **Note:** If the remainder is less than the SSI income limit, refer the person to SSA. See Section G-4312, Ping-Pong, for this exception.
5	Determine the amount of COLA disregard if appropriate. The RSDI COLA is disregarded in determining QMB/SLMB/QI-1 eligibility for the months of January through February.
6	Deduct the COLA disregard amount, if appropriate, for the QMB/SLMB/QI-1 program.
7	The remainder is countable income. Compare the remainder to the appropriate income limit to test for the income element of eligibility. QMB – The remainder must not exceed the limit. SLMB – The remainder must be less than the limit. QI-1 – Must be equal to or greater than the lower limit, but less than the upper limit.

G-5140 Reserved for Future Use

Revision 19-4; Effective December 1, 2019

G-5141 Reserved for Future Use

Revision 19-4; Effective December 1, 2019

G-5150 Medicaid Buy-In for Children Program (MBIC)

Revision 11-3; Effective September 1, 2011

See Section N-6300, Eligibility Income Budgeting, for budgeting steps for the MBIC program.

G-6000, Institutional Eligibility Budget Types

Body

Revision 18-3; Effective September 1, 2018

Reminders:

- Monitor eligibility at least every three months if the individual's total countable income is within $10 of the income limit.
- When income tax is withheld from retirement, pensions and disability benefits, use the gross amount for the eligibility calculation.
- If the person has VA, see Section E-4311.2, $90 VA Pension and Institutional Setting.

The person or couple is considered to be living in a institutional living arrangement beginning with the first day that:

- the person (or couple) lives in a Medicare-SNF or Medicaid certified long-term care facility; and
- the person (or couple) has been confined to one or more Medicaid certified long-term care facilities (for example, Medicare-SNF, NF or ICF/IID) for at least 30 consecutive days.

G-6100, Institutional Eligibility Budgets

Body

Revision 09-4; Effective December 1, 2009

Eligibility is determined for individuals and couples (in institutional living arrangements) who:

- apply for retroactive Medicaid coverage; or
- apply for or have eligibility redetermined under federally optional MEPD programs.

When a person not already eligible for Medicaid moves to an institutional setting, the income standard used and the income counted depend on whether the budget is for an individual, companion or couple case. Income is tested against the special income limit. See Appendix XXXI, Budget Reference Chart.

G-6110 Individual Institutional Eligibility Budget

Revision 09-4; Effective December 1, 2009

When a person applies for Medicaid, an individual budget is prepared if a person in an institutional setting is:

- single;
- widowed; or
- divorced.

Note: An individual budget is also used when a person is married and has a community spouse, but the community spouse refuses to cooperate in providing information and circumstances indicate possible abuse or neglect by the community spouse.

The income of the person is considered against the special income limit standard for an individual.

G-6120 Couple Institutional Eligibility Budget

Revision 18-3; Effective September 1, 2018

A couple budget is prepared when a person is residing in the same institutional setting with an eligible spouse (i.e., a spouse who is aged or has a disability) and they are:

- presenting themselves to the community as a married couple;
- determined to be married for purposes of receiving Social Security benefits; or
- recognized as married under state law.

The incomes of both spouses are considered against the special income limit standard for a couple.

Prepare two individuals budgets when a married couple:

- resides in different institutional settings; or
- is ineligible as a couple.

G-6130 Companion Institutional Eligibility Budget

Revision 09-4; Effective December 1, 2009

An institutional companion budget is prepared for a person in an institutional setting if:

- the person has a community spouse; and
- the couple meets the definition of a couple in Section G-6120, Couple Institutional Eligibility Budget, except the criterion that the couple live together does not apply.

Note: If the institutional setting is a waiver, the couple could be living together. If the institutional setting is a Medicaid certified facility, then the couple will not be living together since the criterion for a companion budget is a community spouse.

In preparing a companion institutional budget for a person, spousal impoverishment treatment of income and resources applies. See Chapter J, Spousal Impoverishment.

For the eligibility budget, the income of the person in the institutional setting is considered against the special income limit standard for an individual.

G-6200, Special Income Limit for the Eligibility Budget

Body

Revision 09-4; Effective December 1, 2009

A special income limit is used to determine income eligibility for a person in an institutional setting who is not already eligible for Medicaid or for a person who becomes ineligible for Medicaid because of the move to an institutional setting.

The special income limit for a person is equal to or less than 300% of the full individual Supplemental Security Income (SSI) federal benefit rate.

The special income limit for a couple is twice the special income limit for an individual.

To qualify for the special income limit, a person or couple must:

- have countable income that exceeds the reduced SSI federal benefit rate; and
- reside in a Medicaid-certified long-term care facility for 30 consecutive days;
- receive a level of care or medical necessity determination that qualifies the person or couple for Medicaid; or
- be approved by a Texas health and human services agency to receive services under a Home and Community-Based Services waiver program and receive the services within one month after approval.

Note: The special income limit is used if the person is 65 years of age or older and in a Medicaid-certified institution for mental diseases for 30 consecutive days.

G-6210 Thirty Consecutive Days and the Special Income Limit

Revision 09-4; Effective December 1, 2009

Eligibility under the special income limit is not effective until the person has been in an institutional setting for a period of 30 consecutive days. Once the person has been in the institutional setting for the 30 consecutive days, use the special income limit retroactively for the month in which the person started the 30 consecutive days period.

Note: When a full Medicaid-eligible recipient moves into an institutional setting, the recipient does not have to meet the 30 consecutive days requirement to be eligible for Medicaid in an institutional setting.

The 30 consecutive days are not disrupted if the person:

- makes a three-day therapeutic home visit with a planned return to the facility;
- is admitted to a hospital with a planned return to the facility;
- moves from a Medicaid-certified facility to another Medicaid-certified facility; or
- moves to a Home and Community-Based Services waiver program.

If a person dies before meeting the 30 consecutive days requirement without moving to a non-institutional setting, the person is considered to have met the requirement for application of the special income limit.

If the person does not complete the 30 consecutive days stay in an institutional setting, the special income limit is not used. The income limit for a non-institutional program must be used instead and the person must meet the criteria in another MEPD group as described in Chapter A, General Information and MEPD Groups.

G-6300, Institutional Eligibility Budget Steps

Body

Revision 09-4; Effective December 1, 2009

Step	Procedure
1	Determine the appropriate income limit for either an individual or couple using the special income limit. See Appendix XXXI, Budget Reference Chart.
2	Determine monthly earned income. See the following: Section G-2000, Income Treatment Section E-3000, Earned and Unearned Income Section E-2000, Exempt Income Section E-2200, Earned Income Exemption Section E-1700, Things That Are Not Income Section E-1770, Mandatory Payroll Deductions
3	Determine monthly unearned income, including income from support and maintenance, if appropriate. See the following: Section G-2000, Income Treatment Section E-3000, Earned and Unearned Income Section E-1700, Things That Are Not Income Section E-2000, Exempt Income Section E-4000, Fixed Income Section E-5000, Variable Section E-9000, Infrequent or Irregular If the person has VA, see Section E-4311.2, $90 VA Pension and Institutional Setting.
4	Do **not** subtract either the: • $20-general exclusion, or • earned income exclusion in Section G-4000, Noninstitutional Exclusions. Compare the remainder to the appropriate SSI FBR to test for the income element of eligibility **Note:** If the remainder is less than the reduced SSI federal benefit rate, refer the person to the Social Security Administration.
5	The remainder is countable income. Compare the remainder to the appropriate income limit to test for the income element of eligibility. The remainder must be equal to or less than the special income limit.

See Section G-5130, Medicare Savings Programs (MSP), for determination of a MSP program.

G-6400, Institutional Excess Income

Body

Revision 09-4; Effective December 1, 2009

When the applicant is obviously income ineligible based on the submitted application, see Section B-2500, Explaining Policy vs. Giving Advice, in determining the appropriate actions to take and the actions to avoid.

See Section F-6800, Qualified Income Trust (QIT), for policy information, and Appendix XXXVI, Qualified Income Trusts (QITs) and Medicaid for the Elderly and People with Disabilities (MEPD), for more information concerning a QIT and a sample.

The QIT option is not available for individuals in a noninstitutional setting such as Community Attendant Services.

G-7000, Prior Coverage

Body

Revision 21-3; Effective September 1, 2021

A person may be eligible for Medicaid coverage for up to three months prior to the month of application. Prior coverage may be continuous or there may be interrupted periods of eligibility.

A person does not need to be eligible in the month of application (or current month) to be eligible for one or more months of prior Medicaid. The person must meet all financial and non-financial eligibility requirements for the month(s) of requested Medicaid coverage.

To meet eligibility requirements, the person must:

- be aged, blind or disabled and meet all other non-financial criteria;
- have resources below the applicable resource limit at 12:01 a.m. on the first day of the month;
- have income below the applicable income limit; and
- have received Medicaid-covered services that have not been paid or will be reimbursed by the provider.

Test eligibility separately for each of the prior months and grant eligibility in whole-month increments. Verify the amounts and dates of unpaid or reimbursable services by obtaining a copy of unpaid medical bills or a billing statement from the provider (dated within the last six months).

If eligible for retroactive Medicaid, the person should notify their medical provider and provide a copy of the eligibility notice, so any retroactive claims can be processed appropriately.

Related Policy

Special Income Limits, G-1320
Co-Payment for SSI Cases, H-6000
Medicaid Buy-In (MBI) Income Limits, M-5200

G-7100, Prior Coverage for SSI Applicants

Body

Revision 18-3; Effective September 1, 2018

The Supplemental Security Income (SSI) application asks the individual about unpaid or reimbursable medical bills in the prior three months. An affirmative response is reported to the state using the State Data Exchange (SDX) system. A person claiming unpaid or reimbursable medical expenses incurred during the three months before the date of application receives a computer-generated notice to contact the Texas Health and Human Services Commission (HHSC) if they want their eligibility for prior coverage determined.

- **Certified Recipients** —For certified SSI recipients, Medicaid coverage automatically begins with the month prior to the first month of SSI payment. Prior coverage may be determined for the preceding two months if the individual meets all Medicaid eligibility requirements.
- **Denied Applicants** — For denied SSI applicants who have medical expenses, the retroactive period remains the three months prior to the SSI application month.

- **Deceased Applicants** — For SSI applicants who die before the SSI eligibility decision by the Social Security Administration (SSA), and for whom SSA will not make a determination, the retroactive period is the three months prior to the receipt of an HHSC application from a bona fide agent. (see G-7210)

To apply for retroactive medical coverage, the individual must complete an HHSC application form. Use SSI program criteria when determining prior coverage eligibility.

A person may be eligible for more than one retroactive period if the person applies for SSI more than once. Determination of eligibility on a month-to-month basis may result in non-sequential periods of eligibility.

When the eligibility determination for the open or close time-period is complete for the ME-SSI Prior, notify the individual of the decision using Form TF0001, Notice of Case Action.

G-7200, Prior Coverage for Medical Assistance Only Applicants

Body

Revision 12-3; Effective September 1, 2012

Applicants may be eligible for Medicaid coverage during any or all of the three months before the month of application for an ongoing MEPD program. An applicant must have unpaid or reimbursable charges or bills for Medicaid covered services during each month for which prior coverage is requested. He must meet all requirements applicable to the SSI or MEPD programs during each of the months he is eligible.

The department also explores possible three month's prior coverage based on the date of change in the individual's circumstances for an individual transferring from limited Medicaid programs, such as QMB or Community Attendant Services, to full Medicaid benefit programs.

Example: If a QMB individual entered a nursing facility on June 3, the eligibility specialist would explore possible three months prior coverage for March, April and May. The special income limit would potentially be used for June and the SSI income limit would be used for the prior months.

Note: For Title XIX facility payment only, it makes no difference whether the bill is paid or unpaid. Standards for participation mandate reimbursement if Medicaid is established.

G-7210 Prior Coverage for Deceased Applicants

Revision 18-3; Effective September 1, 2018

A bona-fide agent may file an application with HHSC on behalf of a deceased person for Medicaid coverage for any or all of the three months before HHSC receives the application. During each month for which prior coverage is requested, the deceased person must:

- meet all eligibility requirements applicable to the MEPD program;
- meet SSI income and resource limits; and
- have unpaid or reimbursable charges or bills for Medicaid-covered services.

A bona fide agent is a person who is knowledgeable of the decedent's circumstances and can report the required information for eligibility determination accurately and under penalty of perjury. If the information does not establish a date of onset covering the period for which eligibility is being determined, request a disability determination from the HHSC Disability Determination Unit (DDU). Indicate on Form H3034, Disability Determination Socio-Economic Report, that the individual is deceased.

The time period for which eligibility is determined is the three months before the month an HHSC application is received from the decedent's bona fide agent.

When the eligibility determination is complete for the ME-SSI Prior, notify the bona fide agent of the decision using Form TF0001, Notice of Case Action.

G-7300, Prior Coverage for Aliens

Body

Revision 21-3; Effective September 1, 2021

A person ineligible for Medicaid due to undocumented status or not having an appropriate alien status may be eligible for Medicaid to cover an emergency medical condition in:

- the three months prior to the month of application only;
- the month of application only; or
- the month of application and up to three prior months.

More than one emergency medical period can be reported in the above time frames. Use Form H3038, Emergency Medical Services Certification, to verify treatment for an emergency medical condition and the dates of the emergency period. A new Form H3038 is needed for each emergency medical period.

The Form H3038 must:

- indicate the begin and end dates of the emergency condition;
- have the handwritten signature of the medical practitioner who provided the emergency treatment; and
- be signed and dated by the applicant on page 2.

Note: A stamped or electronic signature of the attending practitioner is not acceptable.

A medical practitioner is a person who holds a license to practice medicine, including the following:

- physician (MD);
- osteopathic medical physician (DO);
- advance nurse practitioner (ANP); or
- registered nurse (RN).

Note: A licensed practical nurse (LPN), a licensed vocational nurse (LVN), or a midwife do not meet the definition of medical practitioner.

Verification of unpaid medical bills is not required for prior coverage for emergency Medicaid. Provide Medicaid coverage for the duration of the emergency period as indicated on the Form H3038.

Chapter H, Co-Payment

H-1000, General Information for Co-Payment

H-1100, Texas Administrative Code Rules

Body

Revision 12-2; Effective June 1, 2012

The following is taken from Subchapter C, Financial Requirements, Division 6, Budgeting for Eligibility and Co-Payment.

§358.438. Determination of Co-payment.

(a) After a person or couple in an institutional setting is determined eligible for a Medicaid-funded program for the elderly and people with disabilities, the Texas Health and Human Services Commission (HHSC) determines the person's or couple's co-payment in accordance with:

(1) Section 1902(a)(17) of the Social Security Act (42 U.S.C. §1396a(17)), relating to the general authority;

(2) Section 1902(a)(50) and (q) of the Social Security Act (42 U.S.C. §1396a(50) and (q)), relating to personal needs; and

(3) Section 1924 of the Social Security Act (42 U.S.C. §1396r-5), relating to institutionalized spouses with community spouses.

(b) To determine the co-payment for a person or couple in an institutional setting, HHSC follows 42 CFR §§435.725, 435.726, and 435.735, including the optional deduction for a home maintenance allowance for a person or couple described in 42 CFR §435.725(d).

(c) To determine the co-payment for a person or couple receiving services under the Program of All-Inclusive Care for the Elderly (PACE) in a PACE setting, HHSC follows §1934(i) of the Social Security Act (42 USC §1396u-4(i)).

(d) HHSC follows §1924(d) of the Social Security Act (42 U.S.C. §1396r-5(d)), concerning the protection of income for the community spouse, to determine the minimum monthly maintenance needs allowance, and to determine an institutionalized spouse's co-payment.

§358.439. Guardianship Fee.

In determining the co-payment for a person receiving services in an institutional setting, the Texas Health and Human Services Commission (HHSC) may deduct a guardianship fee, if any, up to an amount set by the court, from the person's total countable income.

(1) The deduction is limited to guardianship-related costs and fees, subject to the limitations of §32.02451 of the Texas Human Resources Code, Section 670 of the Texas Probate Code, and this section, as determined by HHSC.

(2) HHSC deducts the guardianship-related costs and fees from total countable income after deducting the personal needs allowance, but before deducting any other allowances.

(3) The deduction is effective the later of:

(A) the month the judge signs the court order awarding guardianship-related costs and fees;

(B) the first month of eligibility for which the person has a co-payment; or

(C) the first day of the month that the applicant or recipient provides HHSC with a copy of the court order awarding the guardianship-related costs and fees.

(4) HHSC does not deduct any amount of guardianship-related costs and fees awarded before the date the court order was signed. The deduction is prospective only.

(5) HHSC does not deduct a guardianship establishment fee unless a new guardian is named in the most recent court order.

(6) HHSC does not deduct any guardianship-related costs and fees ordered after the recipient has died.

(7) To receive the deduction, an applicant or recipient must provide a copy of the court order to HHSC no later than the date specified by HHSC. No deduction will be given until the applicant or recipient provides HHSC with a copy of the court order awarding the guardianship-related costs and fees by submitting the court order as specified by HHSC.

(8) The deduction authorized by this section is limited to a guardianship of the person. No deductions are allowed for any other type of guardianship.

§358.440. Dependent Allowance.

(a) In determining a person's co-payment, the Texas Health and Human Services Commission (HHSC) may deduct a dependent allowance from a person's total countable income.

(1) For a person with at least one dependent relative at home, HHSC allows the individual Social Security Income (SSI) federal benefit rate for each dependent relative and deducts the individual SSI federal benefit rate from the dependent relative's countable income.

(2) For a person with a spouse and at least one dependent relative at home, when spousal impoverishment provisions apply, HHSC determines the dependent allowance in accordance with 42 U.S.C. §1396r-5.

(b) The amount of the dependent allowance may be appealed based on undue hardship caused by financial duress as determined by HHSC, in accordance with HHSC's fair hearing rules in Chapter 357 of this title (relating to Hearings).

§358.441. Payroll Deductions.

(a) In determining a person's co-payment, the Texas Health and Human Services Commission (HHSC) calculates earned income each month by subtracting the following mandatory payroll deductions:

(1) income tax;

(2) social security tax;

(3) required retirement withholding; and

(4) required uniform expenses.

(b) After a person or couple in an institutional setting is determined eligible, HHSC applies the payroll deductions described in subsection (a) of this section to:

(1) an applicant or recipient;

(2) an applicant's or recipient's spouse; and

(3) a dependent relative of either spouse.

H-1200, Income That Is Not Used in the Co-Payment

Body

Revision 18-1; Effective March 1, 2018

Determine the copayment for a Medicaid eligible individual or couple residing in an institution, receiving services under the Program of All Inclusive Care for the Elderly (PACE) in a PACE setting, or receiving services under a Home and Community Based Waiver program.

When determining the copayment, consider the total income available to the individual from all sources. Certain payments that are not income and certain exempt income are not considered in the copayment budget. The total income for the copayment budget may be different from the total income for the eligibility budget.

When determining the copayment, do not include the following:

- exempt income (see Section E-2000);
- things that are not income (see Section E-1700), such as:
  - medical care and services;
  - certain social services;
  - receipts from the sale of a resource;
  - miscellaneous items, such as income tax refunds;
  - proceeds of a loan;
  - wage-related payments;
  - mandatory payroll deductions from earned income (see E-1770); and
  - cafeteria plans.
- interest or dividends accrued on certain excluded or partially excluded resources (see E-3331.2);
- interest and dividends earned on an ABLE account (see E-3331.4); and
- VA Aid and Attendance allowance, housebound allowance, and payment adjustment for unusual medical expenses (see E-4300, E-4311.2, E-4315). **Reminder:** If these payments are deposited into a qualifying income trust (QIT) account, they are countable as copayment.

Note: Income tax withheld from unearned income is not a deductible expense for the copayment calculation.

H-1300, Variable Income and Co-Payment

Body

Revision 09-4; Effective December 1, 2009

See Section E-5000, Variable Income.

See Section E-3331, Interest and Dividends.

- Determine if any interest or dividends are accrued on fully countable resources and count the interest or dividends as income in the co-payment budget.
- Determine if any interest or dividends are accrued on all other resources and count the interest or dividends accrued as income in the co-payment budget (refer to the treatment of that particular resource as outlined in the handbook).

H-1400, Order of Deductions from Countable Income

Body

Revision 12-1; Effective March 1, 2012

HHSC deducts the following amounts, in the following order, from the person's total countable income:

1. Personal needs allowance. See Section H-1500, Personal Needs Allowance (PNA).
2. Guardianship fees. See Section H-1550, Guardianship Fees.
3. Maintenance needs of spouse. See Section J-7200, Spousal Co-Payment.
4. Maintenance needs of family (for a person with a family at home, an additional amount for the maintenance needs of the family). See Section H-1600, Dependent Allowance.
5. Incurred Medical Expenses. See Section H-2000, Incurred Medical Expenses.

Optional deduction: Allowance for home maintenance. See Section H-1700, Deduction for Home Maintenance.

H-1500, Personal Needs Allowance

Body

Revision 10-1; Effective March 1, 2010

A personal needs allowance (PNA) is an amount of a recipient's income that a recipient in an institutional setting may retain for personal use. It will not be applied against the costs of medical assistance furnished in the facility. Each recipient in an institutional setting may retain a PNA in an amount set by the executive commissioner of the Health and Human Services Commission in accordance with Chapter 32 of the Texas Human Resources Code. For SSI recipients who receive the $30 reduced federal benefit, the state will issue a supplement to allow for a PNA at the minimum level set by the executive commissioner.

Beginning Jan.1, 2006, the PNA is $60.

From Sept. 1, 2003, through Dec. 31, 2005, the PNA was $45.

From Sept. 1, 2001, through Aug. 31, 2003, the PNA was $60.

From Sept. 1, 1999, through Aug. 31, 2001, the PNA was $45; prior to that, it was $30.

Note: See Section E-4300, VA Benefits, for treatment of payments from the Department of Veterans Affairs. See Section E-4311.2, $90 VA Pension and Institutional Setting, regarding automation limitations and the VA $90 capped pension.

H-1550 Guardianship Fees

Revision 19-4; Effective December 1, 2019

When determining the co-payment for a person receiving services in an institutional setting, guardianship fees, up to an amount set by the court, are deducted from the person's total countable income.

The allowable court-ordered guardianship fee deduction may include the following:

- Monthly guardianship fees up to $250
- Costs related to establishing the guardianship up to $1,000
- Costs related to terminating the guardianship up to $1,000
- Administrative costs related to the guardianship up to $1,000 over a three-year period

Note: Costs related to establishing or terminating the guardianship can exceed $1,000 if the costs in excess are supported by documentation acceptable to the court and the costs are approved by the court. Costs might include compensation and expenses for an attorney ad litem, guardian ad litem, and reasonable attorney fees for an attorney representing the guardian.

Only allow a deduction for actual amounts in the court order.

Allow the reduction in the person's co-payment to be effective the later of the following:

- the month in which the judge signs the court order awarding guardianship fees;
- the first month of Medicaid eligibility in which the person has a co-payment; or
- the first day of the month the person provides HHSC with a copy of the court order.

Route any administrative cost more than $1,000 over a three-year period, or any cost exceeding the $1,000 for establishing or terminating the guardianship, through the regional attorney for guidance.

Do not allow a reduction in the person's co-payment for guardianship fees ordered after HHSC receives verification that the person has died. If the date of death is not verified, staff must clear the discrepancy. Do not allow the guardianship fees as a deduction in the co-payment until the discrepancy has been cleared.

Related Policy

Date of Death Denials and Verification Sources, B-9300
Guardians and Other Agents, F-1231
Order of Deductions from Countable Income, H-1400

H-1600, Dependent Allowance

Body

Revision 10-3; Effective September 1, 2010

A dependent family member may be either spouse's minor or dependent children, dependent parents and dependent siblings (including half brothers, half sisters and siblings gained through adoption) who were living in an institutionalized client's home before the client's institutionalization, and who are unable to support themselves outside the client's home because of medical, social or other reasons.

Non-Spousal

The dependent allowance is calculated by subtracting the dependent's income from the SSI federal benefit rate for an individual when there is not a community spouse. Mandatory payroll deductions also apply to a dependent's earned income.

Spousal

If in a spousal situation, the dependent allowance is calculated by subtracting the dependent's income from 150% of the monthly federal poverty level (FPIL) for a family of two, and dividing by three. Mandatory payroll deductions also apply to a dependent's earned income. The dependent family member must have been living in the person's home before the person's absence, must continue to live with the community spouse and must be unable to support himself outside the home because of medical, social or other reasons. See Section J-7400, Spousal Impoverishment Dependent Allowance, for more information on dependent allowance in a spousal budget.

H-1700, Deduction for Home Maintenance

Body

Revision 20-2; Effective June 1, 2020

HHSC allows a deduction from a co-payment if a person intends to return home within six months of admission to an institutional setting and needs to meet expenses in maintaining the home. The deduction is based on the person's mortgage or rent payment and average utility charges, excluding phone. The amount deducted cannot exceed the SSI income limit, not including the $20 disregard. The first month of the six-month period is the month of admission to the institution.

Note: A separate deduction for maintenance of the home is not allowable in companion cases. The spousal allowance provides for home maintenance in those cases.

The home maintenance deduction is allowable if:

- the person notifies the eligibility specialist that he expects to be in an institutional setting for at least 30 consecutive days, but no more than six months;
- the eligibility specialist receives a practitioner's certification within 90 days of admission. The practitioner certifies that the person is likely to leave the institution within six months of admission; and
- the eligibility specialist receives evidence within 90 days of admission that the person needs to maintain and provide for the expenses of the home to which he may return.

  Note: The day of admission to the institutional setting is day zero.
  - **Example 1:** A person entered a nursing facility on March 1. An application was received on May 30, which included a completed and signed Form H1280, Statement of Residence Maintenance Needs. The applicant signed the form on March 28 and the physician's signature was dated April 15. The day of entry to the nursing home on March 1 would be counted as day zero. The 90th day would be May 30. It is calculated by the following: 31 days in March (30 countable days, since March 1 would be counted as day zero), 30 days in April (30 countable days) and 31 days in May (30 countable days) for a total of 90 days. May 31 would be 91 days. Application was received on May 30; thus, Form H1280 was received by the 90th day.
  - **Example 2:** A person entered a nursing facility on April 1. An application was received on July 10, which included a completed and signed Form H1280. The applicant signed the form on April 29 and the physician's signature was dated May 15. The day of entry to the nursing home on April 1 would be counted as day zero. The 90th day would be June 30. It is calculated by the following: 30 days in April (29 countable days, since April 1 would be counted as day zero), 31 days in May (31 countable days) and 30 days in June (30 countable days) for a total of 90 days. Application was received on July 10; thus, Form H1280 was not received by the 90th day. The individual is not eligible for the home maintenance deduction.

Use Form H1280, Statement of Residence Maintenance Needs, to obtain the person's and practitioner's declaration. Use the amount reported on Form H1280 as the home maintenance deduction amount as long as it does not exceed the SSI income limit, not including the $20 disregard. No additional verification is needed.

To ensure the home maintenance allowance is included as a deduction in the recipient’s co-payment calculation, staff makes the following selections within the appropriate Logical Unit of Work (LUW):

- on the Shelter Expense LUW, select an expense type of “Rent” or “Mortgage”;
- on the Utility Expense LUW, select the expense type “gas/propane, water, electric”; and
- select Form H1280, Statement of Residence Maintenance Needs, as verification for both the Shelter and Utility Expense LUWs.

Note: If any other source of verification is selected, the home maintenance allowance will not be allowed in the co-payment.

The system will automatically end the home maintenance allowance in the sixth month after the month of admission and will:

- end date the appropriate shelter or utility records;
- adjust the ongoing co-payment; and
- generate Form TF0001, Notice of Case Action, and Form TF0001P, Provider Notice, to notify both the recipient and the facility of the ongoing co-payment.

H-1800, Medicare Part B Premium

Body

Revision 21-1; Effective March 1, 2021

In most cases, the Medicare Part B premium is deducted from the Social Security or Railroad Retirement check. In some situations, a person will be billed for the Medicare Part B premium, usually via a quarterly invoice.

The base or standard Medicare Part B premium changes from year to year. For 2021, the standard premium is $148.50 per month. This amount can vary due to several factors:

- A person did not enroll in Medicare the year that they became eligible, so the premium is higher.
- A person's premium can be lower than the standard premium if the cost of living (COLA) increase on the RSDI is less than the increase in the monthly Medicare premium. In other words, the monthly RSDI benefit cannot be less than the previous year's benefit.
- A person may be enrolled in a Medicare Advantage Plan (Medicare Part C), which may have a lower Medicare Part B premium deduction due to the discount offered by the plan.

In all situations, the Medicare Part B premium is indicated on the State Online Query (SOLQ) or Wire Third-Party Query (WTPY). Staff must use the amount as verified in SOLQ.

The monthly standard Medicare Part B premium is:

Date Range	Amount
Jan. 1, 2021 to present	$148.50
Jan. 1, 2020 to Dec. 31, 2020	$144.60
Jan. 1, 2019 to Dec. 31, 2019	$135.50
Jan. 1, 2018 to Dec. 31, 2018	$134.00
Jan. 1, 2017 to Dec. 31, 2017	$134.00
Jan. 1, 2016 to Dec. 31, 2016	$121.80
Jan. 1, 2013 to Dec. 31, 2015	$104.90
Jan. 1, 2012 to Dec. 31, 2012	$99.90
Jan. 1, 2011 to Dec. 31, 2011	$115.40

H-2000, Incurred Medical Expenses

H-2100, Deduction of Incurred Medical Expenses

Body

Revision 20-2; Effective June 1, 2020

A Medicaid recipient may pay for health care costs not covered by Medicaid. Some of these expenses, referred to as incurred medical expenses (IMEs), may be deducted from a recipient’s personal income when calculating co-payment amounts.

When calculating a recipient's co-payment amount, certain IMEs not covered or reimbursed by a third party are deducted. HHSC limits these expenses to Medicare and other general health insurance premiums, deductibles and coinsurance, and to medical care and services that are recognized by state law but not covered under the Medicaid state plan.

An open-ended IME is an ongoing expense that occurs every month. For example, Medicare Part B premiums and general health insurance premiums are open-ended IMEs.

An IME for a set amount that a recipient will pay off within a specific time period is not open-ended. For example, dentures or wheelchairs are not open-ended IMEs.

Process IME requests as a change.

Within 10 workdays of receipt of a request for an IME deduction, staff must:

- process the IME request;
- enter the IME information into the Texas Integrated Eligibility Redesign System (TIERS); and
- notify the recipient, the nursing facility, and the IME provider of the co-payment adjustment.

Related Policy

Redetermination Cycle, B-8200
IME Notices, H-2900

H-2110 When to Consider an IME Deduction

Revision 16-2; Effective June 1, 2016

An incurred medical expense (IME) deduction applies only to Medicaid recipients with a co-payment amount other than zero.

The recipient must provide verification of all medical expenses to be considered.

In spousal impoverishment budgets with a co-payment amount other than zero, an IME deduction is allowed when an IME is paid for by the recipient or the recipient’s community-based spouse.

H-2120 Medically Necessary

Revision 16-2; Effective June 1, 2016

Before allowing an incurred medical expense (IME) deduction, the expense must be certified as medically necessary.

Medically necessary is defined as the need for medical services in an amount and frequency sufficient, according to accepted standards of medical practice, to preserve health and life and to prevent future impairment.

Form H1263-A, Certification of Medical Necessity – Durable Medical Equipment or Other IME, is used for certification of medical necessity. The form must be completed, signed, and dated by the recipient's physician or a nurse practitioner, clinical nurse specialist, or physician's assistant who is working in collaboration with the recipient's physician.

Form H1263-B, Certification of No Medical Contraindication – Dental, is used for dental IME recipients. By signing Form H1263-B, the attending physician (medical practitioner) certifies that the dental treatment is not medically contraindicated for the recipient. The physician is not able to certify medical necessity for dental services.

H-2130 Form H1263-A and Form H1263-B

Revision 18-4; Effective December 1, 2018

Form H1263-A, Certification of Medical Necessity - Durable Medical Equipment or Other IME, is used to request an IME deduction for medically necessary durable medical equipment.

Form H1263-B, Certification of No Medical Contraindication – Dental, is used to request an IME deduction for necessary non-emergency dental services.

Form H1263-A and Form H1263-B must be signed with handwritten dates and signatures by the recipient or the recipient's authorized representative (AR) and the recipient's attending practitioner. A stamped signature is not acceptable.

If Form H1263-A or Form H1263-B is received with a stamped signature, staff must:

- pend the case;
- send Form H1052-IME to notify the provider and the recipient of the delay in processing due to the need for a handwritten signature; and
- request a new Form H1263-A or Form H1263-B with handwritten signatures.

The signature dates of the recipient or the recipient's AR and the recipient's attending physician on Form H1263-A or Form H1263-B must **not** be more than 90 days apart.

If the signature dates are more than 90 days apart, staff must:

- pend the case;
- send Form H1052-IME, Notice of Delay in Decision for Incurred Medical Expenses, to notify the recipient or the recipient's AR and the IME provider of the delay in processing; and
- request a new Form H1263-A or Form H1263-B.

Staff must request a new Form H1263-A or Form H1263-B and send Form H1052-IME if Form H1263-A or Form H1263-B is received without any of the following:

- signature of the recipient, or the recipient's AR;
- a description of authority to act for the recipient listed in Section II of Page 2; or
- signature of the recipient's attending practitioner.

There are no restrictions on who can complete Form H1263-A or Form H1263-B, however, the recipient or the recipient's AR must sign Form H1263-A or Form H1263-B, Section II of page 2 to indicate a request for a deduction from the recipient's personal income to pay for an incurred medical expense.

If the recipient is unable to sign and does not have a designated AR, legal guardian or POA, the following can sign the form on the recipient's behalf:

- nursing facility administrator;
- social worker; or
- director of nursing.

If the recipient has a designated AR but someone other than the AR signs Form H1263-A or Form H1263-B, verify the AR is aware of the IME request. If unable to contact by telephone, pend the case and send Form H1052-IME to request the AR sign Form H1263-A or Form H1263-B. If Form H1263-A or Form H1263-B is not returned with the signature of the designated AR, deny the IME request.

This will ensure all parties are knowledgeable of the IME request. If the AR has changed, thoroughly document that explanation in the case record.

Submitting to HHSC

Send completed Form H1263-A and Form H1263-B to HHSC via mail or fax.

Fax to: 877-447-2839
Or
Mail to:
Texas Health and Human Services Commission
P.O. Box 149027
Austin, TX 78714-9027

H-2140 Deductions for Insurance Premiums

Revision 16-2; Effective June 1, 2016

Premiums for general health insurance policies, including premiums for limited scope polices for vision and dental, may be allowable incurred medical expenses (IMEs). Allow an IME deduction when a recipient provides verification that a policy is assignable, the coverage effective date, and the premium amount.

Assignable means the benefits may be paid to the health care provider.

If a health insurance policy is not assignable, payments are made directly to a recipient. The policy is considered an income maintenance policy and is not an allowable IME.

Use Form H1253, Verification of Health Insurance Policy, if a recipient requests help to obtain verification for a policy.

Verification of the first premium payment is not required prior to allowing an IME deduction.

Assignable general health insurance policies must be reported on the Third Party Resource screen in the system of record.

For IME requests for dental insurance premiums, use Form H1053-IME, Provider Notice of Incurred Medical Expense Decision, to notify a dental insurance provider that an IME deduction request is approved or denied. Form H1053-IME does not contain space for co-payment information. To safeguard confidentiality, **do not** add co-payment information to the form or provide the information to any provider (either verbally or in writing) without written authorization from the recipient.

H-2150 Non-Allowable Deductions – General IME

Revision 16-2; Effective June 1, 2016

Texas Health and Human Services Commission (HHSC) does not allow deductions for:

- items covered by the nursing facility (NF) vendor payment (including, but not limited to, diapers, sitters, durable medical equipment, dietary supplements or physical, speech, or occupational therapy);
- covered services that are beyond the amount, duration, and scope of the Medicaid state plan (including, but not limited to, additional prescription drugs);
- services covered by the Medicaid state plan but delivered by non-Medicaid providers;
- expenses for medical services received before the applicant's medical effective date;
- premiums for cancer or other disease-specific insurance policies, or general health, dental, or vision insurance policies with benefits that cannot be assigned;
- premiums for insurance policies that pay a flat rate benefit to the insured or income maintenance policies;
- health care services provided outside of the U.S.;
- expenses incurred during a transfer of assets penalty (including, but not limited to, nursing facility bills);
- expenses for eyeglasses, contact lenses, hearing aids, services provided by a chiropractor or a podiatrist (these are covered through the Medicaid program);
- expenses covered by STAR+PLUS managed care organizations (MCOs) either:
    - as an NF add-on service, including medically necessary durable medical equipment, such as customized power wheelchairs (CPWCs), augmentative communication devices (ACDs), emergency dental services, and physician ordered rehabilitation services (also called goal directed therapies); or
    - as value-added services (VAS). VAS are extra benefits offered by an MCO beyond Medicaid-covered services. VAS may include routine dental, vision, podiatry, and health and wellness services. **Note**: A recipient may choose to utilize the MCO VAS or the IME process; and
- expenses incurred by Medicaid-eligible recipients 21 years of age or older requiring mental health and counseling services provided by a licensed psychologist, licensed professional counselor, licensed clinical social worker or a licensed marriage and family therapist (effective for dates of service on or after Dec. 1, 2005).

H-2200, Third Party Reimbursement Considerations

Body

Revision 16-2; Effective June 1, 2016

Incurred medical expense (IME) deductions are allowed for reimbursements by the recipient to a third party who has paid an allowable IME on behalf of the recipient after it is determined the following conditions exist:

- recipient and third party had an agreement prior to the IME that the third party would be reimbursed; or
- recipient's medical condition precluded such an agreement.

H-2300, IME Budget Adjustments Due to Changes in Living Arrangement

Body

Revision 18-4; Effective December 1, 2018

If the recipient is no longer eligible for a Medicaid type program with a co-payment, do not make any retroactive adjustments to allow the full IME amount. The IME deduction stops and payment of any remaining balance is an agreement between the recipient and the IME provider.

In addition, do not retroactively adjust the co-payment amount for an IME deduction if the recipient:

- discharges from the facility;
- no longer receives waiver services; or
- is not responsible for payment of the IME because someone has been paying the bill on the recipient's behalf.

Recipient Moves from Facility to Community Waiver

When a facility Medicaid recipient moves to the community with waiver Medicaid benefits, continue the approved IME deduction when there is a co-payment amount other than zero.

The IME deduction ceases if there is no co-payment amount for the community waiver program.

Recipient Moves from Community Waiver to Facility

When a Medicaid waiver recipient with an approved IME deduction enters or returns to a Medicaid facility, verify if the recipient has any balance due on the IME allowance. If there is a balance due, approve a co-payment deduction for the remaining balance of the IME. If a Medicaid recipient re-enters a nursing facility and has an outstanding balance due on an IME incurred during a previous facility stay, allow an IME deduction for the remaining balance.

H-2310 IME Budget Adjustments Due to Death

Revision 18-4; Effective December 1, 2018

Do not process IME requests received more than 10 calendar days after a recipient's date of death. The recipient's authorized representative, family or trustee is responsible for paying the IME provider after the recipient's death.

Process IME requests received within 10 calendar days of a recipient's date of death.

If the IME is approved:

- adjust the recipient's co-payment retroactively to the first month services were provided; and
- notify the recipient's authorized representative, the nursing facility and the IME provider.

If the IME is not approved:

- document the reason for the denial in TIERS Case Comments and notify the authorized representative and the IME provider of the denial;
- send Form TF0001, Notice of Case Action, to notify the recipient's authorized representative; and
- send Form H1053-IME, Provider Notice of Incurred Medical Expense, to notify the IME provider.

H-2400, Ongoing IME Budget

Body

Revision 12-1; Effective March 1, 2012

Average and project medical expenses, but reconcile the projection with actual expenses every six months, per 42 Code of Federal Regulations §435.725(e).

For routine dental incurred medical expense (IME) deductions, retroactively allow the deduction beginning the first month the work began. Do not allow any routine dental IME deductions until after the dental work has been completed.

Example 1: Form H1263-B, Certification of No Medical Contraindication – Dental, for dentures is received on May 24, 2010. Dental work began in March 2010. Lower the co-payment in the month of March 2010 and ongoing.

For non-routine dental IME deductions, allow the deduction beginning the first month following approval. Do not allow any deductions for non-routine before approval is received.

Example 2: Form H1263-B for implants is received on June 19, 2010. Approval is received on Form H1263-B on July 15, 2010. Dental work begins Aug. 2, 2010. Lower the co-payment in the month of August 2010 and ongoing.

Documentation of the IME deductions should be entered in the automated system, even if the co-payment amount is $0. See Appendix XVI, Documentation and Verification Guide.

H-2500, Medicare Part D Related Expenses

Body

Revision 16-2; Effective June 1, 2016

Medicare Part D related expenses may include:

- Part D premiums;
- prescription drug co-payments/costs;
- prescription drug deductibles; and
- non-formulary Part D drugs.

Allow Medicare Part D related expenses as an incurred medical expense (IME) deduction for a recipient who:

- has Medicare;
- has a co-payment; and
- is receiving home and community-based waiver services, or is residing in a long-term care (LTC) facility.

If a recipient provides verification of payment of an out-of-pocket Medicare Part D related expense, allow the expense as an IME.

Form H1263, Certification of Medical Necessity, is not necessary to request an IME deduction for Medicare Part D related expenses, but may be used for documentation of a request. If a recipient is unable to make a request and has no authorized representative, facility staff or home and community-based waiver case managers may provide verification and request an IME deduction.

H-2600, Reserved for Future Use

Body

Revision 16-2 ; Effective June 1, 2016

H-2700, Dental

Body

Revision 17-4; Effective December 1, 2017

Dental services that are not medically contraindicated for the individual may be allowable incurred medical expense (IME) deductions. Requests for dental IMEs must include the following:

- a completed, signed Form H1263-B, Certification of No Medical Contraindication – Dental; and
- an invoice or billing statement indicating the dental services provided, the date of the dental services, and the appropriate Current Dental Terminology (CDT) code(s).

A treatment plan is not required, but may be received along with an invoice or billing statement.

A treatment plan is a schedule of procedures and appointments needed to restore, step-by-step, an individual's oral health. The treatment plan must be presented to the individual for approval and should include:

- a description of the individual's condition;
- the duration of the treatment plan as prescribed by the dentist; and
- a list of the dental procedures recommended by the dentist, including:
  - a description of each service or procedure;
  - the appropriate Current Dental Terminology (CDT) code; and
  - the expected cost for each service.

Invoice or Billing Statement - A summary of the dental services provided and the amount the individual is expected to pay the dentist. The invoice should include the:

- date(s) of the dental service(s);
- description of each dental procedure provided;
- appropriate CDT code(s) for each dental procedure; and
- cost for each dental procedure provided.

Note: If the individual has dental insurance, the invoice must reflect any services covered by the dental insurance plan and clearly indicate the remaining balance after any adjustments.

Form H1263-B, submitted with a dental invoice, is only valid for the delivered services listed on the invoice.

Form H1263-B, submitted with a proposed treatment plan, is valid for up to 12 months for dental services:

- identified on the dental treatment plan; and
- delivered within 12 months of the date of the initial dental treatment.

All IME requests for dental services associated with a dental treatment plan must include an invoice indicating the dental services provided, the date the services were provided, and the appropriate CDT code(s).

Note: Additional dental services not listed on the original treatment plan and/or dental services provided past the 12 months require a new Form H1263-B.

Form H1263-B, signed by the attending physician, is verification that the requested dental services are not medically contraindicated. If Form H1263-B is received from a requester with a notation that the attending physician does not agree that the procedure is not medically contraindicated for the recipient, deny the IME request. Notify the provider and the recipient or recipient's authorized representative of the denial using the appropriate notice.

If Form H1263-B is received from a requester without a physician signature, do not process the IME. Notify the provider and the recipient or recipient's authorized representative of a delay in processing the deduction for the requested IME using Form H1052-IME, Notice of Delay in Decision for Incurred Medical Expense.

H-2710 Using the TX Dental IME Fee Schedule

Revision 21-3; Effective September 1, 2021

Determine the appropriate incurred medical expense (IME) deduction by comparing the fees submitted by a dental provider to the fees listed in the TX Dental IME Fee Schedule. The fee schedule is available for staff use on the LOOP.

The TX Dental IME Fee Schedule is based on the American Dental Association (ADA) Survey of Fees at the 90th percentile for the West South Central Region, General Dentistry, and contains the ADA's Current Dental Terminology (CDT) codes. The TX Dental IME Fee Schedule is updated yearly. The TX Dental IME Fee Schedule separates the CDT codes between routine and non-routine dental services.

Due to legal liabilities associated with the copyright for the ADA Survey of Fees, the TX Dental IME Fee Schedule is a view-only internal document and is only accessible by HHS enterprise employees. Do not print, make copies, or distribute any of the TX Dental IME Fee Schedule.

The amount allowed for a code cannot exceed the amount listed on the TX Dental IME Fee Schedule. If the dental provider submits a charge with an amount greater than the maximum allowable amount listed for a code, allow the amount listed on the TX Dental IME Fee Schedule for that code as an IME deduction. If a dental provider submits a charge less than the amount allowed on the TX Dental IME Fee Schedule, allow the lesser amount as an IME deduction.

Examples:

- The dental provider submits a charge for code D0272 with the amount of $60. The code D0272, under Radiographs, reflects a maximum of $55. Consider $55 as an IME deduction.
- The dental provider submits a charge for code D0150 with the amount of $60. The code D0150, under Clinical Oral Evaluation, reflects a maximum of $107. Consider $60 as an IME deduction.

Any CDT code(s) listed on the TX Dental IME Fee Schedule may be allowable as an IME.

Contact the dental provider to resolve the discrepancy if the treatment plan received contains:

- a discrepancy in the CDT code and description;
- a CDT code not listed on the TX Dental IME Fee Schedule; or
- no CDT code listed.

H-2720 Non-Allowable Deductions – Dental

Revision 21-3; Effective September 1, 2021

Dental services are not allowable IMEs for Medicaid recipients in intermediate care facilities for individuals with intellectual disabilities (ICFs/IID). A recipient in an ICF/IID receives dental care through the Medicaid program.

The following items are unallowable as an IME:

- adjustments to the fees for X-rays or other procedures performed by mobile dentists;
- sedation charges, CDT code D9248;

- more than two times per year per patient for dental exams;
- more than four times per year per patient for dental cleanings;
- more than one time per year per patient for X-rays;
- aesthetic treatments, CDT codes D9972, D9973, D9974 and D9975;
- trip charges (house call fees), CDT codes D0171, D9410, D9430 and D9440, and finance charges (these are not reasonable medical expenses and cannot be considered when determining IMEs); and
- further add-ons or increased fees for the initial denture and fittings.

Each of the following CDT codes should not be allowed more than two times per year per patient:

- initial or routine exams (D0120, D0150, D0180);
- problem focused exams (D0140, D0160, D0170);
- scaling, root planning or debridement (D4341, D4342, D4346, D4355); and
- Periodontal Maintenance (only for patients who have received active periodontal therapy in the previous 24 months) (D4910).

Each of the following CDT codes should not be allowed more than four times per year per patient:

- dental cleanings (D1110);
- topical fluoride treatments (D1204, D1206); and
- Oral Hygiene Instructions (D1330).

H-2730 Reserved for Future Use

Revision 13-2, Effective June 1, 2013

H-2740 Reserved for Future Use

Revision 13-2, Effective June 1, 2013

H-2750 Codes Not on the TX Dental IME Fee Schedule

Revision 20-2; Effective June 1, 2020

The TX Dental IME Fee Schedule is based on the American Dental Association (ADA) Survey of Dental Fees. The ADA Survey of Dental Fees Catalog is published every two years. Current Dental Terminology (CDT) codes can change between publications.

HHSC has a contract with The University of Texas Health Science Center at San Antonio (UTHSCSA) for a Texas-licensed dentist to ensure dental-incurred medical expense (IME) determinations are appropriate and cost effective.

Until the TX Dental IME Fee Schedule is updated, submit clarification requests to the contracted dentist for review regarding CDT codes not on the TX Dental IME Fee Schedule.

Due to the Health Insurance Portability and Accountability Act (HIPAA), external email communication with the contracted dentist must be encrypted. Use encrypted email (such as Voltage) when sending IME requests to

the contracted dentist.

Note: Do not send any IME requests via regular email to the contracted dentist.
Use the following procedure to submit request(s) for review of the CDT code(s) via email to the contracted dentist:

- Title the email subject line with only the first and last initial of the recipient's name and CDT code (for example, M.S. CDT 5822). If there are multiple codes, list all of the CDT codes that need review in the subject line.
- In the body of the email, provide the CDT code, description of the CDT code (as listed on the treatment plan), the amount charged for that CDT code, and any additional questions or comments.
- Scan and attach the treatment plan and any supporting documentation (except form H1263-B, Certification of No Medical Contraindication - Dental) to the encrypted email

Staff who do not have access to encryption email software, must send IME requests via fax to the contracted dentist. Ensure the fax cover sheet has the fax number and region number for the requestor. The contracted dentist will respond via fax to the requestor.

Use the following procedures to submit request(s) for review of CDT code(s) via fax to the contracted dentist:

- Send an email to the contracted dentist and indicate when the fax will be sent (for example, "Treatment plan has been faxed" or "Treatment plan is being faxed this morning"). This will ensure the fax is monitored.
- Title the email subject line with only the first and last initial of the recipient's name.
- Fax the treatment plan, along with **a copy of the email**, to the attention of the contracted dentist.

If a dental treatment plan contains CDT codes that are on the non-routine schedule and CDT codes that are not on either schedule, send the complete treatment plan or request to the contracted dentist for review.

Contracted Dentist Contact Information:

Dr. Jeff Hicks
hicksj@uthscsa.edu
Phone: 210-567-3450
Fax: 866-313-1395

H-2751 Hospice Recipients

Revision 20-2; Effective June 1, 2020

For hospice recipients with a dental incurred medical expense (IME), Current Dental Technology (CDT) codes notated with an asterisk (*) (cleanings, exams and X-rays) on the routine schedule can be allowed by staff without further review.

For CDT codes not marked with an asterisk (cleanings, exams and X-rays), submit the request to the contracted dentist for clearance. The contracted dentist reviews each request for hospice recipients whether the CDT codes are routine or non-routine.

Before sending the request to the contracted dentist, obtain the following:

- documentation from the hospice provider/attending practitioner regarding the prognosis; and
- the reason for the dental request and how the dental services will benefit the recipient.

Due to the Health Insurance Portability and Accountability Act (HIPAA), external email communication with the contracted dentist must be encrypted. Staff must use encrypted email (such as Voltage) when sending IME requests to the contracted dentist.

Note: Do not send any IME requests via regular email to the contracted dentist.

Use the following procedure to submit request(s) for review of the CDT code(s) via email to the contracted dentist:

- In the email subject line, start with the word "HOSPICE" in all caps and include **only** the first and last initial of the recipient's name and CDT code (for example, HOSPICE – M.S. CDT 5822). If there are multiple codes, list all of the CDT codes in the subject line.
- In the body of the email, provide the CDT code, description of the CDT code (as listed on the treatment plan) and the amount charged for that CDT code.
- Scan and attach the treatment plan and any supporting documentation (except form H1263-B, Certification of No Medical Contraindication – Dental) to the encrypted email.

Staff who do not have access to encryption email software must send the request via fax to the contracted dentist. Ensure the fax cover sheet has the fax number and region number of the requestor. The contracted dentist will respond via fax to the requestor.

Use the following procedures to submit request(s) for review of CDT code(s) via fax to the contracted dentist:

- Send an email to the contracted dentist and indicate when the fax will be sent (for example, "Treatment plan has been faxed" or "Treatment plan is being faxed this morning"). This will ensure the fax is monitored.
- Title the email subject line with only the first and last initial of the recipient’s name.
- Fax the treatment plan, along with **a copy of the email**, to the attention of the contracted dentist.

After the contracted dentist reviews the request, an email response will be returned with the decision.

Contracted Dentist Contact Information:

Dr. Jeff Hicks
hicksj@uthscsa.edu
Phone: 210-567-3450
Fax: 866-313-1395

H-2760 Replacement of Lost Dentures

Revision 10-3; Effective September 1, 2010

The replacement of dentures is an allowable incurred medical expense (IME) as long as the recipient/authorized representative provides written verification from the facility that the facility will not cover the replacement of lost dentures. The verification request for a facility’s written statement is to be sent to the recipient/authorized representative and not the dental provider. The recipient or the authorized representative is to provide the facility’s written statement to the MEPD specialist. The request for replacement of lost dentures is to be initiated by the recipient/authorized representative, not the dental provider.

H-2770 Emergency Dental Services

Revision 16-2; Effective June 1, 2016

STAR+PLUS managed care organizations are responsible for payment of emergency dental services for nursing facility recipients. Emergency dental services are not allowable incurred medical expenses.

H-2780 Reserved for Future Use

Revision 20-2; Effective June 1, 2020

H-2790 When the Co-Payment Adjustment is Not Used to Pay Dental Provider

Revision 10-3; Effective September 1, 2010

Payment for services in accordance with the agreed treatment plan is a matter between the recipient and the dental provider. The recipient or the recipient's payee is expected to actually pay the dental provider in a timely manner using the income from the co-payment adjustment.

If the MEPD specialist is notified the recipient has not appropriately used the income from the co-payment adjustment to pay the dental bill, the MEPD specialist consults with legal counsel as to the appropriate action to take.

H-2800, Durable Medical Equipment

Body

Revision 16-2; Effective June 1, 2016

Certain medically necessary DME may be allowable incurred medical expense (IME) deductions. Examples include:

- customized, manual wheelchairs; and
- basic, power wheelchairs.

Certain medically necessary DME expenses are not allowable IME deductions, if they are:

- covered by a third party;
- covered under the Texas Medicaid State Plan;
- included in the nursing facility (NF) vendor payment; or
- included as NF add-on services.

Examples of medically necessary DME included in NF vendor payments are:

- standard wheelchairs;
- walkers;
- crutches;
- canes;
- air mattresses;
- hospital beds;

- trapeze bars;
- ventilators;
- oxygen equipment, such as tanks, concentrators, tubing, masks, valves and regulators; and
- DME that could be used by other residents, such as oversized wheelchairs or beds.

Note: If a recipient wishes to keep DME that is covered by the vendor payment for personal use only, the recipient is responsible for the purchase and it is not an allowable IME. See The *Nursing Facility Requirements for Licensure and Medicaid Certification Handbook* for additional information.

Direct recipients to their NF representative to request DME items included in the NF vendor payment.

Any repairs to DME for which an IME deduction was allowed are the responsibility of the NF. Refer to the Texas Department of Aging and Disability Services rules at Texas Administrative Code §19.2601(b)(8)(C), Vendor Payment (Items and Services Included).

Use Form H1263-A, Certification of Medical Necessity – Durable Medical Equipment or Other IME, for a DME IME request.

H-2810 Using the DME Fee Schedule

Revision 16-2; Effective June 1, 2016

Determine the appropriate incurred medical expense (IME) deduction by comparing fees submitted by a durable medical equipment (DME) provider to the fees listed in the DME fee schedule.

The Medicare fee schedule for DME contains Healthcare Common Procedural Coding System (HCPCS) codes used by DME providers to file claims. The Texas-specific amounts allowed for IME claims for each code are available on the HHSC Office of Social Services Intranet. The DME Fee Schedule is updated, as needed.

There are no copyright issues with the DME Fee Schedule posted on the Office of Social Services Intranet. This fee schedule is available to the public on the Centers for Medicare and Medicaid Services website.

The amount allowed for a particular HCPCS code cannot exceed the amount listed on the DME fee schedule. If the DME provider submits a charge with an amount greater than the maximum allowable amount listed for a particular code, allow the amount listed on the DME Fee Schedule for that particular code as an IME deduction. If a DME provider submits a charge less than the amount allowed on the DME Fee Schedule, allow the lesser amount as an IME deduction.

Examples:

- The DME provider submits a charge for code E2214 with the amount of $35.00. The code E2214, Pneumatic caster tire, reflects a maximum of $32.52. Consider $32.52 as an IME deduction.
- The DME provider submits a charge for code E2603 with the amount of $120.00. The code E2603, Skin protect cushion < 22 inches, reflects a maximum of $126.07. Consider $120.00 as an IME deduction.

Not all codes listed on the DME fee schedule are allowable as IME deductions. IME requests for codes highlighted in gray or codes not listed on the fee schedule should be submitted for review to state office. See Section H-2830, DME Exception Processing/Codes Not on the Fee Schedule.

Contact the DME provider to resolve the discrepancy if the treatment plan received contains:

- a discrepancy in the HCPCS code and description;
- an HCPCS code not listed on the DME Fee Schedule; or

- no HCPCS code listed.

H-2820 DME Procedures

Revision 18-1; Effective March 1, 2018

Use the following procedures to process incurred medical expense (IME) requests for durable medical equipment (DME).

1. If the MEPD specialist receives an IME request, send Form H1263-A, Certification of Medical Necessity – Durable Medical Equipment or Other IME, to the requestor within two working days of receipt of the request.
2. Inform the requestor to have Form H1263-A completed and the service or equipment provider submit written, detailed specifications for the requested service or equipment to the recipient's attending practitioner after assessing the recipient's needs. The specifications must include the following:
   - a detailed explanation of medical equipment/services recommended;
   - an itemized listing of all equipment and accessories and costs;
   - the appropriate DME Healthcare Common Procedural Coding System (HCPCS) code for each service or equipment; and
   - a clear explanation of why the nursing facility equipment will not meet the recipient's needs.
3. The recipient's attending practitioner, physician assistant or advance practice nurse employed by the attending practitioner, must sign and date the form that lists the medical procedure and the itemized list of equipment and accessories that includes the explanation of why the nursing facility equipment is not adequate for the recipient.
4. The requestor submits to the MEPD specialist:
   - completed Form H1263-A;
   - a provider service statement reflecting service or equipment provided along with the appropriate HCPCS code(s); and
   - a statement from the provider showing the equipment is delivered and the date of delivery.

   The MEPD specialist must document on the form the date the form was received by the agency.

   If the request does not contain a detailed explanation or identification of the equipment needed, return the request to the provider. Explain to the provider that more information is needed regarding the need to identify the equipment or an explanation for the need of the equipment.
5. Once the completed Form H1263-A, written/detailed specifications and itemized list are received, the MEPD specialist determines the correct amount of the recipient's co-payment adjustment by comparing the fees submitted by the provider to the appropriate HCPCS codes and charges on the Medicare DME Fee Schedule. This is in accordance with Section B-8200, Redetermination Cycles, for treatment of a change. Within this same time frame, the MEPD specialist ensures entry into the appropriate automated system and notifies the recipient of the co-payment adjustment, using Form H4808, Notice of Change in Applied Income/Notice of Denial of Medical Assistance, or Form H1259, Correction of Applied Income, in accordance with established agency notification requirements.
6. Complete the same type of form that was sent to notify the recipient of the IME adjustment and mail it to the provider with only the following information:
   - the particular claim that is approved;
   - total amount approved;
   - recipient's co-payment is adjusted (not the actual co-pay amount); and
   - the beginning month of the co-payment or adjustment.

To safeguard confidentiality, do **not** send a notice to a provider that includes specific information about the recipient's finances, sources of income or the amount of co-payment. Do **not** use auto-populated forms or a copy

of the same notice that was sent to the recipient. If a provider inquires about a recipient's finances, refer the provider to the recipient or the recipient's authorized representative. Do **not** refer the provider to nursing facility staff.

Reminder: To safeguard confidentiality, do **not** provide the co-payment amount to any provider (either verbally or in writing) without written authorization from the recipient.

H-2830 DME Exception Processing/Codes Not on the Fee Schedule

Revision 17-3; Effective September 1, 2017

The Medicare fee schedule does not contain all of the Healthcare Common Procedural Coding System (HCPCS) codes used by durable medical equipment (DME) providers. Medicare considers these codes as miscellaneous codes or codes not otherwise specified or classified. Based on the DME exception processing information from the Centers for Medicare & Medicaid Services, certain miscellaneous codes may be allowable incurred medical expense (IME) deductions even though the HCPCS codes are not identified on the Medicare fee schedule.

Based on the DME exception process, determine the amount of the IME deduction for allowable miscellaneous codes and allowable codes not listed on the fee schedule using the following steps.

- Request the wholesale pricing in writing from the DME provider for each HCPCS miscellaneous code on the invoice.
- Multiply the wholesale price by 40 percent to obtain the markup amount.
- Add the wholesale price and the markup amount for the total fee.
- Allow up to the total amount as an IME deduction.

Example: K0108 wholesale price is $350. $350 x 40 percent = $140. $140 is the markup amount. $350 + $140 = $490 total amount. $490 is the allowable IME.

If a DME provider does not provide the wholesale pricing for a particular HCPCS miscellaneous code, do not allow that code as an IME deduction. Do not deny the entire IME request. Use Form H1052-IME, Notice of Delay in Decision for Incurred Medical Expenses, to notify the provider of a delay in processing the IME and include the additional information needed to process the request. If the wholesale price is not provided, process the IME request for the remaining codes. If the wholesale price is provided after the remaining IME has been approved, process the change and allow the code as an IME deduction.

H-2840 DME Modifier Code for Rental Items

Revision 10-3; Effective September 1, 2010

Because of Medicare regulations regarding durable medical equipment (DME), an individual owns the DME after a set number of payments. This is common for wheelchairs.

On the Medicare Fee Schedule, some DMEs are considered capped rental items. In these situations, the first Modifier column (column labeled Mod) will reflect only RR for rented. The DME supplier must transfer ownership of the capped rental equipment to the individual after the 13th continuous month of rental. An individual in an institution makes a one-time purchase instead of renting the DME. Calculate the incurred medical expense (IME) deduction by multiplying the monthly rental amount on the Medicare Fee Schedule by 13. This is the total allowable amount of IME deduction for this item.

Example: An individual purchased a heavy-duty wheelchair with modifications specific for his use. The code submitted with Form H1263-A, Certification of Medical Necessity – Durable Medical Equipment or Other IME, is K0006. The monthly rental amount for this code is 125.41. The total IME deduction for this DME is $1,630.33 ($125.41 x 13).

To safeguard beneficiary access to quality equipment throughout the duration of the rental period, Medicare requires that the DME supplier may not provide different equipment from that which was initially furnished to the individual at any time during the 13-month rental for capped rental DME unless one of the following exceptions applies:

- the equipment is lost, stolen or irreparably damaged;
- the equipment is being repaired while loaner equipment is in use;
- there is a change in the beneficiary's medical condition such that the equipment initially furnished is no longer appropriate or medically necessary; or
- the DME carrier determines that a change in equipment is warranted.

Based on this, an individual is limited to only one IME deduction for each identified DME during the capped rental period. If an exception is met and a need is identified for a change, request the DME provider to submit a copy of the exception request/approval.

H-2850 Wheelchairs

Revision 18-3; Effective September 1, 2018

Customized Power Wheelchairs

A customized power wheelchair (CPWC) is a covered service in a nursing facility (NF). Direct individuals to request CPWCs through a recipient's managed care organization.

Customized Manual Wheelchairs (CMWCs)

CMWCs may be considered for an incurred medical expense (IME) deduction for an NF recipient with:

- A completed, signed, and dated Form H1263-A, Certification of Medical Necessity – Durable Medical Equipment or Other IME
- Written and detailed specifications and an itemized list of the requested durable medical equipment (DME) and all accessories
- Clear, written explanation, signed by the physician, of why the NF equipment will not meet the recipient's needs

Before allowing an IME deduction, if the recipient has a positive preadmission screening and resident review (PASRR) evaluation, verify what type of positive PASRR the person has.

A NF recipient with a positive PASRR evaluation for an intellectual disability (ID) or a developmental disability (DD) is eligible to receive DME through NF specialized services. Do not consider an IME deduction for a CMCW. Direct these individuals to the NF to request a CMWC as a NF specialized service.

A NF recipient with a positive PASRR evaluation for Mental Illness (MI) is not eligible to receive DME through NF specialized services. Requests for CMWCs can be considered for an IME deduction.

Basic Power Wheelchairs

Basic power wheelchairs that are **not** customized can be considered for an IME deduction if the following verification is received:

- a completed, signed, and dated Form H1263-A; and
- a clear, written explanation, signed by the physician, of why the NF equipment will not meet the recipient's needs.

Basic power wheelchairs include the wheelchair, necessary batteries and may include the following basic components. Do not allow separate charges for the items listed below:

- lap belt or safety belt;
- battery charger;
- batteries (initial);
- complete set of tires and casters, any type;
- leg rests;
- foot rests or foot platform;
- arm rests;
- any weight-specific components (braces, bars, upholstery, brackets, motors, gears, etc.), as required by a person's weight capacity; and
- controller and input device.

H-2860 Reserved for Future Use

Revision 20-2; Effective June 1, 2020

H-2870 When the Co-Payment Adjustment is Not Used to Pay DME Provider

Revision 10-3; Effective September 1, 2010

Payment for services in accordance with the agreed plan is a matter between the recipient and the durable medical equipment (DME) provider. The recipient or the recipient's payee is expected to actually pay the DME provider in a timely manner using the income from the co-payment adjustment. If the MEPD specialist is notified the recipient has not appropriately used the income from the co-payment adjustment to pay the DME bill, the MEPD specialist consults with legal counsel as to the appropriate action to take.

H-2900, IME Notices

Body

Revision 20-4; Effective December 1, 2020

Form TF0001, Notice of Case Action, is used to notify a recipient, authorized representative (AR), or both that a request for an IME deduction is approved or denied.

Form TF0001P, Provider Notice of Case Action, is used to notify the nursing facility that a co-payment adjustment has been approved.

For approved IME requests, TIERS automatically generates Forms TF0001 and TF0001P with the following information:

- a note that the co-payment adjustment is for an IME allowance and that the funds must be used to pay the IME provider;
- the reason for the IME adjustment (receipt of dental services or durable medical equipment);
- the date the IME item or service was received; and
- the total amount of the IME allowance.

For denied IME requests, TIERS automatically generates Forms TF0001 and TF0001P, but the forms do not reflect changes in the co-payment or provide a reason for denial when the IME request is denied.

IME Provider Notice

For both dental or durable IME requests, use Form H1053-IME, Provider Notice of Incurred Medical Expense Decision, to notify an IME provider that a request for an IME deduction is approved or denied.

- If the IME request is approved, the form will list the services and total amount of the IME allowed.
- If the IME request is denied, the form will list the services not allowed, and staff manually add additional comments to why the IME request was denied.
- Do not add co-payment information to this form.

Reminder: To safeguard confidentiality, do **not** provide the co-payment amount to any provider (either verbally or in writing) without written authorization from the recipient or the recipient's AR.

Request for Verification of Delivery

When an IME request does not include proof of delivery or verification of the date services were provided, use the following forms to request verification of receipt of services from the recipient or the recipient's authorized representative (AR). Do not send the request to the provider. The provider may assist the recipient in providing the requested information, but the recipient or the recipient's AR must complete the form.

- For durable IME requests, use Form H1051-IME, Receipt of Durable Medical Equipment.
- For dental IME requests, use Form H1054-IME, Proof of Dental Services.

Notice of Delay

For both dental or durable IME requests, use Form H1052-IME, Notice of Delay in Decision for Incurred Medical Expenses, to:

- **Notify the recipient** of a delay in processing an IME request when the following information is needed on Form H1263-A, Certification of Medical Necessity – Durable Medical Equipment, or on Form H1263-B, Certification of No Medical Contraindication - Dental:
  - the written signature of the recipient or authorized representative; or
  - a description of the authority to sign for the recipient.
- **Notify the IME provider** of a delay in processing an IME request when the following information is needed:
  - current dental terminology (CDT) or health care common procedural coding system (HCPCS) codes;
  - the written signature of the attending practitioner on Form H1263-A or Form H1263-B; or
  - other information.

Related Policy

Deduction of Incurred Medical Expenses (IMEs), H-2100
IME Budget Adjustments Due to Death, H-2310
Notices, R-1300

H-3000, Averaging and Reconciliation

Body

Revision 13-4; Effective December 1, 2013

HHSC averages monthly income that is predictable but varies in amount from month to month. Types of monthly income that require averaging include, but are not limited to, earned income, royalty income and interest income.

Variable income can be from one source or a combination of sources.

For eligibility budgets, treatment of variable income is the same for all cases. Treatment of variable income in co-payment budgets differs from the eligibility budgets and applies only to community-based waiver and institutional cases.

There are additional treatments for variable income for the co-payment budgets that include reconciliation and restitution.

The examples in this section are for demonstration purposes only. They may not reflect the current spousal allowance amounts.

H-3100, When to Project

Body

H-3110 Variable Income

Revision 09-4; Effective December 1, 2009

1. The person has income that fluctuates from month to month (such as earnings, royalties, dividends, interest, rents, etc.) and the average from all sources is $5 or more.

2. Variable income from any combination of sources was received during at least three of the preceding six months, is anticipated to reoccur, and the average from all sources is $5 or more.

   Example: The applicant entered the nursing facility (NF) in January and applied for MEPD the same month. During the six months preceding the month the case is worked (February), the person received the following variable income payments, all of which are anticipated to reoccur during the projection period (March through August).

Month	Source #1	Source #2	Payment Rec.
Aug.			
Sept.	$20		X
Oct.			
Nov.		$20	X
Dec.			

Month Source #1 Source #2 Payment Rec.
Jan.

Since the person did not receive variable income from all sources during at least three of the preceding six months, do not average and project variable income, even though these payments are anticipated to reoccur with the same frequency during the coming six months.

Note: If an eligibility budget is being calculated for the prior month of November, the $20 payment received that month is excluded as infrequent/irregular income in the eligibility budget. There is no co-payment for November, since the person did not enter the NF until January.

3. In spousal impoverishment cases, the community-based spouse received variable income from any combination of sources during at least three of the preceding six months, the variable income is anticipated to reoccur, and the monthly average from all sources is $5 or more.

   Example: The applicant entered the NF in January and applied for Medicaid the same month. The person has no variable income. However, the community-based spouse receives monthly royalty payments from a mineral lease. During the six months preceding the month the case is worked (February), the community-based spouse received monthly royalties as follows: August = $25; September = $30; October = $20; November = $15; December = $22; and January = $25.

   Since the community-based spouse received variable income during at least three of the preceding six months, all payments are anticipated to reoccur during the coming six months, and the average from all sources is $5 or more ($25 + $30 + $20 + $15 + $22 + $25 = $137 ÷ 6 months = $22.83 monthly average). The eligibility specialist projects the $22.83 average as the community-based spouse's income in the co-payment calculation.

4. For applications, variable income which is anticipated to reoccur is calculated into the co-payment budget for the month of certification and is projected over the next six months. If eligibility is being tested for prior months, the amount of variable income actually received during a given month is budgeted as income for that month.

5. For ongoing cases, variable income (earned or unearned) is not calculated into the co-payment budget until the month following the month in which the person received his first variable payment.

   Example (Reviews Only): The person's first monthly variable payment (such as earned income or interest) is received in October. This payment is calculated into the co-payment budget in November to be effective December.

H-3120 Incurred Medical Expenses (IMEs)

Revision 09-4; Effective December 1, 2009

1. IMEs fluctuate from month to month, or they remain constant and are paid on a monthly basis and are anticipated to continue during the coming six-month period.

   Example: A redetermination is performed in February, and the person is making monthly payments for dentures purchased six months ago. During the preceding six months (August through January), the person paid $30 a month for dentures, and these payments are anticipated to continue during the projection period (March through August). The average of IMEs paid from August through January, or $30, is

projected in the co-payment budget from March through August.

2. The person pays IMEs that are regular and fixed and paid on a quarterly, semi-annual or annual basis. These IMEs are converted to a monthly amount and projected over a 12-month period.

3. IMEs that have not been paid in preceding months are anticipated to occur in subsequent months.

   Examples:
   - A relative has been paying the person's insurance premium, but the person will begin paying it in March. The IME is calculated into the co-payment budget in February to be effective March.
   - The person will pay for dental work in monthly installments. Both the dental work and the payments begin in March. The monthly payment is calculated into the co-payment budget in February to be effective March.

H-3200, When Not to Project

Body

H-3210 Variable Income

Revision 10-1; Effective March 1, 2010

1. Variable income is received from all sources in fewer than three of the preceding six months and is not anticipated to increase in frequency. Variable income which is not projected is restituted at the annual redetermination if the amount in the month of receipt is $5 or more.

   Example: The applicant entered the nursing facility (NF) in January and applied for Medicaid in the same month. During the six months preceding the month the case is worked (February), the applicant received the following variable payments, which are anticipated to reoccur during the projection period (March through August).

Month	Source #1	Source #2	Payment Rec.
Aug.			
Sept.	$20		X
Oct.			
Nov.		$20	X
Dec.			
Jan.			

   Since the person did not receive variable income from all sources during at least three of the preceding six months, do not average and project variable income, even though these payments are anticipated to reoccur with the same frequency during the coming six months.

   Note: If an eligibility budget is being calculated for the prior month of November, the $20 payment received that month is excluded as infrequent/irregular income in the eligibility budget. There is no co-payment for November, since the person did not enter the NF until January.

2. Variable income is received during three of the preceding six months from any combination of sources, but payment from at least one of the sources is not anticipated to reoccur during the next six months, and payments from remaining sources were not received during three of the preceding six months.

Examples:

- The applicant entered an NF in January and applied for Medicaid the same month. During the six months preceding the month the case is worked (February), the applicant received the following unearned variable payments, but the payment from Source #3 was a one-time payment and is not anticipated to continue.

Month	Source #1	Source #2	Source #3	Payment Rec.
Payment Rec.				
Aug.	$30			X
Sept.				
Oct.		$30		X
Nov.				
Dec.				
Jan.			$50	X

- Although the person received variable income from all sources during three of the preceding six months, the payment from Source #3 is not anticipated to reoccur. Therefore, the variable payments from Sources #1 and #2 are not averaged and projected for future months.

Note: If eligibility is being determined for the prior month of October, the unearned variable income of $30 received during that month is not countable income, as the amount is less than the infrequent or irregular exclusion of the first $60 unearned in a calendar quarter. (See Section E-9000, Infrequent or Irregular Income.) There is no applied income for October since the person did not enter the NF until January.

- The applicant entered the NF in January and applied for Medicaid the same month. During the six months preceding the month in which the case is worked (February), the person received the following variable payments, but the payment from Source #3, received in October, was a one-time payment and is not anticipated to recur.

Month	Source #1	Source #2	Source #3	Payment Rec.
Aug.	$20			X
Sept.		$20		X
Oct.			$20	X
Nov.				
Dec.	$20	$20		X
Jan.				

- Since the person received variable income from Sources #1 and #2 during three of the preceding six months, the income from Sources #1 and #2 is averaged and projected into the applied income budget for the coming six months (March through August). However, since the one-time $20 payment from Source #3 is not anticipated to recur, it is not included in the average of variable income to be projected.

3. Variable income from all sources was received during three of the preceding six months and is anticipated to recur, but the average of income from all sources is less than $5.

   Example: The applicant entered the NF in January and applied for Medicaid the same month. During the six-month period preceding the month in which the case is worked (February), the person received the following variable payments, all of which are anticipated to recur.

   Month Source Payment Rec.

Month	Source	Payment Rec.
Aug.	$2	X
Sept.	$1	X
Oct.	$2	X
Nov.	$5	X
Dec.	$3	X
Jan.	$4	X

The person received variable payments from all sources during each of the six preceding month; however, since the average of all payment is less than $5 ($2 + $1 + $2 + $5 + $3 + $4 = $17 ÷ 6 months = $2.83) and is not anticipated to increase, that average is not projected into the applied income budget.

H-3220 Incurred Medical Expenses (IMEs)

Revision 09-4; Effective December 1, 2009

1. Medical services were received prior to the medical effective date (MED).

   Example: The person entered the nursing facility (NF) on Jan. 10, applied for Medicaid the same month, and meets all eligibility criteria as of Jan. 10. She underwent routine dental treatment during the preceding October, for which she will be making monthly payments of $30 for 12 months. Since the treatment occurred prior to the medical effective date, no deduction for IMEs is allowed.
2. Someone other than the person (or community-based spouse to whom income is being diverted in the co-payment calculation) is paying the IME.

   Example: A NF person has an assignable general health insurance policy. The premiums are $50 a month and are paid by the person's son. The son states that he will continue to make these premium payments for the person. Since the person is not paying the premiums, they are not deductible as an IME.

H-3230 Both Variable Income and Incurred Medical Expenses (IME)

Revision 09-4; Effective December 1, 2009

Co-payment is $0 and is not anticipated to change. In this situation, semi-annual reviews of variable income/IMEs are not required, and variable income/IMEs may be re-budgeted on an annual basis.

H-3300, How to Budget at Application

Body

H-3310 Variable Income

Revision 09-4; Effective December 1, 2009

If the applicant routinely receives variable income that is anticipated to continue, use an average of variable income received during the six months preceding the application file date, or the six months preceding any

month up to the certification month, and project that average for the coming six-month period. Schedule a special review for the sixth month after the case is certified to rebudget co-payment.

Examples:

- The person applied in January and is being certified in February. The eligibility specialist verifies that the person received variable income totaling $300 from August through January, which is anticipated to reoccur, and obtains an average of $50 per month ($300 ÷ 6 months). This average ($50) is budgeted as variable income in the co-payment calculation. A special review is scheduled for the following August, six months from the certification date.
- The person applied in January and is being certified in March. The eligibility specialist has the option of averaging variable income for any one of the following six-month periods:
  - July through December (six months prior to January, the month in which the application was filed);
  - August through January (six months preceding February, which is a month prior to the March certification month); or
  - September through February (six months prior to the certification month of March).

If variable income is received on a monthly basis and is anticipated to continue, the amount to be projected is an average of variable income received during preceding months. If variable income was received during all six of the preceding months, divide the total received by 6; if there are only five months of variable income, divide the total by 5; if there are only four months of variable income, divide the total by 4; and so on.

Examples:

- The application was filed in January and is being certified in February. The person began receiving monthly variable income six months ago, in August. Variable income received from July through December totaled $400. The average to be projected over the coming six months is $66.67 ($400 total ÷ 6 months = $66.67). A special review is scheduled for the following August to rebudget variable income.
- The application was filed in January and is being certified in February. The person began receiving monthly variable income two months ago, in December. Variable income received for December and January totals $75. The average to be projected over the coming six months is $37.50 ($75 total ÷ 2 months = $37.50). A special review is scheduled for the following August to re-budget variable income.

In spousal impoverishment cases, if the community spouse has variable income that is anticipated to continue, in the co-payment budget use an average of variable income received during the six months preceding the application file date, or the six months preceding any month up to the certification month, and project that average for the coming six-month period. Schedule a special review for the sixth month after the case is certified to rebudget co-payment.

Note: If co-payment is $0 and there is a wide margin of variability for variable income, semi-annual reviews are not required. Variable income should be re-budgeted at each annual redetermination.

Note: Cases with significant month-to-month differences in income amounts should be reviewed quarterly rather than every six months. This quarterly averaging will minimize the impact on a person if he receives income in very low amounts for several months. If the monthly average of variable income from all sources is less than $5, the variable income need not be budgeted for co-payment purposes.

If variable income from all sources was received during at least three of the preceding six months and is anticipated to reoccur, total the variable income received during the preceding six months and divide by six to determine the initial budget. Schedule a special review for the sixth month after the case is worked to rebudget co-payment.

Example: The application is worked in February. The preceding six months are August through January. Variable income totaling $65 from two different sources was received in August, October, December and

January and is anticipated to continue. The average to be projected (from March through August) is $10.83 ($65 ÷ 6 months = $10.83).

Spend Down Situations — Amounts of variable income received during preceding months may differ from amounts anticipated for future months. In these situations, obtain a statement of anticipated income amounts from the source, if possible. If the source cannot provide a statement, expected income must be determined based on other information.

Examples:

- Interest Income — The applicant entered the nursing facility in September, and her Medicaid application is being worked in February. She owns an interest-bearing bank account, but has been spending down resources since September. The current bank account balance is sufficient to continue generating interest. The eligibility specialist budgets the anticipated interest amount based on the best estimate available, considering the reduced account balance and current interest rates, rather than averaging the interest posted during preceding months when the account balance was much higher. A special review is scheduled for no later than August to reconcile.
- Rental Income — The amount of rental income to be projected is a net amount based on gross rents anticipated to be received, less allowable expenses anticipated to be paid, during the six months following the month the case is worked (the month the case is certified).

H-3320 Incurred Medical Expenses (IMEs)

Revision 09-4; Effective December 1, 2009

1. If IMEs are paid on a monthly basis and are anticipated to continue, the amount to be projected is an average of expenses paid in preceding months. If expenses were paid during all six of the preceding months, divide the total by 6; if there are only five months of expenses, divide the total by 5; if there are only four months of expenses, divide the total by 4; and so on.

   Examples:
   - The application was filed in January and is being certified in February. Beginning the preceding August, the person began paying a monthly premium of $50 on an assignable general health insurance policy. The average IME to be projected over the coming six months is $50. This is calculated as follows: $300 total paid ÷ 6 months = $50 average. A special review is scheduled for the following August.
   - The application was filed in January and is being certified in February. Two months ago, in December, the person began paying a monthly premium of $60 on an assignable general health insurance policy. The average IME to be projected over the coming six months is $60. This is calculated as follows: $120 total paid ÷ 2 months = $60 average. A special review is scheduled for the following August.

2. Regular and fixed IMEs which are paid on a quarterly, semi-annual or annual basis are converted to a monthly average and projected for a 12-month period. If these are the person's only recurring IMEs, the case should be monitored at regular intervals (for example, every six months for quarterly and semi-annual payments) to ensure that payments continue, but reconciliation of projected expenses is not required unless the expense is not paid or the amount paid is different from the amount projected.

   Examples:
   - The person entered the nursing facility (NF) in January and the application is being certified in February. She pays quarterly premiums of $150 on an assignable general health insurance policy. This quarterly premium is converted to a monthly amount, and $50 ($150 quarterly premium ÷ 3

months = $50) is budgeted as a monthly IME. A special review is scheduled for the following August to ensure that payments continue. However, reconciliation will not be required in August, unless payment of premiums was discontinued or the premium amount changed.

Note: Reconciliation of fixed IMEs is not required if the amount paid overall is correct, even though the schedule of payments may have been interrupted.

- The person pays a monthly premium of $50 on an assignable general health insurance policy. At the semi-annual review performed in April, the eligibility specialist verifies that in December the person made no premium payment, but made a double payment ($100) in January. Since the overall payment is still $50 per month, reconciliation is not performed for either December or January.

3. For fixed IMEs paid on a monthly basis, the amount to be projected is based on anticipated amounts for the coming six-month period.

   Examples:
   - If the person has been paying a monthly health insurance premium but says he is dropping the policy, do not project the expense in the budget. (The premium expense should be allowed through the month of the last payment.)
   - The person entered the NF in January, and the case is being certified in February. She has been paying monthly premiums of $25 on an assignable general health insurance policy. However, there is verification that these premiums will increase to $35 effective April 1. The eligibility specialist budgets $25 as an IME, and schedules a special review for March to re-budget co-payment based on the new premium amount. At the special review in March, the eligibility specialist budgets an IME deduction of $35 to be effective April.

4. IMEs are projected for no more than six months.

   Exception: If the person's only IME is a fixed amount and there is no variable income, the IME may be projected for a 12-month period. The case is monitored at regular intervals (such as every six months for monthly, quarterly and semi-annual payments) to ensure that payments continue, but reconciliation is not required unless payments were not made or the amount paid is different from the amount projected.

H-3330 Both Variable Income and Incurred Medical Expenses (IME)

Revision 09-4; Effective December 1, 2009

1. Variable income/IMEs to be projected for future months (not to exceed six) are based on income received/expenses paid in months preceding the month in which the application is worked.

2. If variable income was received during three of the preceding six months and is anticipated to reoccur, or if variable income will be received monthly, the amount to be projected for the coming six months is an average of variable income received during preceding months. (If variable income was received in all six of the preceding months, divide the total by 6; if there are only five months of variable income, divide the total by 5; if there are only four months of variable income, divide the total by 4; and so on.)

   If IMEs are paid monthly and are anticipated to reoccur, or if they are in a fixed amount and are paid on a quarterly, semi-annual or annual basis, the amount to be projected for the coming six months is a monthly average of IMEs paid during preceding months.

   Examples:

- The application was filed in January and is being certified in February. The person receives monthly royalties from a mineral lease, which totaled $230 during the preceding six months (August through January). The person also pays a quarterly premium of $150 on an assignable general health insurance policy. There are no other IMEs.

  The amount of variable income to be projected over the coming six months is $38.33. This is calculated as follows: $230 total ÷ 6 months = $38.33 average.

  The amount of IMEs to be projected over the coming six months is $50. This is calculated as follows: $150 quarterly premium ÷ 3 months = $50 average.

- The application was filed in January and is being certified in February. During the preceding six months, the person received the following variable income payments, each of which is anticipated to reoccur:

Month	Source #1	Source #2	Source #3
Sept.	$75		
Nov.		$50	
Jan.			$60

  The person also pays a quarterly premium of $120 on an assignable general health insurance policy. There are no other IMEs.

  The amount of variable income to be projected over the coming six months is $30.83. This is calculated as follows: $75 + $50 + $60 = $185 total ÷ 6 months = $30.83 average.

  The amount of IMEs to be projected over the coming six months is $40. This is calculated as follows: $120 quarterly premium ÷ 3 months = $40 average.

  A special review is scheduled for the following August to re-budget variable income and IMEs.

H-3400, How to Budget at Reviews

Body

H-3410 Variable Income

Revision 09-4; Effective December 1, 2009

When projecting variable income, it is permissible to overlap months (or to skip a month), if verification is unavailable.

Examples:

The case is reviewed in February and verification of variable income for January is unavailable. The options are:

- Average variable income from July through December (total divided by six months), and project that average through the following August. (This is true even though variable income received in July was used in the average calculated at the preceding semi-annual review in August [when the income from the preceding February through July was averaged].) Also at this February semi-annual review, reconcile the months of August through December. (Do not reconcile for July, since that month was reconciled at the previous semi-annual review last August. Never reconcile the same month twice!)

- Average variable income from August through December (total divided by five months), and project that average through the following August. Reconcile for August through December.

Options at the next annual review (the following August) are:

- Average variable income received from January through July (total divided by seven months), and project that average through the following February. Reconcile for January through July.
- Skip January altogether, and average February through July (total divided by six months), and project that average through the following February. Reconcile for January through July.
- If verification of variable income received in July is unavailable, average variable income received from February through June (total divided by five months), or variable income received from January through June (total divided by six months), and project that average through the following February.

H-3420 Incurred Medical Expenses (IMEs)

Revision 09-4; Effective December 1, 2009

1. IMEs which have been projected in the co-payment budget must be re-budgeted at least every six months.

   Exception: If the person's only IME is a fixed amount and there is no variable income, the IME may be projected for a 12-month period. The case is monitored at regular intervals (such as every six months for monthly, quarterly and semi-annual payments) to ensure that payments continue, but reconciliation is not required unless payments were not made or the amount paid is different from the amount projected.
2. IMEs which have not been paid in preceding months, but which are anticipated to occur in subsequent months, may be projected. This will afford the person sufficient income to pay the expense.

   Examples:
   - A relative has been paying the person's insurance premium, but the person will begin paying it in March. The IME is calculated into the co-payment budget in February to be effective March.
   - The person will pay for dental work in monthly installments. Both the dental work and the payments begin in March. The monthly payment is calculated into the co-payment budget in February to be effective March.
3. For fixed IMEs paid on a monthly basis, the amount to be projected is based on anticipated amounts for the coming six-month period.

   Example: The case is being worked in October, and the person has been making monthly premium payments of $25, which are not anticipated to change. During the preceding six months (April through September), no payment was made in May, but a double payment ($50) was made in June. The amount projected (from November through April) is $25 ($150 total payments ÷ 6 months = $25 average).
4. If an IME is expected to cease, such as payments on a dental bill will be completed, schedule a special review to delete the IME from the budget effective the month payment is to cease.

H-3430 Both Variable Income and Incurred Medical Expenses (IME)

Revision 13-4; Effective December 1, 2013

1. Variable income/IMEs which have been projected in the co-payment budget must be re-budgeted at least every six months.

Exception: If the co-payment is $0 and is not expected to change, a 12-month average may be used, and semiannual reviews are not required.

2. If it is discovered after the case is worked that the person receives variable income or pays IMEs, or if variable income/IMEs begin on an active case, base the projected amount on income received/expenses paid in the preceding six-month period, or however many months during the preceding six-month period in which payments/expenses occurred, or the amount expected to be received/paid. The average of the preceding months may be used to project the budget.

Examples:

- An annual review was completed in January. Monthly variable income payments totaling $300 were received during the preceding six months (July through December). The projected variable income amount was $50 ($300 total ÷ 6 months = $50 average). A semiannual review was scheduled for the following July. In April, the eligibility specialist is notified that the person will begin making monthly payments of $50 for dentures. These payments begin in May and are to continue for 48 months. The $50 monthly IME (the amount expected to be paid) is calculated into the co-payment budget in April to be effective in May.

  At the semiannual review in July, the eligibility specialist verifies that the $50 monthly payments for dentures continue, and he averages variable income received from January through June.

- An intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID) application was certified in January, at which time a monthly premium of $60 on an assignable general health insurance policy was projected as an IME. A semiannual review was scheduled for the following July. In April, the eligibility specialist is notified that the person began participating in a sheltered workshop in March and was paid $25 that month. This $25 variable income payment is calculated into the co-payment budget in April to be effective in May.

  At the semiannual review the following July, the eligibility specialist verifies that the person continues to pay the $60 monthly health insurance premium. The eligibility specialist verifies that variable income received from March through June totals $110. The IME amount to be projected for the coming six months continues to be $60. The variable income amount to be projected for the coming six months is $27.50 ($110 total ÷ 4 months = $27.50 average). The annual review is scheduled for the following January.

- An application was certified in January. There were no variable income or IMEs, and the annual review is due the following January. In March, the eligibility specialist is notified that in February the person began renting out her home for $200 per month. There have been no repair/upkeep expenses, and real property taxes are not due until December. However, annual real property insurance totaling $200 will be paid in June.

  The eligibility specialist opts to synchronize the semiannual variable income reviews with the annual review cycle, so a semiannual review is scheduled for July (six months from the January certification). The amount of variable income to be projected through July is $150. This is calculated as follows: $200 annual real property insurance ÷ 4 months (the projection period – April through July) = $50 monthly average; $200 gross monthly rents − $50 allowable deductions = $150 net monthly rents).

  In May, the eligibility specialist is notified that in April the person began paying a quarterly premium of $150 on an assignable general health insurance policy. The eligibility specialist calculates $50 ($150 quarterly premium ÷ 3 months = $50 average) as an IME into the co-payment budget in May to be effective in June.

  At the July semiannual review, the eligibility specialist verifies that the person continues to pay the $150

quarterly ($50 monthly average) health insurance premium. The eligibility specialist also projects rental income through the following January, deducting the real property taxes due in December from gross rents anticipated to be received.

3. Verification of amounts of variable income/IMEs should be for recent months before the month the case is worked. If verification is not available for the month immediately preceding the month in which the case is being worked and there is no anticipated change (such as variable income/IMEs will not terminate nor will the amounts significantly change), do not delay case action pending receipt of verification for the immediate preceding month.

   Example: The case is being reviewed in February, and the preceding six months are August through January. IMEs are a fixed amount and have not changed. Verification of variable income received in January is unavailable. Take an average of the variable income received from July through December (six months), or from August through December (five months), and project that average through August.

4. Temporary fluctuations in the amounts of variable income received/IMEs paid, such as up to two consecutive months in which no variable income was received or IMEs were paid, do not disrupt the six-month review cycle. Variable income/IMEs that cease for three or more consecutive months and that are not anticipated to resume should be deleted from the budget.

5. If receipt of variable income/payment of IMEs resumes after having been deleted from the budget, the new projected amount is based on the amount of variable income/IMEs expected to be received/paid. Historical data may be used for the projection.

6. The eligibility specialist may elect to synchronize or not to synchronize semiannual reviews of variable income/IMEs with the annual review cycle. If the specialist chooses to synchronize, more frequent reviews than every six months may be required.

Example: The specialist is working in a 10-month review cycle and chooses to synchronize variable income/IME reviews with annual reviews. Variable income reviews would be conducted every five months.

H-3500, When to Reconcile

Body

H-3510 Variable Income

Revision 09-4; Effective December 1, 2009

Retroactive reconciliation is not required for stable variable income with narrow fluctuations. The eligibility specialist will average the variable income received during the preceding six months. If average variable income exceeds $4.99 per month, this average is projected for the following six months. This process is repeated every six months.

Unstable variable income or variable income with wide fluctuations must still be retroactively reconciled.

Notes:

- Retroactive reconciliation is always required if requested by the authorized representative.
- Reconciliation performed is for the entire reconciliation period (the block of time considered for reconciliation), and not month-by-month. If the variable income adjustment is a positive number (the person underpaid co-payment), add the adjustment to the co-payment for the most recent month in the reconciliation period.

Example: If reconciling the period of October through March, the most recent month in the reconciliation period is March. Form H1259, Correction of Applied Income, is sent to the person and nursing facility, and after 12 days the co-payment is adjusted in SAS in the most recent month. There is no month-by-month adjustment in the reconciliation period (October-March) in SAS for this underpayment. Form H1201-A, Client Declaration or Streamline Review Worksheet, Page 2, may be utilized to assist in calculating the correct reconciliation period and the most recent month in the reconciliation period.

H-3520 Incurred Medical Expenses (IMEs)

Revision 09-4; Effective December 1, 2009

When IMEs have been projected in the co-payment budget, review the case at least every six months and reconcile the budget according to the monthly IMEs actually paid. If the projected average monthly IMEs and the actual average monthly IMEs are each less than $2, or the difference between the two is less than $1, then reconciliation is not required. (Although reconciliation is optional for these small amounts, reconcile whenever the person requests it.)

Note: Reconciliation performed is for the entire reconciliation period (the block of time considered for reconciliation), and not month-by-month. If the variable income adjustment is a positive number (the person underpaid co-payment), add the adjustment to the co-payment for the most recent month in the reconciliation period.

Example: If reconciling the period of October through March, the most recent month in the reconciliation period is March. Form H1259, Correction of Applied Income, is sent to the person and nursing facility, and after 12 days the co-payment is adjusted in SAS in the most recent month. There is no month-by-month adjustment in the reconciliation period (October-March) in SAS for this underpayment. Form H1201-A, Client Declaration or Streamline Review Worksheet, Page 2, may be utilized to assist in calculating the correct reconciliation period and the most recent month in the reconciliation period.

H-3600, When Not to Reconcile

Body

H-3610 Variable Income

Revision 09-4; Effective December 1, 2009

1. The average monthly variable income adjustment for the reconciliation period is less than $5.

2. Variable income is stable with minor fluctuations.

   Example: The review is completed in February, with the preceding six months being August through January. Actual variable income for the period totaled $100; projected variable income for the period totaled $75. Calculation: $100 Total Actual − $75 Total Projected = +$25 Income Adjustment. Divide the income adjustment by the number of months (+$25 ÷ 6 = +$4.17). The +$4.17 monthly average is less than +$5, so reconciliation is not required. Do not reconcile if the monthly average is less than +$5.

H-3620 Incurred Medical Expenses (IMEs)

Revision 09-4; Effective December 1, 2009

1. If the person's only IME is a fixed amount, there is no variable income, and the IME has been projected for a 12-month period. The case is monitored at regular intervals (such as every six months for monthly, quarterly and semi-annual payments) to ensure that payments continue, but reconciliation is not required unless the payments are no longer made or the amount paid is different from the amount projected.
2. If a missed monthly IME payment was made up by a double payment in a subsequent month, do not reconcile for the missed payment.

H-3630 Both Variable Income and Incurred Medical Expenses (IME)

Revision 09-4; Effective December 1, 2009

If co-payment is $0 and reconciliation would not change the co-payment amount, do not reconcile.

H-3700, How to Reconcile

Body

H-3710 Variable Income

Revision 12-1; Effective March 1, 2012

- To obtain the variable income adjustment, subtract the total projected income from the total actual income.

  Note: Make adjustments in the Service Authorization System Online (SASO).

  Example: The review is completed in February with the preceding six months being August through January. Actual variable income for this period totaled $200; projected variable income for the period totaled $75. Calculation: $200 − $75 = +$125. $125 ÷ 6 = +$20.83 per month (reconcile since monthly average is over $5).

  If the variable income adjustment is a positive number (for example, the person underpaid co-payment), add the adjustment to the co-payment for the most recent month in the reconciliation period.

  Examples:
  - If reconciling the period of October through March, the most recent month in the reconciliation period is March. Form H1259, Correction of Applied Income, is sent to the person and nursing facility, and after 12 days the co-payment is adjusted in SAS in the most recent month. There is no month-by-month adjustment in the reconciliation period (October-March) in SAS for this underpayment. Form H1202-A, MAO Worksheet-Income Changes, Page 2, may be used to assist in calculating the correct reconciliation period and the most recent month in the reconciliation period.
  - Same situation as the first example above. Co-payment for the most recent month in the reconciliation period (January) was $230. Add the variable income adjustment (+$125) to the co-payment for January. Calculation: $230 co-payment for January + $125 variable income adjustment = $355 reconciled co-payment for January.

- If the variable income adjustment is a negative number (for example, the person overpaid co-payment), subtract it from the co-payment for the most recent month in the reconciliation period. If the co-payment for the most recent month in the reconciliation period is insufficient to absorb the adjustment, subtract the excess negative adjustment from the next-to-most-recent month in the reconciliation period.

  Example: The review is completed in February, with the preceding six months being August through January. Actual variable income for this period totaled $100; projected variable income for this period totaled $150. Calculation: $100 actual − $150 projected = –$50 variable income adjustment. Co-payment for the most recent month in the reconciliation period (January) was $25. Co-payment for the next-to-most-recent month in the reconciliation period (December) was also $25. Reconciliation for January: $25 co-payment − $50 variable income adjustment = $0 (or –$25 rollback). Thus, reconciled co-payment for January is $0.

  Reconciliation for December: $25 co-payment − $25 rollback = $0 reconciled co-payment.

- If co-payment must be increased or decreased because of income averaging, use Form H1259 to correct retroactive periods. Notify the person about the correction to co-payment. Send copies of the notice and Form H1259 to the nursing facility. For ongoing adjustments, process through the automated system.

H-3720 Incurred Medical Expenses (IMEs)

Revision 09-4; Effective December 1, 2009

To obtain the IME adjustment, subtract total actual expenses from total projected expenses.

Example: A review is completed in February, with the reconciliation period being August through January. Actual IMEs for the reconciliation period totaled $90; projected IMEs totaled $60. Calculation: $60 total projected − $90 total actual = –$30 IME adjustment. Reconcile as it is to the person's advantage.

H-3730 Both Variable Income and IMEs

Revision 09-4; Effective December 1, 2009

1. ach review of variable income/IMEs (at least every six months), determine the total actual amount of variable income received/IMEs paid during the reconciliation period (the block of months being considered for reconciliation).

2. Total the amount of variable income/IMEs that were projected during the reconciliation period (the same block of months considered for reconciliation in the paragraph above).

   Note: Use reconciliation worksheet to complete your calculations.

3. If the IME adjustment is a negative number, subtract it from the variable income adjustment. The difference is the overall adjustment.

   Examples:
   - A review is completed in October, with the reconciliation period being April through September. Actual variable income totaled $150, and actual IMEs totaled $90. Projected variable income totaled $160, and projected IMEs totaled $60.

        - Calculation of income adjustment $150 actual − $160 projected = –$10 income adjustment.
        - Calculation of IME adjustment $60 projected &minus $90 actual = –$30 IME adjustment.
        - Overall adjustment –$10 income adjustment + –$30 IME adjustment = –$40 overall adjustment.
    - A review is completed in October, with the reconciliation period being April through September. Actual variable income for this period totaled $160; actual IMEs totaled $60. Projected variable income totaled $150; projected IMEs totaled $50. Monthly co-payment for the reconciliation period was $150.
        - Calculation for variable income $160 actual &minus $150 projected = +$10 variable income adjustment.
        - Calculation for IMEs $50 projected &minus $60 actual = –$10 IME adjustment.
        - Overall adjustment +$10 variable income adjustment + –$10 IME adjustment = $0 overall adjustment.

    There is no adjustment to the co-payment for the most recent month in the reconciliation period (September).

4. If the IME adjustment is a positive number, add it to the variable income adjustment. The difference is the overall adjustment.

    Examples:

    Same as second example above, except that actual income totaled $170 and actual IMEs totaled $90. Projected income totaled $160, and projected IMEs totaled $150.
    - Calculation of variable income $170 actual − $160 projected = +$10 income adjustment.
    - Calculation of IMEs $150 projected − $90 actual = +$60 IME adjustment.
    - Overall adjustment +$10 income adjustment + $60 IME adjustment = +$70 overall adjustment. Since the overall adjustment exceeds the monthly threshold of +$5 (+$70 ÷ 6 months = +$11.67 > +$5 monthly threshold), reconcile the entire overall adjustment.

5. If the overall adjustment for the reconciliation period is a positive number, this means the person underpaid co-payment. If the overall adjustment is +$30 or more (+$30 ÷ 6 months = +$5 per month), reconcile the overall adjustment. If the overall adjustment is +$29.99 or less (+$29.99 ÷ 6 months = +$4.99 or less), do not reconcile.

    Examples:
    - A review is performed in October, with the period considered for reconciliation being April through September. The variable income adjustment is +$10; the IME adjustment is +$10. Thus, the overall adjustment is +$20 (+$10 variable income adjustment + $10 IME adjustment = +$20). Since the overall adjustment is less than +$30 (+$20 ÷ 6 months = +$3.33 < $5 threshold), do not reconcile.
    - Same situation as above, except that the variable income adjustment is +$15; the IME adjustment is +$15. Thus, the overall adjustment is = +$30 (+$15 variable income adjustment + $15 IME adjustment = +$30). Since the overall adjustment is equal to the +$5 monthly threshold (+$30 overall adjustment ÷ 6 months = +$5), reconcile for the most recent month in the reconciliation period (September). Co-payment for September was $240.

        Reconciliation for September: $240 co-payment + $30 overall adjustment = $270 reconciled co-payment.
    - The case is worked in October, and verification of variable income for September is unavailable. The eligibility specialist averages variable income from March through August (total divided by six months), and projects that average through the following April. He reconciles for the months of April through August (five months). (He does not reconcile for March, since that month was reconciled at the previous semi-annual review the preceding April. Never reconcile for the same month twice!)

The variable income adjustment is +$60; the IME adjustment is –$30. Thus, the overall adjustment is +$30 (+$60 variable income adjustment − $30 IME adjustment = +$30). Since the overall adjustment exceeds the monthly threshold $30 ÷ 5 months = $6 > + $5 threshold), reconcile for the most recent month in the reconciliation period (August). Co-payment for August was $300.

Reconciliation for August: $300 co-payment + $30 overall adjustment = $330 reconciled co-payment.

6. If the overall adjustment for the reconciliation period is a negative number, this means the person overpaid co-payment. For overpaid co-payment in any amount, reconcile using Form H1259. Do not perform a month-by-month reconciliation. Rather, subtract the overall adjustment from co-payment for the most recent month in the reconciliation period.

   Example: The case is worked in October. At the previous semi-annual review the preceding April, variable income for March was unavailable, so the eligibility specialist averaged variable income received from September through February, and projected that average through this review month (October). At this review (in October), the eligibility specialist reconciles for the months of March through September (seven months). (He does not reconcile for February, since that month was reconciled at the previous semi-annual review the preceding April. Never reconcile for the same month twice!) Co-payment from March through September was $200.

   The variable income adjustment is –$10, and the IME adjustment is –$10. Thus, the overall adjustment, is –$20 (–$10 variable income adjustment, –$10 IME adjustment). Since the overall adjustment is a negative number, it must be subtracted from co-payment for the most recent month in the reconciliation period (September).

   Reconciliation for September: $200 co-payment − $20 overall adjustment = $180 reconciled co-payment.

7. If the negative overall adjustment exceeds co-payment for the most recent month in the reconciliation period, roll the excess negative adjustment back and subtract the excess amount from the co-payment for the next-to-most-recent month in the reconciliation period.

   Example: A review is performed in October, with the period considered for reconciliation being April through September. Monthly co-payment for the reconciliation period was $45. The variable income adjustment is –$30; the IME adjustment is –$20. Thus, the overall adjustment is –$50 (–$30 variable income adjustment + –$20 IME adjustment = –$50).

   Reconciliation for September: $45 co-payment − $50 overall adjustment = $0 (or –$5 rollback). Reconciled co-payment for September is $0.

   Reconciliation for August: $45 co-payment − $5 rollback = $40 reconciled co-payment for August.

8. Never reconcile for the same calendar month twice, even at different reviews. While it is permissible to overlap months in averaging and projecting variable income, it is not permissible to overlap months for reconciliation purposes.

   Example: A review is performed in October, with the period considered for reconciliation being April through September. Verification of variable income received in September is not available, so the eligibility specialist averages variable income from March through August and projects that average through the following April. (This is true even though at the previous six-month review the preceding April, variable income for March was part of the average for October through the March, which was projected through this review month (October). At this review, the eligibility specialist reconciles for the

months of April through August. The month of March was reconciled at the previous review the preceding April.

H-3800, How to Reconcile Co-Payment in ICF/ID Cases with Earned Income

Body

Revision 12-1; Effective March 1, 2012

Step 1

Determine the total actual and projected co-payment amounts for the reconciliation period.

Actual Co-payment — For each month in the reconciliation period, calculate the actual co-payment (co-payment based on actual variable income received and incurred medical expenses (IMEs) paid). Calculate the personal needs allowance (PNA)/protected earned income (PEI) allowance based on actual earnings received. Total the actual co-payment for the reconciliation period.

Note: For fixed income, do not include an increase that is subject to restitution policy rather than reconciliation policy.

Projected Co-payment — Total co-payment amounts for each month in the reconciliation period.

Example: A review is completed on an ICF-ID case in January, with the preceding six months being July through December.

Actual Co-payment (AI)

Month	Fixed	Earned	Other	IMEs	PNA/PEI	App. Inc.
July	$250	$60	$0	$0	$105.00	$205.00
August	$250	$75	$0	$0	$112.50	$212.50
September	$250	$85	$0	$0	$117.50	$217.50
October	$250	$78	$0	$0	$114.00	$214.00
November	$250	$65	$0	$0	$107.50	$207.50
December	$250	$80	$0	$0	$115.00	$215.00
Total						$1,271.50

Projected AI

Month	From Co-pay Screen
July	$275
August	$275
September	$275
October	$275
November	$275
December	$275
Total	$1,650

Step 2

Determine the co-payment adjustment by subtracting total projected co-payment for the reconciliation period from the total actual co-payment for the reconciliation period. The result is the co-payment adjustment.

A. Total Actual Co-payment (from Step 1)	$1,271.50
B. Total Projected Co-payment (from Step 1)	– $1,650.00
C. Total Co-payment Adjustment	– $378.50
D. Number of Months in Reconciliation Period	÷ 6
E. Average Monthly Adjustment	– $63.08

If the average monthly adjustment is +$4.99 or less, stop. Do not reconcile.

If the average monthly adjustment is +$5 or more, proceed to Step 3.

If the average monthly adjustment is a negative (–) figure in any amount, proceed to Step 3.

Step 3

Reconcile co-payment for the most recent month in the reconciliation period.

If the total co-payment adjustment (from Step 2C) is a positive (+) number, add it to the co-payment for the most recent month in the reconciliation period. The result is the co-payment adjustment.

If the total co-payment adjustment (from Step 2C) is a negative (–) number, subtract it from the co-payment for the most recent month in the reconciliation period. The result is reconciled co-payment.

A. Co-payment Month: December	$275.00
B. Total co-payment adjustment (from Step 2C)	– $378.50
C. Reconciled co-payment	$–103.50
D. If A.-B. is less than $0, enter the negative (–) amount here	(– $103.50) Excess Negative Adjustment

If there is an "excess negative adjustment" from Step 3D, proceed to Step 4.

Step 4

If there is an "excessive negative adjustment" (from Step 3D), subtract the excess amount from the co-payment for the next-to-most-recent month in the reconciliation period.

H-4000, Co-Payment Budget Types

H-4100, Individual and Couple Cases

Body

Revision 15-3; Effective September 1, 2015

If a person or couple is already eligible for Medicaid and enters an institutional setting, or after a person or couple in an institutional setting is determined eligible for MEPD, the Texas Health and Human Services Commission (HHSC) calculates the person's or couple's co-payment.

Ideally, the total countable income for the co-payment budget would be the same as the total countable income for the eligibility budget. Payments not considered as income in the eligibility and co-payment budgets are addressed in Section E-1700, Things That Are Not Income, and Section E-2000, Exempt Income. However, the total countable income for the co-payment budget may be different from the total countable income for the eligibility budget. When dealing with wages, normally earnings (including deductions) are considered in the eligibility budget. Mandatory payroll deductions are not considered when determining the co-payment budget. When determining the co-payment, consider the following:

- Section E-1760, Wage-Related Payments
- Section E-1770, Mandatory Payroll Deductions
- Section E-3110, Wages

HHSC nets the person's and spouse's earned income each month by subtracting the following mandatory payroll deductions:

- Income tax
- Social Security tax
- Required retirement withholdings
- Required uniform expenses

Due to automation limitations and requirements, special treatment for the co-payment occurs when the person:

- receives certain Department of Veterans Affairs (VA) benefits, or
- does not have vendor payment coverage due to a transfer penalty or a substantial home equity disqualification.

People whose VA benefits are capped at $90 per month keep the full $90 as a personal needs allowance (PNA).

The law (United States Code [U.S.C.], Title 38, Part IV, Chapter 55, §5503) provides that the VA pension amount for an institutionalized Medicaid recipient with neither a spouse nor child (or in the case of a surviving spouse, no child) cannot exceed $90 per month. Do not use the $90 VA pension in determining what a person in an institutional setting must pay to the facility toward the cost of care. Do not count the limited VA pension, up to the amount of $90, as income in the eligibility or co-payment budget. There is no interaction between the reduced pension and the PNA. If the veteran has income from other sources, the income from other sources may be considered countable for co-payment purposes. HHSC performs the co-payment calculations to determine the amount of the veteran's liability toward the cost of care.

Because of automation limitations, the VA $90 capped pension will be included in the PNA calculation.

- For a non-SSI Medicaid recipient in an institutional living arrangement who does not have a VA pension capped at $90 per month, the total PNA will be up to the current maximum of $60.
- For a non-SSI Medicaid recipient in an institutional setting who has a VA pension capped at $90 per month, the total PNA may be up to $150 ($90 VA plus up to $60 PNA).
- State supplementation is not allowed for a Medicaid recipient who is not an SSI recipient.
- The VA $90 capped pension and PNA calculation does not impact the protected earned income allowance.

If the veteran does not have another source of income from which to deduct the $60 PNA, the PNA will continue to be $90 and the co-payment will be zero. In a situation in which the veteran's other source of income is less than $60, the PNA will be $90 plus the amount of other income, not to exceed $60. There is no state supplement to bring the PNA up to $60 if the veteran does not have other income from which to subtract the PNA. The PNA deduction comes **first** in the order of all co-payment deductions, including those for incurred medical expenses (IMEs).

Note: See Section E-4300, VA Benefits, for treatment of payments from the Department of Veterans Affairs. See Section E-4311.2, $90 VA Pension and Institutional Setting, regarding automation limitations and the VA $90 capped pension.

If the person is eligible for Medicaid but has a transfer of assets penalty or a substantial home equity disqualification, follow Appendix XXIII, Procedure for Designated Vendor Number to Withhold Vendor Payment. For policy information on transfer penalties and substantial home equity disqualifications, see the following:

- Chapter I, Transfer of Assets
- Section F-3600, Substantial Home Equity
- Section F-3610, Persons Impacted by Substantial Home Equity Disqualification
- Section F-3620, Persons Not Impacted by Substantial Home Equity Disqualification
- Section F-3630, When the Equity Value is Greater Than the Limit
- Section F-3640, Reverse Mortgage or Home Equity Loan
- Section F-3650, Documentation
- Section F-3660, Undue Hardship

To determine the co-payment for a person or couple, use the following budget steps.

Step 1. Determine the person's monthly net earned and gross unearned income.

Notes:

- VA aid and attendance benefits, housebound allowances, and reimbursements for unusual or continuing medical expenses are exempt from both eligibility and co-payment. However, if these payments are deposited into a qualifying income trust (QIT) account, they are countable for co-payment.
- Do not consider child support as a deduction from an individual's co-pay if it is withheld from unearned income because of garnishment. See Section E-1400, Garnishment or Seizure.

Step 2. Add net earned and gross unearned income.

Step 3.

Individual Budget

Subtract the personal needs allowance of $60 from available income for an individual budget. Subtract the guardian fee allowance, if applicable. Subtract the Medicare Part B premium, if applicable. Subtract incurred medical expenses. Subtract the home maintenance allowance, if applicable. The remainder is the co-payment.

Couple Budget

Subtract the personal needs allowance of $120 from the combined available income for a couple budget. Subtract the guardian fee allowance, if applicable. Subtract the Medicare Part B premium, if applicable. Subtract incurred medical expenses. Subtract the home maintenance allowance, if applicable. Divide the remainder by 2 to determine the co-payment for each spouse.

H-4200, Companion Cases

Body

Revision 09-4; Effective December 1, 2009

For Companion Cases, see Chapter J, Spousal Impoverishment.

H-5000, ICF/IID Co-Payments

Body

Revision 15-3; Effective September 1, 2015

To determine the co-payment for a person living in an approved public or private ICF/IID facility, use the following budget steps. The difference in the co-payment calculation for this group is that a person who has earned income in excess of $30 per month may receive an additional allowance. The purpose of the additional allowance is to provide the ICF/IID person who has a short- or long-term objective of semi-independent or independent living the additional resources to make the transition possible.

H-5100, ICF/IID Individual and Couple Cases

Body

Revision 12-3; Effective September 1, 2012

For individuals and couples, follow the steps in this section.

HHSC nets the person's and spouse's earned income each month by subtracting the following mandatory payroll deductions:

- income tax,
- Social Security tax,
- required retirement withholdings, and
- required uniform expenses.

H-5110 ICF/IID Individual

Revision 15-3; Effective September 1, 2015

Determine the person's monthly net earned and gross unearned income.

Determine the personal needs allowance (PNA) for a person as follows:

Person earns $30 or less.

Step	Description
1.	Deduct the $60 PNA from the unearned income.
2.	To the extent the unearned income is less than $60, deduct the difference from the earned income.
3.	Deduct all remaining earned income up to $30.
4.	Add the deductions from steps 1 through 3 to determine the total PNA/PEI allowance.

Note: The total PNA/PEI must be at least $60.

Example: Person receives $300 RSDI and earns $30 per month.

Step	Description
1.	$300 unearned – $60 PNA = $240
2.	NA
3.	$30 earned – $30 PEI = $0
4.	$60 PNA + $30 PEI = $90 PNA/PEI

Person's earnings exceed $30 but not $120.

Step	Description
1.	Deduct the $60 PNA from the unearned income.
2.	To the extent the unearned income is less than $60, deduct the difference from the earned income.
3.	Deduct $30 from the remaining earned income, plus one-half of the remainder.
4.	Add the deductions from steps 1 through 3 to determine the total PNA/PEI deduction.

Example: Person earns $120 per month and receives $12.50 SSI.

Step	Description

Step	Description
1.	$12.50 unearned – $60 PNA = –$47.50
2.	$120 earned – $47.50 = $72.50
3.	$72.50 remaining earned – $30 = $42.50 divided by 2 = $21.25
4.	$12.50 + $47.50 + $30 + $21.25 = $111.25 PNA/PEI

Person's earnings exceed $120.

Step	Description
1.	Deduct the $60 PNA from the unearned income.
2.	To the extent the unearned income is less than $60, deduct the difference from the first $120 of the earned income.
3.	Of the monies remaining from the first $120 of earned income, deduct $30 and one-half of the remainder.
4.	Deduct 30 percent of the earnings in excess of $120.
5.	Add the deductions from Steps 1 through 4 to determine the total PNA/PEI allowance.

Example 1: Person receives $300 RSDI and earns $250.

Step	Description
1.	$300 unearned – $60 PNA = $240
2.	NA
3.	$120 earned – $30 = $90 divided by 2 = $45
4.	$250 earned – $120 = $130 x .30 = $39
5.	$60 PNA + $30 + $45 + $39 = $174 PNA/PEI

Example 2: Person receives $7.50 SSI and earns $130.

Step	Description
1.	$7.50 unearned – $60 = –$52.50
2.	$120 earned – $52.50 = $67.50
3.	$67.50 remaining earned – $30 = $37.50 divided by 2 = $18.75
4.	$130 earned – $120 = $10 x .30 = $3
5.	$7.50 + $52.50 + $30 + $18.75 + $3 = $111.75 PNA/PEI

References:

- Subtract the guardian fee allowance, if applicable.
- Subtract incurred medical expenses.
- Subtract the home maintenance allowance, if applicable.
- The total net earned income and gross unearned income minus the total personal needs allowance and other allowable deductions is the co-payment.

H-5120 ICF/IID Couple

Revision 12-3; Effective September 1, 2012

Determine the personal needs allowance for a couple as follows:

1. If neither spouse has earned income, or if the only spouse with earned income does not have an ICF/IID level of care, the personal needs allowance for the couple is $60 for each spouse.
2. If either spouse is an ICF/IID person who has monthly earned income, determine the personal needs allowance for each separately based on their individual monthly incomes.

Note: If one spouse has a level of care other than an ICF/IID level of care, the personal needs allowance for that individual is $60, regardless of whether the individual has earned income. Combine the individual personal needs allowance for the couple.

Subtract the total personal needs allowance from the total of net earned income and gross unearned income of the couple.

References

- Subtract guardian fee allowance, if applicable.
- Subtract incurred medical expenses.
- Subtract home maintenance allowance, if applicable.
- Divide the remainder by two to determine the co-payment for each spouse.

H-5130 ICF/IID Companion

Revision 12-3; Effective September 1, 2012

A separate deduction for maintenance of the home is not allowable in companion cases.

The spousal allowance provides for home maintenance in those cases.

To determine the co-payment budget for a companion situation, use the following steps:

Step	Procedure
1	Determine the countable net earned and gross unearned income of the person.
2	Subtract the personal needs allowance, including the protected earned income allowance (if any) of the person based on his own net income. Subtract guardian fee allowance, if applicable.
3	Add the spouse's countable net earned and gross unearned income to the remainder.
4	Subtract the spousal allowance.
5	1. If there are no dependents, go to Step 6. 2. If there are dependents, determine the dependent allowance. 3. Subtract the dependent allowance.
6	Subtract incurred medical expenses.

The remainder is the co-payment.

Example: The couple has the following income:

Person	Spouse	
$250	RSDI	$800 Net Earnings

Person	Spouse	
$130		Net Earnings

Calculation for personal needs and protected earned income allowance:

$250 RSDI unearned income
− 60 PNA
$190 remainder

Calculation for protected earned income when earnings are greater than $120:

$120 Deduct $30 from the first $120 of earned income
− 30
$ 90 divided by 2 = $45 and get one-half the remainder

Calculation for 30% of earnings in excess of $120:

$130 Earnings
−120 First $120 of earned income
$10 x .3 = $3 (30% of earnings in excess of $120)

Calculation for Total PNA/PEI:

$60 PNA
30 $30 deduction
45 One-half the remainder deduction
+ 3 (30% of earnings in excess of $120)
$138 Total PNA/PEI

Co-payment calculation:

	RSDI	$250
	Net earnings	+ 130
Step 1:	Total	$380
Step 2:	Total PNA/PEI	− 138
	Income available for diversion	$242
Step 3:	Spouse's income	+ 800
	Total	$1,042
Step 4:	Spousal allowance	−2,841
Step 5:	NA	
Step 6:	NA	
	Co-payment	$0

H-6000, Co-Payment for SSI Cases

Body

Revision 21-1; Effective March 1, 2021

People are eligible for Medicaid benefits as SSI cash recipients if they live in approved Medicaid long-term care facilities and their countable income does not fully meet the SSI standard payment amount.

Note: As long as these people remain SSI cash recipients, the Social Security Administration (SSA) determines eligibility, and HHSC budgets the payment plan.

Determine the co-payment for SSI cases based on what the SSI payment should have been instead of by the actual SSl payment received. SSA will recoup any erroneous payments.

Under SSI policy, a person is eligible for the full standard payment amount in the month of entry to a Medicaid long-term care facility. Prior to entry to the Medicaid long-term care facility, the individual must have been living in a non-institutional setting or in a private institution in which Medicaid made no substantial payments for any part of that month. For any subsequent month in which the person lives in the facility throughout the month, HHSC uses the reduced SSI payment standard.

Note: The reduced SSI payment standard is $30.

The reduced SSI payment standard applies to all subsequent months if the person continues to live in the Medicaid long-term care facility throughout the month. A person is entitled to the reduced SSI payment standard for the month of entry into a Medicaid long-term care facility only if:

- the person was living in a public institution or in a Medicaid medical treatment facility for every day of the month before the date of admission to the long-term care facility; or
- Medicaid was paying more than half of the person's cost of care.

Note: HHSC supplements the reduced SSI payment standard by $30 per month so that SSI recipients also have a $60 personal needs allowance.

A couple may be eligible under the full SSI payment standard for a couple during the month one or both spouses enter a Medicaid medical treatment facility in which Medicaid is expected to make substantial payments.

If only one spouse enters a facility and remains there throughout the subsequent month(s), SSA separates the payments for the subsequent month(s) to reflect the living arrangements of each spouse. If both spouses enter the Medicaid medical facility and Medicaid makes substantial payments for each spouse, SSA lowers the SSI payment standard to the reduced standard for a couple ($60) for the months after the month of entry.

Through SSI monitoring, determine if an SSI recipient has other income. Calculate the co-payment and notify Provider Claim Services.

The following amounts are the SSI federal benefit rate for the periods shown:

Time Period	Individual	Couple
Jan. 1, 2021 to present	$794.00	$1,191.00
Jan. 1, 2020 to Dec. 31, 2020	$783.00	$1,175.00
Jan. 1, 2019 to Dec. 31, 2019	$771.00	$1,157.00
Jan. 1, 2018 to Dec. 31, 2018	$750.00	$1,125.00
Jan. 1, 2017 to Dec. 31, 2017	$735.00	$1,103.00

Time Period	Individual	Couple
Jan. 1, 2016 to Dec. 31, 2016	$733.00	$1,100.00
Jan. 1, 2015 to Dec. 31, 2015	$733.00	$1,100.00
Jan. 1, 2014 to Dec. 31, 2014	$721.00	$1,082.00
Jan. 1, 2013 to Dec. 31, 2013	$710.00	$1,066.00
Jan. 1, 2012 to Dec. 31, 2012	$698.00	$1,048.00
Jan. 1, 2011 to Dec. 31, 2011	$674.00	$1,011.00
Jan. 1, 2010 to Dec. 31, 2010	$674.00	$1,011.00
Jan. 1, 2009 to Dec. 31, 2009	$674.00	$1,011.00
Jan. 1, 2008 to Dec. 31, 2008	$637.00	$956.00
Jan. 1, 2007 to Dec. 31, 2007	$623.00	$934.00
Jan. 1, 2005 to Dec. 31, 2005	$579.00	$869.00
Jan.1, 2004 to Dec. 31, 2004	$564.00	$846.00
Jan.1, 2003 to Dec. 31, 2003	$552.00	$829.00
Jan. 1, 2002 to Dec. 31, 2002	$545.00	$817.00
Jan. 1, 2001 to Dec. 31, 2001	$531.00	$796.00
Jan. 1, 2000 to Dec. 31, 2000	$512.00	$769.00
Jan. 1, 1999 to Dec. 31, 1999	$500.00	$751.00
Jan. 1, 1998 to Dec. 31, 1998	$494.00	$741.00
Jan. 1, 1997 to Dec. 31, 1997	$484.00	$726.00
Jan. 1, 1996 to Dec. 31, 1996	$470.00	$705.00
Jan. 1, 1995 to Dec. 31, 1995	$458.00	$687.00
Jan. 1, 1994 to Dec. 31, 1994	$446.00	$669.00
Jan. 1, 1993 to Dec. 31, 1993	$434.00	$652.00
Jan. 1, 1992 to Dec. 31, 1992	$422.00	$633.00
Jan. 1, 1991 to Dec. 31, 1991	$407.00	$610.00
Jan. 1, 1990 to Dec. 31, 1990	$386.00	$579.00
Jan. 1, 1989 to Dec. 31, 1989	$368.00	$553.00
Jan. 1, 1988 to Dec. 31, 1988	$354.00	$532.00
Jan. 1, 1987 to Dec. 31, 1987	$340.00	$510.00
Jan. 1, 1986 to Dec. 31, 1986	$336.00	$504.00
Jan. 1, 1985 to Dec. 31, 1985	$325.00	$488.00
Jan. 1, 1984 to Dec. 31, 1984	$314.00	$472.00
July 1, 1983 to Dec. 31, 1983	$304.30	$456.40
July 1, 1982 to June 30, 1983	$284.30	$426.40
July 1, 1981 to June 30, 1982	$264.70	$397.00
July 1, 1980 to June 30, 1981	$238.00	$357.00
July 1, 1979 to June 30, 1980	$208.20	$312.30
July 1, 1978 to June 30, 1979	$189.40	$284.10
July 1, 1977 to June 30, 1978	$177.80	$266.70
July 1, 1976 to June 30, 1977	$167.80	$251.80
July 1, 1975 to June 30, 1976	$157.70	$236.60
July 1, 1974 to June 30, 1975	$146.00	$219.00
Jan. 1, 1974 to June 30, 1974	$140.00	$210.00

From Jan. 1, 1974, to June 30, 1988, the reduced SSI standard payment amount was $25 for a person and $50 for a couple.

H-6100, Exceptions to Reduced SSI Payment Standard

Body

Revision 09-4; Effective December 1, 2009

SSI persons who enter a Medicaid long-term care facility can continue to receive their community-based SSI payment in the following situations:

- Section 1619 eligibility

  Disabled individuals with earnings greater than the SSI benefit rate can continue to receive SSI or Medicaid benefits or both under Section 1619 of the Social Security Act (Public Law 99-643, effective July 1, 1987). These individuals can receive the community-based SSI payment for two months after the month of entry to a Medicaid facility.

- Temporary institutionalization

  Effective July 1, 1988, Public Law 100-203 allows SSI persons who meet certain requirements to continue receiving their SSI benefits while they are temporarily confined to a medical facility.

  These continued benefits may be made for up to three months after the month of entry if:
  - the individual notifies the SSA that he expects to be in a medical facility for at least a full calendar month but for fewer than 90 days;
  - SSA receives a physician's certification within 10 days after the close of the month of admission. The physician certifies that the individual is likely to leave the facility no later than the 91st consecutive day after admission; and
  - SSA receives evidence within 10 days after the close of the month of admission that the individual needs to maintain and provide for the expenses of the home or living arrangement to which he may return.

In each situation, the SSI person is allowed to keep SSI benefits for the first two or three calendar months, respectively, after the month of entry. Neither law affects the SSI benefit for the month of entry. Because the Nursing Home Billing System generally does not consider the SSI benefit toward calculating the co-payment for months after the month of entry, do not process Form H1259, Correction of Applied Income, for these cases.

H-6200, SSI Certifications

Body

H-6210 Manual Certification Procedures

Revision 16-3; Effective September 1, 2016

Some SSI recipients do not appear on the SDX tapes and therefore are not shown as Medicaid eligible on HHSC's computer system. Cases that are provided Medicaid coverage by means of a manual certification include the following:

- Prior SSI recipients who are not currently eligible and who were never certified for Medicaid on HHSC's computer system;
- SSI recipients who are issued a check manually by the Social Security district office;
- SSI recipients shown on the Social Security master file but not shown on HHSC's computer system; and
- SSI applicants with unpaid or reimbursable medical bills in Texas who move out of the state before SSI eligibility is approved.

The Social Security district office must initiate the manual certification procedure. When applicable, the Social Security district office completes a manual certification form and mails it to HHSC's Data Integrity department. Data Integrity certifies these persons for ME – Temporary Manual SSI. These persons are sent a Your Texas Benefits Medicaid ID card by the state office. A person remains certified for ME – Temporary Manual SSI Medicaid until the person's information appears on the SDX tape or until SSA submits a manual request to deny the eligibility. Cases for persons certified for ME – Temporary Manual SSI must be manually updated by the Social Security district office.

If an SSI recipient contacts a Social Security office requesting assistance in obtaining a Your Texas Benefits Medicaid ID card, the recipient's current Medicaid status must be determined before a manual certification form is initiated. When a request is received by the SSA representative regarding the current eligibility status of the SSI recipient, the eligibility specialist provides the requested information by verifying the recipient's status through system inquiry or via regional procedures.

If Medicaid status cannot be determined locally, the Social Security representative submits a manual certification form, assuming that the SSI recipient is not certified for Medicaid. (If the SSI recipient is currently certified as Medicaid eligible, the form is retained in state office for future reference.)

If an SSI recipient contacts HHSC requesting assistance in obtaining a Your Texas Benefits Medicaid ID card, obtain the name, address and Social Security number. Perform inquiry through the automated systems to verify Medicaid status. If the SSI recipient is not certified for Medicaid, or if current status cannot be determined, inform the Social Security district office that a manual certification is needed.

If an SSI recipient is certified for Medicaid but circumstances exist that may have stopped the receipt of the Your Texas Benefits Medicaid ID card, refer the recipient to the Social Security district office. If no change in circumstances occurred, send an email to Data Integrity, ME Unit.

Data Integrity attempts to resolve the problem and reports the action taken. Notify the Social Security district office (using Form H1016, Supplemental Security Income Referral) of any change reported by SSI recipients.

Reminder: Manual certifications are sent to state office by SSA when SSA cannot process the SSI certification on the SDX due to systems limitations. Do not issue a Form H1027 for manual certifications unless authorized by Data Integrity in state office.

H-6220 Emergency Manual Certification

Revision 16-3; Effective September 1, 2016

In some instances, it may be necessary for a newly certified SSI recipient to obtain emergency medical services before the receipt of the Your Texas Benefits Medicaid ID card. The SSA representative determines if the recipient's situation is considered a medical emergency. If the representative determines that a medical emergency does exist, the following procedures are followed by the department and SSA to ensure that the recipient has access to the appropriate services.

An eligible SSI recipient who has not received his Medicaid number and the Your Texas Benefits Medicaid ID card and has a medical emergency may request immediate assistance in obtaining an emergency Medicaid certification. In this situation, the local SSA representative contacts a local Medicaid eligibility specialist or supervisor.

When the SSA representative contacts you regarding the current eligibility status of the SSI recipient, provide the requested information by verifying the recipient's status through system inquiry or regional procedures. The SSA representative informs HHSC staff:

- that an emergency manual certification is being sent to the Data Integrity in state office and about the nature of the recipient's emergency; and
- identification information for the recipient, including:
  - name;
  - Social Security number;
  - address;
  - telephone number; and
  - special instructions needed for contact.

Data Integrity staff expedite the processing of the emergency Medicaid certification. Section staff also contacts local HHSC staff to authorize completion of the appropriate Form H1027.

When authorization is received from Data Integrity staff, expedite the delivery of the form to the recipient and, if necessary, notify the provider of the recipient's Medicaid eligibility.

Reminder: Emergency manual certifications are orally expedited to HHSC for the purpose of issuing an appropriate Form H1027. A newly certified SSI recipient usually does not yet have a Medicaid number. Do not issue Form H1027-A until authorized to do so by Data Integrity in state office.

H-6230 SSI Payment Placed in Suspense by SSA

Revision 11-1; Effective March 1, 2011

An SSI recipient may be eligible to receive an SSI payment, but does not receive it because of some problem. Problems may occur because of a change of address, returned check, change of payee or other reasons that cause the payment to be placed in suspense.

A suspense code on the SDX tape is interpreted as a denial of Medicaid because the person is not receiving an SSI payment. When the person is reinstated in a current pay status, Medicaid eligibility is also reinstated.

Cases placed in suspense and the reasons for suspension may be recognized by the denial code shown on the SSI case screen. The codes are:

S04 — Suspended — Disability decision pending
S05 — Suspended — Substantial, gainful activity development pending
S06 — Suspended — Recipient's address unknown
S07 — Suspended — Returned checks for other than address, payee change or death of payee
S08 — Suspended — Representative payee development pending
S09 — Suspended — Recipient refuses to cooperate
S20 — Suspended — Potential rollback case or no disability payment made before 7-73
S21 — Suspended — The recipient is presumptively disabled and has already received payments

If an SSI recipient whose case is in a suspense status contacts HHSC, ask the recipient to contact SSA so that the cause of the suspense action may be promptly resolved. Unless an emergency situation exists, do not contact SSA to initiate a manual certification for the recipient. If SSA verifies that the recipient has been denied SSI assistance because of entry into a Medicaid facility, take an MEPD application for assistance.

H-6240 Residence in a Public Institution or Acute Care Hospital

Revision 13-1; Effective March 1, 2013

Eligibility for recipients in acute care hospitals is determined using the SSI federal benefit rate.

Generally, a person is not eligible for SSI if he/she is a resident of a public institution throughout the calendar month. The following definitions apply for purposes of this policy:

Institution — An establishment that makes available some treatment or services, besides food and shelter, to four or more persons who are not related to the proprietor.

Public institution — An establishment that is operated or controlled by federal or state or government unit, or a political subdivision, such as the city or county.

Except for patients in Medicaid facilities and certain persons described in this section, persons who are inmates and live in public institutions throughout the calendar month are not eligible for medical assistance:

- A person is considered a resident of a public institution if he receives the substantial portion of his food and shelter while living in the institution. This is true whether he is receiving treatment and services available in the institution or whether he or someone else is paying for his food, shelter and services. A person is not considered a resident of a public institution if he lives in a public educational institution and is enrolled in or registered for the institution's educational or vocational training.
- A person is considered to be living in an institution throughout the calendar month if she lives there from the first day of a month through the last day of that month. SSA considers a person to be living in an institution continuously if she transfers from one institution to another or is temporarily absent without being discharged. A person is also considered a resident of an institution throughout a month if she:
    - is born in the institution and remains throughout the rest of the month of her birth; or
    - lives in an institution on the first day of a month and dies in the institution during that month.
- A person who is placed in a Medicaid-certified facility (Medicare-SNF, NF or ICF/IID) after permanent release from a jail, prison, reformatory, or other correctional or holding facility is not considered to be under the control of that institution. In these cases, the person could be eligible for Medicaid if he meets all eligibility criteria.

Some persons may be eligible for SSI although they are residents of a public institution throughout the month. These exceptions are as follows:

- A person lives throughout the calendar month in a medical care facility, and Medicaid pays or is expected to pay more than 50% of the person's cost of care.
- A person lives for:
    - part of the month in a public institution; and
    - the rest of the month in a public or private medical care facility in which Medicaid pays or is expected to pay more than 50% of the person's cost of care.
- A person lives in a publicly operated community residence that serves no more than 16 residents. Community residences, for this purpose, do not include medical care facilities, educational or vocational training institutions, jails or other facilities for restraint of prisoners or persons being held pending disposition of legal charges.

H-6250 Residence in a Medical Care Facility

Revision 11-1; Effective March 1, 2011

SSI uses a reduced federal benefit rate of $30 for individuals and $60 for couples if:

- they live in a public or private medical care facility; and
- Medicaid pays, or is expected to pay, more than 50% of the cost of the individual's or couple's care; or
- a child under age 18 lives in a medical care facility where a substantial part (more than 50%) of the cost of his care is paid by a health insurance policy issued by a private provider of such insurance, or where a substantial part (more than 50%) of the cost of his care is paid for by a combination of Medicaid payments and payments made under a health insurance policy issued by a private provider of such insurance.

Note: The reduced federal benefit rate applies for an SSI recipient during the penalty period when there has been a transfer of assets. (See Chapter I, Transfer of Assets.)

Reduced benefits apply in the following situations:

- An individual or couple lives in one or more medical care facilities throughout the calendar month, and Medicaid pays, or is expected to pay, more than 50% of the cost of care in each facility.
- An individual or couple lives for a part of the month in a public institution and the rest of the month in a public or private medical care facility in which Medicaid pays, or is expected to pay, more than 50% of the cost of care.
- A child under age 18 lives for part of a month in a public institution and for the rest of the month in a public or private medical care facility where a substantial part (more than 50%) of the cost of care is being paid under a health insurance policy issued by a private provider or by a combination of Medicaid and payments under a health insurance policy issued by a private provider.

If an individual or couple lives in more than one private medical facility throughout a calendar month, and Medicaid pays less than 50% of the cost of care in at least one of the facilities, the individual or couple may be entitled to the full SSI federal benefit rate.

In some instances, Medicaid liability may exist for only part of a month, even though the individual or couple lives in one private Medicaid facility throughout that month. The variables that would affect Medicaid liability include, but are not limited to, the medical effective date, level-of-care/medical necessity determination effective date and the 30-day limit on hospital services. If these limitations would cause Medicaid to pay for less than 50% of the cost of care, the affected individual or couple may be entitled to the full SSI federal benefit rate.

Medicaid also does not pay for nursing facility care when the PASARR assessment indicates that placement is not appropriate.

H-6260 Facility Administrator Responsibilities

Revision 13-1; Effective March 1, 2013

If an individual who is receiving or who is potentially eligible to receive SSI benefits enters a Medicaid facility (Medicare-SNF, NF or ICF/IID), refer the administrator to the Nursing Facility Requirements for Licensure and Medicaid Certification Handbook for appropriate procedures. The administrator should notify SSA that an SSI recipient has entered the facility. For potential SSI recipients, the administrator is responsible for contacting SSA to secure a protected date of filing for SSI and to ensure that an eligibility determination is completed.

H-6270 SSI Monitoring

Revision 12-1; Effective March 1, 2012

Upon notification or discovery of a person receiving SSI entering an institutional setting, determine if the SSI will continue upon entry or if the SSI will be denied.

If the recipient's SSI benefits are anticipated to continue, send Form H1224, SSI Monitoring Letter, to the recipient, spouse or authorized representative.

Do not send Form H1224 if the recipient's SSI benefits are anticipated to be denied as a result of entry into the facility.

Reference: See Section B-7200, SSI Cash Benefits Denied Due to Entry into a Medicaid Facility.

Note: In addition to providing verification of the recipient's income and resources, Form H1224 is used to obtain information regarding transfers of assets by an SSI recipient.

After eligibility for ME-SSI benefits is reported to HHSC and admission forms and medical necessity or level of care are processed, the Service Authorization System Online (SASO) is updated with a co-payment. Review the SASO co-payment for accuracy. (See Chapter H, Co-Payment.) If correct, no action is needed. If incorrect, complete Form H1259, Correction of Applied Income (The Amount You Pay to the Facility), and enter changes into SASO. Remember to hold for 12 days if the co-payment is being increased. When Form H1259 is processed to correct co-payment, the co-payment change requires a "force" action in SASO. If ongoing co-payment has a force, future updates will not reflect in SASO. If the recipient does not have income other than SSI, no further monitoring is required. Check co-payment in SASO for accuracy. If the recipient has variable income along with SSI, monitor the case every six months.

If the recipient has other non-variable income along with SSI, a periodic review is required to ensure that the payment plan is correct. Conduct the periodic review at least every 12 months. Use the same procedure for reviews as is used for initial monitoring.

H-7000, Medicare and Co-Payment

Body

Revision 12-3; Effective September 1, 2012

H-7100 General Information

Revision 09-4; Effective December 1, 2009

Under Title XVIII of the Social Security Act, Medicare Part A coverage includes payment for limited nursing facility (NF) care as an extension of hospital care.

Medicare covers a maximum of 100 days in a skilled nursing facility (SNF), also referred to as extended care facilities. A team, consisting of physicians and nurses, determines whether the person meets Medicare's criteria for SNF at admission and at weekly reevaluations. Many persons do not use the entire 100 days, or may have hospital readmissions during their SNF period. A return to the hospital is not part of the available 100 days.

Medicare covers all charges for the first 20 days of SNF care. The following 80 days are coinsurance days. Medicare covers all of the medical expenses during this period; the person pays a coinsurance rate toward room and board. Medicare-covered services in an NF include skilled nursing care, physician services, physical/occupational/speech therapy, prescriptions, routine dental care and room and board.

For a Medicaid applicant or person who is certified for Medicare payments while in a Medicare SNF, Medicare pays the entire bill for the first through the 20th day. There is no coinsurance for that period. The person is eligible for coinsurance vendor payment beginning on the 21st day. Coinsurance continues through the 100th day if the person's stay is covered by Medicare.

A person can be certified for Medicaid during the entire SNF period, provided the person resides in a Medicaid NF. A co-payment is calculated for the coinsurance period, with vendor payment covering the balance of the SNF rate. There is no co-payment for the first 20 days of full SNF coverage.

Notes:

- Begin the eligibility determination process when a person files an application for Medicaid upon admission to the Medicare-SNF part of a Medicaid facility.
- Because the person must have been in a hospital for at least three days before SNF admission, always explore prior medical coverage. **Reminder:** The special income limit is applicable once the person (or couple) has been confined to one or more Medicaid-approved long-term care facilities (Medicare-SNF, NF or ICF/MR) for at least 30 consecutive days.
- Accept the Medicare determination of need for SNF care as a medical necessity determination.
- The NF must submit documentation that sets the rate at which the facility is paid.

Under certain limited conditions, Medicare will pay some NF costs for Medicare beneficiaries who require skilled nursing or rehabilitation services. To be covered, the person must receive the services from a Medicare-certified SNF after a qualifying hospital stay. A qualifying hospital stay is the amount of time spent in a hospital just before entering a nursing facility. This is at least three days. Care must begin within 30 days after leaving the hospital. The person’s doctor must order daily skilled nursing or rehabilitation services that the person can get only in an SNF. "Daily" means seven days a week for skilled nursing services and five days a week or more for skilled rehabilitation services.

H-7200 Medicare-Related Financial Responsibilities for Skilled Nursing Facility Care

Revision 09-4; Effective December 1, 2009

Number of Days	Person's Responsibility	Medicare's Responsibility
1-20	Nothing	Everything
21-100	20% skilled nursing facility care co-payment per day paid after 20 days of care (21-100). See Appendix XXXI, Budget Reference Chart.	The rest
Over 100	Everything	Nothing

H-7300 Medicaid Coverage Issues Related to Nursing Facility Costs

Revision 12-3; Effective September 1, 2012

- Community Attendant Services (CAS) (ME-Community Attendant) coverage, provides Medicaid payment for attendant care only. This coverage does not provide for nursing facility (NF) vendor payment, doctor visits, hospital stays, medically necessary items or prescription drug coverage.
- Regular Medicaid coverage provides Medicaid payment for NF vendor payment, doctor visits, hospital stays, medically necessary items or prescription coverage. Medicaid is the payer of last resort and a medical necessity is required for vendor payment in an NF. Vendor payment is also subject to co-payments. Medicaid coverage provides for payment of prescription drug coverage, except when the person is dually eligible for both Medicare and Medicaid.
- Qualified Medicare Beneficiary (MC-QMB) coverage indicates that Medicaid pays the Medicare premiums, deductibles and co-insurance, including Medicare-covered hospital and NF stays.

Examples:

Recipient 1 — When a person with only MC-QMB (also known as a Pure Q) enters a skilled nursing facility (SNF) from a hospital, Medicare will cover 100% of the SNF vendor costs for days 1-20. Medicare will cover 80% of the SNF vendor costs for days 21-100. As a Pure Q person, Medicaid's Q covers 100% of the remaining 20% of the SNF vendor costs for days 21-100. The person will not be responsible for the remaining 20% of the SNF vendor costs (the Medicare co-payment per day for days 21-100). As a Pure Q person, the person is not responsible for the amount of co-payment a Medicaid person must pay for nursing care.

Note: If the person does not remain a Pure Q recipient and becomes certified for full Medicaid, use the Recipient 2 example.

Recipient 2 — When a person living in the community enters an SNF from a hospital and is dually eligible for both Medicare and Medicaid (MQMB), Medicare will cover 100% of the SNF vendor costs for days 1-20. Even though the person is Medicaid eligible, test the person for institutional coverage that is subject to transfer of assets and excess home equity policy. The 30-day stay requirement is not necessary. If the recipient is Medicaid eligible for vendor payment:

- Make retroactive adjustments to ensure the correct benefits are reflected in the system of record if necessary.
- The recipient will not be responsible for the remaining 20% of the SNF vendor costs (the Medicare co-payment per day for days 21-100).
- The recipient will have a calculated Medicaid co-payment beginning day 21 and continuing.
- Notify the recipient of the responsibility for the Medicaid co-payment.

Recipient 3 — When a CAS recipient (ME-Community Attendant) recipient who has Medicare but not MC-QMB enters an SNF from a hospital, Medicare will cover 100% of the SNF vendor payment for days 1-20. Medicare will cover 80% for days 21-100. The recipient's Medicaid eligibility in an NF needs to be determined. Test the person for institutional coverage that is subject to transfer of assets and excess home equity policy. The 30-day stay requirement is necessary. If the recipient is Medicaid-eligible for vendor payment:

- Make retroactive adjustments to ensure the correct benefits are reflected in the system of record if necessary.
- The recipient will not be responsible for the remaining 20% of the SNF vendor costs (the Medicare co-payment per day for days 21-100).
- The recipient will have a calculated Medicaid-co-payment beginning day 21 and continuing.
- Notify the recipient of the responsibility for the Medicaid-co-payment.

If the person is not Medicaid-eligible for vendor payment and is not eligible for Pure Q, use the chart in Section H-7200, Medicare-Related Financial Responsibilities for Skilled Nursing Facility Care. Deny the person and send the appropriate denial notice. There will not be a calculated Medicaid-co-payment.

Recipient 4 — When a CAS (ME-Community Attendant) recipient with Qualified Medicare Beneficiary (MC-QMB) only enters an SNF from a hospital, Medicare will cover 100% of the SNF vendor payment for days 1-20.

Medicare will cover 80% for days 21-100. The recipient's Medicaid eligibility in an NF needs to be determined. Test the person for institutional coverage that is subject to transfer of assets and excess home equity policy. The 30-day stay requirement is necessary. If the recipient is Medicaid eligible for vendor payment:

- Make retroactive adjustments to ensure the correct benefits are reflected in the system of record if necessary.
- The recipient will not be responsible for the remaining 20% of the SNF vendor costs (the Medicare co-payment per day for days 21-100).
- The recipient will have a calculated Medicaid-co-payment beginning day 21 and continuing.
- Notify the recipient of the responsibility for the Medicaid-co-payment.

If the person is not Medicaid eligible for vendor payment but is eligible for Pure Q, notify the recipient and use the Recipient 1 example.

H-7400 Medicare and Medical Effective Date

Revision 09-4; Effective December 1, 2009

The medical effective date for a person in a Medicare skilled nursing facility (SNF) potentially can be as early as the first day of the month of entry to the nursing facility or the first day of a prior month. If eligible, this will ensure payment of any other medical expenses (including returns to the hospital during the initial 20 days of full Medicare coverage). At certification, the eligibility worker must verify and document in the case record that either the person:

- remains in the SNF section, or
- has been discharged to Medicaid.

Medicare approval of the applicant for the SNF meets the medical necessity (MN) requirement. If the medical effective date (MED) is prior to the applicant's move to Medicaid days in the facility, the MN requirement has been met.

Note: If the person remains in the SNF when the case is certified, it is recommended that a special review be scheduled to monitor for the completed MN determination when SNF does end.

Examples:

- Marsha Ford is admitted to an SNF as full Medicare on 11-15-XX. The 21st SNF day is 12-05-XX. Form H1200 is received 12-14-XX. Application is ready to certify 01-03-XX. The eligibility worker verifies that the person has unpaid/reimbursable hospital bills for 11-XX. Ms. Ford is still in the SNF days and has met all eligibility criteria as of 12:01 a.m. 11-01-XX. MED = 11-01-XX. Co-payment begins 12-05-XX.
- Fred McDaniel is admitted to an SNF as full Medicare on 03-24-XX. The 21st SNF day is 04-13-XX. Form H1200 is received 04-05-XX. He is discharged from the SNF to Medicaid on 05-20-XX. Application is ready to certify 06-15-XX. Mr. McDaniel meets all eligibility criteria as of 12:01 a.m. 03-01-XX. MED = 03-01-XX. Co-payment begins 04-13-XX. MN is not necessary, as MED is prior to discharge to Medicaid.

H-7100, General Information

Body

Revision 09-4; Effective December 1, 2009

Under Title XVIII of the Social Security Act, Medicare Part A coverage includes payment for limited nursing facility (NF) care as an extension of hospital care.

Medicare covers a maximum of 100 days in a skilled nursing facility (SNF), also referred to as extended care facilities. A team, consisting of physicians and nurses, determines whether the person meets Medicare's criteria for SNF at admission and at weekly reevaluations. Many persons do not use the entire 100 days, or may have hospital readmissions during their SNF period. A return to the hospital is not part of the available 100 days.

Medicare covers all charges for the first 20 days of SNF care. The following 80 days are coinsurance days. Medicare covers all of the medical expenses during this period; the person pays a coinsurance rate toward room and board. Medicare-covered services in an NF include skilled nursing care, physician services, physical/occupational/speech therapy, prescriptions, routine dental care and room and board.

For a Medicaid applicant or person who is certified for Medicare payments while in a Medicare SNF, Medicare pays the entire bill for the first through the 20th day. There is no coinsurance for that period. The person is eligible for coinsurance vendor payment beginning on the 21st day. Coinsurance continues through the 100th day if the person's stay is covered by Medicare.

A person can be certified for Medicaid during the entire SNF period, provided the person resides in a Medicaid NF. A co-payment is calculated for the coinsurance period, with vendor payment covering the balance of the SNF rate. There is no co-payment for the first 20 days of full SNF coverage.

Notes:

- Begin the eligibility determination process when a person files an application for Medicaid upon admission to the Medicare-SNF part of a Medicaid facility.
- Because the person must have been in a hospital for at least three days before SNF admission, always explore prior medical coverage. **Reminder:** The special income limit is applicable once the person (or couple) has been confined to one or more Medicaid-approved long-term care facilities (Medicare-SNF, NF or ICF/MR) for at least 30 consecutive days.
- Accept the Medicare determination of need for SNF care as a medical necessity determination.
- The NF must submit documentation that sets the rate at which the facility is paid.

Under certain limited conditions, Medicare will pay some NF costs for Medicare beneficiaries who require skilled nursing or rehabilitation services. To be covered, the person must receive the services from a Medicare-certified SNF after a qualifying hospital stay. A qualifying hospital stay is the amount of time spent in a hospital just before entering a nursing facility. This is at least three days. Care must begin within 30 days after leaving the hospital. The person’s doctor must order daily skilled nursing or rehabilitation services that the person can get only in an SNF. "Daily" means seven days a week for skilled nursing services and five days a week or more for skilled rehabilitation services.

H-7200, Medicare-Related Financial Responsibilities for Skilled Nursing Facility Care

Body

Revision 09-4; Effective December 1, 2009

Number of Days	Person's Responsibility	Medicare's Responsibility
1-20	Nothing	Everything
21-100	20% skilled nursing facility care co-payment per day paid after 20 days of care (21-100). See Appendix XXXI, Budget Reference Chart.	The rest

Number of Days	Person's Responsibility	Medicare's Responsibility
Over 100	Everything	Nothing

H-7300, Medicaid Coverage Issues Related to Nursing Facility Costs

Body

Revision 12-3; Effective September 1, 2012

- Community Attendant Services (CAS) (ME-Community Attendant) coverage, provides Medicaid payment for attendant care only. This coverage does not provide for nursing facility (NF) vendor payment, doctor visits, hospital stays, medically necessary items or prescription drug coverage.
- Regular Medicaid coverage provides Medicaid payment for NF vendor payment, doctor visits, hospital stays, medically necessary items or prescription coverage. Medicaid is the payer of last resort and a medical necessity is required for vendor payment in an NF. Vendor payment is also subject to co-payments. Medicaid coverage provides for payment of prescription drug coverage, except when the person is dually eligible for both Medicare and Medicaid.
- Qualified Medicare Beneficiary (MC-QMB) coverage indicates that Medicaid pays the Medicare premiums, deductibles and co-insurance, including Medicare-covered hospital and NF stays.

Examples:

Recipient 1 — When a person with only MC-QMB (also known as a Pure Q) enters a skilled nursing facility (SNF) from a hospital, Medicare will cover 100% of the SNF vendor costs for days 1-20. Medicare will cover 80% of the SNF vendor costs for days 21-100. As a Pure Q person, Medicaid's Q covers 100% of the remaining 20% of the SNF vendor costs for days 21-100. The person will not be responsible for the remaining 20% of the SNF vendor costs (the Medicare co-payment per day for days 21-100). As a Pure Q person, the person is not responsible for the amount of co-payment a Medicaid person must pay for nursing care.

Note: If the person does not remain a Pure Q recipient and becomes certified for full Medicaid, use the Recipient 2 example.

Recipient 2 — When a person living in the community enters an SNF from a hospital and is dually eligible for both Medicare and Medicaid (MQMB), Medicare will cover 100% of the SNF vendor costs for days 1-20. Even though the person is Medicaid eligible, test the person for institutional coverage that is subject to transfer of assets and excess home equity policy. The 30-day stay requirement is not necessary. If the recipient is Medicaid eligible for vendor payment:

- Make retroactive adjustments to ensure the correct benefits are reflected in the system of record if necessary.
- The recipient will not be responsible for the remaining 20% of the SNF vendor costs (the Medicare co-payment per day for days 21-100).
- The recipient will have a calculated Medicaid co-payment beginning day 21 and continuing.
- Notify the recipient of the responsibility for the Medicaid co-payment.

Recipient 3 — When a CAS recipient (ME-Community Attendant) recipient who has Medicare but not MC-QMB enters an SNF from a hospital, Medicare will cover 100% of the SNF vendor payment for days 1-20. Medicare will cover 80% for days 21-100. The recipient’s Medicaid eligibility in an NF needs to be determined. Test the person for institutional coverage that is subject to transfer of assets and excess home equity policy. The 30-day stay requirement is necessary. If the recipient is Medicaid-eligible for vendor payment:

- Make retroactive adjustments to ensure the correct benefits are reflected in the system of record if necessary.

- The recipient will not be responsible for the remaining 20% of the SNF vendor costs (the Medicare co-payment per day for days 21-100).
- The recipient will have a calculated Medicaid-co-payment beginning day 21 and continuing.
- Notify the recipient of the responsibility for the Medicaid-co-payment.

If the person is not Medicaid-eligible for vendor payment and is not eligible for Pure Q, use the chart in Section H-7200, Medicare-Related Financial Responsibilities for Skilled Nursing Facility Care. Deny the person and send the appropriate denial notice. There will not be a calculated Medicaid-co-payment.

Recipient 4 — When a CAS (ME-Community Attendant) recipient with Qualified Medicare Beneficiary (MC-QMB) only enters an SNF from a hospital, Medicare will cover 100% of the SNF vendor payment for days 1-20. Medicare will cover 80% for days 21-100. The recipient's Medicaid eligibility in an NF needs to be determined. Test the person for institutional coverage that is subject to transfer of assets and excess home equity policy. The 30-day stay requirement is necessary. If the recipient is Medicaid eligible for vendor payment:

- Make retroactive adjustments to ensure the correct benefits are reflected in the system of record if necessary.
- The recipient will not be responsible for the remaining 20% of the SNF vendor costs (the Medicare co-payment per day for days 21-100).
- The recipient will have a calculated Medicaid-co-payment beginning day 21 and continuing.
- Notify the recipient of the responsibility for the Medicaid-co-payment.

If the person is not Medicaid eligible for vendor payment but is eligible for Pure Q, notify the recipient and use the Recipient 1 example.

H-7400, Medicare and Medical Effective Date

Body

Revision 09-4; Effective December 1, 2009

The medical effective date for a person in a Medicare skilled nursing facility (SNF) potentially can be as early as the first day of the month of entry to the nursing facility or the first day of a prior month. If eligible, this will ensure payment of any other medical expenses (including returns to the hospital during the initial 20 days of full Medicare coverage). At certification, the eligibility worker must verify and document in the case record that either the person:

- remains in the SNF section, or
- has been discharged to Medicaid.

Medicare approval of the applicant for the SNF meets the medical necessity (MN) requirement. If the medical effective date (MED) is prior to the applicant's move to Medicaid days in the facility, the MN requirement has been met.

Note: If the person remains in the SNF when the case is certified, it is recommended that a special review be scheduled to monitor for the completed MN determination when SNF does end.

Examples:

- Marsha Ford is admitted to an SNF as full Medicare on 11-15-XX. The 21st SNF day is 12-05-XX. Form H1200 is received 12-14-XX. Application is ready to certify 01-03-XX. The eligibility worker verifies that the person has unpaid/reimbursable hospital bills for 11-XX. Ms. Ford is still in the SNF days and has met all eligibility criteria as of 12:01 a.m. 11-01-XX. MED = 11-01-XX. Co-payment begins 12-05-XX.

- Fred McDaniel is admitted to an SNF as full Medicare on 03-24-XX. The 21st SNF day is 04-13-XX. Form H1200 is received 04-05-XX. He is discharged from the SNF to Medicaid on 05-20-XX. Application is ready to certify 06-15-XX. Mr. McDaniel meets all eligibility criteria as of 12:01 a.m. 03-01-XX. MED = 03-01-XX. Co-payment begins 04-13-XX. MN is not necessary, as MED is prior to discharge to Medicaid.

H-8000, Vendor Payments and Payment Corrections

H-8100, Co-Payment Corrections

Body

Service Authorization System Online (SASO) reflects future co-payment amounts. These amounts are based on the amount of each individual's income that is reported.

If a recipient is living in a long-term care facility other than a state supported living center or a state center, use Form H1259, Correction of Applied Income, to correct co-payment amounts in TIERS.

Note: The nursing facility is required to refund co-payment overcharged to the recipient. Reconciliation does not apply to home and community based waivers or assisted living facilities.

H-8110 Adjustments from Income Averaging

Revision 12-1; Effective March 1, 2012

When income is averaged, review the case at least every six months and reconcile the budget according to the monthly income actually received. If both the projected average income and the actual monthly income are each less than $2, or if the difference between the two is less than $1, then reconciliation is not required. If co-payment must be increased or decreased because of income averaging, use Form H1259, Correction of Applied Income, to correct retroactive periods. Notify the recipient about the correction to co-payment. Send copies of this notice and Form H1259 to the nursing facility. For ongoing adjustments, submit through the automated system.

Note: Make corrections in the Service Authorization System Online (SASO).

Although reconciliation is not required for certain small amounts, reconcile whenever the recipient requests it.

If the variable income adjustment is a positive number (the recipient underpaid co-payment), add the adjustment to the co-payment for the most recent month in the reconciliation period.

Example: If reconciling the period of October through March, the most recent month in the reconciliation period is March. Form H1259 is sent to the recipient and nursing facility, and after 12 days the co-payment is adjusted in SASO in the most recent month.

There is no month-by-month adjustment in the reconciliation period (October-March) in SASO for this underpayment. Page 2 of Form H1202-A, MAO Worksheet – Income Changes, may be used to assist in calculating the correct reconciliation period and the most recent month in the reconciliation period.

H-8120 Other Adjustments

Revision 12-3; Effective September 1, 2012

When adjustments for retroactive periods are needed for reasons other than to reconcile for income averaging, use the following procedures:

For MEPD cases, use Form H1259, Correction to Applied Income, only to report retroactive decreases in a recipient's co-payment. If the recipient's correct co-payment is more than that reported on the Service Authorization System Online (SASO) see H-8200, Procedures Relating to Overpayments, through H-8230, Cases Not Submitted for Prosecution. To update a recipient's co-payment for future months, process through the automated system. The effective date of the change shown in SASO is based on the effective date of the disposition action in the automated system.

For SSI cases, use Form H1259 to report any changes in co-payment. Increases in co-payment are effective the first day of the month after the date Form H1259 is completed. If the recipient's correct co-payment is more than that reported on SASO, use procedures in H-8200. The procedures for correcting co-payment do not apply to cases of fraud. In conducting a review or verifying co-payment, do not submit Form H1259 if fraud is indicated. Follow fraud procedures outlined in the Fair and Fraud Hearings Handbook.

H-8200, Procedures Relating to Overpayments

Body

H-8210 Willful Withholding of Information

Revision 10-1; Effective March 1, 2010

In the Medicaid program, fraud means deliberate misrepresentation or willful withholding of information for the purpose of obtaining public assistance, either for self or another individual.

Clearly indicate willful withholding of information that affects eligibility or the amount of co-payment. Do not accuse recipients of fraud.

Reference: For further explanations of fraud referral procedures, refer to the Fair and Fraud Hearings Handbook.

Willful withholding of information includes:

- willful misstatements, oral or written, made by a recipient or authorized representative in response to oral or written questions from the department concerning the recipient's income, resources or other circumstances that may affect the amounts of benefits. These misstatements may include understatements or omission of information about income and resources.
- willful failure by the recipient or authorized representative to report changes in income, resources or other circumstances that may affect the amounts of benefits, if the department has clearly notified the recipient or authorized representative of his obligation to report these changes.

When a recipient or authorized representative signs the application/review form, he certifies that he understands that failure to fulfill his obligation to provide correct, complete information and to keep the department informed of changes may be considered willful withholding of information. Because of this willful withholding of information, the department is allowed to recover the overpayments.

H-8220 Overpayments Resulting from Suspected Fraud

Revision 10-1; Effective March 1, 2010

In cases of suspected fraud, follow these steps:

Step	Procedure
1	Certify continued assistance in the correct amount or deny the case. Observe notification of adverse action and appeal procedures.
2	To report waste, abuse or fraud, please use the HHSC online reporting form at oig.hhsc.texas.gov, TIERS, GWS or call toll-free 1-800-436-6184.
3	Complete periodic and special reviews while the case is investigated for suspected fraud. Contact the Investigations Division to determine whether the periodic review may cause problems or advise them of changes in circumstances. **Example:** The authorized representative who is suspected of willfully withholding information dies after the report is submitted to the Investigations Division. Contact the Investigations Division and advise them of the individual's death.

H-8230 Cases Not Submitted for Prosecution

Revision 10-1; Effective March 1, 2010

If the prosecuting attorney or the investigator determines that the case is not suitable for prosecution, the investigator tries to arrange a voluntary plan of restitution.

If the investigator does not arrange repayment, the MEPD staff is informed that the case not presented for prosecution and no plan of repayment arranged. Seek restitution for the amount of overpayment.

If the investigative unit does schedule repayment, you will be notified via Form H1018, Overpayment Claim. Seek restitution for the amount of the uncollected overpayment.

H-8300, Restitution

Body

H-8310 Restitution Defined

Revision 12-4; Effective December 1, 2012

Restitution is securing payment from a recipient when fraud is not indicated or pursued and when the recipient has been undercharged co-payment because of previously unreported or under-reported monthly income or resources that do not involve income averaging.

Restitution applies only to recipients in intermediate and skilled nursing facilities and in community-based ICF/IID facilities. The department does not seek restitution from recipients or recipients' authorized representatives for vendor payments made to state supported living centers or state centers. The department does not seek restitution from recipients or recipients' authorized representatives on home and community based waiver cases, including those living in assisted living facilities.

H-8320 Restitution Procedures

Revision 12-1; Effective March 1, 2012

Recipients or responsible relatives for recipients must notify the department within 10 calendar days of changes in income, resources and other circumstances that affect the amount of benefits received. Any department employee who receives or obtains information from or about a recipient is responsible for relaying the information immediately to the appropriate eligibility specialist. If a recipient has been undercharged co-payment because of previously unreported or under-reported monthly income or resources that do not involve income averaging, and fraud is not indicated, pursue voluntary restitution. Discuss the situation with the recipient and send Form H1225, Restitution. Record restitution requests in case comments.

Calculate the amount of restitution based on the difference between the correct daily co-payment and the previously collected daily co-payment. Multiply this amount by the number of days the recipient was in the facility. For months in which a recipient was ineligible, the amount of restitution sought is the total amount of vendor payments made by the department for those months. Include the reason for the restitution request on Form H1225.

With the following exception, do not request restitution for the current month until the month is over. If ineligibility is a result of resources on hand and the recipient will be ineligible until resources are reduced, restitution may be requested for a current month.

Overpayments of restitution are refundable from Fiscal Management Services.

H-8330 Overpayments Considered for Restitution

Revision 13-1; Effective March 1, 2013

HHSC pursues restitution for MEPD and SSI cases if the overpayment is not the result of department error or income averaging and any of the following situations occur:

- Actual income received in any month varies by $5 or more from budgeted income.
- Fraud is suspected and cumulative vendor payment does not exceed $100.

Note: If the difference between the actual and projected income is the result of income averaging and you are submitting Form H1259, Correction of Applied Income, do not pursue restitution. However, if the budget must be corrected for both income averaging and a lump-sum payment, reconcile the averaged income and seek restitution for the lump-sum payment.

- Changes in income were not reported within 10 days from receipt. Restitution is requested beginning with the month the increased income was received.
- A lump-sum payment (including income excluded for eligibility as irregular or infrequent income) raises income more than $5 for any month.
- Initial payment plan (co-payment) for an SSI recipient is understated by $5 or more.
- A recipient is advised about the correct amount of co-payment on the appropriate notification form, but a lower amount appears on the Patient Status Payment Plan Notice because of a processing or coding error.
- A recipient is determined to be ineligible for the month because of unreported or under-reported resources that exceed program limits.
- ICF, SNF or ICF/IID vendor payments have been continued for a denied recipient pending an appeal, and the hearing officer upholds the denial. Seek restitution for the total amount of the vendor payment made between the initial denial effective date and the date payment stops after the hearing decision. If payments are discontinued because the recipient is denied a level of care, the department requests restitution for vendor payments made after the original level-of-care denial date (as shown on Texas Department of State Health Services Form X-27).

- Co-payment has been continued at a lower level pending an appeal of an increase, and the hearing officer sustains the increase. Seek restitution for the difference between the old and new co-payment amounts for the period from the effective date of the original increase until the date of the appeal decision.
- Income tax refunds are subject to restitution policy (in the month of receipt) for co-payment purposes to the extent that withholding tax was excluded in the co-payment budget.

H-8340 Overpayments Not Considered for Restitution

Revision 09-4; Effective December 1, 2009

HHSC does not seek restitution for MEPD and SSI cases in any of the following situations:

- Cumulative overpayment is $5 or less (for any month).
- Overpayment of over $100 is referred for fraud.
- Overpayment is the result of the department's computation error or failure to act on available information.
- A change in regular monthly income (not lump-sum payment) is reported within 10 days of receipt. The department does not seek restitution for the month of receipt or for the subsequent month if the 10-day advance notice period extends beyond the department's computer cutoff date for that month.
- Income is incorrect as a result of an automated across-the-board adjustment.
- The resource limitation was met on the first day of the month. If a recipient's resources exceed the limit during the month, the department does not collect restitution for partial months.
- Co-payment is based on income averaging.

H-8350 Steps for Submitting Restitution Payment

Revision 19-4; Effective December 1, 2019

Step	Procedure
1	Obtain the recipient's cashier's check, money order or personal check in whole dollar amounts.
2	Give the recipient the original Form H4100, Money Receipt.
3	Attach the first copy of Form H4100 to the payment, and send to: Texas Health and Human Services Commission Fiscal Management Services ARTS Billing P.O. Box 149055 Austin, TX 78714-9055
4	Record the payment on the worksheet. **Note:** Submit payments to Fiscal Management Services on the day of receipt.

Related Policy

Restitution Defined, H-8310
Restitution Procedures, H-8320

H-8360 Steps for Requesting a Refund of Restitution Overpayment

Revision 19-4; Effective December 1, 2019

Recipients can request a refund if an incorrect amount of restitution is collected because the recipient was not in the facility for the full month and the refund amount is greater than $1.00.

To request a refund:

Step	Procedure
1	Determine and document the amount of the refund on the worksheet.

2	Send a memo to:
	
	Texas Health and Human Services Commission
	Fiscal Management Services
	ARTS Billing
	P.O. Box 149055
	Austin, TX 78714-9055
	
	• Include the following information:
	  ◦ date of restitution payment and Form H4100, Money Receipt, receipt number;
	  ◦ amount of refund due;
	  ◦ name of the recipient; and
	  ◦ recipient's Social Security number.
	• Request a copy of voucher for case record

Related Policy

Restitution Defined, H-8310
Restitution Procedures, H-8320

Chapter I, Transfer of Assets

I-1000, Transfer of Assets

I-1100, Texas Administrative Code Rules

Body

Revision 09-4; Effective December 1, 2009

The following rules are taken from Subchapter C, Financial Requirements, Division 4, Transfer of Assets, Transfer of Assets on or after Feb. 8, 2006.

§358.401. Transfer of Assets on or after February 8, 2006

(a) This section applies to a person in an institutional setting whose date of application or program transfer request date is on or after October 1, 2006, and who takes an action defined by this section to be a transfer of assets on or after February 8, 2006.

(b) The Texas Health and Human Services Commission (HHSC) uses the definitions under the provisions of §1917(e) of the Social Security Act (42 U.S.C. §1396p(h)).

(1) Assets include all income and resources of a person and of the person's spouse, including any income or resources that the person or the person's spouse is entitled to but does not receive because of action:

(A) by the person or the person's spouse;

(B) by an individual, including a court or administrative body, with legal authority to act in place of or on behalf of the person or the person's spouse; or

(C) by any individual, including any court or administrative body, acting at the direction or upon the request of the person or the person's spouse.

(2) The term "income" has the meaning given such term in §1612 of the Social Security Act (42 U.S.C. §1382a).

(3) The term "resources" has the meaning given such term in §1613 of the Social Security Act (42 U.S.C. §1382b), without regard (in the case of a person in an institutional setting) to the exclusion of the home.

(c) In this section, "person" includes the applicant or recipient as well as:

(1) the person's spouse;

(2) an individual, including a court or administrative body, with legal authority to act in place of or on behalf of the person or person's spouse; and

(3) any individual, including a court or administrative body, acting at the direction or upon the request of the person or the person's spouse.

(d) HHSC applies the penalty for transfers of assets under the provisions of §1917(c)(1) of the Social Security Act (42 U.S.C. §1396p(c)(1)). The provisions of §358.402 of this division (relating to Transfer of Assets before February 8, 2006) continue in effect for transfers on or after February 8, 2006, except to the extent that they are inconsistent with this section.

(1) This paragraph establishes HHSC's treatment of transfers made on or after February 8, 2006, the date of enactment of the Deficit Reduction Act of 2005.

(A) Disposing of assets. If a person in an institutional setting or the spouse of such a person disposes of assets for less than fair market value on or after the look-back date specified in subparagraph (B) of this paragraph, the person is ineligible for medical assistance for services described in subparagraph (C) of this paragraph during the period beginning on the date specified in subparagraph (D) of this paragraph and equal to the number of months specified in subparagraph (E) of this paragraph.

(B) Look-back period.

(i) The look-back date specified in this subparagraph is a date that is 36 months (or, in the case of payments involving a trust or portions of a trust that are treated as assets disposed of by the person pursuant to §358.402(e)(2) of this division or in the case of any other disposal of assets made on or after February 8, 2006, the date of enactment of the Deficit Reduction Act of 2005, 60 months) before the date specified in clause (ii) of this subparagraph.

(ii) The date specified in this clause, with respect to:

(I) a person in an institutional setting, except a person receiving services under a §1915(c) waiver program, is the first date as of which the person both is in an institutional setting and has applied for medical assistance under the Texas State Plan for Medical Assistance; or

(II) a person receiving services under a §1915(c) waiver program, is the date on which the person applies for medical assistance under the Texas State Plan for Medical Assistance or, if later, the date on which the person disposes of assets for less than fair market value.

(C) Ineligible for medical assistance for services. A person in an institutional setting who disposes of assets as described in subparagraph (A) of this paragraph is ineligible for the following services:

(i) nursing facility services;

(ii) a level of care in any institution equivalent to that of nursing facility services; and

(iii) §1915(c) waiver program services.

(D) Beginning date of penalty.

(i) In the case of a transfer of asset made before February 8, 2006, the date of enactment of the Deficit Reduction Act of 2005, the beginning date of penalty, specified in this subparagraph, is the first day of the first month during or after which assets have been transferred for less than fair market value and which does not occur in any other periods of ineligibility under this subsection.

(ii) In the case of a transfer of asset made on or after February 8, 2006, the date of enactment of the Deficit Reduction Act of 2005, the beginning date of penalty, specified in this subparagraph, is the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the person is eligible for medical assistance under the Texas State Plan for Medical Assistance and would otherwise be receiving institutional level of care described in subparagraph (C) of this paragraph based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any other period of ineligibility under this subsection.

(E) Length of ineligibility period.

(i) With respect to a person in an institutional setting, except a person receiving services under a §1915(c) waiver program, the number of months of ineligibility under this subparagraph for such person is equal to the total, cumulative uncompensated value of all assets transferred by the person (or person's spouse) on or after the look-back date specified in subparagraph (B)(i) of this paragraph, divided by the average monthly cost to a private patient of nursing facility services in the state at the time of application.

(ii) With respect to a person receiving services under a §1915(c) waiver program, the number of months of ineligibility under this subparagraph for such person must not be greater than a number equal to the total, cumulative uncompensated value of all assets transferred by the person (or person's spouse) on or after the look-back date specified in subparagraph (B)(i) of this paragraph, divided by the average monthly cost to a private patient of nursing facility services in the state at the time of application.

(iii) The number of months of ineligibility otherwise determined under clause (i) of this subparagraph with respect to the disposal of an asset shall be reduced:

(I) in the case of periods of ineligibility determined under clause (i) of this subparagraph, by the number of months of ineligibility applicable to the person under clause (ii) of this subparagraph has a result of such disposal; and

(II) in the case of periods of ineligibility determined under clause (ii) of this subparagraph, by the number of months of ineligibility applicable to the person under clause (i) of this subparagraph as a result of such disposal.

(iv) HHSC does not round down, or otherwise disregard any fractional period of ineligibility determined under clause (i) or (ii) of this subparagraph with respect to the disposal of assets.

(F) Annuity. The purchase of an annuity made on or after February 8, 2006, the date of enactment of the Deficit Reduction Act of 2005, is treated as the disposal of an asset for less than fair market value unless:

(i) the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant under this title; or

(ii) the State is named as such a beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value.

(G) Annuity exceptions. With respect to a transfer of assets, the term "assets" includes an annuity purchased on or after February 8, 2006, the date of enactment of the Deficit Reduction Act of 2005, by or on behalf of an annuitant who has applied for medical assistance with respect to services in an institutional setting unless:

(i) the annuity is:

(I) an annuity described in subsection (b) or (q) of section 408 of the Internal Revenue Code of 1986; or

(II) purchased with proceeds from:

(-a-) an account or trust described in subsection (a), (c), or (p) of section 408 of such Code;

(-b-) a simplified employee pension (within the meaning of section 408(k) of such Code); or

(-c-) a Roth IRA described in section 408A of such Code; or

(ii) the annuity:

(I) is irrevocable and nonassignable;

(II) is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Department of Health and Human Services); and

(III) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

(H) Promissory note, loan, or mortgage. In the case of a promissory note, loan, or mortgage that does not satisfy the requirements of clauses (i) through (iii) of this subparagraph, the value of such note, loan, or mortgage is the outstanding balance due as of the date of the person's application for medical assistance for services described in subparagraph (C) of this paragraph and this amount would be used to determine the length of ineligibility. For purposes of this paragraph with respect to a transfer of assets, the term "assets" includes funds used to purchase, on or after April 1, 2006, a promissory note, loan, or mortgage unless such note, loan, or mortgage:

(i) has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration);

(ii) provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

(iii) prohibits the cancellation of the balance upon the death of the lender.

(I) Life estate. For purposes of this paragraph with respect to a transfer of assets, the term "assets" includes the purchase of a life estate interest in another individual's home made on or after April 1, 2006, unless the purchaser resides in the home for a period of at least one year after the date of the purchase.

(2) HHSC allows exceptions to transfers of assets under the provisions of §1917(c)(2) of the Social Security Act (42 U.S.C. §1396p(c)(2), if:

(A) the assets transferred were a home, and title to the home was transferred to:

(i) the spouse of such person;

(ii) a child of such person who:

(I) is under 21 years of age; or

(II) is blind or disabled as defined in §1614 of the Social Security Act (42 U.S.C. §1382c);

(iii) a sibling of such person who has an equity interest in such home and who was residing in such person's home for at least one year immediately before the date the person transferred to an institutional setting; or

(iv) a son or daughter of such person (other than a child described in clause (ii) of this subparagraph) who was residing in such person's home for a period of at least two years immediately before the date the person transferred to an institutional setting and who, as determined by the State, provided care to such person which permitted such person to reside at home rather than in such an institution or facility;

(B) the assets:

(i) were transferred to the person's spouse or to another for the sole benefit of the person's spouse;

(ii) were transferred from the person's spouse to another for the sole benefit of the person's spouse;

(iii) were transferred to a trust (including a trust described in §358.402(e)(2) of this division) established solely for the benefit of the person's child described in subparagraph (A)(ii)(II) of this paragraph; or

(iv) were transferred to a trust (including a trust described in §358.402(e)(2) of this division) established solely for the benefit of a person under 65 years of age who is disabled as defined in §1614(a)(3) of the Social Security Act (42 U.S.C. §1382c(a)(3));

(C) a satisfactory showing is made to the State that:

(i) the person intended to dispose of the assets either at fair market value, or for other valuable consideration;

(ii) the assets were transferred exclusively for a purpose other than to qualify for medical assistance; or

(iii) all assets transferred for less than fair market value have been returned to the person; or

(D) HHSC:

(i) determines that the denial of eligibility would work an undue hardship when application of the transfer of assets provision would deprive the person:

(I) of medical care such that the person's health or life would be endangered; or

(II) of food, clothing, shelter, or other necessities of life; and

(ii) provides for:

(I) notice to recipients that an undue hardship exception exists;

(II) a timely process for determining whether an undue hardship waiver will be granted; and

(III) a process under which an adverse determination can be appealed.

(3) Under paragraph (2)(D) of this subsection, a facility in which the person in an institutional setting is residing may file an undue hardship waiver application on behalf of the person with the consent of the person or the person's authorized representative.

(4) For purposes of this subsection effective on or after February 8, 2006, the date of enactment of the Deficit Reduction Act of 2005, in the case of an asset held by a person in common with another individual or individuals in a joint tenancy, tenancy in common, or similar arrangement, the asset (or the affected portion of such asset) is considered to be transferred by such person when any action is taken, either by such person or by any other individual, that reduces or eliminates such person's ownership or control of such asset.

(5) HHSC does not provide for any period of ineligibility for a person due to transfer of resources for less than fair market value except in accordance with this subsection. In the case of a transfer by the spouse of a person which results in a period of ineligibility for medical assistance for such person, HHSC apportions such period of ineligibility (or any portion of such period) among the person and the person's spouse if the spouse otherwise becomes eligible for medical assistance.

(6) In this subsection, the term "resources" has the meaning given such term in §1613 of the Social Security Act (42 U.S.C. §1382b), without regard (in the case of a person in an institutional setting) to the exclusion of the home.

(e) Impact on spousal protected resource amount. In spousal situations, if assets are transferred to a third party before institutionalization or by the community spouse, HHSC does not include the uncompensated amount of the transfer in calculating the spousal protected resource amount or countable resources upon application for Medicaid.

(f) Transfer of income.

(1) A person may incur a transfer penalty by transferring income. Transfers of income include:

(A) waiving the right to receive an inheritance even in the month of receipt;

(B) giving away a lump sum payment even in the month of receipt; or

(C) irrevocably waiving all or part of federal, state, or private pensions or annuities.

(2) The date of transfer is the date of the actual change in income. Interspousal transfers of income are permitted (for example, obtaining a court order to have community property pension income paid to a community spouse).

(3) Because revocable waivers of pension benefits can be revoked and the benefits reinstated, no uncompensated value is developed, and no transfer-of-assets penalty is incurred. Such waivers are subject to the utilization-of-benefits policy, and the person must apply for reinstatement of the full pension amount or the person is ineligible for all Medicaid benefits.

(g) Disclosure and treatment of annuities. HHSC, under the provisions of §1902(a)(18) of the Social Security Act (42 U.S.C. §1396a(18)), requires the following as a condition for the provision of medical assistance for services described in subsection (d)(1)(C) of this section:

(1) An application for assistance (including any recertification of eligibility for such assistance) must disclose a description of any interest the person or community spouse has in an annuity (or similar financial instrument as directed by the United States Department of Health and Human Services), regardless of whether the annuity is irrevocable or is treated as an asset. Such application or recertification form must include a statement that under paragraph (2) of this subsection the State becomes a remainder beneficiary under such an annuity or similar financial instrument by virtue of the provision of such medical assistance.

(2) In the case of disclosure concerning an annuity under subsection (d)(1)(F) of this section, HHSC notifies the issuer of the annuity of the right of the State under such subsection as a preferred remainder beneficiary in the annuity for medical assistance furnished to the person. Nothing in this paragraph shall be construed as preventing such an issuer from notifying persons with any other remainder interest of the State's remainder interest under such subsection.

(3) HHSC establishes categories of transactions that may be treated as a transfer of asset for less than fair market value as the United States Department of Health and Human Services provides guidance.

(4) Nothing in this subsection shall be construed as preventing HHSC from denying eligibility for medical assistance for a person based on the income or resources derived from an annuity described in paragraph (1) of this subsection.

I-1200, Overview of Transfer of Assets

Body

Revision 18-1; Effective March 1, 2018

Transfer of assets policy applies when assets are transferred by a person who resides in an institutional setting (for example, a Medicaid certified long-term care facility) or is receiving home and community-based waiver services through a Home and Community-Based Services waiver, or by the person's spouse or someone else acting on the person's behalf.

Transfer of assets policy does not apply to the mandatory groups of MEPD programs such as Pickle. See Section A-1000, General Information, and Section A-2000, Mandatory Coverage Groups, for information. Transfer of assets policy also does not apply to the Medicare Savings programs such as QMB, SLMB, etc.

There is a "look-back" period to find transfers of assets prior to the date the person is institutionalized or, if later, the date the person applies for Medicaid.

If a transfer of assets for less than fair market value is found, Medicaid must withhold payment for nursing facility care (and certain other long-term care services) for a period of time referred to as the penalty period.

The length of the penalty period is determined by dividing the value of the transferred asset by the average private-pay rate for nursing facility care in Texas. There is no limit to the length of the penalty period.

For certain types of transfers, no penalty is applied. The principal exceptions to the transfer of asset penalty are transfers:

- to a spouse or to a third party for the sole benefit of the spouse;
- by a spouse to a third party for the sole benefit of the spouse;
- to certain disabled individuals or to trusts established for those individuals;
- for a purpose other than to qualify for Medicaid; and
- for which imposing a penalty would cause undue hardship.

Example: Assets transferred to an Achieving a Better Life Experience (ABLE) account for the benefit of a disabled child are not subject to a penalty period. (See Section I-3300 "For the Sole Benefit" Requirements.)

I-1210 Transfer of Assets Terms

Revision 09-4; Effective December 1, 2009

The term assets, with respect to person, includes all income and resources of the person and of the person's spouse, including any income or resources that the person or such person's spouse is entitled to but does not receive because of action by:

- the person or such individual's spouse;
- a person, including a court or administrative body, with legal authority to act in place of or on behalf of the person or such individual's spouse; or
- any person, including any court or administrative body, acting at the direction or upon the request of the person or such individual's spouse.

Examples of actions that would cause income or resources not to be received are:

- irrevocably waiving pension income;
- waiving the right to receive an inheritance;
- not accepting or accessing injury settlements; and
- tort settlements that are diverted by the defendant into a trust or similar device to be held for the benefit of the plaintiff.

I-1300, Transfer of Assets

Body

Revision 09-4; Effective December 1, 2009

As part of Public Law 109-171, Deficit Reduction Act (DRA) of 2005, policy regarding transfer of assets changed when the DRA was signed into law on Feb. 8, 2006. The implementation of the DRA in Texas was effective Oct. 1, 2006.

Transfer of assets policy in Texas before the DRA, based on the Omnibus Budget Reconciliation Act (OBRA) of 1993 (Public Law 103-66), continues with these areas as exceptions found in the DRA transfer of assets rules:

- look-back period;
- penalty start date;
- purchase of life estates;
- purchase of promissory notes, loans or mortgages; and
- undue hardship.

As part of the DRA, there was a major change to the value of a home and eligibility for Medicaid. See Section F-3600, Substantial Home Equity, and Section F-3700, Continuing Care Retirement Communities.

The transfer of assets rules after the DRA are found in Section I-1100, Texas Administrative Code Rules. The transfer of assets policy in Texas before the DRA, based on OBRA 1993 (Public Law 103-66) are found in Section I-9000, Pre-DRA Rules.

I-1310 Persons Impacted by Transfer of Assets

Revision 09-4; Effective December 1, 2009

Transfer of assets policy applies when assets are transferred by a person who resides in an institutional setting (for example, a Medicaid certified long-term care facility) or is receiving home and community-based waiver services through a Home and Community-Based Services waiver, or by the person’s spouse or someone else acting on the person’s behalf.

Transfer of assets policy does not apply to the mandatory groups of MEPD programs such as Pickle. See Section A-1000, General Information, and Section A-2000, Mandatory Coverage Groups, for information. Transfer of assets policy also does not apply to the Medicare Savings programs such as QMB, SLMB, etc.

Under transfer of assets policy, recipients residing in a Medicaid long-term care facility remain eligible for all other Medicaid benefits and continue to receive Medicaid benefits other than vendor payment for the length of the penalty period. However, a person residing in a state supported living center is denied Medicaid for any penalty period resulting from an uncompensated transfer of assets. This is because the only benefit provided under a MEPD program for a person in a state supported living center is vendor payments.

If a person applying for a Home and Community-Based Services waiver requires receipt of waiver services to be eligible for Medicaid, then the person is ineligible for all Medicaid benefits. Based on pre-DRA transfer of assets policy, the Home and Community-Based Services waiver person is ineligible for the length of the penalty period. Based on post-DRA, the Home and Community-Based Services waiver person is ineligible until the transfer does not appear during the look-back period.

Denial of a Home and Community-Based Services waiver based on an uncompensated transfer does not disqualify the person for pure Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) benefits. If all eligibility criteria for QMB or SLMB are met, HHSC staff can certify the person for QMB or SLMB, as appropriate.

In spousal situations, if assets are transferred to a third party before institutionalization or by the community spouse, HHSC does not include the uncompensated amount of the transfer in calculating the spousal protected resource amount or countable resources upon application for Medicaid.

I-1320 Applications and Other Actions on or After Oct. 1, 2006

Revision 09-4; Effective December 1, 2009

Post-DRA transfer of assets policy impacts any person who applies for Medicaid in an institutional setting on or after Oct. 1, 2006. Post-DRA transfer of assets policy also impacts any person who is Medicaid eligible in the community and requests a program transfer for Medicaid in an institutional setting on or after Oct. 1, 2006. This includes:

Applicants — For applications filed on or after Oct. 1, 2006, consider both pre-DRA and post-DRA policy for an institutional program or waiver services.

Program transfer requests — For program transfer requests from any Medicaid program to an institutional program or waiver services on or after Oct.1, 2006, consider both pre-DRA and post-DRA policy.

Redeterminations — For redeterminations of institutional or waiver services worked on or after Oct.1, 2006, consider both pre-DRA and post-DRA policy.

Reported changes — For reported changes worked on or after Oct.1, 2006, consider both pre-DRA and post-DRA policy for institutional or waiver services.

Note: Pre-DRA or post-DRA transfer of assets policies regarding penalty do not apply to an individual who has had continuous Medicaid coverage before March 1, 1981. This includes any person who is Medicaid eligible in the community and requests a program transfer to an institutional program or waiver services and who has had continuous Medicaid coverage before March 1, 1981.

I-1330 Transfer Transaction Date

Revision 09-4; Effective December 1, 2009

If the transfer transaction date is:

- before Feb. 8, 2006, use pre-DRA policy in determining eligibility for vendor payment and waiver services, regardless of the application file date/program transfer or the date of the case manager action for an existing case; or
- on or after Feb. 8, 2006, use pre-DRA and post-DRA policy in determining eligibility for vendor payment and waiver services based on application file date/program transfer or the date of the case manager action for an existing case.

I-1400, Transfer of Income

Body

Revision 09-4; Effective December 1, 2009

A person may incur a transfer penalty by transferring income. Transfers of income include:

- waiving the right to receive an inheritance even in the month of receipt;
- giving away a lump sum payment even in the month of receipt; or
- irrevocably waiving all or part of federal, state or private pensions or annuities.

The date of transfer is the date of the actual change in income, if within the look-back period or during an ongoing month.

Interspousal transfers of income are permitted (for example, obtaining a court order to have community property pension income paid to a community spouse).

Because revocable waivers of pension benefits can be revoked and the benefits reinstated, no uncompensated value is developed, and no transfer of assets penalty is incurred.

Such pension waivers are subject to nonfinancial requirements and the person must apply for reinstatement of the full pension amount or the person is ineligible for all Medicaid benefits.

Example: In August of this year, a person authorized a revocable reduction of $100 per month in her Civil Service Annuity (CSA) benefit, which was effective Sept. 1 of this year. Because gross income is within the special income limit, and all eligibility criteria are met, the person may be certified for Medicaid. The person is sent written notice that she must apply for reinstatement of the full CSA amount within 30 days. If she does so, her eligibility is re-evaluated based upon receipt of the full benefit. If she fails to do so, denial action is initiated.

I-1500, Participation in Transfers

Body

Revision 09-4; Effective December 1, 2009

Any action by the person's co-owner(s) to eliminate the person's ownership interest or control of a joint asset, with or without the person's consent, is a transfer of assets. Placing another person's name on an account or other asset that results in limiting the person's control of an asset (right to dispose) is a transfer of assets.

Joint bank account procedures are consistent with this policy.

I-1510 Participation Examples

Revision 13-2; Effective June 1, 2013

- The person and her brother jointly own (one-half interest each) non-homestead real property. Both of their names appear on the warranty deed. The person's brother, without the person's knowledge or consent, filed another warranty deed that shows him as the sole owner. This action by the person's co-owner constitutes a transfer.
- Joe Davis is a co-signer on a joint bank account, along with his son and daughter. Mr. Davis' children deleted his name from both the styling and signature card. Form H1299, Request for Joint Bank Account Information, shows that all of the funds belonged to Mr. Davis and that the children's names were added so they could access the funds in an emergency. Mr. Davis said he did not know that his name had been deleted, nor did he authorize this action. This must be developed as an uncompensated transfer. Depending upon the circumstances, the undue hardship provisions of Section I-4300, Undue Hardship, may apply.
- The person has a bank account styled solely in his name. His daughter adds her name to the account styling and control as an "and," thereby restricting the person's use of the account without the daughter's approval. This must be developed as an uncompensated transfer.
- When someone uses an applicant’s money to purchase a vehicle, and the title is placed in both the applicant’s name and the other person’s name, consider the entire purchase price of the vehicle as a transfer, because when the applicant’s money was used to purchase a vehicle with the applicant and the other person as owners, the applicant’s ownership or control of the asset was reduced or limited.

Examples

- A vehicle was purchased for $15,000 on June 30, 2012. All of the money was the applicant’s; however, the title was put in the applicant’s and her son’s name because he would be driving her around in the car. The entire $15,000 is considered the transferred amount.
- A vehicle was purchased June 30, 2012, for $10,761.57. $8,100 of the applicant’s money was used, and her son paid the remaining $2,661.57. The title of the car is in both names. The $8,100, which the applicant provided for the purchase, is considered the transferred amount.

I-1600, Partial Transfers

Body

Revision 09-4; Effective December 1, 2009

A partial transfer of real property occurs when a person transfers only a portion of real property. A person may engage in partial transfers of real property repeatedly, once per month over a period of months, with the apparent purpose of gifting away the entirety of the real property while at the same time shortening or avoiding a transfer of assets penalty. This is sometimes referred to as aggressive transferring.

Since the estate planning community incorporates many different approaches in partial transfers of real property, a transaction-by-transaction analysis by agency legal staff is critical for a correct determination of any resulting penalty period. Accordingly, eligibility staff who encounter partial transfers of real property must promptly refer each transaction to their regional attorney for a case-by-case legal opinion.

I-2000, Look-Back Period

I-2100, Look-Back Policy

Body

Revision 13-4; Effective December 1, 2013

Note: Examples in this section may not reflect the most recent amount of the average private-pay cost per day.

Investigation of transfers is part of the application or program transfer process. Activity during the month of application or program transfer and forward is investigated. Activity in the past is also investigated.

The look-back period is established under federal law. The date on which the look-back period is established is based on the application file date or the institutional entry date, whichever is later.

Under pre-DRA transfer of assets policy, the look-back period is 36 months (or 60 months) from the later of the date of:

- institutionalization, or
- Medicaid application.

Under post-DRA transfer of assets policy, the look-back period is 60 months from the later of the date of:

- institutionalization, or
- Medicaid application.

Under both pre-DRA and post-DRA transfer of assets policies:

- When a person is already a Medicaid recipient before entering a nursing facility (NF), intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID), state supported living center, or institution for mental diseases (IMD), the look-back period begins with institutional entry.
- Penalties may be assessed for transfers occurring on or after the look-back date. Penalties cannot be assessed for time frames before the look-back period.

Example: If the application was received during the month of August and the individual entered the nursing facility in August, August sets the look-back period. August is considered month "0." The look-back period begins with July and continues for 36 or 60 months, as appropriate.

For any transfer transaction made on or after Feb. 8, 2006, the look-back period is 60 months from the application file date or program transfer request date. During the implementation phase of the post-DRA transfer of assets policy change, the 36-month look-back period for non-trust transfer transactions will remain in effect until Feb. 28, 2009. The 60-month look-back period will be phased in, and by February 2011, any transfer transactions will require a 60-month look-back period.

- For applications received through February 2009, the look-back period is 36 months. February is the last file month for which the look-back period is 36 months.
- Beginning with applications received in March 2009, add one month to the look-back period until the full 60-month look-back period is fully implemented in February 2011.

Examples:

- Individual enters facility in January 2009. Application for Medicaid is made in March 2009. The look-back period is a total of 37 months (36-month look-back plus a phase-in of one month).
- Individual enters facility in January 2009. Application for Medicaid is made in August 2009. The look-back period is a total of 42 months (36-month look-back plus a phase-in of six months).

I-2110 February 2011 and the 60-Month Look-Back Period

Revision 17-1; Effective March 1, 2017

By February 2011, any transfer transactions will require a 60-month look-back period.

Examples:

- Individual enters facility in January 2011. Application for Medicaid is made in February 2011. Look-back period is 60 months.
- Individual enters facility in January 2011. Application for Medicaid is made in August 2011. Look-back period is 60 months.

This does not negate the pre-DRA policy.

Under pre-DRA transfer of assets policy, there is a 36-month look-back period for most uncompensated transfers. However, there is a 60-month look-back period for certain transfers involving trusts. The look-back periods for trusts and distributions from trusts follow in Section I-2120.

I-2120 Revocable Trusts Under Pre- and Post-DRA

Revision 09-4; Effective December 1, 2009

1. Payments from a revocable trust to or for the benefit of someone other than the person have a 60-month look-back period.

   Examples:

   The following samples are for demonstration purposes only. They may not reflect the current average monthly cost of private-pay care. Examples are based on the amount of the average private-pay cost per day, effective Nov. 1, 2005 ($117.08).

   - John Doe entered a nursing facility and applied for Medicaid in January. January sets the look-back period. January is considered month "0." He created a revocable trust six years ago. In January four years ago, the trustee made a $50,000 cash distribution to Mr. Doe's nephew. This is a transfer of assets with a 60-month look-back period.

     The look-back period begins in December (last month) and ends January five years ago. The distribution in January four years ago falls within the look-back period, and the penalty period is calculated as follows: $50,000 divided by $117.08 (average daily rate for private-pay nursing facility (NF) resident) = 427 days.

     Under pre-DRA transfer of assets policy, the penalty period, which began January four years ago and ended March 3 three years ago, has expired.

     Under post-DRA transfer of assets policy, the penalty period start date is the first day of the month of the medical effective date (MED), if the individual meets all other eligibility criteria.
   - Same situation as above, except that the $50,000 distribution to Mr. Doe's nephew was made in December six years ago.

The look-back period begins in December and ends January five years ago. The distribution in December six years ago falls outside the look-back period and is not subject to penalty.

2. Making a revocable trust irrevocable with payments from corpus/income unavailable to the person is a transfer of assets and has a 60-month look-back period.

   Examples:

   - Joe Bridges entered a nursing facility and applied for Medicaid in January. January sets the looks back period. January is considered month "0." He created a revocable trust six years ago during the first quarter, which became irrevocable on his 75th birthday (January four years ago). The corpus and undistributed income in January four years ago was valued at $100,000. As of January four years ago, there are no conditions under which the trustee may make payments to or for the benefit of Mr. Bridges. This is a transfer of assets with a 60-month look-back period.

     The look-back period begins in December and ends January five years ago. The transfer in January four years ago falls within the look-back period, and the penalty period is calculated as follows: $100,000 divided by $117.08 (average daily rate for private-pay NF resident) = 854 days.

     Under pre-DRA transfer of assets policy, the penalty period, which began January four years ago and ended May 4 two years ago, has expired.

     Under post-DRA transfer of assets policy, the penalty period start date is the first day of the month of the MED, if the individual meets all other eligibility criteria.
   - Same situation as above, except that Mr. Bridges' 75th birthday was in December six years ago.

     The look-back period begins in December and ends January five years ago. The transfer in December six years ago occurred outside the look-back period and is not subject to penalty.

I-2130 Irrevocable Trusts

Revision 09-4; Effective December 1, 2009

1. Payments from an irrevocable trust (where trustee distributions are not available to the person) that are made to (or for the benefit of) someone other than the person have a 36-month look-back period under pre-DRA policy.

   Payments from an irrevocable trust (where trustee distributions are not available to the person) that are made to (or for the benefit of) someone other than the person have a 60-month look-back period under post-DRA policy.

   Example:

   Mary Smith entered the nursing facility (NF) and applied for Medicaid in January. January sets the look-back period. January is considered month "0." Six years ago, she created an irrevocable trust. The trustee has discretion to make distributions to Ms. Smith or for her benefit. The trustee does not make payments to or for the benefit of Ms. Smith, but in January three years ago she made a $75,000 cash distribution to her niece. Under pre-DRA transfer of assets policy, this payment was a transfer of assets with a 36-month look-back period. The look-back period begins in December (last month) and ends January three years ago. The transfer in January three years ago occurred during the look-back period.

   Under post-DRA transfer of assets policy, all transfer of assets will eventually have a 60-month look-back period. During the implementation phase of the post-DRA transfer of assets policy change, use the 36-

month look-back period for this type of transfer transaction through Feb. 28, 2009. The 60-month look-back period will be phased in and by February 2011, any transfer transactions will require a 60-month look-back period.

The penalty period is calculated as follows: $75,000 divided by $117.08 (average daily rate for private-pay NF resident) = 640 days.

Under pre-DRA transfer of assets policy, the penalty period, which began January three years ago and ended Oct. 2 two years ago, has expired. The portion of the current corpus and undistributed income that the trustee could pay to Ms. Smith or for her benefit is a countable resource.

Under post-DRA transfer of assets policy, the penalty period start date is the first day of the month of the medical effective date, if the individual meets all other eligibility criteria. The portion of the current corpus and undistributed income that the trustee could pay to Ms. Smith or for her benefit is a countable resource.

2. Creating an irrevocable trust where trustee payments are unavailable to the person is a transfer of assets with a 60-month look-back period.

   Examples:
   - Rob Jones entered a nursing facility and applied for Medicaid in January. January sets the look-back period. January is considered month "0." In December six years ago, he created an irrevocable trust with a corpus of $100,000. There are no circumstances under which the trustee may make payments to or for the benefit of Mr. Jones. Creation of this trust is a transfer of assets with a 60-month look-back period.

     Under both pre-DRA and post-DRA, the look-back period begins in December (last month) and ends January five years ago. The transfer in December six years ago falls outside the look-back period and is not subject to penalty.
   - Same situation as above, except that Mr. Jones created the trust in January five years ago.

     Under both pre-DRA and post-DRA transfer of assets policies, the look-back period begins in December and ends January five years ago. The transfer in January five years ago falls within the look-back period.

     The penalty period is calculated as follows: $100,000 divided by $117.08 (average daily rate for private-pay NF resident) = 854 days.

     Under pre-DRA transfer of assets policy, the penalty period, which began January five years ago and ended May 4 three years ago, has expired.

     Under post-DRA transfer of assets policy, the penalty period start date is the first day of the month of the medical effective date, if the individual meets all other eligibility criteria. The portion of the current corpus and undistributed income that the trustee could pay to Ms. Smith or for her benefit is a countable resource.
3. Under both pre-DRA and post-DRA, creating an irrevocable trust where the trustee initially has discretion to make payments to the person (or for his benefit), but where payments are unavailable to the person at a later date, is a transfer of assets as of the date payments are unavailable to the person. The look-back period is 60 months.

   Examples:
   - Sue Johnson entered the nursing facility and applied for Medicaid in January. January sets the look-back period. January is considered month "0." She created an irrevocable trust six years ago during the first quarter of the year. Beneficiaries are Ms. Johnson and her niece. The trustee has discretion to make payments to Ms. Johnson or for her benefit until the niece attains age 21. After that date,

payments may only be made to the niece. The niece attained age 21 on Jan.1 two years ago. At that time, the corpus and undistributed income was valued at $100,000. This is a transfer of assets with a 60-month look-back period.

The look-back period begins this past December and ends January five years ago. The transfer in January two years ago falls within the look-back period.

The penalty period is calculated as follows: $100,000 divided by $117.08 (average daily rate for private-pay NF resident) = 854 days.

Under pre-DRA transfer of assets policy, the penalty period began January two years ago and ends May 4 of this year.

Under post-DRA transfer of assets policy, the penalty period start date is the first day of the month of the medical effective date, if the individual meets all other eligibility criteria. The portion of the current corpus and undistributed income that the trustee could pay to Ms. Smith or for her benefit is a countable resource.

- Same situation as above, except that Ms. Johnson's niece attained age 21 in December six years ago.

  The look-back period begins this past December and ends January five years ago. The transfer in December six years ago falls outside the look-back period and is not subject to penalty.

Historical Note: Under pre-DRA transfer of assets policy, because the look-back period is for transfers on or after Aug. 11, 1993, the full 60-month look-back period did not become effective until Aug. 11, 1998.

I-2200, Look-Back Situations

Body

Revision 09-4; Effective December 1, 2009

- When a person applies and is certified for Medicaid more than once because of multiple institutional stays or periods of ineligibility, the look-back date is based on the later of the earliest application for Medicaid or the initial entry into the facility.

Check automated systems, if possible, for the earliest application date on record.

- When an individual applies for a Home and Community-Based Services waiver program, the look-back period is based on the later of the date:
  - of application for the Home and Community-Based Services waiver program (completed, signed application form is received); or
  - after application that the person transfers assets.
- When a person applies for institutional care or a Home and Community-Based Services waiver program but is not certified and then reapplies, a new look-back period is based on the latest application.
- When a person applies and is certified for a Home and Community-Based Services waiver program, subsequently is denied, and reapplies for waiver services, the initial look-back period is still in effect.
- When a look-back period is established, the person is certified in an institutional setting, and then moves to a Home and Community-Based Services waiver program or vice versa, the initial look-back period is still in effect. This is true even when there is a gap in eligibility periods.
- Any additional transfers of assets that occur after the person is certified for Medicaid may be assessed a penalty.

I-3000, Exceptions to the Transfer of Assets

I-3100, Transfer of Home

Body

Revision 20-4; Effective December 1, 2020

Transfer of the person's home does not result in a penalty when the title is transferred to the person's:

- spouse who lives in the home (the transfer penalty applies when the community-based spouse transfers the home without full compensation);
- minor child under age 21 or child who is disabled. Disability must meet Social Security Administration (SSA) disability criteria. Additionally, there is no age limit for the person's child who is determined disabled under the SSA criteria;
- sibling who has equity interest in the home and has lived there for at least one year before the person's institutionalization;
- son or daughter (other than a disabled or minor child) who lived in the home for at least two years before the person's institutionalization and provided care that prevented institutionalization (obtain a written statement from the institutionalized person's attending physician documenting that the person was able to remain in their home because of the care provided by the son or daughter); or
- children, siblings, etc., if the deed is an enhanced life estate or Transfer on Death deed and has been approved by the regional attorney, and the person signs a statement that they intend to return to the home.

Related Policy

Home, F-3000
Overview of Transfer of Assets, I-1200

I-3200, Transfer of Other Assets and the Home

Body

Revision 14-4; Effective December 1, 2014

Under both pre-DRA and post-DRA transfer of assets policies, assets — including the person's home — may be transferred without resulting in a penalty when:

- Transferred to the person's spouse or to another for the sole benefit of that spouse, or from the person's spouse to another for the sole benefit of that spouse.
- Transferred to the person's child who has a disability. Disability must meet SSA disability criteria. Additionally, there is no age limit for the person's child who is determined to have a disability under SSA criteria.
- Transferred to a trust (including an exception trust) established solely for the benefit of the person's child. The child must meet SSA disability criteria. There is no age limit for a child with a disability for transfer of assets purposes.
- Transferred to a trust, including a trust established for the sole benefit of an individual under age 65 who has a disability as defined under SSA disability criteria.
- Satisfactory evidence exists that the person intended to dispose of the resource at fair market value.
- Satisfactory evidence exists that the transfer was exclusively for some purpose other than to qualify for Medicaid.
- Imposition of a penalty would cause undue hardship.
- A person changes a joint bank account to establish separate accounts to reflect correct ownership of and access to funds.

- A person purchases an irrevocable funeral arrangement or assigns ownership of an irrevocable funeral arrangement to a third party, and the funeral arrangement is for the person or the person's spouse.

Note: If the transfer is made to a child who is claiming a disability, but there is no record that the child meets SSA disability criteria, request medical records for the Disability Determination Unit (DDU) to make a disability determination. Submit these records to Austin for imaging.

I-3300, "For the Sole Benefit" Requirements

Body

Revision 09-4; Effective December 1, 2009

Under both pre-DRA and post-DRA transfer of assets policies in determining whether an asset was transferred for the sole benefit of a spouse, child or disabled individual, there must be a written instrument of transfer, such as a trust document, that legally binds the parties to a specified course of action and clearly sets out the conditions under which the transfer was made, as well as who can benefit from the transfer. The instrument or document must provide for the spending of the funds for the benefit of the individual on a basis that is actuarially sound based on the life expectancy of the individual. When the instrument or document does not so provide, there can be no exemption from the penalty.

Note: Trusts created under exception trusts policy are exempt from the actuarially sound distribution provisions of this requirement.

I-3400, Examples of Transfer of the Home

Body

Revision 09-4; Effective December 1, 2009

Under both pre-DRA and post-DRA transfer of assets policies, the situations above are the only situations in which an uncompensated transfer does not result in a penalty. Under the transfer provisions of OBRA 1993, the home is not an excluded resource for institutional persons. Therefore, if the home of an institutionalized person is transferred, unless the transfer meets one of the above criteria, the transfer could affect payment for the person's institutional care.

Situation: Within six months of application, Miss Lucy Katz, a nursing facility applicant, transferred her interest in a family homestead to her sister, Ms. Dulcey Katz, who also owns an interest in the homestead. The Katz sisters lived in the homestead for five years before Lucy's admission to a nursing facility on July 6 of this year.

Action: No penalty for the transfer exists because the applicant's sister also owned an interest in the family homestead, and Dulcey lived in the home for at least one year before Lucy was institutionalized. The eligibility specialist should verify the transfer of the applicant's interest.

Note: If Dulcey had not remained in the home after Lucy left, there would still be no transfer penalty. The one-year residency requirement is at least one year before a person's institutionalization.

Situation: Mr. Roberts, a nursing facility applicant, transferred $50,000 to his son, Ned, within six months of application to meet the needs of Mr. Roberts' disabled adult daughter, Nancy.

Action: No penalty for the transfer of the funds exists because the funds are to be used for the sole benefit of the applicant's disabled daughter. Verify the transfer of the funds, that Nancy is receiving disability benefits and that Ned is using the funds solely for Nancy's benefit according to the transfer instrument. To ensure the funds are

used only for Nancy, expenditures for Nancy should be verified at each annual review until the transfer penalty would have expired.

Situation: Mrs. Smith purchased an annuity that is irrevocably assigned to a funeral expense trust agreement. According to the documents, upon the death of the "annuitant" ("insured"), the trustee of the funeral expense trust must pay burial expenses for that deceased person to the providers of goods and/or services, usually the funeral home. These arrangements are essentially burial contracts, although the arrangements are irrevocable. Because the contracts are burial funds and irrevocable, the purchase of the burial contract for Mrs. Smith is not considered a transfer of assets. At the same time, Mrs. Smith also purchased the same kind of burial contract for her son and daughter-in-law. Based on Section F-4227, Burial Funds, the burial contracts for her son and daughter-in-law do not meet the exclusion criteria. The exclusion is only for:

- person,
- person's spouse, or
- minor child applicant/person with parents whose resources are deemed to the minor child applicant/person.

The purchase of the burial contracts should be considered a transfer of assets, and if appropriate, a penalty assessed.

I-3500, Spousal Impoverishment Transfer Exceptions

Body

Revision 09-4; Effective December 1, 2009

There are no restrictions on transfers between spouses, which occur from the date of institutionalization to the date of the application. The combined countable resources of the couple are considered in determining eligibility during the period from the date of institutionalization to the date of the Medicaid application. For the same reason, transfers between spouses are also permitted before institutionalization.

Based on policy in Chapter J, Spousal Impoverishment, to remain eligible at the end of the initial eligibility period, the institutionalized spouse must reduce resources to which he has access at least to the resource limit. If the institutionalized spouse chooses, he may, during the initial eligibility period, transfer resources from his name to the community spouse's name with no penalty applied to the transfer.

I-3510 Spousal Impoverishment Transfer

Revision 09-4; Effective December 1, 2009

The transfer of assets policy applies only to transfer of assets for less than fair market value to individuals other than the community spouse, if not for the sole benefit of that spouse.

Transfer penalties apply when the community spouse transfers his separate property:

- before institutionalization, or
- after institutionalization but before the Medicaid certification.

Transfer penalties apply when the community spouse transfers community property both before and after institutionalization, if not for the sole benefit of the spouse. **Note:** A penalty can result when the community spouse transfers assets to a third party, not for the sole benefit of either spouse.

I-3520 Spousal Impoverishment Transfer Examples

Revision 12-1; Effective March 1, 2012

- When the institutionalized spouse enters a nursing facility, the couple's combined countable resources are $100,000, and the resources are all in the institutionalized spouse's name. The spousal protected resource amount (SPRA) is $50,000.

  Before application, the institutionalized spouse transfers the entire $100,000 to the community spouse. No transfer of assets penalty applies when eligibility is established.
- When the institutionalized spouse enters a nursing facility, the couple's combined countable resources are $100,000, all in the institutionalized spouse's name. The SPRA is $50,000. The institutionalized spouse transfers all resources to the community spouse without penalty.

  A Medicaid application is filed two and one-half years later. The couple's combined countable resources are $30,000 as of 12:01 a.m. on the first day of the month of application, and the resources are all in the community spouse's name.

  - $30,000 – Combined countable resources
  - – $50,000 – SPRA
  - = $0 – Compared to appropriate resource standard for an individual
- If the institutionalized spouse inherits $20,000 after Medicaid certification, the institutionalized spouse may transfer the entire amount of that inheritance to the community spouse without penalty during the initial eligibility period. However, this $20,000 is treated as income for the month of receipt, and restitution of the full vendor payment for that month is requested. This brings the community spouse's resources to $50,000, the full protected amount.
- If more than $22,000 is inherited, the institutionalized spouse would be ineligible based on resources ($22,001 + $30,000 = $52,001 combined resources).

  - $52,001 – Combined resources
  - – $50,000 – SPRA
  - = $2,001 – > $2,000 and ineligible
- When the institutionalized spouse enters the nursing facility, the couple's combined countable resources are $100,000 ($90,000 in institutionalized spouse's name and $10,000 in the community spouse's name). The protected resource amount is $50,000.

  A Medicaid application is filed eight months later. Before application, the institutionalized spouse transferred $80,000 to the community spouse and spent $10,000 on nursing facility bills. The community spouse then transferred $50,000 to her daughter before the Medicaid application was filed. The couple's combined countable resources are now $40,000 as of 12:01 a.m. on the first day of the month of application, and the resources are all in the community spouse's name.

  - $40,000 – Combined countable resources
  - – $50,000 – SPRA
  - = $0 – Compared to appropriate resource standard for an individual
- The institutionalized spouse is eligible for Medicaid but does not receive nursing facility services. The penalty period for vendor payment is imposed based on the $50,000 uncompensated value of the transfer to the daughter.

  Note: If the institutionalized spouse has a level of care or medical necessity determination and meets all eligibility criteria except for the transfer of assets provisions, the institutionalized spouse may be eligible

to a Your Texas Benefits Medicaid card but not vendor payments. Follow procedures in Appendix XXIII, Procedure for Designated Vendor Number to Withhold Vendor Payment, to put the vendor payment on hold.

- When the institutionalized spouse entered the nursing facility (June 17), the couple's combined countable resources were $30,000. The institutionalized spouse had transferred $10,000 in April, with no compensation, to a son. The uncompensated value is not included when calculating the protected resource amount, and the SPRA is $15,000.

  Under pre-DRA transfer of assets policy, a penalty is imposed should a Medicaid application be filed before the 85-day penalty (based on $117.08) has expired. Under post-DRA transfer of assets policy, a penalty is imposed should a Medicaid application be filed and the transfer is within the look-back period, but the penalty would not start until the medical effective date.

I-3600, Administrative Procedures of Transfers of Nominal Amounts

Body

Revision 10-4; Effective December 1, 2010

Do not develop a penalty period for transfers when the total amount of all transfers per month is $200 or less. For example, if an individual gives a donation of $150 to a charitable organization in the month of December and there are no other transfer transactions in December, no penalty period is developed for the $150 donation. See Section F-4120, Bank Accounts, and Appendix XVI, Documentation and Verification Guide.

I-4000, Determining Uncompensated Value

Body

Revision 12-2; Effective June 1, 2012

The transfer of assets policy applies to the transfer of assets for less than fair market.

- Current market value — The amount of money an item would bring if sold in the current local market.
- Fair market value — The current market value of a resource at the time of its sale or transfer.
- Equity value — The value of a resource based on its fair market value or current market value minus all money owed on the resources and, if sold, any costs usually associated with the sale.
- Uncompensated value — The uncompensated value is the fair market value of a resource at the time of transfer minus the amount of compensation received by the person in exchange for the asset.

When a person gives away or sells an asset for less than fair market value for the purpose of establishing Medicaid, transfer of assets penalty will be evaluated based on the uncompensated value of the transfer asset(s).

I-4100 Compensation

Revision 09-4; Effective December 1, 2009

The uncompensated value may be reduced by compensation received by the person. To reduce the uncompensated value the compensation must meet several requirements.

I-4110 Legal Binding Agreement on or Before the Date of Transfer

Revision 09-4; Effective December 1, 2009

Compensation for a transferred asset must be provided according to terms of an agreement established on or before the date of transfer. This agreement must have been established exclusively for purposes other than obtaining or retaining eligibility for Medicaid services.

Review the written agreement and the circumstances of the agreement to determine if institutional placement or waiver services were a consideration at the time the asset was transferred. If the agreement was oral, obtain a written statement from the person and the person receiving the asset.

The written statements must specify the date and terms of the agreement.

I-4120 Forms of Compensation

Revision 09-4; Effective December 1, 2009

The compensation for an asset can include:

- money,
- real or personal property,
- food,
- shelter, or
- services received by the person.

Compensation also includes all money, real or personal property, food, shelter or services received before the actual transfer if they were provided pursuant to a binding (legally enforceable) agreement whereby the eligible individual would transfer the resource or otherwise pay for such items.

I-4130 Future Compensation

Revision 09-4; Effective December 1, 2009

Compensation must actually have been provided to the person. Future compensation does not satisfy the compensation requirement.

Exception if provided according to terms of an agreement established on or before the date of transfer:

- Future compensation from annuities that are actuarially sound can be considered compensation.
- Consider as compensation the payment or assumption of a legal debt owed by the person who made the transfer in exchange for the asset.

I-4140 Compensation from Services

Revision 09-4; Effective December 1, 2009

Services can be a form of compensation if provided according to terms of an agreement established on or before the date of transfer. Valid receipts for financial expenditures or written statements from the people who were paid to provide the services are needed to validate the receipt of services.

Compensation is not allowed for services that would normally be provided by a family member (such as house painting or repairs, mowing lawns, grocery shopping, cleaning, laundry, preparing meals, transportation to medical care).

I-4150 Cash Compensation

Revision 09-4; Effective December 1, 2009

If the person receives additional cash compensation that was not a part of the transfer agreement from the party who received the transferred asset, reduce the uncompensated value of the transferred asset by the amount of the additional compensation and as of the date the compensation is received. Cash compensation includes direct payments to a third party to meet the person's food, shelter or medical expenses, including nursing facility bills, incurred after the date of the transfer.

I-4160 Examples of Compensation

Revision 12-2; Effective June 1, 2012

Situation: Ms. Walden, a nursing facility applicant, transferred a $10,000 money market account to her daughter, Josephine, the same day Ms. Walden was admitted to a nursing facility and within six months of application. Josephine is not disabled. Ms. Walden authorized the transfer because Josephine had quit her job to take care of her mother for six months before Ms. Walden was institutionalized. Josephine was earning $1,000 gross per month before quitting her job to care for her mother. Ms. Walden said she had told Josephine in December that she would give her the CD as reimbursement for lost wages if Josephine would quit her job to take care of Ms. Walden.

Action: Because Josephine actually quit her job to care for her mother, compensation for Josephine's lost gross wages is acceptable. Verify that Josephine indeed earned $1,000 per month ($1,000 x 6 months = $6,000). The uncompensated amount is $4,000. Divide the uncompensated value by the average daily rate for a private-pay patient and round down to determine the number of days of the penalty period.

Situation: Mr. Dasher, a nursing facility applicant, transferred a $10,000 CD to his son, James, within 60 months of application. Mr. Dasher agreed to this transfer and provided a written statement, specifying the terms of the agreement, because James had paid Mrs. Long $250 each week for seven months to provide in-home care for his father. Mr. Dasher's medical condition had resulted in the need for in-home care and he had insufficient income to pay Mrs. Long and meet his other living expenses. James furnished a written statement from Mrs. Long substantiating that she had been paid $250 each week to take care of Mr. Dasher. In addition, James furnished receipts showing he had paid Mr. Carpenter to do some improvements to Mr. Dasher's home so that Mr. Dasher could more easily maneuver his wheelchair. The receipt for the materials and Mr. Carpenter's services totaled $3,000.

Action: The payments made for Mrs. Long's and Mr. Carpenter's services and the home improvement materials are acceptable compensation. Mrs. Long's services totaled $250 x 4.33 = $1,082.50 x 7 = $7,577.50. The total compensation received was $10,577.50; therefore, there is no uncompensated value.

Situation: Mr. Anderson, a nursing facility applicant, transferred his homestead to his grandson, Joe, within 60 months of application. The fair market value of the property is $40,000. Mr. Anderson had agreed to transfer the home to Joe, who in exchange had assisted Mr. Anderson in maintaining the home. Joe had painted the house last summer and had done the yard work every other week for the past two years. Joe spent $200 for supplies (paint, for example) to paint the house.

Action: The uncompensated value must be developed. The term of the agreement was the house in exchange for home maintenance assistance. Because painting and yard work are services that a family member would normally perform, the value of those services is not an allowable compensation. The cost of the supplies Joe purchased to paint the house is allowable, if Joe can furnish receipts to substantiate the cost. Assuming that Joe did furnish the verification, the uncompensated value is $39,800. Divide the uncompensated value by the average daily rate for a private-pay patient and round down to determine the number of days for the penalty period. The penalty start date is the first day of the month of the Medical Effective Date (MED), if the individual meets all other eligibility criteria.

Situation: In November, Nina Gonzales' nephew gave her $5,000 to assist in paying her mortgage and taxes. There was no agreement that the nephew would be repaid. The following January, Ms. Gonzales entered a nursing facility and applied for Medicaid. That same month (January), Ms. Gonzales' home was sold and she gave her nephew $5,000 of the proceeds.

Action: Because there was no agreement (entered into exclusively for reasons other than obtaining/retaining Medicaid services) that the nephew would be repaid when the home was sold, Ms. Gonzales transferred $5,000 without compensation. If the average daily rate for a private-pay patient is $117.08, Ms. Gonzales is ineligible for facility vendor payments for all of January and through Feb. 11.

I-4200 Rebuttal Procedures

Revision 09-4; Effective December 1, 2009

I-4210 Notification of Opportunity for Rebuttal

Revision 09-4; Effective December 1, 2009

If any amount of uncompensated value exists, HHSC informs the person or authorized representative of the amount of uncompensated value and the length of the penalty period. The penalty period applies unless the person provides convincing evidence that the disposal was solely for some purpose other than to obtain Medicaid services. If, within the periods specified in this paragraph, the person or authorized representative makes no effort to rebut the presumption that the transfer was solely to obtain Medicaid services, HHSC will assume that the presumption is valid. The rebuttal period is 10 workdays after written notification.

Notify the person or authorized representative in person or by telephone about the presumption, the amount of uncompensated value and the length of the penalty period. If personal contact cannot be made within three workdays of determination, immediately mail Form H1226, Transfer of Assets/Undue Hardship Notification, to the person or authorized representative.

Note: If the person or authorized representative is contacted in person or by telephone, immediately follow up with a written notice using Form H1226. If a rebuttal is not received within the specified period, determine the impact of the transferred asset on the person's Medicaid.

See Appendix XVI, Documentation and Verification Guide.

I-4220 Rebuttal of the Presumption

Revision 09-4; Effective December 1, 2009

Transfer of assets statutes presume that all transfers for less than fair market value are to obtain Medicaid services. The person or authorized representative is responsible for providing convincing evidence that the transaction in question was exclusively for some other purpose. To rebut the presumption, the person or authorized representative must provide a written statement and any relevant documentation to substantiate the statement. The statement, oral or written, must include at least the following:

- purpose for transferring the asset;
- attempts to dispose of the asset at fair market value;
- reason for accepting less than fair market value for the asset;
- means of or plan for self-support after the transfer; and
- relationship to the person to whom the asset was transferred.

Consider all statements and documentation provided by the person. The person can successfully rebut the presumption that the asset was transferred to obtain Medicaid services only if the person convincingly demonstrates that the asset was transferred exclusively for some other purpose. If the person had some other purpose for transferring the asset but obtaining Medicaid services seems to have also been a factor in the decision to transfer, the presumption is not successfully rebutted.

If a person does not rebut the presumption that the asset was transferred to obtain Medicaid services or if his rebuttal is unsuccessful, consider the uncompensated value of the transferred asset to determine the length of the penalty period for institutional and home/community-based waiver services.

If a person is determined to have successfully rebutted the presumption that the asset was transferred to obtain Medicaid services, the supervisor must review and concur with the decision. Record this concurrence in the case record.

I-4221 Exclusively for Some Purpose Other than to Qualify

Revision 09-4; Effective December 1, 2009

The presence of one or more of the following factors, while not conclusive, may indicate that the asset was transferred exclusively for some purpose other than to qualify for assistance. This list does not include every possible factor.

- After transfer of the asset, one of the following occurs:
  - unanticipated drastic change in the person's health, resulting in a greatly increased need for medical care;
  - unexpected loss of other resources that would have precluded eligibility; and
  - unexpected loss of income that would have precluded eligibility without an income-diversion trust.
- Total resources would have remained below the resource limits since the transfer occurred if the resource was retained.
- The transfer was made as a result of a court order or other legal commitment, such as a judgment or debt owed.

I-4300 Undue Hardship

Revision 09-4; Effective December 1, 2009

A person may claim undue hardship when imposition of a transfer penalty would result in discharge to the community and/or inability to obtain necessary medical services so that the person's life is endangered. Undue hardship also exists when imposition of a transfer penalty would deprive the person of food, clothing, shelter or other necessities of life. Undue hardship relates to hardship to the person, not the relatives or responsible parties of the person. Undue hardship does not exist when imposition of the transfer penalty merely causes the person inconvenience or when imposition might restrict lifestyle, but would not cause risk of serious deprivation.

Undue hardship may exist when any one of the following conditions exists:

- location of the receiver of the asset is unknown to the person, other family members or other interested parties, and the person has no place to return in the community and/or receive the care required to meet the person's needs;
- person can show that physical harm may come as a result of pursuing the return of the asset, and the person has no place to return in the community and/or receive the care required to meet the person's needs; or
- receiver of the asset is unwilling to cooperate (such as an Adult Protective Services exploitation or potential fraud case) with the person and HHSC, and the person has no place to return in the community and/or receive the care required to meet the person's needs.

If a person claims undue hardship, HHSC must make a decision on the situation as soon as possible, but within 30 days of receipt of the request for a waiver of the penalty. The person has the right to appeal an adverse decision on undue hardship.

HHSC must permit the institution in which the individual is residing to file for an undue hardship waiver on behalf of an individual who would be subject to a penalty period resulting from a transfer of assets. Before filing for an undue hardship waiver, the institution must have the consent of the individual or the individual's authorized representative. In addition to requesting an undue hardship waiver, the institution may present information on behalf of the individual and may, with the specific written consent of the individual or the individual's authorized representative, represent the individual in an appeal of an undue hardship denial decision.

At a minimum, a written statement explaining the person's reasons for the transfer, who received the asset, how that person can be located, why the person's needs cannot be met and why there is undue hardship for the person must be included in the documentation.

The supervisor must sign off on all undue hardship cases.

I-4310 Undue Hardship Example

Revision 09-4; Effective December 1, 2009

Situation: Mr. Nelson Stiles, a nursing facility applicant, provided his bank statements as resource verification. The statements indicated that $1,000 was withdrawn from his account for the previous six consecutive months. He stated that he allowed his niece, who knew his personal identification number on his Pulse Card, to take the money. He thinks she took the money to pay off her debts and has now left the state. He does not know where she is and does not know if he will see her again. He said he has no other living relatives. He does not own a home or know anyone he could live with who could help to take care of him.

Action: This is an acceptable case of undue hardship. Document the case thoroughly and obtain the necessary approval signatures.

I-4100, Compensation

Body

Revision 09-4; Effective December 1, 2009

The uncompensated value may be reduced by compensation received by the person. To reduce the uncompensated value the compensation must meet several requirements.

I-4110 Legal Binding Agreement on or Before the Date of Transfer

Revision 09-4; Effective December 1, 2009

Compensation for a transferred asset must be provided according to terms of an agreement established on or before the date of transfer. This agreement must have been established exclusively for purposes other than obtaining or retaining eligibility for Medicaid services.

Review the written agreement and the circumstances of the agreement to determine if institutional placement or waiver services were a consideration at the time the asset was transferred. If the agreement was oral, obtain a written statement from the person and the person receiving the asset.

The written statements must specify the date and terms of the agreement.

I-4120 Forms of Compensation

Revision 09-4; Effective December 1, 2009

The compensation for an asset can include:

- money,
- real or personal property,
- food,
- shelter, or
- services received by the person.

Compensation also includes all money, real or personal property, food, shelter or services received before the actual transfer if they were provided pursuant to a binding (legally enforceable) agreement whereby the eligible individual would transfer the resource or otherwise pay for such items.

I-4130 Future Compensation

Revision 09-4; Effective December 1, 2009

Compensation must actually have been provided to the person. Future compensation does not satisfy the compensation requirement.

Exception if provided according to terms of an agreement established on or before the date of transfer:

- Future compensation from annuities that are actuarially sound can be considered compensation.
- Consider as compensation the payment or assumption of a legal debt owed by the person who made the transfer in exchange for the asset.

I-4140 Compensation from Services

Revision 09-4; Effective December 1, 2009

Services can be a form of compensation if provided according to terms of an agreement established on or before the date of transfer. Valid receipts for financial expenditures or written statements from the people who were paid to provide the services are needed to validate the receipt of services.

Compensation is not allowed for services that would normally be provided by a family member (such as house painting or repairs, mowing lawns, grocery shopping, cleaning, laundry, preparing meals, transportation to medical care).

I-4150 Cash Compensation

Revision 09-4; Effective December 1, 2009

If the person receives additional cash compensation that was not a part of the transfer agreement from the party who received the transferred asset, reduce the uncompensated value of the transferred asset by the amount of the additional compensation and as of the date the compensation is received. Cash compensation includes direct payments to a third party to meet the person's food, shelter or medical expenses, including nursing facility bills, incurred after the date of the transfer.

I-4160 Examples of Compensation

Revision 12-2; Effective June 1, 2012

Situation: Ms. Walden, a nursing facility applicant, transferred a $10,000 money market account to her daughter, Josephine, the same day Ms. Walden was admitted to a nursing facility and within six months of application. Josephine is not disabled. Ms. Walden authorized the transfer because Josephine had quit her job to take care of her mother for six months before Ms. Walden was institutionalized. Josephine was earning $1,000 gross per month before quitting her job to care for her mother. Ms. Walden said she had told Josephine in December that she would give her the CD as reimbursement for lost wages if Josephine would quit her job to take care of Ms. Walden.

Action: Because Josephine actually quit her job to care for her mother, compensation for Josephine's lost gross wages is acceptable. Verify that Josephine indeed earned $1,000 per month ($1,000 x 6 months = $6,000). The uncompensated amount is $4,000. Divide the uncompensated value by the average daily rate for a private-pay patient and round down to determine the number of days of the penalty period.

Situation: Mr. Dasher, a nursing facility applicant, transferred a $10,000 CD to his son, James, within 60 months of application. Mr. Dasher agreed to this transfer and provided a written statement, specifying the terms of the agreement, because James had paid Mrs. Long $250 each week for seven months to provide in-home care for his father. Mr. Dasher's medical condition had resulted in the need for in-home care and he had insufficient income to pay Mrs. Long and meet his other living expenses. James furnished a written statement from Mrs. Long substantiating that she had been paid $250 each week to take care of Mr. Dasher. In addition, James furnished receipts showing he had paid Mr. Carpenter to do some improvements to Mr. Dasher's home so that Mr. Dasher could more easily maneuver his wheelchair. The receipt for the materials and Mr. Carpenter's services totaled $3,000.

Action: The payments made for Mrs. Long's and Mr. Carpenter's services and the home improvement materials are acceptable compensation. Mrs. Long's services totaled $250 x 4.33 = $1,082.50 x 7 = $7,577.50. The total compensation received was $10,577.50; therefore, there is no uncompensated value.

Situation: Mr. Anderson, a nursing facility applicant, transferred his homestead to his grandson, Joe, within 60 months of application. The fair market value of the property is $40,000. Mr. Anderson had agreed to transfer the home to Joe, who in exchange had assisted Mr. Anderson in maintaining the home. Joe had painted the house

last summer and had done the yard work every other week for the past two years. Joe spent $200 for supplies (paint, for example) to paint the house.

Action: The uncompensated value must be developed. The term of the agreement was the house in exchange for home maintenance assistance. Because painting and yard work are services that a family member would normally perform, the value of those services is not an allowable compensation. The cost of the supplies Joe purchased to paint the house is allowable, if Joe can furnish receipts to substantiate the cost. Assuming that Joe did furnish the verification, the uncompensated value is $39,800. Divide the uncompensated value by the average daily rate for a private-pay patient and round down to determine the number of days for the penalty period. The penalty start date is the first day of the month of the Medical Effective Date (MED), if the individual meets all other eligibility criteria.

Situation: In November, Nina Gonzales' nephew gave her $5,000 to assist in paying her mortgage and taxes. There was no agreement that the nephew would be repaid. The following January, Ms. Gonzales entered a nursing facility and applied for Medicaid. That same month (January), Ms. Gonzales' home was sold and she gave her nephew $5,000 of the proceeds.

Action: Because there was no agreement (entered into exclusively for reasons other than obtaining/retaining Medicaid services) that the nephew would be repaid when the home was sold, Ms. Gonzales transferred $5,000 without compensation. If the average daily rate for a private-pay patient is $117.08, Ms. Gonzales is ineligible for facility vendor payments for all of January and through Feb. 11.

I-4200, Rebuttal Procedures

Body

I-4210 Notification of Opportunity for Rebuttal

Revision 09-4; Effective December 1, 2009

If any amount of uncompensated value exists, HHSC informs the person or authorized representative of the amount of uncompensated value and the length of the penalty period. The penalty period applies unless the person provides convincing evidence that the disposal was solely for some purpose other than to obtain Medicaid services. If, within the periods specified in this paragraph, the person or authorized representative makes no effort to rebut the presumption that the transfer was solely to obtain Medicaid services, HHSC will assume that the presumption is valid. The rebuttal period is 10 workdays after written notification.

Notify the person or authorized representative in person or by telephone about the presumption, the amount of uncompensated value and the length of the penalty period. If personal contact cannot be made within three workdays of determination, immediately mail Form H1226, Transfer of Assets/Undue Hardship Notification, to the person or authorized representative.

Note: If the person or authorized representative is contacted in person or by telephone, immediately follow up with a written notice using Form H1226. If a rebuttal is not received within the specified period, determine the impact of the transferred asset on the person's Medicaid.

See Appendix XVI, Documentation and Verification Guide.

I-4220 Rebuttal of the Presumption

Revision 09-4; Effective December 1, 2009

Transfer of assets statutes presume that all transfers for less than fair market value are to obtain Medicaid services. The person or authorized representative is responsible for providing convincing evidence that the transaction in question was exclusively for some other purpose. To rebut the presumption, the person or authorized representative must provide a written statement and any relevant documentation to substantiate the statement. The statement, oral or written, must include at least the following:

- purpose for transferring the asset;
- attempts to dispose of the asset at fair market value;
- reason for accepting less than fair market value for the asset;
- means of or plan for self-support after the transfer; and
- relationship to the person to whom the asset was transferred.

Consider all statements and documentation provided by the person. The person can successfully rebut the presumption that the asset was transferred to obtain Medicaid services only if the person convincingly demonstrates that the asset was transferred exclusively for some other purpose. If the person had some other purpose for transferring the asset but obtaining Medicaid services seems to have also been a factor in the decision to transfer, the presumption is not successfully rebutted.

If a person does not rebut the presumption that the asset was transferred to obtain Medicaid services or if his rebuttal is unsuccessful, consider the uncompensated value of the transferred asset to determine the length of the penalty period for institutional and home/community-based waiver services.

If a person is determined to have successfully rebutted the presumption that the asset was transferred to obtain Medicaid services, the supervisor must review and concur with the decision. Record this concurrence in the case record.

I-4221 Exclusively for Some Purpose Other than to Qualify

Revision 09-4; Effective December 1, 2009

The presence of one or more of the following factors, while not conclusive, may indicate that the asset was transferred exclusively for some purpose other than to qualify for assistance. This list does not include every possible factor.

- After transfer of the asset, one of the following occurs:
  - unanticipated drastic change in the person's health, resulting in a greatly increased need for medical care;
  - unexpected loss of other resources that would have precluded eligibility; and
  - unexpected loss of income that would have precluded eligibility without an income-diversion trust.
- Total resources would have remained below the resource limits since the transfer occurred if the resource was retained.
- The transfer was made as a result of a court order or other legal commitment, such as a judgment or debt owed.

I-4300, Undue Hardship

Body

Revision 09-4; Effective December 1, 2009

A person may claim undue hardship when imposition of a transfer penalty would result in discharge to the community and/or inability to obtain necessary medical services so that the person's life is endangered. Undue

hardship also exists when imposition of a transfer penalty would deprive the person of food, clothing, shelter or other necessities of life. Undue hardship relates to hardship to the person, not the relatives or responsible parties of the person. Undue hardship does not exist when imposition of the transfer penalty merely causes the person inconvenience or when imposition might restrict lifestyle, but would not cause risk of serious deprivation.

Undue hardship may exist when any one of the following conditions exists:

- location of the receiver of the asset is unknown to the person, other family members or other interested parties, and the person has no place to return in the community and/or receive the care required to meet the person's needs;
- person can show that physical harm may come as a result of pursuing the return of the asset, and the person has no place to return in the community and/or receive the care required to meet the person's needs; or
- receiver of the asset is unwilling to cooperate (such as an Adult Protective Services exploitation or potential fraud case) with the person and HHSC, and the person has no place to return in the community and/or receive the care required to meet the person's needs.

If a person claims undue hardship, HHSC must make a decision on the situation as soon as possible, but within 30 days of receipt of the request for a waiver of the penalty. The person has the right to appeal an adverse decision on undue hardship.

HHSC must permit the institution in which the individual is residing to file for an undue hardship waiver on behalf of an individual who would be subject to a penalty period resulting from a transfer of assets. Before filing for an undue hardship waiver, the institution must have the consent of the individual or the individual's authorized representative. In addition to requesting an undue hardship waiver, the institution may present information on behalf of the individual and may, with the specific written consent of the individual or the individual's authorized representative, represent the individual in an appeal of an undue hardship denial decision.

At a minimum, a written statement explaining the person's reasons for the transfer, who received the asset, how that person can be located, why the person's needs cannot be met and why there is undue hardship for the person must be included in the documentation.

The supervisor must sign off on all undue hardship cases.

I-4310 Undue Hardship Example

Revision 09-4; Effective December 1, 2009

Situation: Mr. Nelson Stiles, a nursing facility applicant, provided his bank statements as resource verification. The statements indicated that $1,000 was withdrawn from his account for the previous six consecutive months. He stated that he allowed his niece, who knew his personal identification number on his Pulse Card, to take the money. He thinks she took the money to pay off her debts and has now left the state. He does not know where she is and does not know if he will see her again. He said he has no other living relatives. He does not own a home or know anyone he could live with who could help to take care of him.

Action: This is an acceptable case of undue hardship. Document the case thoroughly and obtain the necessary approval signatures.

I-5000, Calculation of Penalty Period

Body

Revision 21-3; Effective September 1, 2021

The penalty period is determined by dividing the uncompensated value of all assets transferred by the average monthly cost of nursing facility care for a private-pay patient. The penalty period calculation applies to the transfer of both income and resources.

Examples in this section may not reflect the most recent amount of the average private-pay cost per day that is used for the transfer of assets divisor.

When a person has both substantial home equity that exceeds the established limit and a transfer of assets penalty, place the person in Home Equity Manor first. If the person provides proof that the reduced home equity value is at or below the established limit, then place the person in Mason Manor for the duration of the transfer penalty.

The penalty start date is the first day of the month of the medical effective date, if the person meets all other eligibility criteria.

I-5100, Transfer of Assets Divisor

Body

Revision 21-3; Effective September 1, 2021

Effective Date	Transfer of Assets Divisor
Sept. 1, 2021	$237.93
Sept. 1, 2019	$213.71
Sept. 1, 2017	$172.65
Sept. 1, 2015	$162.41
Sept. 1, 2013	$156.34
Sept. 1, 2011	$142.92
Sept. 1, 2009	$130.88
Sept. 1, 2007	$122.50
Nov. 1, 2005	$117.08

Effective Sept. 1, 2021, the daily rate is $237.93. Use $237.93 to determine the penalty period for case actions disposed on or after Sept. 1, 2021. Partial amounts should be rounded down to the whole number of days. The result will be the number of days of the penalty period.

Related Policy

Calculation of Penalty Period, I-5000

I-5200, The Penalty Start Date

Body

Revision 09-4; Effective December 1, 2009

Historical Notes:

- For applications or program transfer requests received before Oct. 1, 2006, regardless of when the transfer occurred, the penalty start date was the first day of the transfer transaction month.
- For applications or program transfer requests received on or after Oct.1, 2006, with a transfer before Feb. 8, 2006, the penalty start date was the first day of the transfer transaction month. The penalty period count for both of these began with the first day of the month in which the transfer occurred, even if the transfer occurred late in the month. (**Example:** If the transfer occurs on Nov. 20 and the penalty period is 45 days, begin the count on Nov. 1.)
- For applications or program transfer requests received on or after Oct. 1, 2006, with a transfer on or after Feb. 8, 2006, the penalty start date is the first day of the month of the medical effective date, if the individual meets all other eligibility criteria.

I-5210 Examples of the Penalty Start Date

Revision 09-4; Effective December 1, 2009

Example 1

File Date	08/24/2006
Look-Back Period	36 months, 07/2006 through 08/2003
Date of Transfer	03/17/2006
Value of Transfer	$20,000
Medical Effective Date	09/01/2006 (over resource limit 08/01/2006)
Penalty Start Date	03/01/2006 – The application file date is before 10/01/2006 and the transfer was after 02/08/2006. Use pre-DRA transfer of assets policy. The penalty would start 03/01/2006 – first day of the transfer transaction month.

Example 2

File Date	10/24/2006

Look-Back Period	36 months, 09/2006 through 10/2003
Date of Transfer	02/01/2006
Value of Transfer	$20,000
Medical Effective Date	11/01/2006 (over resource limit 10/01/2006)
Penalty Start Date	02/01/2006 – The application was filed on or after 10/01/2006 and the transfer was before 02/08/2006. Use pre-DRA transfer of assets policy. The penalty would start 02/01/2006 – first day of the transfer transaction month.

Example 3

File Date	10/24/2006
Look-Back Period	36 months, 09/2006 through 10/2003
Date of Transfer	05/01/2006
Value of Transfer	$20,000
Medical Effective Date	11/01/2006 (over resource limit 10/01/2006)
Penalty Start Date	11/01/2006 – The application was filed on or after 10/01/2006 and the transfer was on or after 02/08/2006. Use post-DRA transfer of assets policy. The penalty would start 11/01/2006 – first day of the month of the medical effective date, if the individual meets all other eligibility criteria.

I-5220 Multiple Transfers

Revision 09-4; Effective December 1, 2009

When multiple transfers occur during the look-back period in such a way that the penalty period for each transfer overlaps, treat the transfers as a single event. The uncompensated values are lumped together and divided by the average daily rate for a private-pay individual in a nursing facility. Start the penalty period with the first day of the month of medical effective date (MED), if the individual meets all other eligibility criteria.

Under post-DRA transfer of assets policy, the issue of "overlapping" penalties on applications will not occur since all transfers during the look-back period are lumped together and started with the first day of the month of MED, if the individual meets all other eligibility criteria.

I-5221 Multiple Transfers Example

Revision 13-4; Effective December 1, 2013

File Date	Jan. 2, 2013
Look-Back Period	60 months, December 2012 through January 2008
Date of Transfer	1) Nov. 1, 2008 and 2) Dec. 10, 2008
Value of Transfer	1) $5,000 and 2) $8,000
Medical effective date	Jan. 1, 2013
Penalty Start Date	Jan. 1, 2013

When multiple transfers occur during the look-back period in such a way that the penalty period for each transfer overlaps, treat the transfers as a single event. The uncompensated values are lumped together and divided by the average daily rate for a private-pay individual in a nursing institution. Total of $13,000 ÷ $156.34 = 83 days. Penalty period begins Jan. 1, 2013, and runs through March 24, 2013.

I-5230 Reported Changes and Redeterminations

Revision 09-4; Effective December 1, 2009

Reported Changes

If a penalty period ends and a subsequent transfer occurs, a new penalty period is established effective the month of the subsequent transfer. This means there may be a gap between penalty periods. Follow procedures below for notice, restitution and closing vendor payments.

Redeterminations

When a current Medicaid recipient transfers an asset, the penalty start date begins on the first day of the transfer month, if the transfer occurs later than the date of application. As a result, there may be a gap between penalty periods.

Example: A 365-day penalty begins Jan. 1 and ends Dec. 31. The following April another transfer is made, resulting in a 306-day penalty that begins April 1 and ends Jan. 31 of the following year.

When a transfer is reported, do not retroactively impose the penalty. If a penalty period is imposed on an individual who is already eligible for Medicaid, provide the adverse action notice and inform the recipient about the undue hardship exception. Request restitution for retroactive months, unless potential fraud, abuse or exploitation are involved. Follow Section H-8300, Restitution, and Section C-6000, Fraud and Fair Hearings, for fraud referrals. Follow procedures as outlined in Appendix XXIII, Procedure for Designated Vendor Number to Withhold Vendor Payment.

I-5231 Changes and Redetermination Examples

Revision 09-4; Effective December 1, 2009

- Institutionalized individual inherits $20,000 in April.
  - Transfers $20,000 on May 1 and reports it May 1.
  - $20,000/$117.08 = 170.82 days, round down to 170 days.
  - Notice of adverse action provided on May 1.
  - Adverse action expires May 12.
  - Restitute for April and May, since the inheritance is considered income in April and a countable asset as of May 1.
  - Mason Manor effective June 1 (month following notice of adverse action).
  - Total penalty period is 170 days - 31 (days from May restitution) = 139 days remaining in penalty period. The transfer penalty actually begins May 1, but the individual is ineligible for May due to excess resource.
  - Mason Manor begins June 1– Oct. 17.
- Institutionalized individual inherits $20,000 in February.
  - Transfers the $20,000 on May 1 and reports it May 1.
  - $20,000/$117.08 = 170.82 days, round down to 170 days.
  - Notice of adverse action provided on May 1.
  - Adverse action expires May 12.
  - Restitute for February, March, April and May. The inheritance is considered income in February and an asset for March, April and May, as the transfer did not occur until May.
  - Mason Manor effective June 1 (month following notice of adverse action).
  - Total penalty period is 170 days - 31 (days from May restitution) = 139 days remaining in penalty period.
  - Mason Manor begins June 1 – Oct. 17.
- Institutionalized individual inherits $7,150 in November.
  - $7,150 transfer on Nov. 1 and reported on May 1.

- $7,150/$117.08 = 61.06 days, round down to 61 days.
- Notice of adverse action provided on May 1.
- Adverse action expires May 12.
- Restitute for November and December. The individual is ineligible due to income received in November and the transfer penalty begins Nov. 1 and ends Dec. 31.
- Mason Manor is not applicable, as penalty period has expired.

I-5240 Multiple Transfers – Historical

Revision 09-4; Effective December 1, 2009

Historically, when multiple transfers occurred during the look-back period in such a way that the penalty periods for each overlapped, the transfers were treated as a single event. The uncompensated values were lumped together and divided by the average daily rate for a private-pay individual in a nursing facility. If multiple transfers occurred in such a way that the penalty periods did not overlap, then the transfers were treated as separate events and the penalty periods were calculated separately.

A new penalty period cannot be imposed while a previous penalty period is still in effect. Therefore, the penalty periods assessed under pre-DRA transfer of assets (OBRA 1993 rules) and under post-DRA transfer of assets (DRA 2005 rules) for multiple transfers that overlap run separately but consecutively.

Under OBRA 1993 rules transfer of assets policy, the penalty period began the month of transfer.

If the penalty period of the OBRA 1993 rules transfer goes past the medical effective date, then the penalty start date of the DRA 2005 rules transfer will begin immediately after the first penalty period ends.

I-5241 Example Multiple Transfers – Historical

Revision 09-4; Effective December 1, 2009

File Date	01/02/2007
Look-Back Period	36 months, 12/2006 through 01/2004
Date of Transfer	1) 02/01/2006 and 2) 11/10/2006
Value of Transfer	1) $45,000 and 2) $8,000

Medical effective date	01/01/2007
Penalty Start Date	First transfer – $45,000 ÷ 117.08 = 384 days. Using pre-DRA transfer of assets policy, penalty start date is 02/01/2006, which runs through 02/19/2007. Second transfer – $8,000 ÷ 117.08 = 68 days. Using post-DRA transfer of assets policy, penalty start date is 01/01/2007 (medical effective date). Because the penalty start date of the second transfer is before the end date of the first penalty period, begin the penalty for the second transfer immediately after the first penalty period ends.

Transfer penalty of the second transfer for 68 days begins 02/20/2007 and runs through 04/28/2007. Total transfer penalty period is 02/01/2006 through 04/28/2007 (384 days + 68 days = 452-day penalty).

If subsequent transfers of asset occur that do not meet the transfer of assets exceptions after the penalty period begins, add the new penalty to the end of the existing penalty period.

See Section I-1000, Transfer of Assets, for information on the exceptions to transfer of assets penalties.

I-5300, Home and Community-Based Services Waiver Services and State Supported Living Center Services

Body

I-5310 Post-DRA Transfer of Assets Policy

Revision 09-4; Effective December 1, 2009

For applications or program transfer requests filed on or after Oct. 1, 2006, with a transfer on or after Feb. 8, 2006, post-DRA transfer of assets policy is used. Under post-DRA transfer of assets policy, the penalty start date is the first day of the month of MED, if the individual meets all other eligibility criteria. However, an individual must receive waiver services or state supported living center services to be eligible for a waiver program. An individual with a current transfer penalty cannot be certified for a waiver program or state center services. Therefore, an individual who has transferred assets under post-DRA transfer of assets policy would remain ineligible for 60 months forward from each transfer transaction. To be eligible for waiver services or state center services, the 60-month look-back period would need to have expired for each transfer. Follow current denial procedures for state center services or the applicable waiver program.

Example: An individual transferred $5,000 on Oct. 3, 2006, and applies for waivers (or state center services). There is a 36-month look-back period and the individual is not eligible for waiver services (or state center services).

The same individual applies March 2009; the look-back period would be 36 plus one month. The look-back period would span February 2006 - February 2009, which would include the October 2006 transfer transaction date, and the individual would not be eligible for waiver services (or state center services).

The same individual applies April 2009; the look-back period would be 36 plus two months.

As the months advance, so does the look-back period, starting with March 2009.

The same individual applies November 2011; the look-back period would span November 2006 - October 2011. The $5,000 transfer transaction that occurred on Oct. 3, 2006, would not be included in the look-back period.

Exception: If the individual enters an institution and meets all other eligibility criteria, the penalty period would start and continue for the appropriate period of time. If the individual leaves the institution and reapplies for waiver services, eligibility for waiver services can only begin after the penalty period has expired.

Example: An individual enters an institution and applies for Medicaid on May 5, 2007. The individual reports a transfer of $7,150 in April 2007. The penalty period is 61 days ($7,150/117.08 = 61.06 days, round down to 61). The individual meets all other eligibility criteria as of May 1, 2007. The penalty period begins May 1 and ends June 30. The client returns to his home from the institution on May 20 and requests waiver services. Since the individual has an active penalty, waiver services may not begin.

I-5320 Pre-DRA Transfer of Assets Policy

Revision 09-4; Effective December 1, 2009

Pre-DRA transfer of assets policy related to waivers and state supported living center services requires that the same penalty period calculation be used for individuals who apply for home/community-based waiver programs or state supported living center services. Penalty periods continue to run if a client moves from an institutional program to a home/community-based waiver program or vice versa. For pre-DRA transfer of assets policy, the penalty period begins the month of transfer. However, a new penalty period cannot be imposed while a previous penalty period is still in effect. Therefore, the penalty periods assessed under pre-DRA transfer of assets (OBRA 1993 rules) for multiple transfers that overlap run separately but consecutively.

Examples:

- A 365-day penalty period begins in June of this year while the client is in a nursing facility. In October of this year the client is discharged from the nursing facility and elects to receive a home/community-based waiver program. The client is ineligible for waiver services until June of next year.
- A penalty period is 457 days, beginning with the date of transfer on Oct. 15 of last year and ending Dec. 31 of this year. (When determining the penalty period, begin with the first day of the month of the transfer.) Another transfer made in April of this year results in a 395-day penalty, which begins January of next year (after the previous penalty period ends) and ends Jan. 30 of the following year. Thus, the penalty periods run separately but consecutively.

Pre-DRA transfer of assets policy related to waivers and state supported living center services requires that when multiple transfers occur during the look-back period in such a way that the penalty periods for each overlap, the transfers are treated as a single event. The uncompensated values are lumped together and divided by the average daily rate for a private-pay individual in a nursing facility. If multiple transfers occur in such a way that the penalty periods do not overlap, then the transfers are treated as separate events and the penalty periods are calculated separately.

Examples:

- The person made the following transfers during the look-back period: $10,000 in January and $10,000 in July. If the average daily rate for a private-pay patient is $117.08, the penalty period for each transfer is 85 days ($10,000 divided by $117.08 = 85 days). Because the penalty periods for these transfers do not overlap, they are treated as separate events. The penalty period for the first transfer begins 01/01/YY and ends 03/26/YY. The penalty period for the second transfer begins 07/01/YY and ends 09/23/YY.
- The person made the following transfers during the look-back period: $20,000 in January and $20,000 in April. If the average daily rate for a private-pay patient is $117.08, the penalty period for each transfer is

170 days ($20,000 divided by $117.08 = 170 days). The penalty period for the January transfer begins 01/01/YY and ends 06/19/YY. The penalty period for the April transfer begins 04/01/YY and ends 09/17/YY. Because these periods overlap, the transfers are treated as a single event. The penalty period is calculated as follows: $40,000 divided by $117.08 = 341-day penalty. This penalty period begins the month in which the first transfer occurred (01/01/YY) and ends 12/7/YY.

Use pre-DRA transfer of assets policy for applications or program transfer requests filed before Oct. 1, 2006, regardless of when the transfer occurred. The penalty start date is the first day of the transfer transaction month.

I-5500, Transfer Penalties and Institutions for Mental Diseases

Body

Revision 09-4; Effective December 1, 2009

The persons in institutions for mental diseases (IMDs) who are assessed transfer penalties remain eligible for all other Medicaid benefits, but Medicaid does not make IMD vendor payments during the penalty period. Send a letter to the hospital reimbursement manager stating that the client is not eligible for IMD vendor payment because of a transfer of assets. Include the beginning and ending dates of the penalty period.

I-5600, Apportioning Penalty Period Between Spouses

Body

Revision 09-4; Effective December 1, 2009

Under pre-DRA transfer of assets policy, when a spouse transfers an asset that results in a penalty for the client, the penalty period must, in certain instances, be apportioned between the spouses. Both spouses must be eligible for Medicaid institutional services or home/community-based waiver services during the same time period for apportionment to occur. Apportionment occurs when:

- the spouse is institutionalized and is Medicaid eligible; or
- the spouse would be eligible for home/community-based waiver services; and
- some portion of the penalty against the client remains at the time the above conditions are met.

Under post-DRA transfer of assets policy, when a spouse transfers an asset that results in a penalty for the client, the penalty period must, in certain instances, be apportioned between the spouses. Both spouses must be eligible for Medicaid institutional services during the same time period for apportionment to occur. Apportionment occurs when:

- the spouse is institutionalized and is Medicaid eligible; and
- some portion of the penalty against the client remains at the time the above conditions are met.

Note: If a penalty period apportionment results in an odd day, the extra penalty day is assessed to one member (male) of the couple. Do not split the day. Penalty periods are assessed in whole days for both pre-DRA and post-DRA transfer of assets policy.

Example: Mr. Able enters a nursing facility and applies for Medicaid. Mrs. Able transfers an asset that results in a 1,095-day penalty against Mr. Able. Three hundred and sixty five days into the penalty period, Mrs. Able enters a nursing facility and applies for Medicaid. The penalty period against Mr. Able still has 730 days to run. Because Mrs. Able is now in a nursing facility and a portion of the original penalty period remains, the remaining 730 days of penalty must be apportioned between Mr. and Mrs. Able. Therefore, Mr. and Mrs. Able each have a 365-day penalty period.

Under pre-DRA transfer of assets policy, when one spouse is no longer subject to a penalty (for example, the spouse no longer receives institutional or home/community-based waiver services, or the spouse dies), the remaining penalty period applicable to both spouses must be served by the remaining spouse.

Under post-DRA transfer of assets policy, when one spouse is no longer subject to a penalty (for example, the spouse no longer receives institutional services or the spouse dies), the remaining penalty period applicable to both spouses must be served by the remaining spouse.

Example: In the above example, the 730-day penalty period was apportioned equally between Mr. and Mrs. Able, making each have 365 days. After 181 days, Mr. Able leaves the nursing facility, but Mrs. Able remains. Because Mr. Able is no longer subject to the penalty, the remaining total penalty (368 days) must be imposed on Mrs. Able. If Mr. Able returns to the nursing facility before the end of the 368-day period, the remaining penalty would again be apportioned between the two spouses.

I-5700, Return of Transferred Asset

Body

Revision 09-4; Effective December 1, 2009

If the transferred asset is subsequently returned to the individual, the transfer is nullified and the penalty period is erased retroactive to the initial month of penalty. The asset is treated as though never transferred, and is excluded or counted, as appropriate, in determining the client's eligibility for those months in which the asset was in someone else's possession.

In spousal cases, if the individual and or spouse transferred an asset before the individual entered the nursing facility and the asset is returned after institutionalization, the spousal protected resource amount must also be recalculated.

Examples:

- If an excluded asset such as a homestead was transferred and subsequently returned, the transfer is nullified and the penalty period is erased retroactive to the initial month of penalty. Because the asset is excluded, it has no effect on countable assets when determining eligibility for those months in which the resource was in someone else's possession. If the client is in Mason Manor, submit Form H3618-A, Resident Transaction Notice for Designated Vendor Numbers, to report him discharged from Vendor No. 5997 and admitted to the nursing facility, with vendor payments reinstated, retroactive to the date the penalty period began.
- If a countable asset such as a certificate of deposit was transferred and subsequently returned, its value is added to the value of other countable assets when determining current eligibility, as well as eligibility for those months in which the asset was in someone else's possession. If the client is in Mason Manor and would have been resource ineligible for those months in which the asset was in someone else's possession, do not retroactively discharge the client from Mason Manor.

For a penalty period to be nullified or erased retroactively, all of the asset in question or its equity value must be returned to the client. When only part of an asset or its equivalent value is returned, the penalty period is not nullified or erased retroactive but is recalculated based on the remaining amount of uncompensated transfer and the penalty period will be for a shorter length of time.

- If the partial returned asset is excluded, it has no effect on countable assets when determining eligibility for those months in which the asset was in someone else's possession. If the client is in Mason Manor and the penalty recalculation results in an end to the penalty, enter the day after the last day of the penalty period. Submit Form H3618-A to report the client discharged from Vendor No. 5997 and admitted to the nursing facility, with vendor payments reinstated.

- If the partial returned asset is countable, such as a certificate of deposit, the returned value is added to the value of other countable assets when determining current eligibility, as well as eligibility for those months in which the asset was in someone else's possession. If the client is in Mason Manor and would have been resource ineligible for those months in which the asset was in someone else's possession, do not retroactively discharge the client from Mason Manor.

Payment on the principal of a note is the return of a transferred asset and reduces the penalty accordingly.

I-6000, Purchase of Assets and Transfer of Assets

Body

Revision 09-4; Effective December 1, 2009

Examples in this section may not reflect the most recent amount of the average private-pay cost per day that is used for the transfer of assets divisor.

I-6100, Purchase of a Life Estate

Body

I-6110 Policy Implementation Dates

Revision 09-4; Effective December 1, 2009

For applications or program transfer requests filed before Oct. 1, 2006, or for case actions before Oct. 1, 2006, regardless of the date of purchase of a life estate, follow pre-DRA policy for life estates and remainder interests. Do not consider the purchase of a life estate as a transfer of assets, unless the purchase price of the life estate exceeds the fair market value (FMV) of the life estate.

For applications or program transfer requests filed on or after Oct. 1, 2006, or for case actions on or after Oct. 1, 2006, with a purchase of a life estate before April 1, 2006, follow pre-DRA policy as outlined in Section F-4212, Life Estates and Remainder Interests. Do not consider the purchase of a life estate as a transfer of assets, unless the purchase price of the life estate exceeds the FMV of the life estate.

For applications or program transfer requests filed on or after Oct. 1, 2006, or for case actions on or after Oct. 1, 2006, with a purchase of a life estate on or after April 1, 2006, consider the purchase of a life estate on or after April 1, 2006, as a potential transfer of assets and follow post-DRA policy.

I-6120 Post-DRA Transfer of Assets Policy

Revision 09-4; Effective December 1, 2009

Note: The post-DRA changes pertaining to a life estate do not apply to the retention or reservation of a life estate by an individual transferring real property.

When an individual purchases a life estate on or after April 1, 2006, the potential for a transfer of assets occurs. A purchase of a life estate on or after April 1, 2006, is a transfer unless both of the following conditions are met:

- The individual purchasing a life estate in another individual's home actually resides in the home.

- The individual continues to reside in the home for a period of at least one year after the date of purchase.

I-6121 One-Year Residency Requirement

Revision 09-4; Effective December 1, 2009

The months of residence for the one-year period must be consecutive. Less than one year of occupancy after the date of purchase results in treatment as a transfer of assets for less than fair market value (FMV). When evaluating the facts of the purchase of a life estate, determine whether the individual lived in the home by considering factors, such as whether the individual's mail was delivered there or whether the individual paid the property taxes or utilities.

If the purchaser of the life estate moves out of the home before the end of the one-year period, the date of the purchase of the life estate is the date of transfer and the full amount paid for the life estate is the countable amount of the transfer.

The purchase amount of the life estate should not be reduced or prorated to reflect an individual's residency for a period of time less than a year.

Continue to consider Medicaid resource eligibility and transfer of assets rules, even in a case where an individual purchasing a life estate in the home of another individual does live there for at least one year. Unless the property in which the individual has purchased the life estate qualifies as the individual's excluded home, the value of the life estate is counted as a resource in determining Medicaid eligibility.

In determining the value of life estates, continue to follow policy as life estates and remainder interests and the use of the life estate tables in Appendix X, Life Estate and Remainder Interest Tables. The life estate can be excluded as a homestead.

Under pre-DRA and post-DRA policy, consider as a transfer of assets the purchase for a life estate when the payment for the life estate exceeds the FMV of the life estate.

Use Appendix X to determine the FMV. Calculate the difference between the purchase price paid and the FMV.

If an individual makes a gift or transfer of a life estate interest, the value of the life estate, as calculated under Appendix X, is treated as a transfer of assets.

Example 1

Date of Life Estate Purchase	11/15/2005
Amount of Life Estate Purchase	$7,500 – FMV was paid for the life estate interest.
File Date	01/25/2006
Institution Entry	01/15/2006

Living Arrangement	Individual resided in the home until date of entry to institution, which is less than one year after date of purchase.
MED	01/01/2006
Penalty Start Date	Use pre-DRA policy. No transfer of assets. Application for Medicaid was before 10/01/2006 and life estate interest was purchased before 04/01/2006. Use policy in Section F-4212, Life Estates and Remainder Interests.

Example 2

Date of Life Estate Purchase	05/11/2006
Amount of Life Estate Purchase	$5,000 – FMV
File Date	10/15/2006
Institution Entry	08/15/2006
Living Arrangement	The individual resided in the home until entry to the institution, which is less than one year after the date of purchase.
MED	10/01/2006
Penalty Start Date	Use post-DRA policy. Start penalty with the medical effective date month — 10/01/2006. A transfer penalty applies to this situation since the individual did not reside in the home with the purchased life estate for one year after date of purchase. Purchase amount is $5,000 ÷ 117.08 = 42 days. Penalty start date is 10/01/2006 through 11/11/2006.

Example 3

Date of Life Estate Purchase	05/15/2006
Amount of Life Estate Purchase	$6,000 – FMV
File Date	12/11/2007
Institution Entry	12/11/2007
Living Arrangement	The individual resided in the home until date of entry to institution, which is greater than one year.
Medical Effective Date	12/01/2007
Penalty Start Date	Use post-DRA policy. No transfer penalty applies to this situation since the individual resided in the home for more than one year after date of purchase. Use policy in Section F-4212, Life Estates and Remainder Interests, for resource treatment of the life estate.

Example 4

Date of Life Estate Purchase	05/11/2006
Amount of Life Estate Purchase	$3,500 – FMV is $2,000.
File Date	06/06/2007
Institution Entry	06/06/2007
Living Arrangement	The individual resided in the home until date of entry to the institution, which is greater than one year.

Medical Effective Date	06/01/2007
Penalty Start Date	Using post-DRA policy, no transfer penalty applies to the purchase of the life estate since the individual resided in the home for more than one year after date of purchase, except that the individual paid more than FMV for the purchase of the life estate. Difference between FMV of $2,000 and amount paid is $1,500 ÷ 117.08 = 12 days. Penalty start date policy — Use post-DRA since the transfer was after 02/08/2006 and application was after 10/01/2006. Penalty starts the medical effective date month of 06/01/2007. Penalty would be from 06/01/2007 through 06/12/2007.

I-6200, Purchase of a Promissory Note, Loan or Mortgage

Body

I-6210 Policy Implementation Dates

Revision 09-4; Effective December 1, 2009

For applications or program transfer requests filed before Oct. 1, 2006, or for case actions before Oct. 1, 2006, regardless of the date of purchase of a promissory note, loan or mortgage, follow policy for promissory notes, loans and property agreements.

Do not consider the purchase of a promissory note, loan or mortgage as a transfer of assets, unless the transaction of the promissory note, loan or mortgage is considered a transfer of assets for less than fair market value (FMV).

For applications or program transfer requests filed on or after Oct. 1, 2006, or for case actions on or after Oct. 1, 2006, with a purchase of a promissory note, loan or mortgage before April 1, 2006, follow policy outlined in Section F-4150, Promissory Notes, Loans and Property Agreements. Do not consider the purchase of a promissory note, loan or mortgage as a transfer of assets, unless the transaction of the promissory note, loan or mortgage is considered a transfer of assets for less than FMV.

For applications or program transfer requests filed on or after Oct. 1, 2006, or for case actions on or after Oct. 1, 2006, with a purchase of a promissory note, loan or mortgage on or after April 1, 2006, consider the purchase of these on or after April 1, 2006, as a potential transfer of assets.

I-6220 Post-DRA Transfer of Assets Policy

Revision 09-4; Effective December 1, 2009

When an individual purchases a promissory note, loan or mortgage on or after April 1, 2006, the potential for a transfer of assets occurs. A purchase of a promissory note, loan or mortgage on or after April 1, 2006, is a transfer unless all of the following conditions are met:

- The repayment term must be actuarially sound.
- Payments must be made in equal amounts during the term of the loan with no deferral of payments and no balloon payments.
- The promissory note, loan or mortgage must prohibit the cancellation of the balance upon the death of the lender.

If a promissory note, loan or mortgage does not satisfy these three requirements, the countable value considered for transfer of assets is the outstanding balance due as of the date of the individual's application for Medicaid or, for an existing Medicaid recipient, the program transfer request date.

To determine if actuarially sound, use life expectancy tables by accessing the online actuarial publication from the Social Security Administration's Period Life Table.

If a promissory note, loan or mortgage is not a transfer, consider Medicaid resource eligibility and transfer of assets policy for persons purchasing a promissory note, loan or mortgage. Section F-4150, Promissory Notes, Loans and Property Agreements, also indicates that if the purchase of the promissory note, loan or mortgage was for less than the FMV, a transfer of assets transaction occurs.

I-7000, Reserved for Future Use

Body

Revision 09-4; Effective December 1, 2009

I-8000, Reserved for Future Use

Body

Revision 09-4; Effective December 1, 2009

I-9000, Pre-Deficit Reduction Act (DRA) Rules

I-9100, Texas Administrative Code Rules

Body

Revision 09-4; Effective December 1, 2009

The following rules are taken from Subchapter C, Financial Requirements, Division 4, Transfer of Assets.

§358.402. Transfer of Assets before February 8, 2006

(a) Introduction.

(1) The Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) (P.L. 103-66) revised policy for transfers of assets that occur on or after August 11, 1993, when an uncompensated value remains.

(2) The penalty for transfers of assets affects payments for institutional facility services (nursing facility (NF) care, intermediate care facility for persons with mental retardation or related conditions (ICF/MR) provider services, care in state supported living centers and state centers, and care in institutions for mental diseases (IMD)) and eligibility for §1915(c) waiver program services. Both the recipient and the service provider are notified of the penalty period.

(3) Except for residents of state supported living centers and state centers, persons in an institutional setting remain eligible for all other Medicaid benefits and continue to receive monthly identification forms for the length of the penalty period. For residents of state supported living centers and state centers, Medicaid eligibility is denied for any penalty period resulting from an uncompensated transfer of assets. This is because the only Medicaid benefit a resident of a state supported living center or state center receives is provider payments.

(4) If the Medicaid eligibility of a person receiving services under a §1915(c) waiver program requires receipt of waiver services, then the person is ineligible for all Medicaid benefits for the length of the penalty period. Denial of §1915(c) waiver program services based on an uncompensated transfer of assets does not disqualify the person for pure Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) benefits, as described in Chapter 359 of this title (relating to Medicare Savings Program).

(5) A person in a noninstitutional setting who is eligible for Medicaid may transfer assets without penalty, provided the person does not become institutionalized or apply for §1915(c) waiver program services. A transfer of assets does not affect eligibility for QMB or SLMB benefits.

(6) In spousal situations, if assets are transferred to a third party before institutionalization or by the community spouse, the Texas Health and Human Services Commission (HHSC) does not include the uncompensated amount of the transfer in calculating the spousal protected resource amount or countable resources upon application for Medicaid.

(b) Definitions. The following words and terms, when used in this section, have the following meanings unless the context clearly indicates otherwise.

(1) Person—"Person" includes the applicant or recipient, as well as:

(A) the person's spouse;

(B) an individual, including a court or administrative body, with legal authority to act in place of or on behalf of the person or person's spouse; and

(C) any individual, including a court or administrative body, acting at the direction or upon the request of the person or the person's spouse.

(2) Assets —

(A) Assets include all income and resources of a person and of the person's spouse, including any income or resources that the person or the person's spouse is entitled to but does not receive because of action:

(i) by the person or the person's spouse;

(ii) by an individual, including a court or administrative body, with legal authority to act in place of or on behalf of the person or the person's spouse; or

(iii) by any individual, including a court or administrative body, acting at the direction or upon the request of the person or the person's spouse.

(B) Actions that would cause income or resources not to be received include:

(i) irrevocably waiving pension income;

(ii) waiving the right to receive an inheritance;

(iii) not accepting or accessing injury settlements; and

(iv) a defendant diverting tort settlements into a trust or similar device to be held for the benefit of the plaintiff.

(c) Transfer of income.

(1) A person may incur a transfer penalty by transferring income on or after August 11, 1993. Transfers of income include:

(A) waiving the right to receive an inheritance even in the month of receipt;

(B) giving away a lump sum payment even in the month of receipt; or

(C) irrevocably waiving all or part of federal, state, or private pensions or annuities.

(2) The date of transfer is the date of the actual change in income, if on or after August 11, 1993. Interspousal transfers of income are permitted (for example, obtaining a court order to have community property pension income paid to a community spouse).

(3) Because revocable waivers of pension benefits can be revoked and the benefits reinstated, no uncompensated value is developed, and no transfer-of-assets penalty is incurred. Such waivers are subject to the utilization-of-benefits policy, and the person must apply for reinstatement of the full pension amount or the person is ineligible for all Medicaid benefits.

(d) Exceptions to transfers of assets.

(1) Transfer of the person's home does not result in a penalty when the title is transferred to the person's:

(A) spouse, who lives in the home (the transfer penalty applies when the community spouse transfers the home without full compensation);

(B) minor or disabled child (a disabled child must meet Social Security Administration disability criteria; there is no age limit for a disabled child for transfer of assets purposes);

(C) sibling who has equity interest in the home and has lived there for at least one year before the person transferred to an institutional setting; or

(D) son or daughter (other than a disabled or minor child) who lived in the home for at least two years before the person transferred to an institutional setting and provided care that prevented institutionalization. To substantiate this claim, there must be a written statement from the person's attending physician or a professional social worker familiar with the case documenting the care provided by the son or daughter.

(2) Assets, including the person's home, may be transferred without resulting in a penalty when:

(A) transferred to the person's spouse or to another for the sole benefit of that spouse, or from the person's spouse to another for the sole benefit of that spouse;

(B) transferred to the person's child or to a trust, including an exception trust described in §1917(d)(4) of the Social Security Act (42 U.S.C. §1396p(d)(4)), established solely for the benefit of the person's child. The child must meet Social Security Administration disability criteria. There is no age limit for a disabled child for transfer of assets purposes;

(C) transferred to a trust, including an exception trust as specified in §1917(d)(4) of the Social Security Act (42 U.S.C. §1396p(d)(4)), established for the sole benefit of a person under 65 years of age who meets Social

Security Administration disability criteria;

(D) satisfactory evidence exists that the person intended to dispose of the resource at fair market value;

(E) satisfactory evidence exists that the transfer was exclusively for some purpose other than to qualify for Medicaid;

(F) imposition of a penalty would cause undue hardship;

(G) a person changes a joint bank account to establish separate accounts to reflect correct ownership of and access to funds; or

(H) a person purchases an irrevocable funeral arrangement or assigns ownership of an irrevocable funeral arrangement to a third party.

(3) In determining whether an asset was transferred for the sole benefit of a spouse, child, or person with a disability, there must be a written instrument of transfer, such as a trust document, which legally binds the parties to a specified course of action and which clearly sets out the conditions under which the transfer was made, as well as who can benefit from the transfer. The instrument or document must provide for the spending of the funds involved for the benefit of the person on a basis that is actuarially sound based on the life expectancy of the person involved. When the instrument or document does not so provide, there can be no exemption from the penalty. Exception trusts created under §1917(d)(4) of the Social Security Act (42 U.S.C. §1396p(d)(4)) are exempt from the actuarially sound distribution provisions of this section.

(4) The situations in paragraphs (1) - (3) of this subsection are the only situations in which an uncompensated transfer does not result in a penalty for care in an institutional setting. Under the transfer provisions of OBRA 1993, the home is not an excluded resource for a person in an institutional setting. Therefore, if the home of a person in an institutional setting is transferred, unless the transfer meets one of the criteria in paragraphs (1) - (3) of this subsection, it could affect payment for the person's care in an institutional setting.

(e) Look-back period.

(1) Penalties may be assessed for transfers occurring on or after the look-back date. Penalties cannot be assessed for time frames prior to the look-back period.

(2) The law prescribes a 36-month look-back period for most uncompensated transfers. However, there is a 60-month look-back period for certain transfers involving trusts. The look-back periods for trusts and distributions from trusts are defined in subparagraphs (A) and (B) of this paragraph.

(A) Revocable trusts.

(i) Payments from a revocable trust to or for the benefit of someone other than an applicant or recipient have a 60-month look-back period.

(ii) Making a revocable trust irrevocable with payments from corpus/income foreclosed to the applicant or recipient is a transfer of assets and has a 60-month look-back period.

(B) Irrevocable trusts.

(i) Payments from an irrevocable trust (where trustee distributions are not foreclosed to the applicant or recipient) which are made to (or for the benefit of) someone other than the applicant or recipient have a 36-month look-back period.

(ii) Creating an irrevocable trust where trustee payments are foreclosed to the applicant or recipient is a transfer of assets with a 60-month look-back period.

(iii) Creating an irrevocable trust where the trustee initially has discretion to make payments to the applicant or recipient (or for the applicant's or recipient's benefit), but where payments are foreclosed to the applicant or recipient at a later date is a transfer of assets as of the date payments are foreclosed to the applicant or recipient. The look-back period is 60 months.

(3) The look-back period is 36 months (or 60 months) from the later of the date of:

(A) institutionalization; or

(B) Medicaid application.

(4) When a person is already a Medicaid recipient before entering an NF, an ICF/MR, a state supported living center, a state center, or an IMD, the look-back period begins with institutional entry.

(5) When a person applies and is certified for Medicaid more than once because of multiple institutional stays or periods of ineligibility, the look-back date is based on the later of the earliest application for Medicaid or the initial entry into the facility.

(6) When a person applies for a §1915(c) waiver program, the look-back period is 36 months or 60 months from the later of the date:

(A) of application for waiver services (completed, signed application form is received in HHSC office); or

(B) after application that the person transfers assets.

(7) When a person applies for services in an institutional setting but is not certified and then reapplies, a new look-back period is based on the latest application.

(8) When a person applies and is certified for a §1915(c) waiver program, subsequently is denied, and reapplies for waiver services, the initial look-back period is still in effect.

(9) When a look-back period is established, the person is certified, and then moves from a Medicaid-certified long-term care facility to a §1915(c) waiver program or vice versa, the initial look-back period is still in effect. This is true even when there is a gap in eligibility periods.

(10) Any additional transfers of assets that occur after the person is certified for Medicaid may be assessed a penalty.

(f) Calculation of penalty period.

(1) There is no limit to the penalty period under OBRA 1993. The penalty period is determined by dividing the uncompensated value of all assets transferred by the average monthly cost of nursing facility care for a private-pay patient.

(2) The penalty period calculation applies to the transfer of both income and resources.

(3) The same penalty period calculation is used for a person who applies for a §1915(c) waiver program. Penalty periods continue to run if a person moves from a Medicaid-certified long-term care facility to a §1915(c) waiver program or vice versa.

(4) The penalty period begins the month of transfer. However, a new penalty period cannot be imposed while a previous penalty period is still in effect. Therefore, the penalty periods assessed under OBRA 1993 rules for multiple transfers that overlap run separately but consecutively. (5) If a penalty period ends and a subsequent transfer occurs, a new penalty period is established effective the month of the subsequent transfer. This means there may be a gap between penalty periods.

(6) When multiple transfers occur during the look-back period in such a way that the penalty periods for each overlap, the transfers are treated as a single event. The uncompensated values are lumped together and divided by the average monthly rate for a private-pay patient in a nursing facility. If multiple transfers occur in such a way that the penalty periods do not overlap, then the transfers are treated as separate events and the penalty periods are calculated separately.

(g) Apportioning penalty periods between spouses.

(1) When a person's spouse transfers an asset that results in a penalty for the person, the penalty period must, in certain instances, be apportioned between the spouses. Both spouses must be eligible for Medicaid in an institutional setting during the same time period for apportionment to occur. Apportionment occurs when:

(A) the spouse:

(i) is institutionalized and is Medicaid eligible; or

(ii) would be eligible for a §1915(c) waiver program; and

(B) some portion of the penalty against the person remains at the time the conditions in this paragraph are met.

(2) When one spouse is no longer subject to a penalty (for example, the spouse is no longer in an institutional setting, or the spouse dies), the remaining penalty period applicable to both spouses must be served by the remaining spouse.

(h) Return of transferred asset.

(1) For transfers occurring on or after August 11, 1993, if the transferred asset is subsequently returned to the person, the transfer is nullified and the penalty period is erased retroactive to the month of transfer. The asset is treated as though never transferred, and is excluded or counted, as appropriate, in determining the person's eligibility for those months in which the asset was in someone else's possession. In spousal cases, if the person or the person's spouse transferred an asset before the person entered the nursing facility and the asset is returned after institutionalization, the spousal protected resource amount must also be recalculated.

(2) For a penalty period to be nullified, all of the asset in question or its fair market value must be returned to the person. When only part of an asset or its equivalent value is returned, the penalty period can be reduced but not eliminated. For example, if only half the value of the asset is returned, the penalty period can be reduced by one-half. Payment on the principal of a note is the return of a transferred asset and reduces the penalty accordingly.

(i) Spouse-to-spouse transfers under spousal impoverishment provisions.

(1) There are no restrictions on interspousal transfers occurring from the date of institutionalization to the date of application; the reason is that at application and throughout the initial eligibility period (12 full months following the medical effective date), the combined countable resources of the couple are considered in determining eligibility. For the same reason, interspousal transfers are also permitted before institutionalization. A penalty can result when the community spouse transfers assets to a third party, not for the sole benefit of either spouse.

(2) To remain eligible at the end of the initial eligibility period, the person in an institutional setting must reduce resources to which the person has access at least to the resource limit. If the person chooses, the person may, during the initial eligibility period, transfer resources from his or her name to the community spouse's name with no penalty applied to the transfer. The transfer-of-assets policy applies only to transfer of assets for less than fair market value to someone other than the community spouse if not for the sole benefit of that spouse.

(3) Transfer penalties apply when the community spouse transfers his or her separate property before institutionalization, or after institutionalization but before certification. Transfer penalties apply when the

community spouse transfers community property both before and after institutionalization, if not for the sole benefit of the spouse.

(j) Compensation. Compensation, in the form of funds, real property, or services, must actually have been provided to a person. Future compensation does not satisfy the compensation requirement except for annuities which are actuarially sound. Compensation, however, may be in the form of payment or assumption of a legal debt owed by the individual making the transfer. Compensation is not allowed for services that would be normally provided by a family member (such as house painting or repairs, mowing lawns, grocery shopping, cleaning, laundry, preparing meals, transportation to medical care). The person must provide valid receipts for financial expenditures or written statements from the individuals who were paid to provide the services. If the person receives additional cash compensation that was not a part of the transfer agreement from the party who received the transferred asset, the uncompensated value of the transferred asset must be reduced by the amount of the additional compensation and as of the date the compensation is received. Cash compensation includes direct payments to a third party to meet the person's food, shelter, or medical expenses, including nursing facility bills, incurred after the date of the transfer. Compensation for a transferred asset must be provided according to terms of an agreement established on or before the date of transfer. This agreement must have been established exclusively for purposes other than obtaining or retaining eligibility for Medicaid services.

(k) Participation in transfers. Any action by a person's co-owner(s) to eliminate the person's ownership interest or control of a joint asset, with or without the person's consent, is a transfer of assets. Placing another person's name on an account or other asset that results in limiting the person's control of an asset (right to dispose) is a transfer of assets.

(l) Rebuttal procedures.

(1) Notification of opportunity for rebuttal. If any amount of uncompensated value exists, HHSC advises the person or authorized representative of the amount of uncompensated value and the length of the penalty period. The penalty period applies unless the person provides convincing evidence that the disposal was solely for some purpose other than to obtain Medicaid services. If, within the periods specified in this paragraph, the person or authorized representative makes no effort to rebut the presumption that the transfer was solely to obtain Medicaid services, HHSC assumes that the presumption is valid. The rebuttal period is five working days after oral notification (by HHSC to the person) and seven working days after written notification.

(2) Rebuttal of the presumption. Transfer-of-assets statutes presume that all transfers for less than fair market value are to obtain Medicaid services. The person or authorized representative is responsible for providing convincing evidence that the transaction in question was exclusively for some other purpose. To rebut the presumption, the person or authorized representative must provide a written statement and any relevant documentation to substantiate his or her statement. The statement, oral or written, must include at least the following:

(A) purpose for transferring the asset;

(B) attempts to dispose of the asset at fair market value;

(C) reason for accepting less than fair market value for the asset;

(D) means of or plan for self-support after the transfer; and

(E) relationship to the person to whom the asset was transferred.

(m) Undue hardship.

(1) A person may claim undue hardship when imposition of a transfer penalty would result in discharge to the community and/or inability to obtain necessary medical services so that the person's life is endangered. Undue hardship also exists when imposition of a transfer penalty would deprive the person of food, clothing, shelter, or

other necessities of life. Undue hardship relates to hardship to the person, not the relatives or responsible parties of the person. Undue hardship does not exist when imposition of the transfer penalty merely causes the person inconvenience or when imposition might restrict his lifestyle but would not put him at risk of serious deprivation.

(2) Undue hardship may exist when any one of the following conditions specified in subparagraphs (A) - (C) of this paragraph exists:

(A) location of the receiver of the asset is unknown to the person, or other family members, or other interested parties, and the person has no place to return in the community and/or receive the care required to meet his or her needs;

(B) the person can show that physical harm may come as a result of pursuing the return of the asset, and the person has no place to return in the community and/or receive the care required to meet his or her needs; or

(C) receiver of the asset is unwilling to cooperate with the person and HHSC, and the person has no place to return in the community and/or receive the care required to meet his or her needs.

(3) If a person claims undue hardship, HHSC makes a decision on the situation as soon as possible but within 30 days after receipt of the request for a waiver of the penalty. The person has the right to appeal an adverse decision on undue hardship.

Chapter J, Spousal Impoverishment

J-1000, Spousal Impoverishment Overview

J-1100, Texas Administrative Code Rules

Body

Revision 10-3; Effective September 1, 2010

The following rules are taken from Subchapter C, Financial Requirements, Division 5, Spousal Impoverishment.

§358.411. Purpose and Application.

(a) This division establishes the criteria under which income and resources are protected for a community spouse, in accordance with 42 U.S.C. §1396r-5.

(b) This division applies to an institutionalized spouse whose continuous period in an institutional setting begins on or after September 30, 1989. For this division only, a reference to an institutional setting includes the receipt of services under the Program of All-Inclusive Care for the Elderly (PACE).

(c) This division applies to a person who is in an institutional setting and has a community spouse. It is not necessary for the community spouse to meet citizenship and residency requirements.

(d) This division does not apply to a couple with a void or annulled marriage.

(e) In the case of a divorce, the provisions of this division apply through the end of the calendar month of the court order granting the divorce.

§358.412. Definitions.

In this division, the following words and terms have the following meanings, unless the context clearly indicates otherwise.

(1) Community spouse—The spouse of an institutionalized spouse who is not living in a setting that provides medical care and services.

(2) Dependent family member—A minor or dependent child, dependent parent, or dependent sibling of an institutionalized spouse or a community spouse who resides with the community spouse. [**Note**: A dependent family member can be either spouse's minor or dependent children, dependent parents and dependent siblings (including half brothers, half sisters and siblings gained through adoption) who were living in an institutionalized client's home before the client's institutionalization, and who are unable to support themselves outside the client's home because of medical, social or other reasons.]

(3) Institutional setting—In this division only, a living arrangement in which a person applying for or receiving Medicaid:

(A) lives in a Medicaid-certified long-term care facility;

(B) receives services under a §1915(c) waiver program; or

(C) receives services under the Program of All-Inclusive Care for the Elderly (PACE).

(4) Institutionalized spouse—A person who:

(A) receives care in an institutional setting;

(B) has met or is likely to meet the criterion in subparagraph (A) of this paragraph for at least 30 consecutive days; and

(C) is married to a spouse who does not meet the criterion in subparagraph (A) of this paragraph.

(5) Spousal protected resource amount (SPRA)—That portion of a couple's combined countable resources reserved for the community spouse and deducted from the couple's combined countable resources in determining eligibility.

§358.413. Spousal Impoverishment Treatment of Income and Resources.

The Texas Health and Human Services Commission follows §1924 of the Social Security Act (42 U.S.C. §1396r-5), regarding the treatment of income and resources for certain institutionalized spouses in institutional settings.

§358.414. Assessment of Resources to Determine a Spousal Protected Resource Amount.

(a) Assessment. Upon request of either the institutionalized spouse or the community spouse, or either spouse's authorized representative, the Texas Health and Human Services Commission (HHSC) assesses the couple's resources to determine the spousal protected resource amount (SPRA). The request and assessment may be made any time from the beginning of the continuous period in an institutional setting to the date of application for Medicaid.

(b) Assessment request. If the request described in subsection (a) of this section is not part of an application for Medicaid, the couple must provide information on their resources and verification as required by HHSC. If the couple does not provide the verification within the time frame requested by HHSC, HHSC does not complete the assessment and takes no further action.

(c) Assessment date. HHSC assesses the couple's combined countable resources as of 12:01 a.m. on the first day of the month in which the first continuous period in an institutional setting began. When determining the first day of the month in an institutional setting for the SPRA, HHSC may count days the person spent in a hospital if the person admits directly from the hospital to an institutional setting. After the continuous period begins, hospital stays and therapeutic home visits are not considered as breaks in the 30-consecutive-day period.

§358.415. Calculation of the Spousal Protected Resource Amount.

(a) The Texas Health and Human Services Commission (HHSC) calculates the spousal protected resource amount (SPRA) as of the assessment date described in §358.414(c) of this division (relating to Assessment of Resources to Determine a Spousal Protected Resource Amount).

(b) When determining the SPRA, HHSC excludes the following resources regardless of value:

(1) one automobile; and

(2) a home, if:

(A) the community spouse or dependent family member continues to live in the home while the person is in the institutional setting;

(B) the community spouse lives in another state on out-of-state property, whether or not the institutionalized spouse has ownership interest; or

(C) the community spouse had been living in the out-of-state property as a home but is not residing there during the assessment and initial eligibility period and the community spouse signs a statement of intent to return to the home.

(c) The SPRA is the greater of:

(1) one-half of the couple's combined countable resources, not to exceed the maximum resource amount set by federal law; or

(2) the minimum resource amount set by federal law.

(d) HHSC calculates the SPRA as described in this section whether the SPRA is calculated at the time of application for Medicaid or before an application for Medicaid is filed. After HHSC determines the SPRA, the SPRA does not change unless:

(1) the SPRA was based on incomplete or inaccurate information, as described in §358.416(f)(1) of this division (relating to Initial Application and the Spousal Protected Resource Amount); or

(2) the SPRA is expanded as described in §358.420 of this division (relating to Expanding the Spousal Protected Resource Amount).

(e) The couple may not appeal the SPRA at the time of the assessment. The couple may appeal the SPRA after an application for Medicaid is filed.

§358.416. Initial Application and the Spousal Protected Resource Amount.

(a) Upon receiving an application for Medicaid, the Texas Health and Human Services Commission (HHSC) calculates the couple's combined countable resources, without regard to community or separate property laws or the spouses' respective ownership interests, as of 12:01 a.m. on the first day of the month in which eligibility is being determined. HHSC follows the resource exclusions for an automobile and a home, regardless of value, as described in §358.415 of this division (relating to Calculation of the Spousal Protected Resource Amount).

(b) If an assessment of resources to determine the spousal protected resource amount (SPRA) has not previously been completed, HHSC determines the SPRA at initial application, in accordance with §358.415 of this division.

(c) HHSC deducts the SPRA from the couple's combined countable resources calculated in subsection (a) of this section. HHSC follows §1924(a)(3) and §1924(c)(2) of the Social Security Act (42 U.S.C. §1396r-5(a)(3) and 42 U.S.C. §1396r-5(c)(2)) when determining resource eligibility of the institutionalized spouse at the initial eligibility determination.

(d) If the SPRA determined at assessment is either the federal minimum or maximum resource amount, and the federal minimum or maximum resource amount increases before completion of the initial application for Medicaid, HHSC uses the federal minimum and maximum resource amounts in effect at the time of completion of the initial application.

(e) If the institutionalized spouse is found ineligible for Medicaid at the initial application and reapplies, HHSC deducts the same SPRA for subsequent applications.

(f) If an institutionalized spouse, after having been certified, is subsequently denied and reapplies for Medicaid:

(1) if the institutionalized spouse should never have been certified and was denied because of unreported resources, HHSC calculates a new SPRA at reapplication, taking into account the previously unreported resources; and

(2) if the institutionalized spouse was denied for any other reason, HHSC does not deduct the SPRA and counts only the institutionalized spouse's resources at reapplication.

(g) After eligibility is established for the institutionalized spouse, HHSC follows §1924(c)(4) of the Social Security Act (42 U.S.C. §1396r-5(c)(4)) in the separate treatment of resources.

§358.417. Treatment of Resources of the Institutionalized Spouse after the Initial Eligibility Period.

After the initial eligibility period of the institutionalized spouse, the Texas Health and Human Services Commission does not apply the spousal protected resource amount and counts only the institutionalized spouse's resources for the purpose of eligibility redetermination, in accordance with Division 2 of this subchapter (relating to Resources).

§358.418. Refusal of a Community Spouse to Cooperate.

(a) If a community spouse refuses to cooperate in providing information to establish a spousal protected resource amount (SPRA) during an assessment as described in §358.414(b) of this division (relating to Assessment of Resources to Determine a Spousal Protected Resource Amount), the Texas Health and Human Services Commission (HHSC) does not complete the assessment and takes no further action.

(b) If an assessment is undertaken in conjunction with an eligibility determination at the initial application, and a community spouse refuses to furnish information, HHSC determines the living arrangement before the continuous period in an institutional setting began.

(1) If the couple was living in the same household, HHSC denies the application based on the couple's failure to furnish information. Living in the same household includes temporary separations.

(2) If the couple was not living in the same household, HHSC determines the purpose of separation, the length of separation, and resources or income commingled or managed jointly by one spouse or a third party.

(c) If the community spouse refuses to cooperate in providing information, and circumstances indicate possible abuse or neglect by the community spouse, HHSC considers the institutionalized spouse as an individual for purposes of determining eligibility and calculating the co-payment.

§358.419. Separation to Circumvent Medicaid Policy.

(a) The Texas Health and Human Services Commission (HHSC) evaluates the information provided by a couple to determine if a couple separated before the continuous period in an institutional setting began to avoid the pooling of resources under Medicaid spousal impoverishment provisions, if:

(1) the separation occurred after a change in the health of the institutionalized spouse;

(2) the community spouse potentially owns separate resources; or

(3) the ownership of commingled resources was changed recently.

(b) A couple has the right to rebut HHSC's determination that a separation occurred to circumvent Medicaid policy. To rebut HHSC's determination, either spouse or either spouse's authorized representative must provide a written statement or evidence to HHSC to substantiate the separation as directed on the written notification of HHSC's determination that a separation occurred to circumvent Medicaid policy.

(c) If HHSC determines that circumstances indicate there was no intent to circumvent Medicaid policy, HHSC treats the institutionalized spouse as an individual for purposes of determining Medicaid eligibility and calculating the co-payment.

§358.420. Expanding the Spousal Protected Resource Amount.

(a) This section applies to an institutionalized spouse whose continuous period in an institutional setting begins on or after September 1, 2004.

(b) An institutionalized spouse may request that HHSC expand the spousal protected resource amount (SPRA) to produce additional income for the community spouse. To determine whether to expand the SPRA, HHSC considers the countable amount of non-resource-produced and non-investment income of the community spouse and compares the countable amount of non-resource-produced and non-investment income to the minimum monthly maintenance needs allowance (MMMNA). The MMMNA is the minimum income level for a community spouse set by the Centers for Medicare and Medicaid Services.

(1) If the community spouse's countable non-resource-produced and non-investment income is less than the MMMNA, HHSC considers the available income (countable non-resource-produced income minus the personal needs allowance) of the institutionalized spouse and adds the institutional spouse's available income to the community spouse's countable non-resource-produced and non-investment income and compares the combined incomes to the MMMNA.

(2) If the total amount of the community spouse's own income plus the amount of available income diverted from the institutionalized spouse is equal to or greater than the MMMNA, then HHSC does not expand the SPRA.

(3) If the total amount of the community spouse's own income plus the amount of available income diverted from the institutionalized spouse is less than the MMMNA, then HHSC determines an expanded SPRA as described in subsections (c) - (e) of this section.

(c) If, after the diversion of the institutionalized spouse's available income, the community spouse's total income is less than the MMMNA, the couple can protect an amount of resources equal to the dollar amount that must be deposited in a one-year certificate of deposit (CD), at current interest rates, to produce interest income equal to

the difference between the MMMNA in effect at the time of the request and other countable income not generated by either spouse's countable resources. The couple is not required to invest in the CD as a condition of eligibility.

(d) To determine the amount of the expanded SPRA, HHSC determines the current interest rate of a one-year CD as published in the local newspaper or provided by a local bank. HHSC then determines the amount of resources required to produce income, at the specified interest rate, that would increase the community spouse's income to the MMMNA.

(e) The amount of resources to be protected is determined by using the methodology described in paragraphs (1) - (4) of this subsection. This methodology is to be used to determine the maximum amount of resources to be protected regardless of the actual income the couple's resource may or may not be producing.

(1) Subtract from the amount of the MMMNA the community spouse's monthly income from all sources other than resources of the couple (including any income that must first be diverted by the institutionalized spouse as required by subsection (b) of this section). The result is the additional monthly income needed by the community spouse.

(2) Multiply by 12 the additional monthly income needed by the community spouse (from paragraph (1) of this subsection). The product equals the annual income needed by the community spouse.

(3) Divide the product from paragraph (2) of this subsection by the interest rate described in subsection (d) of this section. The result is the expanded SPRA, subject to paragraph (4) of this subsection.

(4) The expanded SPRA must not exceed the value of the couple's combined countable resources as of the first month of the continuous period in an institutional setting.

§358.421. Treatment of Income for Eligibility and Co-payment.

(a) To be eligible for Medicaid, an institutionalized spouse must have countable income that does not exceed the special income limit for an individual and meet all other eligibility criteria.

(b) In determining the income of an institutionalized spouse or community spouse for purposes of determining a co-payment, the Texas Health and Human Services Commission follows §1924(b)(2) and (d) of the Social Security Act (42 U.S.C. §1396r-5(b)(2) and (d)). See also Division 6 of this subchapter (relating to Budgeting for Eligibility and Co-payment).

§358.422. Notice and Fair Hearing.

The Texas Health and Human Services Commission follows §1924(e) of the Social Security Act (42 U.S.C. §1396r-5(e)) concerning notices and fair hearings for matters relating to spousal impoverishment.

§358.423. Transfer of Assets and Spousal Impoverishment.

See Division 4 of this subchapter (relating to Transfer of Assets) for requirements governing a transfer of assets under spousal impoverishment circumstances.

J-1200, Spousal Impoverishment Purpose

Body

Revision 15-3; Effective September 1, 2015

Effective September 30, 1989, Public Law 100–360 provides for the protection of income for the community spouse and certain dependent family members when the other spouse is institutionalized. Use the spousal impoverishment policies to determine Medicaid eligibility for individuals who:

- are likely to be in an institutional setting for a continuous period, or
- are eligible for Home and Community-Based Services and likely to need such services for at least 30 consecutive days, and
- have a spouse living in the community.

Spousal impoverishment requires a valid existing marriage. In Texas, there are three ways to terminate a marriage:

- Void Marriages — A determination that the marriage could not have existed because of one of the following legal impediments: the parties married within a prohibited degree of consanguinity (for example, nephew or niece), or at least one party has a previous marriage that has not been resolved. Void marriages do not require a lawsuit, and the marriage may be declared void in a collateral action (for example, contest of will). A legal marriage between parties never existed.
- Annulments — Also called voidable marriages. Grounds for annulment include, but are not limited to, marrying under the influence of drugs/alcohol, at least one party being incapacitated or the marriage being coerced. Annulments require court action, but under common law, an annulment is retroactive to the date of marriage.
- Divorce — Requires court action, and the marriage is dissolved effective the date of the divorce decree.

Spousal impoverishment provisions do not apply in the case of void or annulled marriages. If there is a void marriage or a court annulment of the marriage, always treat the person as an individual. In the case of a divorce, spousal impoverishment provisions apply through the end of the calendar month in which the divorce is issued.

Spousal impoverishment provisions do not apply when determining Medicare Savings Programs (MSP) eligibility for either spouse. When determining resource eligibility for MSP, consider resources in the institutionalized spouse's name even if they are protected for the community spouse.

A resource assessment is part of the spousal impoverishment process. The purpose of the resource assessment is to determine a protected resource amount, which is the portion of the total resources that is reserved for the community spouse and deducted from the couple's combined resources in determining eligibility.

An institutionalized spouse is a spouse who is either (1) likely to reside in an institutional setting (for example, a medical institution and/or nursing facility) for a continuous period of institutionalization, or (2) eligible for Home and Community-Based Services and likely to need such services for at least 30 consecutive days. For spousal impoverishment policy, when determining the first continuous period of institutionalization, a medical care facility includes any of the following:

- Hospital, including a U.S. Department of Veterans Affairs (VA) hospital
- Nursing facility, whether private-pay or Medicaid
- Intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID)
- Institution for mental diseases (IMD)
- Rehabilitation facility

A community spouse is a spouse who is not living in a medical institution or nursing facility. An incarcerated spouse is **not** considered a community spouse for spousal impoverishment purposes.

The community spouse could be living in any of the following settings and still be considered a community spouse:

- Personal care setting
- Adult foster care setting

- Supervised living setting
- Residential care facility setting

However, if the community spouse is living in a personal care facility, check the bill to see if the spouse is actually living in a medical facility. If the personal care facility is billing for room and board only, the spouse meets the definition of a community spouse. If the personal care facility is billing for the services of any medical professional (such as a registered nurse [RN], licensed vocational nurse [LVN], doctor, etc.), the spouse does not meet the definition of a community spouse and spousal impoverishment polices do not apply.

See Section J-1500, Change in Martial Status.

J-1300, Spousal Definitions

Body

Revision 15-3; Effective September 1, 2015

Community spouse — A person who is not living in a setting that provides medical care/services and who is married to:

- an institutionalized person, or
- a person who has been determined eligible for a Home and Community-Based Services waiver program.

Note: The community spouse of an institutionalized person may receive services under a Home and Community-Based Services waiver program, which will not affect the spousal diversion.

Dependent family member — Either spouses' minor or dependent children, dependent parents or dependent siblings (including half brothers, half sisters and siblings gained through adoption) who were:

- living in an institutionalized recipient's home before the recipient's institutionalization; or
- living with a recipient of a Home and Community-Based Services waiver program; and
- who are unable to support themselves outside the recipient's home because of medical, social or other reasons.

First continuous period of institutionalization — A spouse who is likely to reside in one or more of the following medical care facilities for a continuous period of institutionalization:

- Hospital, including a VA hospital
- Nursing facility, whether private-pay or Medicaid
- ICF/IID
- IMD
- Rehabilitation facility

Institutional setting — In this chapter only, a living arrangement in which a person applying for or receiving Medicaid:

- lives in a Medicaid-certified long-term care facility,
- receives services under a Home and Community-Based Services waiver program, or
- receives services under the Program of All-Inclusive Care for the Elderly (PACE).

Institutionalized spouse — A person who is married to a spouse residing in the community and who:

- receives care in an institutional setting, and
- has met or is likely to meet the continuous period of institutionalization for at least 30 consecutive days.

or

- is eligible for a Home and Community-Based Services waiver program, and
- is likely to need such services for at least 30 consecutive days.

Spousal protected resource amount (SPRA) — The portion of a couple's combined countable resources that is reserved for the community spouse and deducted from the couple's combined countable resources in determining eligibility.

J-1400, Community Spouse Cooperation

Body

J-1410 Refusal of a Community Spouse to Cooperate

Revision 09-4; Effective December 1, 2009

If a community spouse refuses to cooperate in providing information to establish a spousal protected resource amount (SPRA) during an assessment HHSC does not complete the assessment and takes no further action. See Section J-4000, Assessment and SPRA.

If an assessment is started in conjunction with an eligibility determination at the initial application, and a community spouse refuses to furnish information, HHSC determines the living arrangement before the continuous period in an institutional setting began and takes the following action:

- If the couple was living in the same household, HHSC denies the application based on the couple's failure to furnish information. Living in the same household includes temporary separations.
- If the couple was not living in the same household, HHSC determines the purpose of separation, the length of separation, and resources or income commingled or managed jointly by one spouse or a third party.
- If the community spouse refuses to cooperate in providing information, and circumstances indicate possible abuse or neglect by the community spouse, HHSC considers the institutionalized spouse as an individual for purposes of determining eligibility and calculating the co-payment.

J-1420 Separation to Circumvent Medicaid Policy

Revision 09-4; Effective December 1, 2009

Evaluate the information provided by a couple to determine if a couple separated before the continuous period in an institutional setting began to avoid the pooling of resources under Medicaid spousal impoverishment provisions, if:

- the separation occurred after a change in the health of the institutionalized spouse;
- the community spouse potentially owns separate resources; or
- the ownership of commingled resources was changed recently.

A couple has the right to rebut HHSC's determination that a separation occurred to circumvent Medicaid policy. To rebut HHSC's determination, either spouse or either spouse's authorized representative must provide a written statement or evidence to HHSC to substantiate the separation as directed on the written notification of HHSC's determination that a separation occurred to circumvent Medicaid policy.

If HHSC determines that circumstances indicate there was no intent to circumvent Medicaid policy, HHSC treats the institutionalized spouse as an individual for purposes of determining Medicaid eligibility and calculating the co-payment.

The rebuttal period is five workdays after oral notification (by HHSC to either spouse) and seven workdays after written notification. The institutionalized spouse, community spouse or responsible party must provide written statements or evidence to substantiate the separation.

Obtain supervisory approval of this evaluation of additional evidence. If circumstances indicate there was no intent to circumvent Medicaid policy, HHSC treats the institutionalized spouse as an individual for consideration of resources, income and co-payment.

J-1500, Change in Marital Status

Body

Revision 10-2; Effective June 1, 2010

Spousal impoverishment requires both:

- an institutional spouse, and
- a spouse living in the community.

When there is a reported change to the status of the community spouse, the situation must be evaluated. Evaluation of any dependent family member situation would also be required when there is a change to the status of the community spouse or dependent family member.

The dependent allowance changes to the SSI FBR when there is no community spouse.

J-1510 Community Spouse Dies

Revision 12-1; Effective March 1, 2012

If the marriage ends by death in the same month it began, treat the marriage as if it had never existed. Otherwise, the end of marriage is effective the month after the month of death.

If the community spouse dies, the SPRA and income diversion are allowed through the month in which the community spouse dies. Beginning the month after the death of the community spouse, consider the surviving spouse as an individual.

Things to Consider

With the death of the community spouse, determine if there is a change in the authorized representative who signed the application/redetermination under penalty of perjury. See Section B-3220, Who May Sign an Application for Assistance.

Re-evaluate available assets due to the death of a spouse. For example:

- pensions could adjust;
- available resource exclusions could change; and
- resources could change due to inheritance.

Co-payment Changes

Enter the information concerning the community spouse's date of death on the Individual Information screen. Ensure notice is sent for any co-payment change.

The community spouse was eligible for the income diversion the month of death, but restitution is applicable for subsequent months until the co-payment is corrected. Do not seek restitution for the month the community spouse died. Do restitute for subsequent months until the co-payment is changed in the system of record.

The dependent allowance changes to the SSI FBR when there is no community spouse.

J-1520 Before Certification the Community Spouse Enters an Institutional Setting

Revision 15-4; Effective December 1, 2015

If the community spouse moves into an institutional setting (e.g., a medical institution or nursing facility) before certification of the first institutionalized spouse, determine if the spouses can be considered a couple.

Prepare a couple budget if a person is living with an eligible spouse (i.e., a spouse who is aged or has a disability) and they are:

- presenting themselves to the community as a married couple,
- determined to be married for purposes of receiving Social Security benefits, or
- recognized as married under state law.

To qualify for the special income limit, a person or couple must:

- have countable income that exceeds the reduced SSI FBR,
- reside in a Medicaid-certified long-term care facility for 30 consecutive days or be determined eligible for Home and Community-Based Services and be likely to need such services for at least 30 consecutive days, and
- receive a level of care or medical necessity determination that qualifies the person or couple for Medicaid.

If the spouses can be considered a couple, consider the incomes of both spouses against the special income limit standard for a couple.

If the spouses cannot be considered a couple or are not eligible as a couple, consider each spouse as an individual.

Notes:

- Use the special income limit if the person is age 65 or older and in a Medicaid-certified institution for mental diseases for 30 consecutive days. The dependent allowance is the SSI FBR when there is no community spouse.
- HHSC allows spousal diversions to a community spouse who is receiving services under a Home and Community-Based Services waiver program. Count the diversion as income to the community spouse in the waiver budget.

J-1530 After Certification the Community Spouse Enters an Institutional Setting

Revision 15-4; Effective December 1, 2015

After certification of the institutional spouse, the SPRA and diversion of income stops when the former community spouse moves to an institutional setting either:

- during the initial 12-month eligibility period, or
- after the initial 12-month eligibility period.

When determining income for each spouse, allow the income diversion through the month in which the former community spouse moves to an institutional setting and consider it as income to the former community spouse. For the month following the move to an institutional setting, budget the former community spouse's income without the diversion. The diversion becomes part of the co-payment budget for the first institutional spouse effective the month after the former community spouse moves to an institutional setting.

If the community spouse moves into an institutional setting (e.g., a medical institution or nursing facility) after certification of the first institutionalized spouse, determine if both spouses can be considered a couple. See Section G-6000, Institutional Eligibility Budget Types.

A couple budget is prepared if a person is living with an eligible spouse (i.e., a spouse who is aged or has a disability) and they are:

- presenting themselves to the community as a married couple,
- determined to be married for purposes of receiving Social Security benefits, or
- recognized as married under state law.

To qualify for the special income limit, a person or couple must:

- have countable income that exceeds the reduced SSI FBR,
- reside in a Medicaid-certified long-term care facility for 30 consecutive days, and
- receive a level of care or medical necessity determination that qualifies the person or couple for Medicaid.

If they can be considered a couple, the incomes of both spouses are considered against the special income limit standard for a couple.

If both spouses cannot be considered a couple or are not eligible as a couple, budget each spouse as an individual.

Note: The special income limit is used if the person is age 65 or older and in a Medicaid-certified institution for mental diseases for 30 consecutive days.

Things to Consider

If the spouses are eligible as a couple, a new application may not be required unless it is time for the annual redetermination. See Section B-3220, Who May Sign an Application for Assistance, if there has been a change in the authorized representative, power of attorney or legal guardian.

Verify resources as of 12:01 a.m. the month in which the former community spouse's medical effective date falls. When determining resources and transfers, see the information in Section I-3000, Exceptions to the Transfer of Assets, and Section I-5600, Apportioning Penalty Period Between Spouses.

Co-payment Changes

Enter the information concerning the community spouse's change in living arrangement to an institutional setting. Ensure notice is sent for any co-payment change.

Do not seek restitution for the month the former community spouse moved to an institutional setting. Do restitute for subsequent months until the co-payment is changed in the system of record.

The dependent allowance changes to the SSI FBR when there is no community spouse.

Example 1:

Spouse 1 entered the nursing facility in February of last year. Spouse 2 remained in the community. Combined countable resources as of 12:01 a.m. on Feb. 1 of last year were $50,000. An SPRA of $25,000 was determined at assessment. After spending down assets on the nursing facility and outstanding debts, spouse 1 filed an application this month. Two months ago, spouse 2 entered the same nursing facility. Treat as a couple case. If the spouses are not eligible as a couple, test their eligibility as individuals.

Example 2:

Spouse 1 entered the nursing facility on Feb. 2 of this year. Spouse 2 continued to live in their home. Combined countable assets for the month of entry were $14,000. The minimum SPRA was determined and the case certified in March. The couple's only income was their Social Security of $650 for spouse 1 and $900 for spouse 2, so the applied income was $0. Form H1279, Spousal Impoverishment Notification, was sent.Spouse 2 entered the same facility in April. Resources at 12:01 a.m. on April 1 totaled $9,000 in spouse 2's name. Spouse 2 is no longer a community spouse. Spousal impoverishment policy no longer applies. Spouse 2 is not resource-eligible.

- Complete the appropriate screens in the system of record to reflect that the community spouse is now in an institutional setting.
- Restitute for the month after spouse 2's entry if these changes do not process before cutoff.

J-1540 Spouses Divorce

Revision 12-1; Effective March 1, 2012

If the marriage ends by divorce or annulment in the same month it began, treat the marriage as if it never existed. Otherwise, the end of marriage is effective the month after the month of divorce or annulment.

The SPRA and income diversion are allowed through the month in which the marriage ended. Beginning the month after the marriage ended, consider the institutional spouse as an individual.

Things to Consider

With the end of the marriage, determine if there is a change in the authorized representative who signed the application/redetermination under penalty of perjury. See Section B-3220, Who May Sign an Application for Assistance.

Re-evaluate available assets due to the divorce or annulment. For example:

- pensions could adjust;
- available resource exclusions could change; and
- resources could change due to judges orders.

Co-payment Changes

Complete the appropriate screens in the system of record to reflect the community spouse's change in status. Ensure notice is sent for any co-payment change.

The community spouse was eligible for the income diversion the month of divorce or annulment, but restitution is applicable for subsequent months until the co-payment is corrected. Do not seek restitution for the month the marriage ended. Do restitute for subsequent months until the co-payment is changed in the system of record.

The dependent allowance changes to the SSI FBR when there is no community spouse.

J-2000, Spousal Treatment of Income and Resources

Body

Revision 10-2; Effective June 1, 2010

Spousal impoverishment policy does not change the determination of what constitutes income or resources, or the methodology and standards for determining and evaluating income and resources.

J-2100, Spousal Treatment of Income

Body

Revision 09-4; Effective December 1, 2009

Spousal impoverishment policy does not change the determination of what constitutes income or the methodology and standards for determining and evaluating income. See Chapter E, General Income. For spousal impoverishment, do not consider Section E-7000, Deeming Income, or Section E-8000, Support and Maintenance.

J-2110 Income Eligibility Test for the Institutional Spouse

Revision 09-4; Effective December 1, 2009

For the income eligibility test, separate treatment of income is required. During any month in which an institutionalized spouse is in an institutional setting, no income of the community spouse is used to determine the eligibility of the institutionalized spouse. When totaling countable income for the institutional spouse, consider the following.

If payment of income is made:

- solely in the name of the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;
- in the names of the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and
- in the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse’s interest (or, if payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse).

An institutionalized spouse can rebut the treatment of the income based on the assumed ownership interest by establishing a preponderance of evidence that the ownership interests in income are different.

J-2111 Treatment of Interest from a Joint Account

Revision 09-4; Effective December 1, 2009

For treatment of jointly owned accounts with liquid assets such as a joint bank account, follow Appendix XXV, Accessibility to Income and Resources in Joint Bank Accounts, in determining how to treat the interest. Also refer to the policy for treatment of interest in the following items:

- Section E-3331, Interest and Dividends;
- Section E-5000, Variable Income; and
- Section E-9000, Infrequent or Irregular Income.

J-2112 Treatment of Income from a Trust

Revision 09-4; Effective December 1, 2009

If income from a trust is countable, the income is considered available to each spouse as provided in the trust. If the trust does not specifically address how the income is to be distributed and payment of income is made:

- solely to the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;
- to both the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and
- to the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse).

J-2113 Other Treatment of Income

Revision 09-4; Effective December 1, 2009

When income is received, but there is no instrument establishing ownership, one-half of the income shall be considered to be available to the institutionalized spouse and one-half to the community spouse.

An institutionalized spouse can rebut the treatment of the income based on the assumed ownership interest by establishing a preponderance of evidence that the ownership interests in income are different.

J-2200, Spousal Treatment of Resources

Body

Revision 10-2; Effective June 1, 2010

For the resource eligibility test, combined treatment of resources is required by federal regulations. In determining the resources of an institutionalized spouse, regardless of any state laws relating to community property or the division of marital resources, all the resources held by either the institutionalized spouse, community spouse or both shall be considered to be available to the institutionalized spouse.

When totaling countable resources for the institutional spouse consider the total value of the resources to the extent either the institutionalized spouse or the community spouse has an ownership interest.

Use Chapter F, Resources, for treatment of resources to determine countable value. Apply exclusions, as appropriate, keeping in mind the federal requirement to use the combined resources regardless of any state laws relating to community property or the division of marital resources.

For the assessment and the initial eligibility period, follow these exceptions to the resource exclusions in Chapter F and do not consider in the countable value the following resources:

- one automobile; and
- a home, if:
  - the community spouse or dependent family member continues to live in the home while the person is in the institutional setting;
  - the community spouse lives in another state on out-of-state property, whether or not the institutionalized spouse has ownership interest; or
  - the community spouse had been living in the out-of-state property as a home but is not residing there during the assessment and initial eligibility period and the community spouse signs a statement of intent to return to the home.
- household goods and personal effects (see Section F-4222, Household Goods and Personal Effects).

Determine countable resources based on resources of the couple beginning with the first month for which eligibility is being tested (including prior months). Follow standard resource requirements to verify the resources as of 12:01 a.m. on the first day of the month.

Countable resources can be reduced by the amount of funds encumbered before 12:01 a.m. on the first day of the month by any checks written before that time that have not yet been processed by the financial institution. For further information about encumbered funds, see Section F-1311, Encumbered Funds, and Section F-1312, Nursing Facility Refunds.

At application, resource eligibility will be determined from the countable resource. See Section J-5000, Spousal Initial Application.

J-2210 Out-of-State Home and Spousal Impoverishment

Revision 09-4; Effective December 1, 2009

With the following exceptions, a person who applies for and receives Medicaid benefits in Texas is not allowed to exclude a home in another state. Otherwise, if the person considers his home in another state to be his principal place of residence, he is not a Texas resident, and he must apply for assistance in his home state.

- If the community spouse lives in another state in a house that the institutional spouse claims is not his homestead, to determine the protected resource amount and initial eligibility, exclude the out-of-state property as a part of resources totally excluded regardless of value. If the institutional spouse still has an ownership interest in the property at the first annual redetermination, HHSC considers the value of the property a countable resource that is real property. This situation does not affect residency requirements.

As long as the institutionalized spouse intends to remain in the state where he is institutionalized, he is considered a resident.
- If the community spouse lives in another state in a house that is the institutional spouse's homestead, the home is excluded in the resource assessment and throughout the initial eligibility period of 12 months. If the institutional spouse still has an ownership interest in the property at the first annual redetermination, the home is a countable resource. If the community spouse is not living in the out-of-state home, the community spouse must sign a statement of intent to return for the home to be excluded for the resource assessment and initial eligibility period of 12 months.

See Section F-3000, Home, and Section F-3500, Out-of-State Home Property.

J-3000, Spousal Transfer of Assets

J-3100, Spousal Transfer of Resources

Body

Revision 09-4; Effective December 1, 2009

There are no restrictions on interspousal transfers occurring from the date of institutionalization to the date of the MEPD application; the reason is that at application and throughout the initial eligibility period (first annual redetermination date set by the automated system), the combined countable resources of the couple are considered in determining eligibility. For the same reason, interspousal transfers are also permitted before institutionalization. A penalty can result when the community spouse transfers assets to a third party, not for the sole benefit of either spouse.

To remain eligible at the end of the initial eligibility period, the institutionalized spouse must reduce resources to which he has access at least to the resource limit. If the institutionalized spouse chooses, he may, during the initial eligibility period, transfer resources from his name to the community spouse's name with no penalty applied to the transfer. The transfer-of-assets policy applies only to transfer of assets for less than fair market value to individuals other than the community spouse, if not for the sole benefit of that spouse.

Transfer penalties apply when the community spouse transfers his separate property before institutionalization, or after institutionalization but before the MEPD certification. Transfer penalties apply when the community spouse transfers community property both before and after institutionalization, if not for the sole benefit of the spouse.

J-3110 Spousal Resource Transfer Examples

Revision 12-1; Effective March 1, 2012

- When the institutionalized spouse enters a nursing facility, the couple's combined countable resources are $100,000, and the resources are all in the institutionalized spouse's name. The spousal protected resource amount (SPRA) is $50,000.

  Before application, the institutionalized spouse transfers the entire $100,000 to the community spouse. No transfer of assets penalty applies when eligibility is established.
- When the institutionalized spouse enters a nursing facility, the couple's combined countable resources are $100,000, all in the institutionalized spouse's name. The SPRA is $50,000. The institutionalized spouse transfers all resources to the community spouse without penalty.

A Medicaid application is filed two and one-half years later. The couple's combined countable resources are $30,000 as of 12:01 a.m. on the first day of the month of application, and the resources are all in the community spouse's name.

- $30,000 Combined countable resources
- – $50,000 SPRA
- = $0 Compared to appropriate resource standard for an individual

- If the institutionalized spouse inherits $20,000 after Medicaid certification, the institutionalized spouse may transfer the entire amount of that inheritance to the community spouse without penalty during the initial eligibility period. However, this $20,000 is treated as income for the month of receipt, and restitution of the full vendor payment for that month is requested. This brings the community spouse's resources to $50,000, the full protected amount.

- If more than $22,000 is inherited, the person would be ineligible based on resources ($22,001 + $30,000 = $52,001 combined resources).

  - $52,001 Combined resources
  - – $50,000 SPRA
  - = $2,001 > $2,000 and ineligible
- When the person enters the nursing facility, the couple's combined countable resources are $100,000 ($90,000 in person's name and $10,000 in the community spouse's name). The protected resource amount is $50,000.

  A Medicaid application is filed eight months later. Before application, the person transferred $80,000 to the community spouse and spent $10,000 on nursing facility bills. The community spouse then transferred $50,000 to her daughter before the Medicaid application was filed. The couple's combined countable resources are now $40,000 as of 12:01 a.m. on the first day of the month of application, and the resources are all in the community spouse's name.

  - $40,000 Combined countable resources
  - – $50,000 SPRA
  - = $0 Compared to appropriate resource standard for an individual

  The applicant is eligible for Medicaid but does not receive nursing facility services. The penalty period for vendor payment is imposed based on the $50,000 uncompensated value of the transfer to the daughter. **Note:** If the institutional spouse has a level of care or medical necessity determination and meets all eligibility criteria except for the transfer of assets provisions, the institutional spouse may be eligible to receive Your Texas Benefits Medicaid card but not assistance in paying for the cost of care in the long-term care facility. Follow procedures in Appendix XXIII, Procedure for Designated Vendor Number to Withhold Vendor Payment, to put the vendor payment on hold.

- When the institutional spouse entered the nursing facility (June 17), the couple's combined countable resources were $30,000. The institutionalized spouse had transferred $10,000 in April, with no compensation to a son. The uncompensated value is not included when calculating the protected resource amount, and the SPRA is one-half of $30,000, which would be $15,000. However, $15,000 is less than the current minimum SPRA amount; thus, the SPRA would be the current minimum SPRA amount.

  Under post-DRA transfer of assets policy, a penalty is imposed should a Medicaid application be filed and the transfer is within the look-back period, but the penalty would not start until the medical effective date. (If under pre-DRA transfer of assets policy, a penalty is imposed should a MEPD application be filed before the 85-day penalty [based on $117.08] has expired.)

The transfer of assets divisor used for all of the above illustrations may not reflect the most recent average private-pay cost per day amount.

J-3200, Spousal Transfer of Income

Body

Revision 09-4; Effective December 1, 2009

A person potentially incurs a transfer penalty by transferring income. Transfers of income include:

- waiving the right to receive an inheritance even in the month of receipt;
- giving away a lump sum payment even in the month of receipt; or
- irrevocably waiving all or part of federal, state or private pensions or annuities.

The date of transfer is the date of the actual change in income, if within the look-back period or during an ongoing month.

Interspousal transfers of income are permitted (for example, obtaining a court order to have community property pension income paid to a community spouse).

J-3300, Other Transfer Information

Body

Revision 09-4; Effective December 1, 2009

See Chapter I, Transfer of Assets, for requirements governing other transfer of assets under spousal impoverishment circumstances.

J-4000, Assessment and SPRA

Body

Revision 14-2; Effective June 1, 2014

The purpose of the assessment is to determine a protected resource amount, which is that portion of total resources reserved for the community spouse and deducted from the couple's combined resources in determining eligibility.

J-4100, Time Frame to Request the Assessment

Body

Revision 09-4; Effective December 1, 2009

Upon request of either the institutionalized spouse or the community spouse, or either spouse's authorized representative, assess the couple's resources to determine the spousal protected resource amount. The request and assessment may be made any time from the beginning of the continuous period in an institutional setting to the date of application for Medicaid.

J-4110 Automatic SPRA

Revision 09-4; Effective December 1, 2009

An automatic SPRA occurs when a community Medicaid recipient requests a program transfer to an institutional setting; use minimum SPRA at the time of the request.

J-4200, Assessment Request

Body

Revision 09-4; Effective December 1, 2009

If the request for the assessment of resources to determine the SPRA is not part of an application for Medicaid, the couple must provide information on their resources and verification as required by HHSC.

Inform the couple and/or representative of the verifications required to complete an assessment and the time frame to return the verification(s). The couple must provide requested verification of resources within 30 days of the request for assessment, or the request is void. Complete the assessment within 45 days after receipt of verification requested.

If the couple does not provide the verification(s) within the time frame requested by HHSC, HHSC does not complete the assessment and takes no further action.

Note: The couple may not appeal the SPRA at the time of the assessment. The couple may appeal the SPRA after an application for Medicaid is filed.

J-4210 Procedures for Processing the Assessment Request

Revision 09-4; Effective December 1, 2009

Step	Procedure
1	Assessment is requested. Send Form H1272, Declaration of Resources.
2	**Note:** Form H1272 is not used as an application. If the assessment and application are requested at the same time, only an HHSC application for MEPD Medicaid is needed.
3	If all necessary documentation is not received within 15 calendar days of return of completed Form H1272, send Form H1273, Request for Assessment Information. If the needed documentation is not received by the 30th calendar day, discontinue the assessment.
4	If all necessary documentation is received by the 30th calendar day, the assessment must be completed by the 45th calendar day from the receipt of the signed Form H1272.
5	When the assessment is complete, send Form H1274, Medicaid Eligibility Resource Assessment Notification, showing the protected resource amount. **Note:** This form must be sent whether or not the assessment is completed at the same time as an application.

J-4300, Assessment Date

Body

Revision 09-4; Effective December 1, 2009

HHSC assesses the couple's combined countable resources as of 12:01 a.m. on the first day of the month in which the first continuous period in an institutional setting began. When determining the first day of the month in an institutional setting for the SPRA, HHSC may count days the person spent in a hospital if the person is admitted directly from the hospital to an institutional setting. After the continuous period begins, hospital stays and therapeutic home visits are not considered as breaks in the 30-consecutive-day period. See Section G-6210, 30 Consecutive Days and the Special Income Limit.

Note: When determining the first day of month of institutionalization for the SPRA, institutionalization can be based on hospitalization if the individual is admitted directly to the nursing facility from the hospital stay.

J-4310 Determining the Assessment Date for a Home and Community-Based Services Waiver

Revision 09-4; Effective December 1, 2009

The SPRA is assessed as of 12:01 a.m. on the first day of the month that the application was received for the financial Medicaid eligibility component. See Chapter O, Waiver Programs, Demonstration Projects and All-Inclusive Care.

- If the waiver application is certified, the SPRA assessment date does not change unless it was based on incomplete or inaccurate information.
- If the waiver application is not certified and the individual reapplies, the SPRA assessment date is 12:01 a.m. on the first day of the month of the re-application month.

J-4311 Examples of the Assessment Date

Revision 09-4; Effective December 1, 2009

If spousal impoverishment is applicable and:

an institutionalized Medicaid recipient requests a program transfer to a waiver,	use the established SPRA.	This is considered an institutional SPRA.
a community applicant applies for a waiver,	assess resources as of 12:01 a.m. on the first day of the month of the MEPD application.	This is considered a waiver SPRA if the waiver application is certified.

If spousal impoverishment is applicable and:

an institutionalized applicant applies for Medicaid and then a waiver before being certified,	assess resources as of 12:01 a.m. on the first day of the month of institutionalization. Institutionalization can be based on hospitalization if the individual is admitted directly to the facility from the hospital stay.	This is considered an institutional SPRA. **Note:** When determining the 30-day stay requirement, consider both the days in a medical facility and the days in the waiver setting.
a community applicant applies for a waiver and then enters a medical facility before being certified,	assess resources as of 12:01 a.m. on the first day of the month of institutionalization from a medical facility regardless if the applicant remains in the medical facility or returns to community waiver services before certification.	This is considered an institutional SPRA. **Note:** When determining the 30-day stay requirement, consider both the days in a medical facility and the days in the waiver setting.

Note: When determining the first day of month of institutionalization for the SPRA, institutionalization can be based on hospitalization if the individual is admitted directly to the nursing facility from the hospital stay.

J-4400, SPRA Calculation

Body

Revision 14-2; Effective June 1, 2014

Use the following for the calculation of the SPRA at the time of the assessment request without an application or with the receipt of the MEPD application.

Calculate the SPRA as of the assessment date described in Section J-4300, Assessment Date. When determining the SPRA, determine countable resources using policy in Section J-2200, Spousal Treatment of Resources. To determine the amount of the SPRA, divide the countable resources by two and the result will be the amount to compare to the maximum and minimum SPRA amount set by federal law.

The SPRA is the greater of:

- one-half of the couple's combined countable resources, not to exceed the maximum resource amount set by federal law; or
- the minimum resource amount set by federal law.

Calculate the SPRA as described above whether the SPRA is calculated at the time of application for Medicaid or before an application for Medicaid is filed.

Resource exclusions determined in the SPRA are the same exclusions used in the eligibility determination at application.

Note: The equity value of the home does not impact spousal impoverishment policy and treatment of the home during the assessment process. If the person’s community spouse, child or disabled adult child is living in the home, substantial home equity policy does not apply. See Section F-3600, Substantial Home Equity.

J-4500, Changing the Assessment Amount

Body

Revision 09-4; Effective December 1, 2009

With an automatic SPRA, no additional verification is necessary to establish the amount of the SPRA. Send Form H1274, Medicaid Eligibility Resource Assessment Notification, indicating the minimum SPRA and the right to appeal. See Section J-4110, Automatic SPRA.

See Section J-4311, Examples of the Assessment Date, for information about an institutional SPRA or Home and Community-Based Services waiver SPRA.

With an institutional SPRA, the SPRA assessment date and amount do not change unless they are based on incomplete or inaccurate information.

With a Home and Community-Based Services waiver SPRA, if the application is certified, the SPRA assessment date and amount do not change unless they are based on incomplete or inaccurate information. If the application is not certified, the SPRA assessment date is re-established if the individual reapplies.

The SPRA amount must not be deducted from resources for an individual who is found eligible, who is certified, or who is subsequently denied and then reapplies. Only those resources in the name of the Home and Community-Based Services waiver (institutionalized) spouse are considered at reapplication.

If an institutional spouse was certified incorrectly because of unreported resources and the case is subsequently denied, the original SPRA amount is not used when the institutional spouse reapplies for Medicaid. A new SPRA amount that includes the previously unreported resources must be calculated.

The SPRA can change if it is expanded as described in Section J-6000, SPRA Expansion.

J-5000, Spousal Initial Application

Body

Revision 13-3; Effective September 1, 2013

Upon receiving an application for Medicaid, calculate the couple's combined countable resources, without regard to community or separate property laws or the spouses' respective ownership interests, as of 12:01 a.m. on the first day of the month in which eligibility is being determined.

See Section J-2200, Spousal Treatment of Resources.

If an assessment of resources to determine the spousal protected resource amount (SPRA) has not previously been completed, determine the SPRA at initial application, using Section J-4000, Assessment and SPRA.

When the assessment is complete, send Form H1274, Medicaid Eligibility Resource Assessment Notification. If the institutionalized spouse is found eligible for Medicaid, ensure Form H1279, Spousal Impoverishment Notification, is sent at certification along with the eligibility notice.

If the SPRA determined at assessment is either the federal minimum or maximum resource amount, and the federal minimum or maximum resource amount increases before completion of the initial application for Medicaid, use the federal minimum and maximum resource amounts in effect at the time of completion of the initial application.

If the institutionalized spouse is found ineligible for Medicaid at the initial application and reapplies, deduct the same SPRA for subsequent applications.

If an institutionalized spouse, **after having been certified** (even if there are ineligible months within the three months prior, month of application and any months through certification), is subsequently denied and reapplies for Medicaid:

- if the institutionalized spouse should never have been certified and was denied because of unreported resources, calculate a new SPRA at reapplication, taking into account the previously unreported resources; and
- if the institutionalized spouse was denied for any other reason, do not deduct the SPRA and count only the institutionalized spouse's resources at reapplication.

Note: A case is not considered "certified" until a **decision or certification has taken place** and there may be **both ineligible as well as eligible months within this certification decision.** The total countable combined resources of the couple are considered within the certification decision. See Section J-8000, After Initial Eligibility Period, for treatment of resources after certification.

J-5100, Spousal Steps at Application

Body

Revision 09-4; Effective December 1, 2009

Steps in determining countable resources for a spousal application:

Step	Procedure
1	Determine the couple's countable resources at 12:01 a.m. on the first day of the month of application (and three months prior).
2	Determine if an assessment of the SPRA was previously completed. If so, continue. Determine if the SPRA will be automatic, institutional or waiver. Institutional — Determine the SPRA based on the countable resources as of 12:01 a.m. of the first day of the month of medical facility entry. The medical facility entry can start at the date of hospital admission if the person transfers directly from the hospital to the nursing facility without returning to a community setting. Waiver — Determine the waiver SPRA based on the countable resources as of 12:01 a.m. of the first day of the month of receipt of the application.
3	Determine the SPRA, which is the greater of: • the spousal share or one-half of the couple's combined countable resources (not to exceed the maximum as set by federal law); or • the minimum spousal resource standard as set by federal law.
4	Subtract the SPRA from the combined countable resources.
5	Compare the remainder to the appropriate resource limit for an individual.

J-6000, SPRA Expansion

J-6100, Policy and Procedure for SPRA Expansion

Body

Revision 12-3; Effective September 1, 2012

The expanded SPRA allows assets protection above the maximum SPRA set by federal law. The formula provides that the applicant can protect enough assets based on interest earned to create available income up to the minimum monthly maintenance needs allowance.

The SPRA is expanded by either the MEPD specialist via the individual's request and signature on Form H1275, Request for Expanded Protected Resource Assessment, or by a hearing officer via the fair hearing process.

There are two methodologies to determine the expanded SPRA. The date of the first continuous period of institutionalization determines which methodology to use to determine the expanded SPRA. Determine if the first continuous period of institutionalization was:

- before Sept. 1, 2004; or
- Sept. 1, 2004, or after.

Calculate an expanded institutional SPRA based on the month of entry into a medical care facility, not the date of application.

J-6200, Spousal Expansion Sept. 1, 2004, or After

Body

Revision 13-4; Effective December 1, 2013

If the first continuous period of institutionalization was Sept. 1, 2004, or after, follow an income-first methodology in spousal impoverishment Medicaid eligibility evaluations. When using the income-first methodology, the institutionalized spouse must divert all non-resource income minus the institutionalized spouse's personal needs allowance to the community spouse.

If a resource is excluded, the income from such a resource is countable income in the expansion budgeting for the individual and community spouse. For example, an annuity is an excluded resource; thus, the income produced from that annuity is countable income in the spousal budgeting.

To determine the amount of the increased SPRA, the eligibility specialist or hearing officer determines the current interest rate of a one-year certificate of deposit (CD), as published in the local paper or provided by a local bank that offers one-year CDs. The eligibility specialist or hearing officer then determines the amount of resources required to produce income, at the specified interest rate, that would increase the spouse's income to the monthly maintenance needs allowance.

Determine the protected amount of resources by using the formula specified in the following steps. **This formula is to be used to determine the maximum amount of resources to be protected** regardless of the actual income a resource may or may not be producing at the time of the original SPRA or at the time of the appeal hearing. (Use Appendix XXVII, Worksheet for Expanded SPRA on Appeal.)

Step	Procedure

Step	Procedure
1	Subtract the community spouse's non-resource-producing income (including income diverted by the applicant/recipient, if any) from the monthly maintenance needs allowance (MMNA). The difference is additional monthly income needed by the community spouse.
2	Multiply additional monthly income needed by the community spouse from Step 1 by 12. The product equals annual income needed by the community spouse.
3	Multiply annual income needed by the community spouse from Step 2 by 100.
4	Divide the product from Step 3 by the interest rate for a one-year CD (do not use a percentage).

Note: The expanded SPRA may not exceed the value of the couple's combined countable resources as of the first month of entry to a medical care facility for a continuous stay.

Example

Description	Amount
Community spouse's own income =	$608.50
Income diverted from applicant/recipient =	+ $750
Community spouse's total income =	$1,358.50
CD interest rate =	6%

Step 1:

Amount	Description
$2,610.00	MMNA in effect at the time of the filing of the appeal
– $1,358.50	community spouse's total income
$1,251.50	monthly income needed

Step 2:

Amount	Description
$1,251.50	monthly income needed
× 12	months
$15,018	annual income needed

Step 3:

Amount	Description
$15,018	annual income needed
× 100	multiplier
$1,501,800	product

Step 4:

Amount	Description
$1,501,800	annual income needed
÷ 6	CD interest rate
$250,300	amount needed to increase SPRA to meet MMNA

Step 5:

The expanded SPRA is the lesser of:

- $250,300, or
- the value of the couple's total combined countable resources as of the first month of entry to a medical care facility for a continuous stay.

When determining the post-eligibility co-payment and the amount available for spousal diversion, the eligibility specialist uses the actual dollar amount produced if the actual amount is in excess of the amount a one-year CD would produce. However, if the actual amount a resource produces is less than the amount a one-year CD would produce, the eligibility specialist uses the amount a one-year CD would produce. (Use Appendix XXVIII, Worksheet for Spouse's Income [Post-Expanded SPRA Appeals].)

The institutionalized spouse's income placed into a qualified income trust (QIT) is considered income in the calculation of the expanded SPRA.

The expanded SPRA cannot exceed the total countable assets determined for the initial SPRA.

Use Appendix XXVII.

Note: Form H1275, Request for Expanded Spousal Protected Resource Assessment, must be signed by the applicant/authorized representative.

J-6210 Sharing Required Information

Revision 09-4; Effective December 1, 2009

After the expanded SPRA appeal, income attributed to the institutionalized spouse (for both eligibility and co-payment purposes) is:

- the total actual income from resources to which the institutionalized spouse has sole title; plus
- one-half of actual income from resources to which the institutionalized spouse and the community spouse have joint title.

After the expanded SPRA appeal, income attributed to the community spouse (for purposes of determining the spousal diversion) is the higher of:

- the total actual income from all resources to which the community spouse has sole title, plus one-half of actual income from resources to which the institutionalized spouse and community spouse have joint title; or
- imputed income from all resources included in the expanded SPRA (whether or not the community spouse has title to those resources).

Consider the imputed income only during the initial eligibility period. After the initial eligibility period, actual income generated by a resource is countable to whichever spouse holds title. If the spouses have joint title, one-half of the actual income is countable to each spouse.

Examples:

- Jon Janis enters the nursing facility on Jan. 2, 2009. He applies for Medicaid on Jan. 15, 2009. Before entering the facility, he lived with his wife, Josie. She still resides in their home. Their total countable combined resources is $500,000.

Description	Amount
Total Countable Combined Resources	$500,000 ÷ 2 = $250,000, thus use
SPRA	– $109,560
Compare	= $390,444 > $2,000 Not eligible

- Form H1275, Request for Expanded Protected Resource Assessment, is signed and Mr. Janis diverts all of his non-resource monthly income. Mr. Janis has monthly income of $1,900. Mrs. Janis has monthly income of $800. Both incomes are non-resource produced income. Income first method is used and $1,900 – $60 PNA = $1,840 + Mrs. Janis' income $800 = $2,640 < $2,739 MMMNA; this amount is determined to be available for the spouse. Enter this amount into Step 2 of Appendix XXVII. New SPRA is calculated. CD interest rate is 4.5%.

Step 1:

Amount	Description
$2,739	MMNA in effect at the time of the filing of the appeal
– $2,650	community spouse's total income
$99	monthly income needed

Step 2:

Amount	Description
$99	monthly income needed
× 12	months
$1,188	annual income needed

Step 3:

Amount	Description
$1,188	annual income needed
× 100	multiplier
$118,800	annual income needed

Step 4:

Amount	Description
$118,800	annual income needed
÷ 4.5	CD interest rate
$26,400	amount needed to increase SPRA to meet MMNA

Step 5:

The expanded SPRA is less than the original SPRA of $109,560.

- When the expanded SPRA is less than the original SPRA, use the original SPRA to determine eligibility.

Amount	Description
Total Countable Combined Resources	$500,000
Maximum SPRA	– $109,560
Compare	= $390,440 > $2,000 Not eligible

- Bob Barrister enters the nursing facility on Jan. 10, 2009. He applies for Medicaid on Feb. 15, 2009. Before entering the facility, he lived with his wife, Betty. She still resides in their home. Their total countable combined resources equal $500,000.

Amount	Description
Total Countable Combined Resources	$500,000 ÷ 2 = $250,000, thus use
SPRA	– $109,560
Compare	= $390,440 > $2,000 Not eligible

- Mr. Barrister has monthly income of $1,900. Mrs. Barrister has monthly income of $1,200. Both incomes are non-resource produced income. Since the first continuous period of institutionalization was on or after Sept. 1, 2004, use the income first method for determining the expanded SPRA.
- Calculation: Mr. Barrister's income $1,900 – $60 PNA = $1,840 + Mrs. Barrister's income $1,200 = $3,040 > $2,739 MMMNA.
- The calculation of the person's net non-resource produced income and the spouse's non-resource produced income resulted in an amount greater than the MMMNA.
- Do not expand the SPRA.

J-6300, Expanded SPRA for Home and Community-Based Services Waiver Programs

Body

Revision 15-3; Effective September 1, 2015

In waiver cases with a community spouse, the waiver individual (i.e., the institutionalized spouse) can make a request or file an appeal to increase the SPRA to produce additional income for the community spouse.

Usually in a waiver situation, income-first expanded SPRA is only considered when the individual has a QIT. The expanded SPRA cannot exceed the combined resources as of the SPRA assessment date for a waiver.

An expanded SPRA in a waiver case is available only:

- after the waiver individual (i.e., the institutionalized spouse) diverts all of the waiver individual's available income (i.e., the waiver individual's gross income minus the current special income limit — 300 percent cap for an individual) to the community ineligible spouse, and
- the community ineligible spouse's resulting total income is less than the current minimum monthly maintenance needs allowance (MMMNA).

Do not develop the expanded SPRA for a waiver if, after diverting all of the waiver individual's available income (i.e., the waiver individual's gross income minus the current special income limit — 300 percent cap for an individual) to the community ineligible spouse, the community ineligible spouse's resulting total income is equal to or more than the current MMMNA.

Calculate the expanded SPRA for a waiver if, after diverting all of the waiver individual's available income (i.e., the waiver individual's gross income minus the current special income limit — 300 percent cap for an

individual) to the community ineligible spouse, the community spouse's resulting total income is less than the current MMMNA.

See Appendix XXXI, Budget Reference Chart, for the current amounts.

Procedure for Increased SPRA Consideration

Step	Procedure
1	The waiver individual (i.e., the institutionalized spouse) diverts all of the waiver individual's available income (i.e., the waiver individual's gross non-resource produced [NRP] income minus the current special income limit — 300 percent cap for an individual) to the community ineligible spouse. Gross NRP income − 300 percent cap for an individual = Amount available for diversion
2	Add the community ineligible spouse's gross NRP income to the amount from step 1. Spouse's gross NRP income + Amount available for diversion = Spouse's resulting total income
3	If the community ineligible spouse's resulting total income is **less than** the current MMMNA, increase the SPRA. If the community ineligible spouse's resulting total income is **equal to or more than** the current MMMNA, do not increase the SPRA.

J-6310 Expanded SPRA for Home and Community-Based Services Waiver Applicants in an Assisted Living Facility or Adult Foster Care

Revision 15-3; Effective September 1, 2015

If the person is living in an assisted living facility or adult foster care setting and is receiving waiver services from the STAR+PLUS Waiver (SPW) program:

- Do not develop the expanded SPRA for a waiver if, after diverting all of the waiver individual's available income (i.e., the waiver individual's gross income minus the current Supplemental Security Income [SSI] federal benefit rate [FBR] for an individual) to the community ineligible spouse, the community ineligible spouse's resulting total income is equal to or more than the current MMMNA.
- Calculate the expanded SPRA for a waiver if, after diverting all of the waiver individual's available income (i.e., the waiver individual's gross income minus the current SSI FBR for an individual) to the community ineligible spouse, the community ineligible spouse's resulting total income is less than the current MMMNA.

Procedure for Increased SPRA Consideration for SPW in an Assisted Living Facility/Adult Foster Care Setting

Step	Procedure
1	The waiver individual (i.e., the institutionalized spouse) diverts all of the waiver individual's available income (i.e., the waiver individual's gross non-resource produced [NRP] income minus the current SSI FBR) to the community ineligible spouse. Gross NRP income − SSI FBR for individual = Amount available for diversion
2	Add the community ineligible spouse's gross NRP income to the amount from step 1. Spouse's gross NRP income + Amount available for diversion = Spouse's resulting total income
3	If the community ineligible spouse's resulting total income is **less than** the current MMMNA, increase the SPRA. If the community ineligible spouse's resulting total income is **equal to or more than** the current MMMNA, do not increase the SPRA.

See Appendix XXXI, Budget Reference Chart, for the current amounts.

J-6400, SPRA Expansion before Sept. 1, 2004

Body

Revision 12-4; Effective December 1, 2012

If the first continuous period of institutionalization was before Sept. 1, 2004, follow a resource-first methodology, which allows the $1 diversion procedure to calculate the expanded SPRA. The expanded SPRA looks at only the community spouse's income, plus an income diversion from the spouse in the nursing home, and only $1 diversion is required from the spouse in the nursing home when using the resource-first methodology. (Use Appendix XXVII, Worksheet for Expanded SPRA on Appeal.)

In nursing facility and waiver cases with a community spouse, the applicant/recipient can appeal to increase the SPRA to produce additional income for the spouse. The eligibility specialist or hearing officer may increase the SPRA to a level adequate to produce income up to but not to exceed the monthly maintenance needs allowance.

The couple can protect additional resources. The resources can be equal to the dollar amount that must be deposited in a one-year certificate of deposit (CD), at current interest rates, to produce interest income equal to the difference between the monthly maintenance needs allowance (in effect at the time of the filing of the appeal) and other countable income not generated by either spouse's countable resources. The couple is not required to invest in the CD as a condition of eligibility.

To determine the amount of the increased SPRA, the eligibility specialist or hearing officer determines the current interest rate of a one-year CD as published in the local paper or provided by a local bank that offers one-year CDs. The eligibility specialist or hearing officer then determines the amount of resources required to produce income, at the specified interest rate, that would increase the spouse's income to the monthly maintenance needs allowance.

Determine the protected amount of resources by using the formula specified in the following steps. This formula is to be used to determine the maximum amount of resources to be protected regardless of the actual income a resource may or may not be producing at the time of the original SPRA or at the time of the appeal hearing. (Use Appendix XXVII.)

Step	Procedure
1	Subtract the community spouse's non-resource-producing income (including income diverted by the applicant/recipient, if any) from the monthly maintenance needs allowance (MMNA). The difference is additional monthly income needed by the community spouse.
2	Multiply additional monthly income needed by the community spouse from Step 1 by 12. The product equals annual income needed by the community spouse.
3	Multiply annual income needed by the community spouse from Step 2 by 100.
4	Divide the product from Step 3 by the interest rate for a one-year CD (do not use a percentage).

Note: The expanded SPRA may not exceed the value of the couple's combined countable resources as of the first month of entry to a medical care facility for a continuous stay.

Example

Description	Amount
Community Spouse's own income =	$608.50
Income diverted from applicant/recipient =	+ $750
Community spouse's total income =	$1,358.50
CD interest rate =	6%

Step 1:

Amount	Description
$2,610.00	MMNA in effect at the time of the filing of the appeal
– $1,358.50	community spouse's total income
$1,251.50	monthly income needed

Step 2:

Amount	Description
$1,251.50	monthly income needed
× 12	months
$15,018	annual income needed

Step 3:

Amount	Description
$15,018	annual income needed
× 100	multiplier
$1,501,800	product

Step 4:

Amount	Description

Amount	Description
$1,501,800	annual income needed
÷ 6	CD interest rate
$250,300	amount needed to increase SPRA to meet MMNA

Step 5:

The expanded SPRA is the lesser of:

- $250,300, or
- the value of the couple's total combined countable resources as of the first month of entry to a medical care facility for a continuous stay.

When determining the post-eligibility co-payment and the amount available for spousal diversion, the eligibility specialist uses the actual dollar amount produced if the actual amount is in excess of the amount a one-year CD would produce. However, if the actual amount a resource produces is less than the amount a one-year CD would produce, the eligibility specialist uses the amount a one-year CD would produce. (Use Appendix XXVIII.)

Note: Form H1275, Request for Expanded Spousal Protected Resource Assessment, must be signed by the applicant/authorized representative.

J-6410 Sharing Required Information

Revision 09-4; Effective December 1, 2009

If institutionalization was before Sept. 1, 2004, the eligibility specialist must know how much income the institutionalized spouse wishes to divert to the community spouse to determine the value of additional resources to be protected.

Hearing officers or eligibility specialists should inform the couple or the couple's authorized representative (AR) that the lower the income diversion amount, the higher the expanded SPRA, and that the institutionalized spouse must agree to divert at least $1 for the SPRA to be expanded.

The hearing officer or eligibility specialist should further inform the couple or the couple's AR that once the SPRA is expanded, an additional amount may be diverted to the community spouse whose total income (including income from the expanded SPRA) is less than the MMMNA. The new spousal diversion amount (after the SPRA is expanded) may be recalculated by either the hearing officer or the eligibility specialist.

After the expanded SPRA appeal, income attributed to the institutionalized spouse (for both eligibility and co-payment purposes) is:

- the total actual income from resources to which the institutionalized spouse has sole title; plus
- one-half of actual income from resources to which the institutionalized spouse and the community spouse have joint title.

After the expanded SPRA appeal, income attributed to the community spouse (for purposes of determining the spousal diversion) is the higher of:

- the total actual income from all resources to which the community spouse has sole title, plus one-half of actual income from resources to which the institutionalized spouse and community spouse have joint title; or

- imputed income from all resources included in the expanded SPRA (whether or not the community spouse has title to those resources).

Consider the imputed income only during the initial eligibility period. After the initial eligibility period, actual income generated by a resource is countable to whichever spouse holds title. If the spouses have joint title, one-half of the actual income is countable to each spouse.

J-7000, Income for Eligibility and Co-Payment

Body

Revision 21-3; Effective September 1, 2021

If the recipient does not make the entire spousal allowance available at certification and at each redetermination, obtain a written statement from the recipient or the recipient's authorized representative as to the amount that is being made available and deduct only that amount.

A written statement is not required at redetermination if:

- the community spouse is a Supplemental Security Income (SSI) recipient;
- zero ($0) amount is being diverted to the community spouse; or
- the amount of the spousal diversion at redetermination remains the same.

Diversion of VA income to the community-based spouse may affect the VA income amount. Inform the couple of this possibility and give them the option of not diverting VA income to the community-based spouse. Their decision should be documented in a signed statement.

Financial duress is defined as having insufficient funds to meet living expenses because of debts incurred for medical expenses for the institutionalized spouse, community-based spouse or dependent, or because of replacement of a resource lost through theft or acts of God.

J-7100, Spousal Companion Budget

Body

Revision 09-4; Effective December 1, 2009

Using the special income limit for an individual, HHSC considers only the person's income in determining eligibility. The ineligible spouse's income is considered in determining the amount of co-payment.

J-7200, Spousal Co-Payment

Body

Revision 21-3; Effective September 1, 2021

Budget Steps

To determine the co-payment for a spousal companion case, HHSC nets the person's and spouse's **earned** income each month by subtracting the following mandatory payroll deductions:

- income tax;
- Social Security tax;

- required retirement withholdings; and
- required uniform expenses.

Note: Mandatory payroll deductions also apply to a dependent's earned income in spousal impoverishment cases.

Do not count in-kind support and maintenance income the spouse receives.

A separate deduction for maintenance of the home is not allowable in companion cases. The spousal allowance provides for home maintenance in those cases.

How to Determine Co-Payment for a Spousal Companion Case

Step	Procedure
1	Determine the countable net earned and gross unearned income of the person.
2	Subtract the personal needs allowance (PNA) of $60 for the person. Subtract the guardian fee allowance, if applicable.
3	Add the spouse's countable net earned and gross unearned income to the remainder. (If the spouse's income is more than the minimum monthly maintenance needs allowance [MMMNA], count only the MMMNA.)
4	Subtract the spousal allowance.
5	a) If there are no dependents, go to step 6. b) If there are dependents, determine the dependent allowance. c) Subtract the dependent allowance.
6	Subtract incurred medical expenses. The remainder is the co-payment for the payment plan. See co-payment policy for the deduction of incurred medical expenses.

Notes:

- Enter incurred medical expense deductions on the Medical Expense LUW in TIERS even if the payment plan is $0.
- If the person has signed a statement and is refusing to make the spousal allowance available and there are no dependents, follow procedures for an individual payment plan budget.
- If the community spouse's countable income is greater than the MMMNA, count only the MMMNA in step 3 above.

The following examples are for demonstration purposes only. They may not reflect the current protected resource minimum and maximum amounts.

Examples

A person and their spouse have the following income:

- Person
  - $265 RSDI
  - +$200 Private retirement
  - $465 Total
- Spouse
  - $350 RSDI
  - + $285 Teacher's retirement
  - = $635 Total
- Co-payment calculation:

    - $465 Person's gross income
    - – $60 PNA
    - = $405 Income available for diversion
    - + $635 Spouse's income
    - = $1,040 Total
    - – $3,259.50 Spousal allowance
    - = $0 Co-payment

Another person and their spouse have the following income:

- Person
    - $490 RSDI
    - + $509 Private retirement
    - = $999 Total
- Spouse
    - $450 RSDI
    - + $300 Private retirement
    - + $750 Net earnings
    - = $1,500 Total
- Co-payment calculation:
    - $999 Person's gross income
    - – $60 PNA
    - = $939 Income available for diversion
    - + $1,500 Spouse's income
    - = $2,439 Total
    - – $3,259.50 Spousal allowance
    - = $0 Remainder
    - – $60 Incurred medical expenses
    - = $0 Co-payment

A third person and their spouse have the following income:

- Person
    - $1,250 RSDI
    - + $800 Private retirement
    - = $2,050 Total
- Spouse
    - $1,590 Net earnings
    - Monthly incurred medical expenses are $16.

The person's dependent brother lives with the community spouse. The brother's only income is $500 per month in RSDI disability benefits.

- The brother's dependent allowance is:
    - $2,178 Base amount of dependent allowance
    - – $500 Dependent's gross income
    - = $1,678 Remainder
    - $1,678 divided by 3
    - = $559 Dependent allowance
- Co-payment calculation:
    - $2,050 person's gross income
    - – $60 PNA
    - = $1,990 Income available for diversion
    - + $1,590 Spouse's income
    - = $3,580 Total

- – $3,259.50 Spousal allowance
- = $320.50 Remainder
- – $559.00 Dependent allowance
- = $0.00 Remainder
- – $16 Incurred medical expenses
- = $0.00 Co-payment

Related Policy

Co-Payment, Chapter H

J-7300, ICF/IID Spousal Companion Cases

Body

Revision 21-1; Effective March 1, 2021

A separate deduction for maintenance of the home is not allowable in companion cases. The spousal allowance provides for home maintenance in those cases.

To determine the co-payment for a spousal companion situation for a person with earnings who is in an ICF/IID, use the following steps:

Step	Procedure
1	Determine the countable net earned and gross unearned income of the person.
2	Subtract the personal needs allowance, including the protected earned income allowance (if any) of the person based on their own net income. Subtract the guardian fee allowance, if applicable.
3	Add the spouse's countable net earned and gross unearned income to the remainder.
4	Subtract the spousal allowance.
5	a) If there are no dependents, go to step 6. b) If there are dependents, determine the dependent allowance. c) Subtract the dependent allowance.
6	Subtract incurred medical expenses. The remainder is the co-payment for the payment plan. **Reference:** See Chapter H, Co-Payment, for the deduction of incurred medical expenses.

Example:

The couple has the following income:

- Individual
  - $250 RSDI
  - + $130 Net earnings
- Spouse
  - $800 Net earnings
  - Personal needs and protected earned income allowance calculation:
  - $250 RSDI unearned income
  - – $60 PNA
  - = $190 Remainder

Calculation for PEI when earnings are greater than $120:

- Deduct $30 from the first $120 of earned income:
  - $120
  - – $30
  - = $90 Remainder of first $120 of earned income
- Deduct one-half the remainder of the first $120 of earned income:
  - $90 Remainder of first $120 of earned income
  - / 2
  - = $45 One-half the remainder of the first $120 of earned income
- Deduct 30 percent of earnings more than $120:
  - $130 Earnings
  - – $120 First $120 of earned income
  - = $10 Earnings more than $120
  - x .3
  - = $3 30 percent of earnings more than $120
- Calculation of total PNA/PEI:
  - $60 PNA
  - + $30 PEI deduction from the first $120 of earned income
  - + $45 PEI deduction of one-half the remainder of the first $120 of earned income
  - + $3 PEI deduction of 30 percent of earnings more than $120
  - = $138 Total PNA/PEI
- Co-payment calculation:
  - $250 RSDI
  - + $130 Net earnings
- Step 1
  - = $380 Total
- Step 2
  - – $138 Total PNA/PEI
  - = $242 Income available for diversion
- Step 3
  - + $800 Spouse's income
  - = $1,042 Total
- Step 4
  - – $3,259.50 Spousal allowance
- Step 5 N/A
- Step 6 N/A
  - = $0 Co-payment for payment plan

J-7400, Spousal Impoverishment Dependent Allowance

Body

Revision 21-3; Effective September 1, 2021

To calculate the dependent allowance for spousal cases, subtract the dependent's income from 150 percent of the monthly federal poverty level (FPL) for a family of two and divide the remainder by three. Mandatory payroll deductions also apply to a dependent's earned income.

Dependent family members may be either spouse's minor or dependent children, dependent parents, or dependent siblings (including half-brothers, half-sisters and siblings gained through adoption) who were living in the institutionalized person’s home before the person’s institutionalization and are unable to support themselves outside the person’s home because of medical, social or other reasons.

Note: College students capable of supporting themselves do not meet the definition of a dependent.

The base amounts (150 percent of the FPL for two) for calculating the dependent allowance are:

Time Period	Amount
July 1, 2021 to present	$2,178
July 1, 2020 to June 30, 2021	$2,155
July 1, 2019 to June 30, 2020	$2,114
July 1, 2018 to June 30, 2019	$2,058
July 1, 2017 to June 30, 2018	$2,030
July 1, 2016 to June 30, 2017	$2,003
July 1, 2015 to June 30, 2016	$1,992
July 1, 2014 to June 30, 2015	$1,967
July 1, 2013 to June 30, 2014	$1,939
July 1, 2012 to June 30, 2013	$1,892
July 1, 2011 to June 30, 2012	$1,839

Deduct the entire dependent allowance even if it is not made available to the dependent.

The community spouse can appeal the dependent allowance amount based on undue hardship caused by financial duress. Only hearing officers can set higher diversion amounts for cases of undue hardship. Review cases of undue hardship every six months to monitor for changes in circumstances.

Related Policy

General Information for Co-Payment, H-1000
Dependent Allowance, H-1600

J-8000, After Initial Eligibility Period

Body

Revision 09-4; Effective December 1, 2009

After the initial eligibility period of the institutionalized spouse, HHSC does not apply the spousal protected resource amount and counts only the institutionalized spouse's resources for the purpose of eligibility redetermination, in accordance with Chapter F, Resources.

J-9000, Notice and Fair Hearing

Body

Revision 09-4; Effective December 1, 2009

The couple may not appeal the SPRA at the time of the assessment.

The couple may appeal the SPRA after an application for Medicaid is filed.

Chapter K, Reserved for Future Use

Body

Revision 09-4; Effective December 1, 2009

Chapter L, Reserved for Future Use

Body

Revision 09-4; Effective December 1, 2009

Chapter M, Medicaid Buy-In Program

M-1000, Medicaid Buy-In Program

M-1100, Texas Administrative Code Rules

Body

Revision 12-1; Effective March 1, 2012

§360.101. Overview and Purpose.

(a) This chapter governs the eligibility requirements for the Medicaid Buy-In Program (MBI), which is authorized under §531.02444 of the Texas Government Code, and which provides Medicaid benefits under the option explained in §1902(a)(10)(A)(ii)(XIII) of the Social Security Act (42 U.S.C. §1396a(a)(10)(A)(ii)(XIII)). All references in this chapter to MBI mean the Medicaid Buy-In Program.

(b) MBI is administered by the Texas Health and Human Services Commission (HHSC). All references in this chapter to HHSC mean the Texas Health and Human Services Commission.

(c) MBI provides Medicaid benefits to working persons with disabilities, regardless of age, who apply for Medicaid and meet the requirements explained in this chapter.

(d) Nothing in these rules shall be construed to violate the maintenance of eligibility requirements of section 5001 of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5) and make eligibility standards, methodologies, or procedures under the Texas State Plan for Medical Assistance (or any waiver under section 1115 of the Social Security Act (42 U.S.C. §1315)) more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) that were in effect on July 1, 2008.

§360.103. Applying and Providing Information.

(a) A person applies for MBI by completing an application for MBI and submitting it to HHSC. The date of receipt of the signed application by HHSC is the application filing date, and thus establishes the application month explained in §360.119 of this chapter (relating to Medical Effective Date).

(b) HHSC notifies an MBI recipient in writing when it is time to redetermine the recipient's eligibility. This usually occurs once per year, although HHSC may require a person to reapply sooner if HHSC determines that a special review of the person's eligibility is appropriate. An MBI recipient must reapply when HHSC sends written notice of the requirement to the recipient's case address of record. The written notice explains the

deadline to reapply. If an MBI recipient fails to reapply by the deadline stated in the written notice, HHSC may terminate the recipient's MBI eligibility.

(c) HHSC sends in writing to the person's case address of record the eligibility decision on an application, reapplication, or reported change. If the person disagrees, the person has the right to request a fair hearing to appeal HHSC's decision, as explained in HHSC's fair hearing rules in Chapter 357 of this title (relating to Hearings).

(d) An applicant for MBI must provide HHSC with all requested documentation and information that HHSC advises is necessary to determine the applicant's eligibility. If the applicant fails or refuses to provide requested information by the date specified in a written request from HHSC, HHSC may deny the application for failure to furnish information. When this occurs but the person later provides the requested information, the date that the requested information is provided to HHSC becomes the application filing date explained in subsection (a) of this section.

(e) A person who applies for or is receiving MBI must report to HHSC within 10 calendar days any information that may impact the person's eligibility. If a person fails to comply with the requirements of this subsection, HHSC may redetermine the person's eligibility as of the date the information should have been reported to HHSC.

§360.105. Citizenship, Immigration Status, and Residency.

To be eligible for MBI, a person must meet the citizenship, immigration status, and residency requirements in Chapter 358, Subchapter B, of this title (relating to Nonfinancial Requirements).

§360.107. Disability.

To be eligible for MBI, a person must meet the definition of disabled as defined by the Social Security Administration for purposes of the federal Supplemental Security Income program, as explained in 20 CFR §416.905 and §416.906, except the requirement that the person be unable to engage in any substantial gainful activity does not apply.

§360.109. Work.

To be eligible for MBI, a person must be working and earning income. The person must provide evidence of earnings that is satisfactory to HHSC.

§360.111. Income.

(a) Earned income.

(1) To be eligible for MBI, a person's monthly countable earned income must be less than 250% of the federal poverty level.

(2) Countable earned income means earned income for purposes of the Supplemental Security Income (SSI) program minus all applicable exclusions and exemptions, as explained in 20 CFR §§416.1110 - 416.1112.

(b) Unearned income is entirely excluded under this section, but is considered in the determination of a person's monthly premium amount, as explained in §360.117 of this chapter (relating to Cost Sharing).

§360.113. Resources.

(a) To establish and maintain eligibility for MBI, a person's countable resources must be equal to or less than $3,000 plus the amount of the Supplemental Security Income (SSI) resource limit for an individual that is explained in 20 CFR §416.1205. Countable resources means resources for SSI purposes as defined in 20 CFR §416.1205, minus all applicable exemptions and exclusions explained in 20 CFR §§416.1207 - 416.1239.

(b) In addition to the exemptions and exclusions explained in subsection (a) of this section, the following are not countable resources under this section:

(1) Independence accounts.

(A) An independence account (IA) is a segregated account in a financial institution, the purpose of which is to save for future health care and work-related expenses to increase an individual's independence and employment potential.

(B) Only a person's own earned income may be deposited into an IA, and amounts deposited cannot exceed 50% of the person's gross earnings. If for any SSA Qualifying Quarter a person deposits more than 50% of the person's gross earnings into an account that is designated as an IA, the account loses its IA designation and the funds in the account become a countable resource for the 12-month period beginning with the first month after the SSA Qualifying Quarter. An SSA Qualifying Quarter is a three-month period that ends on March 31, June 30, September 30, and December 31 of each calendar year and during which a person's reported earnings and FICA contributions are enough for SSA to give the person Social Security wage credits.

(C) Only health care or work-related expenses may be paid from an IA. For any SSA Qualifying Quarter, if funds in an IA account are used for any other purpose, the account loses its IA designation and the funds in the account become a countable resource for the 12-month period beginning with the first month after the SSA Qualifying Quarter.

(2) Retirement related tax-sheltered accounts. Retirement related tax-sheltered accounts include IRAs, 401(k)s, TSAs, and KEOUGHs that comply with IRS regulations.

§360.115. Deeming of Income and Resources.

(a) For purposes of MBI eligibility, each person is considered a household of one.

(b) If a person lives with a spouse, the person and spouse are each considered a household of one. The assets of each spouse are considered only with respect to that spouse. In the case of assets owned jointly by both spouses, one half is considered with respect to each spouse.

(c) If a person is a minor and lives with his or her parents, the assets of the parents are not considered with respect to the eligibility of the minor.

§360.117. Cost Sharing.

(a) Monthly premiums. As a condition of establishing initial MBI eligibility and to remain eligible, a person must pay monthly premiums, as explained in this section, based on the amount of the person's countable earned and countable unearned income. A person may be exempt from paying monthly premiums as described in subsection (h) of this section.

(b) Countable earned income. For purposes of this section, countable earned income is as defined in 20 CFR §416.1110 and §416.1111, minus:

(1) earned income that is excluded by federal law, as explained in 20 CFR §416.1112(b); and

(2) mandatory payroll deductions for federal income tax, FICA, and retirement withholding.

(c) Countable unearned income. For purposes of this section, countable unearned income means unearned income, as defined in 20 CFR §§416.1120 - 416.1123, minus the exclusions and exemptions explained in 20 CFR §416.1124.

(d) Calculation of monthly premium. The monthly premium amount equals the amount of a person's countable unearned income for the month that exceeds the Supplemental Security Income (SSI) federal benefit rate for an individual, plus:

(1) $20 when monthly countable earned income is above 150% of the federal poverty level (FPIL) up to and including 185% of the FPIL;

(2) $25 when monthly countable earned income is above 185% of the FPIL up to and including 200% of the FPIL;

(3) $30 when monthly countable earned income is above 200% of the FPIL up to and including 250% of the FPIL; or

(4) $40 when monthly countable earned income is above 250% of the FPIL.

(e) Upper limit on monthly premiums. The upper limit for the total monthly premium per person is $500. If the unearned income premium amount plus the earned income premium amount equals or exceeds $500, then the total monthly premium remains at $500.

(f) Payment of monthly premiums to establish initial eligibility. If the calculation explained in subsection (d) of this section results in an amount greater than $0, HHSC sends the person a written notice of the person's potential eligibility as described in this subsection. The initial eligibility period begins with the earliest benefit month and continues through the end of the latest benefit month identified on the written notice of the person's potential eligibility. This subsection explains the procedures that are followed and the requirements the person must meet to establish eligibility under this section for any or all of the months within the initial eligibility period. The steps are as follows:

(1) HHSC determines that the person is potentially eligible if the person meets all eligibility requirements for MBI other than the requirements of this section.

(2) HHSC sends the person a written notice (the notice) of the person's potential eligibility. The notice identifies the earliest month of potential eligibility and the amount of the monthly premiums due for each month in the initial eligibility period.

(3) The notice also includes:

(A) the total amount in monthly premiums that must be paid to obtain MBI coverage for the entire initial eligibility period; and

(B) the deadline by which payment must be submitted.

(4) The person chooses whether to pay the monthly premiums for either the entire initial eligibility period or for only a portion of the initial eligibility period (according to the months during which the person desires MBI coverage).

(5) The person submits to HHSC, by the deadline stated in the notice, either the total amount due as explained in the notice or a lesser amount if the person is not seeking coverage for the entire initial eligibility period.

(6) If the person submits payment of less than the total amount due to obtain MBI coverage for the entire initial eligibility period, HHSC applies the amount submitted first to satisfy the monthly premium for the month following the month of the notice, then to each prior month of potential eligibility, in reverse chronological

order. After this, if any amount remaining is less than the premium for a full month's coverage, HHSC refunds that amount to the person.

(7) HHSC notifies the person of MBI eligibility and of the beginning date of MBI coverage, based on the amount submitted by the person under paragraph (5) of this subsection.

(8) If no amount is submitted by the deadline stated in the notice, or if the amount submitted is less than one month's premium such that it is refunded to the person as explained in paragraph (6) of this subsection, HHSC denies the person MBI eligibility. A person denied under this paragraph must file a new application for MBI before eligibility can be established.

(g) Payment of monthly premiums after initial eligibility. Monthly premiums after a person establishes initial eligibility under subsection (f) of this section are due and payable to HHSC no later than the last calendar day of each month, and are applied to the following month's eligibility and coverage of MBI benefits. If a monthly premium payment that is due is not received by HHSC by the end of the month, after written notice, HHSC may terminate the person's MBI eligibility.

(h) An MBI recipient residing in a federally declared disaster area is exempt from paying monthly premiums for up to three months beginning with the month in which the disaster is declared. A recipient will only be exempt from paying monthly premiums once per disaster.

§360.119. Medical Effective Date.

Beginning with the three months before the application month, the eligibility effective date for MBI coverage is the first day of the first month in which a person meets all eligibility criteria, including the timely payment of monthly premiums as explained in §360.117 of this chapter (relating to Cost Sharing).

M-1200, Program Overview

Body

Revision 11-4; Effective December 1, 2011

The MBI program is a Medicaid program for individuals with disabilities who are working and earning more than the allowable limits for regular Medicaid. MBI offers those individuals the opportunity to obtain or retain health care coverage through Medicaid. This program allows people with disabilities who are working to earn more income without the risk of losing vital health care coverage. The income limit is up to 250% federal poverty level (FPIL). An individual may have to pay a monthly premium as a condition of eligibility. The amount of the premium is determined on a sliding scale, based on earned and unearned income. For a definition of terms used for MBI, see the Glossary.

MBI recipients receive a Your Texas Benefits Medicaid ID card. If dually eligible for Medicare and Medicaid, prescriptions are available through a Medicare Part D Prescription Drug Plan.

All regular MEPD policies apply to this program except for the eligibility items specifically identified in this chapter. For example, citizenship and Texas residency are not addressed specifically for MBI; therefore, follow regular MEPD policies for citizenship and Texas residency.

All eligibility requirements for this program must be verified. MBI is not a client-declaration program.

M-1300, MBI and Other Programs

Body

M-1310 MBI and Home and Community-Based Services Waivers

Revision 16-2; Effective June 1, 2016

If a person is currently eligible for Medicaid Buy-In (MBI) and requests waiver services, the Long-Term Services and Supports (LTSS) programs (such as STAR+PLUS Waiver) do not require a change in Medicaid type program for payment of services. Do not do a program transfer for ME-Waivers.

Do not calculate a copay for individuals who are MBI-eligible and receive waivers services. A person is not subject to a financial copay unless financial eligibility is determined using the 300% of Supplemental Security Income, Special Income Group limit, e.g., ME-Waivers.

M-1320 MBI and Medicare Savings Programs

Revision 11-4; Effective December 1, 2011

An MBI-eligible applicant/recipient can also have:

- Qualified Medicare Beneficiary (QMB)
- Specified Low-Income Medicare Beneficiary (SLMB)

An MBI-eligible applicant/recipient cannot have:

- Qualifying Individuals-1 (QI-1). The applicant/recipient must choose between MBI and QI-1.
- Qualified Disabled Working Individuals

Note: Deeming of income and resources and support and maintenance applies to the Medicare Savings Program.

M-2000, Automation

Body

Revision 11-4; Effective December 1, 2011

MBI is worked only in the Texas Integrated Eligibility Redesign System (TIERS) and is type of assistance TP 87. The program name displays as ME-Medicaid Buy-In.

M-3000, Non-Financial

Body

Revision 19-4; Effective December 1, 2019

All regular non-financial MEPD policies apply to MBI, except those specifically identified in this chapter.

Non-financial requirements apply only to an MBI applicant/recipient, even if there are other household members.

M-3100, Age

Body

Revision 11-4; Effective December 1, 2011

MBI has no age limit.

M-3200, Disability

Body

Revision 19-4; Effective December 1, 2019

All persons applying for the Medicaid Buy-In (MBI) program must meet the Supplemental Security Income definition of disability. If the person does not have an established Social Security Administration disability determination, request the determination from HHSC's Disability Determination Unit. Follow normal MEPD policy for disability determinations. For MBI, the disability requirement also applies to persons age 65 or older.

The MBI program allows an exception to the requirement that the person be unable to engage in any substantial gainful activity (SGA). For purposes of MBI, a person who is able to engage in SGA still might meet disability requirements because SGA is disregarded in deciding whether the person meets the definition of disabled for MBI.

Related Policy

Disability, D-1400
Requesting a Decision from the Disability Determination Unit (DDU), D-2300

M-3300, Household of One

Body

Revision 15-4; Effective December 1, 2015

Being a household of one means an applicant/recipient is not penalized for assets owned by the spouse. For example, if one member of a couple applies for the MBI program, only the assets of the applicant are considered when determining eligibility for the program. If both an applicant/recipient and spouse own the asset, only half of the asset is considered owned by each spouse. If the person applying for the MBI program is a minor and lives with his or her parents, the assets of the parents are not considered the minor's assets. Consider an MBI recipient/applicant a household of one, regardless of the living arrangement or age. Do not deem income or resources. Do not consider support and maintenance. If an applicant lives with a spouse who is eligible for Medicaid, the applicant and spouse are each considered a household of one.

M-4000, Resources

Body

Revision 11-4; Effective December 1, 2011

All regular MEPD policies for resources apply to this program, except those specifically identified in Chapter M.

Resource Limit	Countable resources must be equal to or less than $2,000.
Exclusions	When determining resource exclusions, use current MEPD eligibility criteria, including the special $3,000 MBI Resource Exclusion.
Count any non-excluded separate resources of the applicant.	
Spouse	Do not count any separate resources of the spouse.
If the person and the ineligible spouse have a jointly owned resource with unrestricted access, consider that each owns an equal share. Divide the countable value of the resource, counting half as available to the applicant.	
Jointly Owned	If a non-excluded resource is jointly owned with other persons (not the spouse), use current MEPD eligibility criteria.

M-4100, Special MBI Resource Exclusions

Body

Revision 11-4; Effective December 1, 2011

Exclude the following resources for MBI:

- Retirement-related accounts
- Independence accounts
- Plan to Achieve Self Support (PASS)
- $3000 MBI Resource Exclusion

M-4110 Retirement Accounts

Revision 11-4; Effective December 1, 2011

For the MBI program, Retirement-related accounts are not countable. These accounts include Individual Retirement Accounts, 401(K)s, Tax Sheltered Annuities, and Keoghs that comply with Internal Revenue Service regulations, and Keogh or HR-10 plans which are qualified employer plans set up by a self-employed individual.

M-4120 Independence Accounts

Revision 11-4; Effective December 1, 2011

An Independence Account is a separate designated account for health care and/or work-related expenses. For the MBI program, **exclude** an Independence Account **if all**:

- funds from the account are used for health care or work-related expenses, and
- deposits into the Independence Account are:
  - from the person's earned income, and
  - equal to or less than 50% of the person's gross earnings for the SSA qualifying quarter.

For the MBI program, **count** an Independence Account **if any**:

- funds from the account are used for non-health care or non-work related expenses, and/or
- deposits into the Independence Account:
  - exceed 50% of the person's earnings for the SSA qualifying quarter,
  - are from sources other than the person's earnings or interest earned on the Independence Account, and
  - include income from another person.

Evaluate the account at each complete redetermination. If the person takes action requiring the Independence Account to be counted, the exclusion for the Independence Account is lost. Consider the account as a countable resource for 12 calendar months beginning with the first month after the SSA qualifying quarter during which the exclusion was lost. The person may again request designation of an Independence Account after the 12-month countable period.

Example: John Smith deposited a $900 gift from his grandmother into the Independence Account in May. The exclusion of the Independence Account was lost. The balance of the Independence Account is a countable resource effective July 1 through June 30 of next year. Effective July of next year, Mr. Smith may request designation of an Independence Account.

If counting the resource results in denial, follow current denial process.

M-4130 Plan for Achieving Self-Support (PASS)

Revision 11-4; Effective December 1, 2011

See Section F-4400, Plan for Achieving Self-Support (PASS).

Do not count the resources and income that are essential for accomplishing the objectives of an SSA or HHSC approved PASS as long as the PASS is in effect. Any money set aside for a PASS must be identifiable from other funds – usually a separate bank account.

PASS resources are considered "set aside" when they are one or more of the following:

- Owned by the individual
- Used to pay for expenses, including expenses already incurred
- Used directly in the job
- Saved for future expenses

Information concerning a PASS and forms for exemption consideration are located on the SSA website at www.ssa.gov/online/ssa-545.pdf.

Send any PASS that needs HHSC approval to OFS Policy, State Office, Mail Code 2090.

For the MBI program, exclude any PASS resources if:

- Resources are part of the PASS
- PASS is approved and in effect
- Money is in a separate PASS account

For the MBI program, end the PASS **if** the person has **neither**:

- Met milestones as scheduled in the PASS
- Set funds aside as agreed in the PASS
- Spent funds as agreed in the PASS

Evaluate the person's ongoing compliance with the PASS at:

- Each complete redetermination
- The report of a change
- Reapplication

If the PASS ends, count the PASS resources the month after the PASS end date. If counting the resources results in the person exceeding the resource limit, follow current denial process.

M-4140 $3,000 MBI Resource Exclusion

Revision 11-4; Effective December 1, 2011

Before comparing the countable resources to the $2,000 resource limit and after allowing all exemptions, exclusions and Special MBI Resource Exclusions (Retirement Accounts, Independence Accounts, PASS), deduct an additional $3,000 MBI resource exclusion.

M-5000, Income

Body

Revision 21-2; Effective June 1, 2021

All regular MEPD policies for income apply to this program, except those specifically identified in Chapter M.

There is no support and maintenance considered for MBI. Do not develop support and maintenance.

There is no deeming of income for this program.

M-5100, Income Verification

Body

Revision 13-3; Effective September 1, 2013

To be eligible, a person must be working and earning income. The person must provide proof of employment. Consider any of the following as proof of employment:

- Tax payment verification under the Federal Insurance Contribution Act (FICA); or
- Tax payment verification under the Self-Employment Contribution Act (SECA); or
- A written explanation that substantiates the person is in an employed status.

Treatment of income will be different for the MBI income eligibility budget and the post eligibility premium budget.

Income limits are subject to change annually. See Appendix XXXI, Budget Reference Chart, for current limits.

M-5200, Medicaid Buy-In Income Limits

Body

Revision 21-2; Effective June 1, 2021

To be eligible for MBI, a person must have countable income less than 250 percent of the federal poverty level (FPL).

Monthly Income Limits for the MBI Program

Date Range	250% FPL
March 1, 2021 to Present	**$2,684**
March 1, 2020 to Feb. 28, 2021	$2,659
March 1, 2019 to Feb. 29, 2020	$2,603
March 1, 2018 to Feb. 28, 2019	$2,530
March 1, 2017 to Feb. 28, 2018	$2,513
March 1, 2016 to Feb. 28, 2017	$2,475
March 1, 2015 to Feb. 29, 2016	$2,453
March 1, 2014 to Feb. 28, 2015	$2,432
March 1, 2013 to Feb. 28, 2014	$2,394
March 1, 2012 to Feb. 28, 2013	$2,328
March 1, 2011 to Feb. 29, 2012	$2,269
March 1, 2010 to Feb. 28, 2011	$2,257

Related Policy

Special Income Limits, G-1320
Co-Payment for SSI Cases, H-6000

M-6000, Budgeting

Body

Revision 11-4; Effective December 1, 2011

The MBI program has different budgeting than other Medicaid programs.

- There are two income-related budgets for the MBI program
- Normally exempt income is considered in the MBI Income Verification. For example, irregular and infrequent income of $30 or less per quarter is excluded in other programs. In the Income Eligibility Budget, all irregular and infrequent earned income is counted.
- The Income Eligibility Budget is based on monthly gross earned income only. Do not consider gross unearned income in the income eligibility budget.
- The Post Eligibility – Premium Budget is based on gross monthly unearned and monthly net earned income.
- Mandatory order of allowable exclusions.
    - Income Limit — 250% federal poverty level (FPIL)
    - Income Verification — Verify that a person currently is employed. Use established verification of earnings.

- Eligibility Budget — Based on all gross earned income, after all allowable exclusions and tested against 250% FPIL. Unearned income is not considered.
- Post Eligibility Budget – Premium Budget — Unearned income and earned income is used to determine the MBI monthly premium amount.

Income limits are subject to change annually. See Appendix XXXI, Budget Reference Chart, for current limits.

For assistance in the budget process, see Appendix XXXIX , Screening Tool and Worksheets.

M-6100, Income Eligibility Budget

Body

Revision 11-4; Effective December 1, 2011

Do not consider unearned income in the income eligibility budget for MBI. The income eligibility test for the MBI program is based on **all gross earned income from wages and self-employment based on a monthly amount.**

Exclusions to the monthly gross earned amount are allowed in the MBI program. The exclusions are subtracted in a mandatory order. The 10 potential exclusions in the mandatory order are:

1. Earned income tax credit payments
2. Child tax credit
3. Infrequent or irregular income equal to or less than $30 per month
4. Earned income of blind or disabled student
5. $20 general income
6. $65 earned income
7. Impairment-related work-related expenses
8. One half of remaining earned income
9. Blind work-related expenses
10. PASS-related earned income

Note: If the person fails to provide verification for the exclusion, do not allow the exclusion in the income eligibility budget. Do not deny the case for "failure to provide" verification.

M-6110 Earned Income Tax Credit Payments Exclusion

Revision 11-4; Effective December 1, 2011

See Section E-2210, Income Tax Credits. An earned income tax credit (EITC) is a special tax credit that reduces the federal tax liability of certain low-income working taxpayers. This tax credit may or may not result in a payment to the taxpayer. EITC payments are allowed as an advance from an employer or as a refund from the Internal Revenue Service (IRS) and are excluded from income, regardless of the tax year involved. Normally this is exempt income – never considered as income and never deducted. For the MBI program, deduct the EITC in the month received from the employer or divide the annual EITC refund from the IRS by 12 to get the monthly EITC exclusion.

M-6120 Child Tax Credit Exclusion

Revision 11-4; Effective December 1, 2011

The child tax credit is the annual amount. Divide the annual child tax credit by 12 to get the monthly child tax credit exclusion. Child tax credit exclusions apply only to the MBI program. Use the federal tax return or other IRS documentation for sources of verification.

M-6130 Infrequent or Irregular Income Exclusion

Revision 11-4; Effective December 1, 2011

The first $30 of infrequent or irregular earned income is excluded in the Income Eligibility Budget. See Section E-9000, Infrequent or Irregular Income.

M-6140 Earned Income - Blind or Students with Disabilities Exclusion

Revision 11-4; Effective December 1, 2011

See Section E-2220, Student Earnings. For the MBI program, consider all gross monthly earned income and allow the income exemption when the MBI person is:

- blind or disabled,
- a student,
- younger than age 22.

See Special Income Exemption for Student in Appendix XXXI, Budget Reference Chart, for the monthly and yearly amount limits for the exemption.

M-6150 $20 General Income Exclusion

Revision 11-4; Effective December 1, 2011

Since unearned income is not considered in the MBI Income Eligibility Budget, subtract the $20 general income exclusion from the remaining earned income after subtracting the first four exclusions.

See Section M-6100, Income Eligibility Budget, for mandatory order of allowable exclusions.

M-6160 $65 Earned Income Exclusion

Revision 11-4; Effective December 1, 2011

Subtract the $65 earned income exclusion from the remaining earned income after subtracting the first five exclusions. Do not subtract the normal "one half of the remaining earnings" as part of the $65 earned income exclusion until Step 8 in the mandatory order of allowable exclusions.

M-6170 Impairment-Related Work-Related Expense (IRWE) Exclusion

Revision 11-4; Effective December 1, 2011

This exclusion is based on the SSI work incentive for persons who are determined to be disabled. The cost of certain items and services that a person with impairment needs in order to work can be deducted from earnings, even though such items and services also are needed for normal daily activities. The IRWE exclusion is subtracted if the MBI person is under age 65 and the items are used to pay expenses directly related to the impairment and needed in order to work.

In the following table, possible IRWE exclusion items are listed. There are also items that are not allowed as IRWE items. Allow only the possible IRWE exclusion item if the person's earnings are used to pay the cost of the item.

Possible IRWE Exclusion Items	Prohibited IRWE Exclusion Items
• Attendant care services • Drugs to control disabling condition • Expendable medical supplies • Medical devices and equipment • Medical services to control disabling condition • Non-medical equipment/services • Other work-related equipment/services • Physical therapy • Prostheses • Service animal expenses • Structural home modifications • Training to use impairment-related item • Transportation • Vehicle Modification	• Expenses that will be reimbursed • Health and life insurance premiums • Routine annual physical examinations • Routine optician services (unrelated to a disabling visual impairment) • Routine dental examinations

M-6180 Blind Work-Related Expense (BWE) Exclusion

Revision 11-4; Effective December 1, 2011

This exclusion is based on the SSI work incentive for persons who are determined to be legally blind. From the earnings of the legally blind MBI person, an exclusion for most **work-related** expenses, whether or not they relate to blindness, is allowed. The MBI person must be:

- legally blind,
- under age 65,
- if age 65 or older, must have received SSI payment due to blindness for the month before attaining age 65.

In the following table, possible BWE exclusion items are listed. There are also items that are not allowed as BWE items. Allow only the possible BWE exclusion item if the person's earnings are used to pay the cost of the item.

Possible BWE Exclusion Items	Prohibited BWE Exclusion Items
• Attendant care services • Child care • Drugs to control disabling condition • Expendable medical supplies • Federal, state and local income taxes • Fees, licenses and dues • Mandatory pension contributions and savings plans • Meals consumed during work or school hours • Medical devices and equipment • Medical services to control disabling condition • Non-medical equipment/services • Other work-related equipment/services • Physical therapy • Prostheses • Service animal expenses • Structural home modifications • Training to use impairment-related item • Transportation • Vehicle modification	• Expenses that will be reimbursed • Expenses claimed on a self-employment tax return • General educational development • In-kind payments • Health and life insurance premiums • Meals consumed outside of work hours • Self care items • Voluntary pension contributions and savings plans • Work-related items furnished by others

M-6190 PASS-Related Earned Income Exclusion

Revision 11-4; Effective December 1, 2011

See Section F-4400, Plan for Achieving Self-Support (PASS), and Section M-4130, Plan for Achieving Self-Support (PASS). This exclusion is based on the SSI work incentive for persons who are determined to be blind or disabled. Any earned income used to fulfill an SSA or HHSC-approved PASS is excluded from the person's earnings as long as the PASS is in effect.

The following are allowable PASS expenses only if the person intends to pay the expense and the expense is necessary to meet an occupational goal. If the expense is reimbursable, it is not allowable.

Possible PASS Exclusion Items

Possible PASS Exclusion Items

- Attendant care services
- Basic living skills training
- Business-related expenses
- Child care
- Drugs to control disabling condition
- Expendable medical supplies
- Federal, state and local income taxes
- Fees, licenses and dues
- Finance and services charges
- Job coaching/counseling services
- Job search or relocation expenses
- Mandatory pension contributions and savings plans
- Meals consumed during work or school hours
- Medical devices and equipment
- Medical services to control disabling condition
- Non-medical equipment/services
- Other work-related equipment/services
- PASS preparation fees
- Physical therapy
- Prostheses
- Service animal expenses
- Shelter and food due to temporary absence from permanent residence
- Specialized clothing and appropriate attire
- Structural home modifications
- Subscription costs for publications for academic or professional purposes
- Training to use impairment-related item
- Transportation
- Vehicle modification

A person may have more than one PASS during the person's lifetime; however, a person is limited to only one PASS at a time.

The SSI work incentives – IRWE, BWE, PASS – allow for earned income exclusions to occur for a person. A person may have an IRWE, a BWE, and a PASS at the same time. Expenses allowed, as an income exclusion from one of the SSI work incentives, must be mutually exclusive unless the expense is for a different reason. For example, child care is allowable under a BWE or a PASS. If the child care is for work and attending night school, allow the expense as an exclusion under one or both of the SSI work incentives depending on what is available to the person. Another example would be transportation. Transportation is allowable under IRWE and BWE. If the gas expense is for work and attending training, allow the expense as an exclusion under one or both of the SSI work incentives depending on what is available to the individual.

M-7000, Premiums

Body

Revision 21-2; Effective June 1, 2021

A person may have to pay a monthly premium as a condition of eligibility. The premium amounts are based on a sliding scale, dependent upon the person's income. The MBI monthly premium amount is determined based on the person's unearned and earned income.

M-7100 Post Eligibility — Premium Budgets

Body

Revision 21-2; Effective June 1, 2021

Premium Budgeting Steps

There are three steps to calculate the premium amount.

Note: While unearned income is excluded in the income eligibility budget, it is used in the calculation of the premium amount.

Step 1

Unearned Income

The unearned income premium amount is based on unearned income after allowable exemptions and exclusions.

Note: Support and maintenance income does not apply to the MBI program.

Find the unearned income premium amount by subtracting the SSI federal benefit rate amount for one person from the person's countable unearned income.

Step 2

Earned Income

Find the earned income premium amount by adding:

- gross earned income minus mandatory payroll deductions; and
- any countable earned self-employment income

This calculation results in the net earnings. If the net earnings are equal to or less than 150 percent of the FPL, the monthly premium is $0. If the net earnings exceed 150 percent of the FPL, the MBI person must pay a monthly premium based on the earned income. Compare the net earnings amount to the FPL ranges to find the earned income premium amount.

The 2021 FPL ranges for the earned income premium amounts are listed in the chart below. Income limits are subject to change annually.

2021 FPL Ranges	Earned Income Premium Amounts (Example Purposes Only)
Earnings at or below 150% FPL (less than or equal to $1,610)	$0
Earnings above 150% FPL up to and including 185% FPL (greater than $1,610 up to and including $1,986)	$20
Earnings above 185% FPL up to and including 200% FPL (greater than $1,986 up to and including $2,147)	$25
Earnings above 200% FPL up to and including 250% FPL (greater than 2,147 up to and including $2,684)	$30

2021 FPL Ranges	Earned Income Premium Amounts (Example Purposes Only)
Earnings above 250% FPL (greater than $2,684)	$40

Step 3

Add the unearned income premium amount to the earned income premium amount to get the total monthly MBI premium amount.

Total Monthly Premium Limit

The total monthly premium may not exceed $500. If the unearned income premium amount plus the earned income premium amount is greater than or equal to $500, then the total monthly premium is $500.

Examples

Below are three examples for calculating the MBI premium.

Example 1

A person has $945 in unearned monthly income. After applying all deductions, the remaining earned income is $1,250.

Step 1: Subtract the SSI federal benefit rate amount for one person from the person's countable unearned income.

Description	Amount
Unearned income	$945
SSI federal benefit rate	–$794

Unearned income premium amount $151

Step 2: Compare the net earned income to the chart showing the FPL ranges to find the earned income premium amount.

Description	Amount
Net monthly earnings	$1,250

Earned income premium amount $0

Step 3: Add the unearned income premium amount to the earned income premium amount to get the total monthly MBI premium amount.

Description	Amount
Unearned income premium amount	$151
Earned income premium amount	+$0
Total monthly premium	**$151**

Example 2

A person has $945 in monthly unearned income and $1,615 in monthly earned income, after applying all deductions.

Step 1: Subtract the SSI federal benefit rate amount from the person's countable unearned income.

Description	Amount
Unearned income	$945
SSI federal benefit rate	–$794
Unearned income premium amount	**$151**

Step 2: Compare the net earned income to the chart showing the FPL ranges to find the earned income premium amount.

Description	Amount
Net monthly earnings	$1,615
Earned income premium amount	**$20**

Step 3: Add the unearned income premium amount to the earned income premium amount to get the total monthly MBI premium amount.

Description	Amount
Unearned income premium amount	$151
Earned income premium amount	+$20
Total monthly premium	**$171**

Example 3

A person has $1,295 in monthly unearned income and $1,689 in monthly earned income, after applying all deductions.

Step 1: Subtract the SSI federal benefit rate amount from the person's countable unearned income.

Description	Amount
Unearned income	$1,295
SSI federal benefit rate	–$794
Unearned income premium amount	**$501**

Step 2: Compare the net earned income to the chart showing the FPL ranges to find the earned income premium amount.

Description	Amount
Net monthly earnings	$1,689
Earned income premium amount	**$20**

Step 3: Add the unearned income premium amount to the earned income premium amount to get the total monthly MBI premium amount.

Description	Amount
Unearned income premium amount	$501
Earned income premium amount	+$20
Total monthly premium	**$500***

* The total of the unearned income premium amount plus the earned income premium amount is $521. However, the total monthly premium cannot exceed **$500**.

Related Policy

Budget Reference Chart, Appendix XXXI

M-8000, Medical Effective Date, Prior Months' Eligibility and Case Actions

M-8100, Medical Effective Dates

Body

Revision 11-4; Effective December 1, 2011

The eligibility begin date for MBI is the first day of the first month in which a person meets all eligibility criteria and pays the required premium, if any is required. Eligibility is established in TIERS, but eligibility is not granted until the first premium is paid. Eligibility is in a suspended status until an MBI person pays the premium. Once the premium is paid, actual eligibility is granted

M-8200, Prior Month's Eligibility

Body

Revision 11-4; Effective December 1, 2011

Eligibility for three prior months to the application month is available with this program.

The coverage date is determined by the application file date and the first premium amount the person chooses to pay. Since potential eligibility is determined up to three months prior to the application file month, the person has the option of choosing the months of coverage. Payments are applied to months in reverse chronological order, beginning with the current or the following month, backwards, up to three months prior.

Payment must be for a full month. Partial month payments will be refunded to the individual. Form H0052, Medicaid Buy-In Refund Notice, will be sent to the individual stating that partial payments are not accepted. The notice also will state that it can take up to 60 days for the refund.

M-8300, Case Actions

Body

M-8310 Disposition

Revision 11-4; Effective December 1, 2011

Since MBI eligibility is determined in TIERS, an initial eligibility determination group (EDG) is created with a "Suspended" status. This will be used when the MBI EDG is approved for potential eligibility. The EDG status will be updated based on vendor communication. The EDG status will be updated to "Approved" when vendor communication confirms that at least one month's premium has been received. The EDG status will be updated to "Denied" when vendor communication confirms that the payment was not received by the due date. If the payment is received during the adverse action time period then the EDG is reopened.

M-8320 Eligibility Summary

Revision 16-4; Effective December 1, 2016

When the Medicaid Buy-In (MBI) potential eligibility EDG is disposed, Form TF0001, Notice of Case Action, is automatically sent to batch but **must not** be sent to the individual. Instead, the eligibility worker sends a

manual Form H0053, Medicaid Buy-In Potential Eligibility Notice, containing the premium amount(s) and the premium due date. If the eligibility worker sends Form H0053 before cut-off, the premium payment is due at the end of the same month and is applied to the following month. If the individual does not make the first payment by the due date, deny the case.

On the first day of every month, TIERS automatically generates Form H0051, Medicaid Buy-In Premium Payment Notice, which is mailed directly to the individual. The notice has a coupon attached and a postage-paid envelope enclosed. The individual submits the premium payment, along with the coupon, by the due date. Failure to make the premium payment by the due date will cause the individual to be denied. Adverse action requirements pertain to MBI.

If an individual whose MBI eligibility was denied for failure to submit premium payments reapplies for MBI, the individual must pay all past due premium payments and current monthly payments to be reinstated into the program. All past due premiums and current premiums must be paid by the due date on Form H0053 sent to the individual for the reapplication.

Note: Premium payments must be received in the form of a check or a money order payable to MBI.

The premium payment address is:
Medicaid Buy-In
P.O. Box 650868
Dallas, TX 75265-9843

Once MBI receives the premium payment and the EDG is disposed, Form TF0001, Notice of Case Action, is automatically sent to batch but **must not** be sent to the individual. Instead, the eligibility worker sends a manual Form H0054, Medicaid Buy-In Eligibility Notice, containing the month(s) of eligibility and the corresponding premium amount(s) received.

M-8400, Initial Premium Due Dates

Body

Revision 13-3; Effective September 1, 2013

The first premium payment is due based on the date of disposition.

- If disposed **before** the current month's cutoff, the payment is due by the end of the disposition month.
- If disposed **after** the current month's cutoff, the payment is due by the end of the following disposition month.

Example 1: Month of application: May. Prior months: April, March and February. If cutoff is May 15, and the MEPD Specialist disposes the case on May 11, the due date of all premiums for ongoing and all prior months (if the individual wants coverage for all) would be May 31,20XX. So payment is due for:

- June – ongoing month and mandatory, must be paid first;
- May – month of application and optional;
- April – prior month one and optional;
- March – prior month two and optional; and
- February – prior month three and optional.

Note: If the individual wants those optional months, he or she must pay in reverse chronological order. This means the ongoing month must be paid first, then the previous month, then the month before that and so forth. Like the order in the example above.

Example 2: Month of application: May. Prior months: April, March and February. If cutoff is May 15, and the MEPD Specialist disposes the case on May 19, the due date of all premiums for ongoing and all prior months (if the individual wants coverage for all) would be June 30, 20XX. So payment is due for:

- July – ongoing month and mandatory, must be paid first;
- June – month after month of application and optional;
- May – month of application and optional;
- April – prior month one and optional;
- March – prior month two and optional; and
- February – prior month three and optional.

Note: If the individual wants those optional months, he or she must pay in reverse chronological order. This means the ongoing month must be paid first, then the previous month, then the month before that and so forth. Like the order in the example above.

M-8410 Ongoing Premium Due Dates

Revision 13-3; Effective September 1, 2013

Monthly premiums are due the end of each month. If payment is not received by the end of the month, the coverage will be terminated at the end of the following month.

- If the remaining amount due is **received** two days prior to cutoff, then there is **no interruption** in coverage.
- If the remaining amount due is **received after the deadline** for payment (two days before cutoff), the **individual is denied** and the payment will be applied to any unpaid months the individual received benefits.
- Funds are to be applied to satisfy the ongoing month and any months premiums were not paid.
- After 12 months from the denial for non-payment the individual can reapply without having to pay any unpaid premium.

Example 1: Payment Received Timely: The due date for the May premium is April 30, 20XX, and cutoff is May 15. If no payment is received by April 30, 20XX, the MEPD Specialist will send a manual denial notice to the individual on that date, but will **NOT** run eligibility (EDBC) and deny the case at that time. If payment **IS** received between the due date (end of previous month) and two days prior to cutoff (in this example, May 13, 20XX) there will be no disruption in coverage.

Example 2: Payment Not Received Timely: The due date for the May premium is April 30,20XX, and cutoff is May 15. If no payment is received by April 30, 20XX, the MEPD Specialist will send a manual denial notice to the individual on that date, but will **NOT** run eligibility (EDBC) and deny the case at that time. If payment **IS NOT** received by two days prior to cutoff (in this example, May 13, 20XX) the MEPD Specialist will run eligibility (EDBC) and deny the case on May 14, 20XX, and document it in case comments. No denial notice needs to be sent at this time because one was previously sent.

M-8411 Non-Sufficient Funds for Ongoing Cases

Revision 13-3; Effective September 1, 2013

Ongoing cases for MBI are certified or approved cases. Individuals are currently on the program as they have made premium payments. Their EDG is in approved status.

The vendor will notify the individual through written notice of non-sufficient funds (NSF) when they occur. The vendor notifies the MEPD Specialist if non-sufficient funds occur.

- If payment is not rectified and received **within the adverse action period** (two days before next month's cutoff), it will be treated as a non-payment and the case denied.
- If the individual makes a replacement payment **within the adverse action period** (two days before cutoff), there will be no disruption in benefits.
- If the individual makes a replacement payment **after the adverse action period** (two days before cutoff) the case will be denied and the payment will be applied to any unpaid months where benefits were received. If there is any remaining payment, it will be refunded to the individual.

M-8412 Non-Sufficient Funds for Suspended Eligible Cases

Revision 13-3; Effective September 1, 2013

Suspended-eligible cases are cases where benefits have not been approved due to pending premium payments. The EDG stays in suspended status until payment is made, eligibility is determined and the case is disposed.

If the premium is not paid because of non-sufficient funds (NSF), the vendor will notify the individual through written notice of non-sufficient funds. The vendor notifies the MEPD Specialist if NSF occurs.

- If no replacement payment is made, benefits will not be granted and the case will be denied.
  - **Example** – Cutoff is June 20, 20XX. The MES disposes the case on June 10, 20XX. The premium payment is due June 30, 20XX. If no premium payment is received by June 30, 20XX, the case is denied.
- If the individual makes a replacement payment **prior** to the due date (end of the month) benefits will be granted.
  - **Example A** – Cutoff is June 20, 20XX. The MES disposes the case on June 10, 20XX. The Premium payment is due June 30, 20XX. The Premium payment received June 15, 20XX. On June 22, 20XX, vendor notifies MEPD the payment was NSF. The individual replaces/rectifies the premium on June 25, 20XX. MES approves the case and benefits granted.
  - **Example B** – Cutoff is June 20, 20XX. MES disposes the case on June 22, 20XX (after cutoff). The Premium payment is due July 31, 20XX. The Premium payment is received July 1, 20XX. On July 10, 20XX, the vendor notifies MEPD the payment was NSF. The individual replaces/rectifies the premium on July 15, 20XX. MES approves the case and benefits granted.
  - **Note:** The individual has to pay the ongoing month first, then any optional month, such as prior months, if this was an application.
- If the individual makes a replacement payment **after** the due date (end of the month) benefits will be denied and payment will be refunded.
  - **Example** — Cutoff is June 20, 20XX. The MES disposes the case on June 10, 20XX. The Premium payment is due June 30, 20XX. The Premium payment is received June 15, 20XX. On June 20, 20XX, the vendor notifies the MEPD the payment was NSF. The individual sends a replacement premium on June 25, 20XX, but it is not received until July 5, 20XX. MES denies the case and benefits on June 30, 20XX. The monies are refunded to the individual.

Note: If the **NSF notification** is received **after the due date** (end of the month), ongoing rules will apply.

Example – Cutoff is June 20, 20XX. The MES disposes the case on June 10, 20XX. The individual received notice to pay the premium on June 20, 20XX. The premium is received on June 30, 20XX; the vendor notifies MEPD and MES approves the case. On July 4, 20XX, the vendor notifies MEPD the payment is NSF. Because the NSF notification was received after the due date – end of the month – MES must use the ONGOING policy. See M-8411,Non-Sufficient Funds for Ongoing Cases.

M-8420 Premium Payment Notices

Revision 15-3; Effective September 1, 2015

On the first day of every month, TIERS automatically generates Form H0051, Medicaid Buy-In Premium Payment Notice, which is mailed directly to the person. The notice has a coupon attached and a postage-paid envelope enclosed. The person submits the premium payment, along with the coupon, by the due date. Failure to make the premium payment by the due date will cause the person to be denied. Adverse action requirements pertain to MBI. A person whose MBI eligibility is denied for failure to submit premium payments must pay all past due premium payments and current monthly payments to be reinstated into the program.

Note: Premium payments must be received in the form of a check or a money order payable to MBI.

The premium payment address is:
MBI
P.O. Box 650868
Dallas, TX 75265-0868

Once MBI receives the premium payment and the EDG is disposed, Form TF0001, Notice of Case Action, is automatically sent to batch but **must not** be sent to the person. The eligibility worker sends a manual Form H0054, Medicaid Buy-In Eligibility Notice, containing the month(s) of eligibility and the corresponding premium amount(s) received.

M-8430 Presidential-Declared Emergency (PDE)

Revision 12-1; Effective March 1, 2012

A PDE hardship exemption will automatically be granted to recipients living in the declared area and premiums waived for three months. Recipients do not have to request a hardship for PDE. TIERS will send an "emergency special notice" to inform recipients at the start of the PDE period that the premiums have been waived. There is no limit to how many PDEs for which a recipient may have premiums waived; however, a recipient may only have up to three months of premiums waived once per emergency.

For MBI recipients, the waiver of premiums for a PDE begins in the month in which the emergency is declared and continues forward for a total of three consecutive months. Premiums for retroactive months will not be waived. Any premiums received and applied to a month in which a PDE is in effect will be refunded.

Example 1: A PDE is declared for March through May. Premiums may be waived for March, April and/or May. Premiums may be waived for one, two or three months, depending on the date the person is approved for MBI.

Example 2: The PDE period is declared for March through May.

March is the month in which the MBI application is received by HHSC. On April 18, the individual residing in a PDE area is approved for MBI. The individual is eligible to have monthly premiums waived for April and May.

Example 3: The PDE period may be longer than three months (e.g., declared in March, extended through July – five months).

Regardless of the length of the PDE, the recipient may only have premiums waived for three consecutive months (e.g., March, April and May), regardless of the PDE time period. In the third month for which premiums have

been waived, Form H0051, Medicaid Buy-in Premium Payment Notice, which has a payment coupon attached, should be mailed no later than the 20th requesting payment for the month of June, even though the emergency period has not ended.

M-8500, Denial Reasons

Body

Revision 21-1; Effective March 1, 2021

In addition to the MEPD denial codes for all programs, there are eleven denial reasons specific to the MBI program. The correct reason for denial must be manually entered in the case comments section of Form TF0001, Notice of Case Action, before the system generates and sends out the notice. Use the following denial reasons for MBI as appropriate.

1. You failed to pay your MBI premium by <the due date>.
2. Your Independence Account is a countable resource from <mmddyy> through <mmddyy> for one or more of the following reasons:
   - Money was used for non-health care or non-work related expenses.
   - Deposits exceed 50% of your earnings for the Social Security Administration qualifying quarter.
   - Deposits are from sources other than earnings or interest earned on this account.
   - Deposits include income from another individual.
3. Your countable income increased because you did not pay a designated impairment-related work expense (IRWE) with your income.
4. Your countable income increased because you did not pay a designated blind work-related expense (BWE) with your income.
5. The resources excluded as part of your Plan to Achieve Self-Support (PASS) are now countable because you have not met the goal dates in your PASS.
6. The resources excluded as part of your PASS are now countable because funds have not been set aside as agreed.
7. The resources excluded as part of your PASS are now countable because funds have not been spent as agreed.
8. The income excluded as part of your PASS is now countable because you have not met the goal dates in your PASS.
9. The income excluded as part of your PASS is now countable because funds have not been set aside as agreed.
10. The income excluded as part of your PASS is now countable because funds have not been spent as agreed.
11. You did not meet the requirements of completing a Social Security Administration Qualifying Quarter.

M-8510 Redeterminations

Revision 11-4; Effective December 1, 2011

Redeterminations for MBI follow regular MEPD policy for redeterminations.

Streamlining methods and passive reviews are not allowed for an MBI redetermination.

M-8520 Appeals

Revision 13-1; Effective March 1, 2013

HHSC is responsible for all appeals including those concerning premiums.

If an individual is dissatisfied with HHSC's decision concerning his eligibility for medical assistance, he has the right to appeal through the appeal process established by HHSC. In certain circumstances, the individual is entitled to receive continued benefits or services until a hearing decision is issued. Whether an individual is entitled to continued assistance is based on requirements set forth in appropriate state or federal law or regulation of the affected program. See the Fair and Fraud Hearings Handbook.

M-9000, Notices and Forms

Body

Revision 21-4; Effective December 1, 2021

Application

Form H1200-MBI, Application for Benefits – Medicaid Buy-In.

Application form for the Medicaid Buy-In (MBI) program. MBI applicants may also submit Form H1200, Application for Assistance — Your Texas Benefits, and write in “MBI” on the top of the form.

Missing Information

Form H1020, Request for Information or Action

Use to request missing information or verification.

Certification

Use Form H0053, Medicaid Buy-In Potential Eligibility Notice, to notify an applicant of potential eligibility for the MBI program.

Use Form H0054, Medicaid Buy-In Eligibility Notice, to notify an applicant of eligibility for the MBI program.

Complete the form by entering the benefit month(s), the certified person, the monthly premium amount(s), the premium due date and all other required information.

Note: After the MBI potential eligibility EDG is disposed, Form TF0001, Notice of Case Action, is automatically generated. Do not send the TF0001 to the applicant as the system-generated notice has incorrect information. Suppress the TF0001 and send a manual Form H0053. The Form H0053 provides instructions on how MBI recipients send in their first premium payment.

Denials

Form TF0001 is automatically generated and sent to batch when an MBI EDG is denied. Staff must confirm the Form TF0001 includes the correct MBI denial reason. If the incorrect reason is listed, manually add the correct reason for denial in the comments section before generating the Form TF0001.

Case in Ongoing Mode (Approved or Denied)

Form H0054, is used to notify a recipient of receipt of their premium payment, months of coverage and premium amount received.

Related Policy

Missing Information Due Dates, B-6420
Denials, B-6500
Denial Reasons, M-8500
MBI Screening Tool and Worksheet, Appendix XXXIX

M-9100, Replacement Medicaid Card

Body

Revision 16-3; Effective September 1, 2016

Your Texas Benefits Medicaid ID card will only be replaced if the card is damaged, lost or stolen. If an individual requests a replacement of their Your Texas Benefits Medicaid ID card, issue a Form H1027-A.

Note: Inform the recipient to call 1-855-827-3748 for a replacement card.

Chapter N, Medicaid Buy-In for Children

N-1000, Medicaid Buy-In for Children

N-1100, Texas Administrative Code Rules

Body

Revision 11-2; Effective June 1, 2011

§361.101. Overview and Purpose.

(a) This chapter governs the eligibility requirements for Medicaid Buy-In for Children (MBIC), which is authorized under §531.02444 of the Texas Government Code. MBIC provides Medicaid benefits under the option explained in §1902(cc) of the Social Security Act (42 U.S.C. §1396a(cc)).

(b) MBIC is a Medicaid buy-in program for children with disabilities administered by the Texas Health and Human Services Commission (HHSC). It provides Medicaid benefits to eligible children with disabilities who are not eligible for Supplemental Security Income (SSI) for reasons other than disability. A child does not have to have applied for SSI in order to meet eligibility requirements for MBIC.

(c) Nothing in these rules shall be construed to violate the maintenance of eligibility requirements of section 5001 of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5) and make eligibility

standards, methodologies, or procedures under the Texas State Plan for Medical Assistance (or any waiver under section 1115 of the Social Security Act (42 U.S.C. §1315)) more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) that were in effect on July 1, 2008.

§361.103. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

(1) Applicant — A person seeking Medicaid benefits under MBIC who is not currently receiving Medicaid services.

(2) Authorized representative — An individual:

(A) who assists and represents a person in the application or eligibility redetermination process, and who is familiar with that person and that person's financial affairs; or

(B) who is a representative payee for an applicant or recipient for another federal benefit.

(3) CFR — Code of Federal Regulations.

(4) Child — An unmarried person under 19 years of age.

(5) Child with disabilities — A child who meets the Supplemental Security Income (SSI) program's definition of disability for children, as explained in 20 CFR §416.906.

(6) Eligibility certification month — Month in which MBIC eligibility is established.

(7) Family — A unit consisting of an applicant or recipient and the applicant's or recipient's parents and siblings who live in the same household as the applicant or recipient.

(8) Federal Poverty Level (FPIL) — The household income guidelines issued annually and published in the Federal Register by the U.S. Department of Health and Human Services. Percentages of these guidelines are used to determine income eligibility for MBIC and certain other public assistance programs. In other programs, the FPIL may be referred to as the Federal Poverty Income Level or the Federal Poverty Guidelines.

(9) HHSC — The Texas Health and Human Services Commission.

(10) Income — Funds a person receives that can be used to meet his or her need for food or shelter.

(11) In-kind support and maintenance — The value of food or shelter furnished to an applicant's or recipient's family.

(12) Intermediate care facility for persons with mental retardation (ICF/MR) — A Medicaid-certified facility that provides care in a 24-hour specialized residential setting for persons with mental retardation or a related condition. An ICF/MR includes a state supported living center and a state center.

(13) MBIC — Medicaid Buy-In for Children. A Medicaid buy-in program that provides Medicaid benefits to children with disabilities who are not eligible for SSI for reasons other than disability.

(14) Medicaid — A state and federal cooperative program, authorized under Title XIX of the Social Security Act and the Texas Human Resources Code, that pays for certain medical and health care costs for people who qualify. Also known as the medical assistance program.

(15) Parent — A child's natural or adoptive parent or the spouse of the natural or adoptive parent.

(16) Premium — A monthly payment to be made by a family to HHSC or its designee to buy MBIC coverage.

(17) Recipient — A person receiving Medicaid benefits under MBIC, including a person whose Medicaid eligibility is being redetermined.

(18) Sibling — A child's unmarried brother or sister (natural, adoptive, or step).

(19) U.S.C. — United States Code.

§361.105. Applying and Providing Information.

(a) A person or the person's authorized representative applies for MBIC by completing an application prescribed by HHSC and submitting it to HHSC in accordance with HHSC instructions. The date of receipt of the completed signed application by HHSC is the application filing date, which establishes the application month explained in §361.119 of this chapter (relating to Medical Effective Date).

(b) An applicant or authorized representative must provide HHSC with all requested documentation and information that HHSC determines is necessary to make an eligibility determination or calculate a monthly premium. If the applicant or authorized representative fails or refuses to provide requested information by the date specified in a written request from HHSC, HHSC may deny the application for failure to furnish information. When this occurs but the person later provides the requested information, the date that the requested information is provided to HHSC becomes the application filing date explained in subsection (a) of this section.

(c) HHSC notifies a recipient in writing when it is time to redetermine the recipient's eligibility. This usually occurs once per year, although HHSC may require a person to send in documentation and information more often if HHSC determines that a special review of the person's eligibility is appropriate. A recipient must provide requested documentation and information when HHSC sends written notice of the requirement to the recipient's case address of record. The written notice explains the deadline to provide the information. If a recipient fails to provide the information by the deadline stated in the written notice, HHSC may terminate the recipient's MBIC eligibility.

(d) An applicant or recipient must report to HHSC within 10 calendar days any information that may impact the person's eligibility or monthly premium amount, in accordance with 42 U.S.C. §1383(e)(1)(A).

§361.107. Nonfinancial Requirements.

(a) Citizenship, immigration status, and residency. To be eligible for MBIC, a child must meet the citizenship, immigration status, and residency requirements in Chapter 358, Subchapter B of this title (relating to Nonfinancial Requirements).

(b) Disability. To be eligible for MBIC, a child must meet the Supplemental Security Income program's definition of disability for children, as explained in 20 CFR §416.906.

(c) Age. A child is eligible for MBIC through the month of his or her 19th birthday, if the child meets all other eligibility criteria.

(d) Marital status. To be eligible for MBIC, a child must not be married.

(e) Living arrangement.

(1) An applicant or recipient must not reside in a public institution, including a jail, prison, reformatory, or other correctional or holding facility, as defined in 42 CFR §435.1009 and §435.1010.

(2) If a recipient enters a nursing facility or intermediate care facility for persons with mental retardation, HHSC does not process the denial of MBIC Medicaid until eligibility for the appropriate institutional Medicaid program is determined.

(f) Social security number. In accordance with 42 CFR §435.910, a child or the child's authorized representative must give the child's social security number to HHSC as a condition of eligibility for MBIC.

(g) Application for other benefits. To be eligible for MBIC, a child or the child's authorized representative must apply for and obtain, if eligible, all other benefits to which the child may be entitled, in accordance with 42 U.S.C. §1382(e)(2).

§361.109. Third-party Resources.

Medicaid is considered the payor of last resort for a person's medical expenses. As a condition of eligibility, in accordance with 42 CFR §§433.138 - 433.148, an applicant or recipient must:

(1) assign to HHSC the applicant's or recipient's right to recover any third-party resources available for payment of medical expenses covered under the Texas State Plan for Medical Assistance; and

(2) report to HHSC any third-party resource within 60 days after learning about the third-party resource.

§361.111. Income.

(a) To be eligible for MBIC, a child's family must have monthly countable income less than or equal to 150% of the Federal Poverty Level (FPIL).

(b) Countable income means:

(1) earned income for purposes of the Supplemental Security Income (SSI) program minus all applicable exclusions and exemptions, as explained in 20 CFR §§416.1110 - 416.1112; and

(2) unearned income for purposes of the SSI program minus all applicable exclusions and exemptions, as explained in 20 CFR §§416.1120 - 416.1124, except HHSC does not count in-kind support and maintenance as income.

(c) To determine the family's monthly countable income, HHSC counts the income of the child applying for or receiving MBIC, the income of the child's parents living in the same household as the child, and the income of the child's ineligible siblings living in the same household as the child.

(1) For a stepparent's income to count, the stepparent must be the current husband or wife of a natural or adoptive parent living in the same household as the child and the natural or adoptive parent.

(2) A sibling's income counts through the month of the sibling's:

(A) 18th birthday; or

(B) 22nd birthday, if the sibling is, as determined by HHSC, regularly attending school, college, or job training.

(3) HHSC calculates the family's monthly countable income as follows:

(A) Total the following:

(i) Monthly countable income of the child applying for or receiving MBIC.

(ii) Combined monthly countable income of the child's parents.

(iii) Countable monthly income of each of the child's ineligible siblings that is in excess of 150% of the FPIL for a household of one, multiplied by 2, plus $85.

(B) Subtract $85 from the total arrived at in subparagraph (A) of this paragraph.

(C) Divide the total arrived at in subparagraph (B) of this paragraph by 2.

§361.113. Employer-sponsored Health Insurance.

As a condition of a child's eligibility for MBIC, a parent of an applicant or recipient living in the same household as the applicant or recipient must apply for, enroll in, and pay any required premiums for an employer-sponsored health insurance plan, if the parent's employer:

(1) offers family coverage under a group health plan that covers the applicant or recipient; and

(2) contributes at least 50 percent of the total cost of annual premiums.

§361.115. Cost Sharing.

(a) Monthly premium requirements for the months after the eligibility certification month. After HHSC establishes MBIC eligibility, HHSC or its designee sends the recipient written notice of the monthly premium amount and the due date for the monthly premium payment. HHSC provides a grace period of 60 days from the date on which the monthly premium is past due for the recipient to pay the monthly premium, in accordance with 42 U.S.C. §1396o(i)(3). If HHSC does not receive a monthly premium payment within the grace period, then HHSC terminates MBIC eligibility, effective the first day of the month after the grace period ends.

(b) Monthly premium requirements for the three months prior to the application month. As described in §361.119 of this chapter (relating to Medical Effective Date), an applicant may receive MBIC coverage for up to three months prior to the application month if the applicant meets the MBIC eligibility requirements. A month prior to the application month is a retroactive month. Prior to certifying MBIC eligibility for a retroactive month, HHSC or its designee sends the applicant written notice of the monthly premium amount for each eligible retroactive month and the due date for the monthly premium payment. HHSC provides the applicant at least 60 days to submit the premium payment for eligible retroactive months, in accordance with 42 U.S.C. §1396o(i)(3). HHSC or its designee must receive, by the due date, a full premium payment for at least one of the eligible retroactive months to certify MBIC eligibility for a retroactive month. If HHSC or its designee receives a premium payment that is less than the total amount due for all of the eligible retroactive months, then HHSC or its designee applies the amount to the eligible retroactive months in reverse chronological order.

(c) Monthly premium amounts. HHSC determines the monthly premium amounts on a sliding scale based on total monthly income as described in §361.111(c)(3)(A) of this chapter (relating to Income).

(1) For a recipient who is not enrolled in employer-sponsored health insurance, HHSC establishes full monthly premium amounts, up to the maximum amounts allowed by federal law.

(2) For a recipient who is enrolled in employer-sponsored health insurance and who receives premium assistance from HHSC under §1906 of the Social Security Act (42 U.S.C. §1396e), HHSC establishes reduced monthly premium amounts.

(d) Monthly premium amounts for a family with more than one MBIC recipient. If there is more than one MBIC recipient in a family, the family pays only one monthly premium amount.

(e) Undue hardship waivers. HHSC may, in its discretion, waive monthly premiums for undue hardship. HHSC determines eligibility for the undue hardship waivers described in paragraphs (1), (2), and (3) of this subsection based on information provided at application or information provided as described in §361.105 of this chapter

(relating to Applying and Providing Information). A recipient must apply for the undue hardship waiver described in paragraph (4) of this subsection. HHSC does not waive monthly premiums for any months prior to the application month.

(1) A recipient who is an American Indian or Alaska Native as defined in 25 U.S.C. §§1603(c), 1603(f), 1679(b) or who has been determined eligible, as an Indian, pursuant to 42 CFR §136.12 or Title V of the Indian Health Care Improvement Act, to receive health care services is exempt from monthly premiums for the duration of enrollment in MBIC.

(2) A recipient who is enrolled in employer-sponsored health insurance, as determined by HHSC, and who does not receive premium assistance from HHSC under §1906 of the Social Security Act (42 U.S.C. §1396e) is exempt from monthly premiums for MBIC as long as the recipient remains enrolled in employer-sponsored health insurance and is not receiving premium assistance.

(3) A recipient residing in a federally declared disaster area is exempt from monthly premiums for three months beginning with the month in which the disaster is declared. A recipient may only receive one undue hardship waiver per disaster.

(4) A recipient or authorized representative may apply for an undue hardship waiver for loss of income.

(A) HHSC may grant an undue hardship waiver for loss of income if the loss of income is due to:

(i) termination of employment because of a layoff or business closing;

(ii) an involuntary reduction in work hours;

(iii) a parent leaving the household because of divorce or separation; or

(iv) a parent's death.

(B) A recipient who is determined by HHSC to be eligible for an undue hardship waiver for loss of income may be exempt from monthly premiums for three months.

(C) A recipient may only receive one undue hardship waiver for loss of income per 12 months.

(D) An undue hardship waiver for loss of income begins the first month for which HHSC or its designee did not receive a premium payment for the recipient.

(f) Cost-share limits. A recipient is exempt from monthly premiums for the remainder of the coverage period when the cost-share expenditures for the recipient reach the cost-share limit. HHSC determines the cost-share limit for a recipient, up to the maximum allowed by 42 U.S.C. §1396o(i)(2)(A).

(g) Tracking cost-share expenditures. For a recipient without employer-sponsored health insurance, HHSC or its designee determines when MBIC premium payments reach the cost-share limit. A recipient with employer-sponsored health insurance must track cost-share expenditures on the form provided by HHSC or its designee and report to HHSC or its designee when the annual cost-share limit is reached. Eligible cost-share expenditures include the monthly premiums for MBIC and cost sharing for employer-sponsored health insurance. HHSC or its designee:

(1) computes the cost-share limit for each recipient and informs the recipient of the cost-share limit at enrollment;

(2) provides the recipient with a form for keeping track of monthly premiums for MBIC and cost sharing for employer-sponsored health insurance; and

(3) provides a refund if HHSC receives a monthly premium payment that causes the recipient to exceed the cost-share limit.

The provisions of this §361.115 adopted to be effective January 1, 2011, 35 TexReg 11572

§361.117. Notice of Eligibility Determination and Right to Appeal.

(a) After making an eligibility determination on an initial application, HHSC sends the applicant:

(1) a written notice of eligibility, including notice of any monthly premium requirements and the medical effective date described in §361.119 of this chapter (relating to Medical Effective Date); or

(2) a written notice of ineligibility and the reason for the decision.

(b) After making an eligibility determination or redetermination, HHSC sends the recipient a written notice of any change in eligibility or monthly premium requirement.

(c) The written notice informs the applicant or recipient of the right to request a hearing to appeal HHSC's decision. The hearing is held in accordance with 42 CFR Part 431, Subpart E and HHSC's fair hearing rules in Chapter 357 of this title (relating to Hearings).

§361.119. Medical Effective Date.

(a) Beginning with the three months before the application month, except as described in subsection (b) of this section, the medical effective date for MBIC coverage is the first day of the first month in which a person meets all eligibility criteria.

(b) The medical effective date for MBIC cannot predate January 1, 2011.

N-1200, Program Overview

Body

Revision 16-1; Effective March 1, 2016

The Medicaid Buy-In for Children (MBIC) program is a Medicaid program for children with disabilities up to the age of 19 with family income up to 300 percent of the federal poverty level (FPIL). A family may have to pay a monthly premium as a condition of eligibility. The amount of the premium is based on the family's income and whether an applicant/recipient is covered under a parent's employer-sponsored health insurance plan. For a definition of terms used for MBIC, see the Glossary.

MBIC recipients receive regular Medicaid benefits, a Medicaid ID card and an MBIC member handbook. The handbook is a guide that has basic information about MBIC. It explains what to do if an applicant/recipient has questions or needs help while in the program.

All regular Medicaid for the Elderly and People with Disabilities (MEPD) policies apply to this program except for the eligibility items specifically identified in this chapter. For example, citizenship and Texas residency are not addressed specifically for MBIC; therefore, follow regular MEPD policies for citizenship and Texas residency.

All eligibility requirements for this program must be verified. MBIC is not a client-declaration program.

N-1300, Medicaid Buy-In for Children and Other Programs

Body

N-1310 MBIC and Nursing Facilities

Revision 21-4; Effective December 1, 2021

Medicaid Buy-In for Children (MBIC) is a community-based Medicaid program. If an MBIC recipient enters a nursing facility or an intermediate care facility for people with intellectual disability or related condition (ICF/IID), contact the authorized representative (AR) to determine how long the recipient's is expected to remain in the facility.

If the facility stay is expected to be less than 90 days, no action is required.

If the facility stay is expected to be more than 90 days, obtain any additional eligibility verifications needed and complete a program transfer to facility Medicaid.

N-1320 MBIC and Home and Community-Based Services Waivers

Revision 21-3; Effective September 1, 2021

Home and Community-Based Services waiver services such as Community Living Assistance and Support Services, are not paid under the MBIC systems eligibility codes. The exception is Texas Home Living (TxHmL). Therefore, if a referral for any other waiver is received, get a new Form H1200, Application for Assistance – Your Texas Benefits. Then gather any other verification needed to determine eligibility for ME-Waivers and complete a program transfer if all eligibility criteria are met.

Note: Medicaid Buy-In for Children (MBIC) will pay for TxHmL waiver services under MBIC systems eligibility codes.

N-1330 MBIC and Medicare Savings Programs

Revision 11-3; Effective September 1, 2011

An MBIC-eligible applicant/recipient can also have:

- Qualified Medicare Beneficiary (QMB)
- Specified Low-Income Medicare Beneficiary (SLMB)

An MBIC-eligible applicant/recipient cannot have:

- Qualifying Individuals-1 (QI-1). The applicant/recipient must choose between MBIC and QI-1.
- Qualified Disabled Working Individuals

Reminder: Resource information is required for Medicare Savings Programs (MSP). Parental deeming of income and resources and support and maintenance applies to MSP.

N-1340 Medicaid Estate Recovery Program (MERP)

Revision 11-3; Effective September 1, 2011

Due to the age of these recipients, the Medicaid Estate Recovery Program (MERP) does not apply to MBIC.

N-2000, Automation

Body

Revision 11-3; Effective September 1, 2011

Medicaid Buy-In for Children (MBIC) is worked only in the Texas Integrated Eligibility Redesign System (TIERS) and is type of assistance "TA-88." The program name displays as "ME-MBIC."

The TIERS system will do the eligibility budgeting and premium calculations for this program. However, staff need to understand the policy.

N-3000, Non-Financial

Body

Revision 13-2; Effective June 1, 2013

All regular, non-financial Medicaid for the Elderly and People with Disabilities (MEPD) policies apply to Medicaid Buy-In for Children (MBIC), except those specifically identified in this chapter.

Non-financial requirements apply only to an MBIC applicant/recipient.

Note: In the eligibility system, list the parent/guardian of the MBIC child as the head of household. The parent/guardian also needs to be listed as the alternate payee as well as the EDG name. This is primarily for any premium reimbursements and managed care purposes.

N-3100, Date of Birth

Body

Revision 11-3; Effective September 1, 2011

Although MEPD policy does not require a date of birth for an applicant/recipient's family members, the Texas Integrated Eligibility Redesign System (TIERS) requires an entry in the date of birth (DOB) field for all members of the family unit for file clearance purposes. If a non-MBIC family unit member does not provide a DOB, use a default DOB of 02-29-1988. The date will automatically make any siblings' age over 22 so they will not be included in either the family unit or budget group. Do not request the DOB for a non-MBIC family member if it is not provided.

N-3200, Age

Body

Revision 11-3; Effective September 1, 2011

Eligibility is available through the end of the month of the child's 19th birthday. If an application is received in the month of the 19th birthday, process the MBIC application and determine eligibility for that month and the three months prior to that application.

Example: Application is received on April 5. Applicant turns 19 on April 17. Determine eligibility for the application month of April and three prior months of January, February and March.

N-3300, Disability

Body

Revision 11-3; Effective September 1, 2011

An applicant/recipient must meet the Supplemental Security Income (SSI) definition of disability. If an applicant/recipient has not had a disability determination made by the Social Security Administration, use HHSC's Disability Determination Unit for disability determinations. Follow regular MEPD policy for disability determinations.

N-3400, Marital Status

Body

Revision 11-3; Effective September 1, 2011

An applicant/recipient must not be married.

N-3500, School or Job Training Attendance

Body

Revision 11-3; Effective September 1, 2011

Verification of school or job training attendance for siblings age 18 through age 22 is required.

N-4000, Resources and Income

Body

Revision 11-3; Effective September 1, 2011

All regular Medicaid for the Elderly and People with Disabilities (MEPD) policies for income apply to this program, except those specifically identified in this chapter.

N-4100, Resources

Body

Revision 11-3; Effective September 1, 2011

There is no resource test for this program.

There is no parental deeming of resources for this program.

N-4200, Income

Body

Revision 11-3; Effective September 1, 2011

Even though there is no resource test for this program, the income from income-producing resources is considered. Determine if the income from income-producing resources is countable using regular MEPD policy.

There is no support and maintenance considered for Medicaid Buy-In for Children. Do not develop support and maintenance.

There is no parental deeming of income for this program.

N-5000, Employer-Sponsored Health Insurance

Body

Revision 11-3; Effective September 1, 2011

As a condition of an applicant's/recipient's eligibility for Medicaid Buy-In for Children (MBIC), a parent living in the same household as the applicant/recipient must apply for, enroll in and pay any required premiums for employer-sponsored health insurance (ESI) if:

- the parent is actively employed, **and**
- the parent's employer offers ESI that meets the following criteria:
  - the ESI is a group health plan that covers the applicant/recipient, and
  - the employer contributes at least 50 percent of the total cost of annual premiums.

N-5100, ESI Chart

Body

Revision 11-3; Effective September 1, 2011

The following chart outlines the eligibility treatment for various situations involving ESI:

If	Then
A parent living in the same household as the applicant/recipient has a job that offers ESI that meets the criteria but (1) the parent is not enrolled in the ESI and (2) there is a future open enrollment period during which the parent can enroll.	Certify an applicant for MBIC if all other eligibility criteria are met. On the ESI Details screen, use "Is there an open enrollment period?" and "open enrollment start date" fields to monitor.
A parent living in the same household as the applicant/recipient has a job that offers ESI that meets the criteria but (1) the parent is not enrolled in the ESI and (2) enrollment is available to the parent at the time of application.	Do not certify the applicant for MBIC until the parent's enrollment in ESI is verified.

If	Then
A parent living in the same household as the applicant/recipient has only unearned income (such as retirement or pension) or self-employment income.	ESI is not an eligibility requirement.
A parent not living in the same household as the applicant/recipient has health insurance that covers the applicant or recipient. **Example:** A father living outside the household that is legally required to carry insurance on the applicant/recipient.	Consider that parent's insurance as a third-party resource (TPR). Follow regular Medicaid for the Elderly and People with Disabilities (MEPD) policy for TPR.
A parent living in the same household as the applicant/recipient has ESI that meets the criteria **and** a parent not living in the same household as the applicant/recipient has health insurance that covers the applicant or recipient.	The parent living in the same household as the applicant/recipient still must apply for, enroll in and pay any required premiums for the ESI. Follow regular MEPD policy for TPR for the other parent's insurance.
An applicant or recipient works and has employer-sponsored health insurance.	Consider the applicant's/recipient's health insurance as TPR. Follow regular MEPD policy for TPR.
A parent living in the same household as the applicant/recipient has begun the enrollment process for ESI, but the employer needs more time to complete the enrollment.	Verify the approximate date of the enrollment decision and certify the applicant for MBIC if all other eligibility criteria are met. On the ESI Details screen, use the "Decision enrollment pending" and "potential insurance follow up date" fields to monitor.
A parent living in the same household as the applicant/recipient voluntarily withdraws from ESI after enrollment.	Deny or terminate the applicant/recipient following regular MEPD policy. Client statement is acceptable verification for voluntary withdrawal from ESI

N-6000, Budgeting

N-6100, Budgeting Concepts

Body

Revision 11-3; Effective September 1, 2011

Medicaid Buy-In for Children (MBIC) has two budgeting concepts: family unit and budget group.

Family unit is used to determine the appropriate federal poverty level (FPIL) to use as an income limit. Budget group is used to determine the countable income of the family unit to compare to the FPIL for eligibility. Budget group is further defined in Section N-6340, Determining the Budget Group.

The total number of members in the family unit is used in eligibility income budgeting to determine the income limit for the family.

N-6200, Determining the Family Unit

Body

Revision 15-4; Effective December 1, 2015

To determine a family unit, count the:

- MBIC applicant or recipient, and

- applicant's or recipient's parents living in the same household (see definition of parent in the Glossary), and
- applicant's or recipient's siblings (eligible or ineligible) living in the same household (see definition of sibling in the Glossary).

For a stepparent to be included in the family unit and the stepparent's income to be considered in the budget group, a stepparent must:

- be the current spouse of a natural or adoptive parent, and
- live in the same household as the MBIC applicant or recipient **and** the natural or adoptive parent.

If neither a stepparent nor the stepparent's income is considered because these criteria are not met, do not consider a stepsibling or their income.

N-6300, Eligibility Income Budgeting

Body

Revision 13-4; Effective December 1, 2013

Eligibility income budgeting for Medicaid Buy-In for Children (MBIC) is different from other MEPD programs. As stated in the beginning of Chapter N, Medicaid Buy-In for Children, the family gross income must not exceed 300 percent of the FPIL. However, due to substantial income exclusions, the income limit used for eligibility is equal to or less than 150 percent FPIL for the family unit size. Each case may have a different income limit. See Appendix XXXI, Budget Reference Chart, for 150 percent FPIL and 300 percent FPIL amounts.

N-6310 Income Treatment

Revision 11-3; Effective September 1, 2011

Treat earned and unearned income the same in MBIC budgeting. Do not deduct:

- the $20-general exclusion, or
- the earned income exclusion of $65 plus one-half of the remaining income.

N-6320 MBIC Income Exclusion

Revision 11-3; Effective September 1, 2011

The MBIC income exclusion is $85 plus one-half of the remaining income and is deducted at the end of the budget calculation.

N-6330 Ineligible Sibling Exclusion

Revision 21-2; Effective June 1, 2021

Allow an exclusion from an ineligible sibling's income before counting the ineligible sibling's income in the eligibility budget. Allow this exclusion for each ineligible sibling in the family unit. Follow these steps to find the ineligible sibling exclusion:

- Use 150 percent FPL for a family of one.
- Multiply that figure by 2.
- Add $85.

The total amount from these steps is the ineligible sibling's exclusion amount. Effective March 2021, this amount is $3,305. Deduct this amount from the ineligible sibling's total income. Count in the budget the ineligible sibling's excess income after the exclusion. If the ineligible sibling's income is less than the total exclusion, disregard all the ineligible sibling's income in the budget.

N-6340 Determining the Budget Group

Revision 15-4; Effective December 1, 2015

The budget group is determined by identifying the members of the family unit whose income is countable in the eligibility budget. The number of people in the family unit and in the budget group may be different.

Do not count any of the income of a family unit member that:

- has needs-based income, such as veteran's pension or Supplemental Security Income (SSI); or
- is a Medicaid-eligible person, such as another MBIC applicant/recipient in the household.

For a stepparent's income to count, the stepparent must:

- be the current spouse of a natural or adoptive parent, and
- live in the same household as the MBIC applicant or recipient **and** the natural or adoptive parent.

If a stepparent's income is not considered because these criteria are not met, do not consider a stepsibling's income either.

Reminders:

- If school or job training attendance has not been verified for an ineligible sibling between ages 18 and 22, that sibling is not part of the family unit and, therefore, is not included in the budget group.
- Consider absences due to active military assignments as temporary and include that individual in the budget group.

N-6350 Budgeting Steps

Revision 11-3; Effective September 1, 2011

Note: The Integrated Eligibility Redesign System (TIERS) will do the eligibility budgeting; however, Medicaid for the Elderly and People with Disabilities (MEPD) specialists must understand the policy.

Begin budgeting with these steps:

1. Determine the family unit members.

2. Use Appendix XXXI, Budget Reference Chart, to find the amount that is 150 percent of the FPIL for the family size that corresponds to the total number of family unit members. This is the income limit for this family. **Example:** There are five family unit members. The income limit is 150 percent of the FPIL for a family of five.
3. Determine the budget group members.
4. Determine the monthly gross countable income, if any, of the MBIC applicant or recipient.
5. Determine the combined monthly gross countable income of the applicant/recipient's parents.
6. For each ineligible sibling, determine any monthly gross countable income that exceeds the ineligible sibling's exclusion amount. If the exclusion amount is greater than the ineligible sibling's income, disregard all of that ineligible sibling's income.
7. Total the income amounts determined in steps 4-6.
8. Subtract $85 from the total in step 7.
9. Divide the amount in step 8 by two.
10. The remainder is countable income. Compare this to the income limit determined in step 2.

N-6351 Examples of Budgeting Steps

Revision 21-2; Effective June 1, 2021

The figures used in these charts are for example only and may not reflect the current FPL limits or the deduction amounts that are based on FPL.

Example 1

Determining Family Unit Members and FPL Limit to Use

Household Composition	Applicant — no income Applicant's parent — gross earnings $1,400 monthly Applicant's stepparent — gross earnings $3,000 monthly Applicant's ineligible 16-year-old sibling — no income Applicant's ineligible 19-year-old sibling, non-student — gross earnings $800 monthly Applicant's ineligible 14-year-old stepsibling — no income
Children Employed	None
Family Unit Members	Applicant Applicant's parent Applicant's stepparent Applicant's ineligible 16-year-old sibling Applicant's ineligible 14-year-old stepsibling
Income Limit	150% FPL for family of five

Note: Since the 19-year-old ineligible sibling is over 18 and not a student, do not consider the sibling or the sibling's income.

Budget Group and Eligibility

Steps	Amount

Steps	Amount
Applicant's monthly gross countable income	$0
Add parents' monthly gross countable income	$4,400
Add each ineligible sibling's gross countable income that exceeds $3,275	$0
Balance of budget group income	$4,400
MBIC exclusion ($85 + one-half of remainder)	$2,242.50
Total countable income	$2,157.50
150% FPL for family of five	≤ $3,880
Eligibility result	Eligible

Example 2

Determining Family Unit Members and FPL Limit to Use

Household Composition	Applicant — Retirement, Survivors, and Disability Insurance (RSDI) $167 Applicant's parent — gross earnings $4,500 monthly Stepparent, died one year ago Applicant's ineligible 16-year-old sibling — gross earnings $100 monthly Applicant's 20-year-old ineligible sibling, student — gross earnings $400 monthly Applicant's 10-year-old stepsibling — no income
Children Employed	2
Family Unit Members	Applicant Applicant's parent Applicant's ineligible 16-year-old sibling Applicant's ineligible 20-year-old sibling (student)
Income Limit	150% FPL for family of four

Note: Since the stepparent is deceased, do not consider the ineligible stepsibling or the ineligible stepsibling's income.

Budget Group and Eligibility

Steps	Amount
Applicant's monthly gross countable income	$167
Add parent's monthly gross countable income	$4,500
Add each ineligible sibling's monthly gross countable income that exceeds $3,305	$0
Balance of budget group income	$4,667
MBIC exclusion ($85 + one-half of remainder)	$2,376
Total countable income	$2,291
150% FPL for family of four	≤ $3,313
Eligibility result	Eligible

Example 3

Determining Family Unit Members and FPL Limit to Use

Household Composition	Applicant — RSDI $88 Applicant's stepparent — gross earnings $5,925 monthly Applicant's parent, died two years ago Applicant's ineligible two-year-old sibling — no income Applicant's ineligible 19-year-old sibling, non-student — gross earnings $800 monthly Applicant's ineligible seven-year-old stepsibling — no income
Children Employed	None
Family Unit Members	Applicant Applicant's ineligible two-year-old sibling
Income Limit	150% FPL for family of two

Note: Since the natural parent died and the stepparent is no longer a current spouse of the natural parent, do not consider the stepparent and the ineligible stepsibling or their income. Since the 19-year-old ineligible sibling is over 18 and not a student, do not consider the sibling or the sibling's income.

Budget Group and Eligibility

Steps	Amount
Applicant's monthly gross countable income	$88
Add parent's monthly gross countable income	$0
Add each ineligible sibling's monthly gross countable income that exceeds $3,305	$0
Balance of budget group income	$88
MBIC exclusion ($85 + one-half of remainder)	$86.50
Total countable income	$1.50
150% FPL for family of two	≤ $2,178
Eligibility result	Eligible

Example 4

Determining Family Unit Members and FPL Limit to Use

Household Composition	Applicant — RSDI $88 Sibling, seven-year-old, also an applicant — RSDI $88 Applicant's parent — gross earnings $7,800 monthly Applicant's other parent, died two years ago Applicant's ineligible two-year-old sibling — no income
Children Employed	None
Family Unit Members	Applicant Applicant's seven-year-old sibling, who is also an MBIC applicant Applicant's parent Applicant's ineligible two-year-old sibling
Income Limit	150% FPL for family of four

Note: If a sibling is also applying for MBIC, count this sibling in the family unit size, but calculate separate budgets since one "eligible" sibling's income is not counted in the other "eligible" sibling's budget group.

Budget Group and Eligibility

Steps	Applicant 1	Applicant 2
First applicant's monthly gross countable income	$88	$88

Steps	Applicant 1	Applicant 2
Second applicant's monthly gross countable income	N/A	N/A
Add parent's monthly gross countable income	$7,800	$7,800
Add each ineligible sibling's monthly gross countable income that exceeds $3,305	$0	$0
Balance of budget group income	$7,888	$7,888
MBIC exclusion ($85 + one-half of remainder)	$3,986.50	$3,986.50
Total countable income	$3,901.50	$3,901.50
150% FPL for family of four	> $3,313	> $3,313
Eligibility result	Not eligible	Not eligible

Note: Use separate budgets when more than one child with disabilities in the same family unit is applying for MBIC.

Example 5

Determining Family Unit Members and FPL Limit to Use

Household Composition	Applicant — RSDI $88 Applicant's parent — RSDI $699 Applicant's ineligible two-year-old sibling — RSDI $88 Applicant's ineligible five-year-old sibling — RSDI $88
Children Employed	None
Family Unit Members	Applicant Applicant's parent Applicant's ineligible two-year-old sibling Applicant's ineligible five-year-old sibling
Income Limit	150% FPL for family of four

Budget Group and Eligibility

Steps	Amount
Applicant's monthly gross countable income	$88
Add parent's monthly gross countable income	$699
Add each ineligible sibling's monthly gross countable income that exceeds $3,305	$0
Balance of budget group income	$787
MBIC exclusion ($85 + one-half of remainder)	$436
Total countable income	$351
150% FPL for family of four	≤ $3,313
Eligibility result	Eligible

Example 6

Determining Family Unit Members and FPL Limit to Use

Household Composition	Applicant — no income Applicant's parent — gross earnings $4,500 monthly Applicant's other parent — $850 Veterans Affairs (VA) benefits with aid and attendance monthly; gross earnings of $300 monthly

Children Employed	None
Family Unit Members	Applicant Applicant's parents
Income Limit	150% FPL for family of three

Budget Group and Eligibility

Steps	Amount	Documentation
Applicant's monthly gross countable income	$0	
Add parents' monthly gross countable income	$4,500	VA income is needs-based, so none of the other parent's income is included in the budget.
Add each ineligible sibling's monthly gross countable income that exceeds $3,305	N/A	
Balance of budget group income	$4,500	
MBIC exclusion ($85 + one-half of remainder)	$2,292.50	
Total countable income	$2,207.50	
150% FPL for family of three	≤ $2,745	
Eligibility result	Eligible	

N-7000, Premiums

Body

Revision 16-4; Effective December 1, 2016

Medicaid Buy-In for Children (MBIC) correspondence refers to a premium as a monthly payment.

A family may have to pay a monthly premium as a condition of eligibility. The premium amounts are based on a sliding scale, dependent upon family income and whether the applicant/recipient is covered under a parent's employer-sponsored health insurance (ESI) plan. If a parent's insurance qualifies, the Health Insurance Premium Payment Program (HIPP) can reimburse the family for the ESI premium (see D-7700, Health Insurance Premium Payment Reimbursement Program). HIPP eligibility is also a determining factor in the MBIC premium amount.

Note: The 50% rule for ESI only applies to eligibility and not to premium calculations.

Premium amounts are calculated using the gross countable family income. In the budgeting examples in Section N-6351, Examples of Budgeting Steps, the amount of gross family income used for premium calculation is the "balance of budget group income." Since the premium amount is calculated before the substantial MBIC exclusion of $85 + one-half of the remainder, 300 percent of the federal poverty level is used for the premium calculations.

Note: In TIERS, list the parent/guardian of the MBIC child as the head of household. The parent/guardian also needs to be listed as the alternate payee as well as the EDG name. This is primarily for any premium reimbursements and managed care purposes.

N-7100, Premiums for Alaskan Native or American Indian

Body

Revision 11-3; Effective September 1, 2011

Premiums are waived if an applicant/recipient is an Alaskan Native or American Indian.

N-7200, Premiums in Multiple MBIC-eligible Families

Body

Revision 11-3; Effective September 1, 2011

If there is more than one MBIC-eligible recipient in the family unit, there will be only one premium per family unit. Each eligibility determination group (EDG) will have a premium amount calculated; however, the lowest premium amount of all EDGs will be the premium charged.

N-7300, Premium Due Dates

Body

Revision 11-3; Effective September 1, 2011

Premiums are due on the fifth of each month.

Premiums are not required for application month, disposition month or any month in between.

Example: Application is received in January 2011. Case is disposed in March 2011 with a medical effective date (MED) of Jan. 1, 2011. No premiums are required for January, February or March. First premium is due April 5. Premiums are required for the month following the disposition month regardless of the MED.

If premiums are required, payment of MBIC premiums is a condition of continued eligibility.

N-7310 Grace Period for Premiums

Revision 11-3; Effective September 1, 2011

An applicant/recipient is given a 60-day grace period to make a premium payment before denial occurs. If a recipient has missed making a premium payment for two consecutive months, the Texas Integrated Eligibility Redesign System (TIERS) will send Form H0062-MBIC, Late Payment Notice, and Form H0065-MBIC, Hardship Form. If a payment is not received by two days before TIERS cutoff, two months after the first missed payment, and a valid hardship is not claimed by the due date on the Form H0065-MBIC, TIERS will auto terminate the MBIC EDG(s) effective the end of that month.

Example: First missed payment is May 5, 2011. On June 5, 2011, the May payment is missed a second time. On June 7, 2011, Form H0062-MBIC, Late Payment Notice, and Form H0065-MBIC, Hardship Form, are sent to the client/authorized representative. Due date for premium payment is July 6, 2011. Due date for a hardship to be claimed is June 17, 2011 (10 days from the date of Form H0065-MBIC). Payment must be received by two days before cut-off in July 2011 or hardship claimed by June 17, 2011. If no payment is received or hardship claimed, denial is effective July 31, 2011. TIERS will auto terminate the MBIC EDG(s) effective the end of that month.

N-7320 Premiums and Reapplication for MBIC

Revision 11-3; Effective September 1, 2011

If a person is denied MBIC, but later reapplies and is eligible for MBIC, there is no requirement to pay the missed premiums from the last eligibility period before new eligibility can be granted.

N-7330 Coordination with the Children with Special Health Care Needs (CSHCN) Program

Revision 11-3; Effective September 1, 2011

If an MBIC applicant/recipient is also eligible for the CSHCN Program through the Department of State Health Services (DSHS), the state will pay the MBIC premium. There is no coordination or verification required by Medicaid for the Elderly and People with Disabilities (MEPD) specialists. Direct payment of the person's medical insurance premiums by anyone on the person's behalf is not considered as income. See Section E-1710, Medical Care and Services That Are Not Income.

DSHS will make referrals of CSHCN persons that may be potentially eligible for MBIC. Some of these people may already be eligible for the Children's Health Insurance Program (CHIP). Based on information from DSHS, there is no requirement for a CSHCN eligible person that is also eligible for CHIP to switch to MBIC. It is the person's choice. If the person chooses to remain in CHIP, document in case comments the person's choice and deny the MBIC application as a voluntary withdrawal.

N-7400, Premium Amounts

Body

Revision 11-3; Effective September 1, 2011

Premium amounts vary based on whether the family does or does not have ESI and whether HIPP is involved or not. Premium amounts are automatically determined by TIERS.

The charts in Section N-7410, Charts for Premium Amounts, outline the premium amounts for persons with:

- no ESI;
- ESI and state-paid HIPP; or
- ESI and no state-paid HIPP.

N-7410 Charts for Premium Amounts

Revision 14-3; Effective September 1, 2014

No ESI

Note: These premium amounts are current. These amounts are subject to change when FPIL limits change.

Family Income	Family of 1 or 2 Premium Amount	Family of 3 or More Premium Amount
At or below 150% FPIL	$0	$0
151–200% FPIL	$90	$115
201–300% FPIL	$180	$230

ESI with State-Paid HIPP

Note: These premium amounts are current. These amounts are subject to change when FPIL limits change.

Family Income	Family of 1 or 2 Premium Amount	Family of 3 or More Premium Amount
At or below 150% FPIL	$0	$0
151–200% FPIL	$25	$35
201–300% FPIL	$50	$70

ESI and No State-Paid HIPP

No premiums are required for families with ESI who are not eligible for HIPP. These families are paying their full share of the premium for ESI and are not expected to also pay a premium for MBIC.

N-7500, Hardship

Body

Revision 11-3; Effective September 1, 2011

A hardship exemption may be granted for loss of income if the loss of income is due to:

- termination of employment because of layoff or business closing;
- involuntary reduction in work hours;
- a parent leaving the household because of divorce or separation; or
- a parent's death (the parent had to be previously residing in the same household as the MBIC applicant/recipient).

No hardship exemption is allowed to waive prior months premium(s).

Hardship exemption is only allowed once per household every 12 calendar months (regardless of how many MBIC recipients are in the household).

A hardship must be requested within 10 days from the date on Form H0065-MBIC, Hardship Form. A hardship request must be in writing; however, a verbal request is acceptable to meet the 10-day deadline. Written follow-up is required.

Example: First missed payment is May 5, 2011. On June 5, 2011, the May payment is missed a second time. On June 7, 2011, Form H0062-MBIC, Late Payment Notice, and Form H0065-MBIC, Hardship Form, are sent to the client/authorized representative. Due date for premium payment is July 6, 2011. Due date for a hardship to be claimed is June 17, 2011 (10 days from date of Form H0065-MBIC). Payment must be received by two days before cut-off in July 2011 or hardship claimed by June 17, 2011. If no payment is received or hardship claimed, denial is effective July 31, 2011. TIERS will auto terminate the MBIC EDG(s) effective the end of that month.

N-7510 Hardship Approval

Revision 11-3; Effective September 1, 2011

Approve a hardship request if one of the valid reasons is met. Do not require verification of hardship reasons. Use client's statement and signature on Form H0065-MBIC, Hardship Form, as proof of the hardship; however, if the reason is something that would potentially impact benefits (such as loss of job), verify the change for potential eligibility changes to ongoing benefits. This does not have to be done before the hardship can be approved. Notify a client/authorized representative of the hardship approval on Form TF0001-MBIC, Hardship Waiver Approved.

If approved, the hardship exemption begins on the first of the month for which a premium payment was not received and is granted for three consecutive months.

Example: Premiums were missed in May and again in June. Hardship was claimed on Form H0065-MBIC, and hardship was approved in July. Premiums are waived for May, June and July.

N-7511 Hardship Approval Reasons

Revision 11-3; Effective September 1, 2011

Form TF0001-MBIC, Hardship Waiver Approved, will be pre-populated with one of the following reasons.

- Someone living with you was laid off their job. – OR – The place where they work closed.
- Someone living with you has less income because they work fewer hours.
- A parent left the house because of a divorce or separation.
- A parent died. (This is an approval reason but this actual verbiage will not print on the TF0001.)

N-7520 Hardship Denial

Revision 11-3; Effective September 1, 2011

Deny a hardship request if:

- none of the valid reasons are met; or
- Form H0065-MBIC, Hardship Form, or a verbal request was not received by the due date; or
- a hardship has been granted within the past 12 calendar months. TIERS will track the12-month period.

Notify a client/authorized representative of the hardship denial via Form TF0001-MBIC, Hardship Waiver Denied.

N-7521 Hardship Denial Reasons

Revision 11-3; Effective September 1, 2011

Form TF0001-MBIC, Hardship Waiver Denied, will be pre-populated with one of the following reasons.

- We didn't get your "Hardship Form" (H0065-MBIC) by the due date.
- It hasn't been 12 months since we last stopped your payments. Your payments can be stopped for three months only once in 12 months.
- You didn't lose money from a job (income) for reasons that allow us to stop your payments.

N-7600, Presidential-Declared Emergency

Body

Revision 11-3; Effective September 1, 2011

A presidential-declared emergency hardship exemption will automatically be granted to recipients living in the declared area and premiums will be waived for three months. Recipients do not have to request a hardship for a presidential-declared emergency. TIERS will send an "emergency special notice" to inform recipients at the start of the presidential-declared emergency period that the premiums have been waived.

For MBIC recipients, the waiver of premiums for a presidential-declared emergency is for the month of declaration and forward for a total of three months.

Hardship exemption and presidential-declared emergency periods can overlap. They do not run consecutively.

Example: A recipient has hardship exemption for January, February and March. A presidential-declared emergency is declared for March. The presidential-declared emergency hardship would normally be allowed for March, April and May. Total number of months the recipient is not required to pay premiums is five, which are January, February, March, April and May.

A presidential-declared emergency has priority over a hardship exemption if the two situations fall during the same time period. If a hardship exemption has been approved but a presidential-declared emergency is granted for the same time period, the client cannot have another hardship exemption for 12 months.

There is no limit to how many times a recipient may receive a presidential-declared emergency hardship; however, a recipient may only receive one presidential-declared emergency per disaster.

N-7700, Prior Months' Premiums

Body

Revision 11-3; Effective September 1, 2011

MBIC correspondence refers to these as "payments for past months."

Prior months' eligibility is not granted until premiums for prior months are paid. If all prior months have a $0 premium, eligibility will be granted upon disposition. If any of the prior months have a premium, the premium is due two months after the initial premium due date.

Example: Application is filed in March, disposed on April 1.The prior months are January and February. The premiums for January and February are due on July 5 (two months after May 5, the initial premium due date).

When premiums are paid, eligibility is granted beginning with the last month of the prior month period. Months cannot be skipped, even if a month with a $0 premium falls between two months that require a premium. In the following examples, January, February and March are prior months.

Examples:

- January is $90, February is $90 and March is $90. As premiums are paid, eligibility is granted first for March, then February, and then January.
- January is $90, February is $0 and March is $90. March has to be paid before February is granted.

Reminder: No hardship is allowed to waive prior months' premium(s).

N-7800, Health Insurance Premium Payment

Body

Revision 11-3; Effective September 1, 2011

If a parent gets health insurance at work, that information will be sent to the HIPP program for review. If certain standards are met, HIPP will pay the entire health insurance premium as a reimbursement to the individual.

Parents/persons who want to learn more can call 1-800-440-0493 or visit www.gethipptexas.org.

When ESI information is entered into TIERS, this information is automatically sent to HIPP. HIPP eligibility is not an MEPD specialist's responsibility; however, HIPP eligibility does impact the MBIC premium amount.

N-7900, Cost-Sharing

Body

Revision 11-3; Effective September 1, 2011

Cost-sharing is the amount a person pays out of their own pocket for health care. Cost-sharing includes MBIC premiums. Recipients will receive information from the premium processing vendor regarding what expenses are included in cost-sharing.

N-7910 Cost-Share Limit

Revision 11-3; Effective September 1, 2011

Each recipient has a cost-share limit. TIERS will calculate a cost-share limit for each recipient and populate the cost-share limit on Form TF0001-MBIC, Initial Certification.

There is no cost-share limit for the prior months.

Cost-share limit is set at the eligibility determination group level. If there is more than one MBIC-eligible recipient in the family unit, there will be only one cost-share limit per family unit. Each EDG will have a cost-share limit calculated; however, the lowest cost-share limit of all EDGs will be used at a case level.

The cost-share limit for each family is set at:

- 5% of countable gross annual income for a family whose countable gross annual income is at or below 200 percent of the FPIL.
- 7.5% of countable gross annual income for a family whose countable gross annual income is 201% to 300% of the FPIL.

The amount of monthly gross countable income in the month following disposition is multiplied by 12 in order to determine the gross annual income used in calculating the cost-share limit. This is the total gross countable income prior to the MBIC exclusion of $85 + one-half.

The cost-share limit can change if there is a change in income during that initial 12-month period. **Example:** MBIC application is received in January 2011 and certified in March 2011. The cost-share limit is based on income budgeted for April 2011 and begins April 2011. In August 2011, a change in income is reported and case action is taken in August (cut-off is taken into consideration). A new cost share limit will begin in September 2011.

N-7920 Cost-Share Period

Revision 11-3; Effective September 1, 2011

A cost-share period is established for each recipient. This period begins the first day of the disposition month and lasts for 12 months. This is the period during which an MBIC recipient's medical costs and MBIC premiums can be counted toward the cost-share limit.

There is no cost-share period for the prior months.

The original cost-share period is retained for MBIC eligibility determination groups when:

- an individual is denied in error and then reactivated; and
- a previously certified MBIC client enters a facility (transfer) and then returns to MBIC within the same cost-share period.

A new cost-share period will be set (based on the new disposition date) when a person reapplies if an MBIC EDG is denied or terminated for any reason except for:

- denied in error, or
- transfer between programs.

N-7930 Tracking Cost-Share Expenses

Revision 11-3; Effective September 1, 2011

A recipient is exempt from MBIC monthly premiums for the remainder of the coverage period when the cost-share expenditures for the recipient reach the cost-share limit.

For a recipient without employer-sponsored health insurance, the premium processing vendor will determine when the MBIC premium payments reach the cost-share limit.

For a recipient with employer-sponsored health insurance and the Health Insurance Premium Payment Program, the recipient must track cost-share expenses. A form will be provided by the premium processing vendor for the recipient to report when the cost-share limit is reached. This form is entitled "Medical Costs List."

The premium processing vendor will provide a refund if a monthly premium payment is received after the cost-share limit has been met. This is automatically tracked by the premium processing vendor.

N-8000, Medical Effective Date, Prior Months' Eligibility and Case Actions

N-8100, Medical Effective Date

Body

Revision 11-3; Effective September 1, 2011

The medical effective date (MED) for Medicaid Buy-In for Children (MBIC) cannot be before Jan. 1, 2011. This includes any prior months' eligibility for MBIC. If an application is received in which the prior months occur before January 2011, determine eligibility for other MEPD programs in those prior months. Do not automatically disregard the prior months because an MBIC application is received and the prior months occur before January 2011.

N-8200, Prior Months' Eligibility

Body

Revision 17-2; Effective June 1, 2017

Eligibility for three prior months to the application month is available for this program. Prior months' eligibility for MBIC cannot be granted before Jan. 1, 2011.

If a premium is required, eligibility for prior months is not granted until premiums have been paid.

See Appendix XLIX, Medicaid Buy-In for Children Forms Chart. Form TF0001-MBIC, Prior Months Eligibility Notice, serves as both the eligibility notice and denial notice. If the premiums are not received by the due date, the prior months are not granted and are denied. Do not send a separate denial notice for failure to pay premium for prior months.

N-8300, Case Actions

Body

N-8310 Verification Checklist and Pending Reasons

Revision 11-3; Effective September 1, 2011

The following new verification checklist and pending reasons have been created for this program. These reasons will be pre-populated by TIERS on Form H1020, Request for Information or Action.

- Send proof that you signed up for your job's health insurance.
- Send proof that shows you get health insurance through your job.
- Send proof that the child applying for Medicaid Buy-In for Children can't be on your job's health insurance plan.
- Send proof that your health insurance company changed.
- Let us know the next date you can enroll in your job's health insurance plan.
- Send proof that your job pays at least half the premium of your health insurance.

N-8320 Change Action Reasons

Revision 11-3; Effective September 1, 2011

The following new change action reasons have been created for this program. These reasons will be pre-populated by TIERS on Form TF0001-MBIC, Change in Monthly Premium Amount or Cost-Share Limit.

- You reached your cost-share limit for this benefit period.
- You did not reach your cost-share limit for this benefit period.
- Your family is making more money (income).
- Your family is making less money (income).
- The number of people in your family changed.
- You have health insurance through your job
- You don't have health insurance through your job.
- The Health Insurance Premium Payment program (HIPP) is paying for your private health insurance.
- The Health Insurance Premium Payment program (HIPP) isn't paying for your private health insurance.

N-8330 Denial Reasons

Revision 11-3; Effective September 1, 2011

In addition to existing MEPD denial codes, new denial reasons have been created for this program. These reasons and references will be pre-populated by TIERS on:

- Form TF0001-MBIC, Case Action Termination;
- Form TF0001-MBIC, Case Action Denial; and
- Form TF0001-MBIC, Prior Months Eligibility.

Section N-8331 below outlines the reasons and references.

N-8331 Denial Reasons and Reference Chart

Revision 11-3; Effective September 1, 2011

Denial Reason	Reference
It is too late to ask for benefits for these months.	1 TAC §361.115(g)
<Child's name> is married.	1 TAC §361.107
You didn't send proof that shows you get health insurance through your job.	1 TAC §361.113
You didn't send proof that shows when your job's health insurance benefits began.	1 TAC §361.113
You didn't send proof that shows your child can't be on your job's health insurance plan.	1 TAC §361.113
You didn't send proof that shows you signed up for your job's health insurance.	1 TAC §361.113
Your payment couldn't be processed.	1 TAC §361.115(a)
<Child's name> is age 19 or older.	1 TAC §361.107

N-8340 Redeterminations

Revision 11-3; Effective September 1, 2011

Redeterminations for MBIC follow regular Medicaid for the Elderly and People with Disabilities (MEPD) policy for redeterminations.

Streamlining methods and passive reviews are not allowed for an MBIC redetermination.

If a case has an MBIC eligibility determination group (EDG) and another ME EDG, the persons in the case will get both a Form H1200-MBIC and another Form H1200 for the redeterminations.

A TIERS MBIC redetermination packet will include:

- Form H1233-MBIC, Redetermination Cover Letter;
- Form H1200-MBIC-R, Application for Benefits – Medicaid Buy-In for Children;
- Form H1028-MBIC, Employment Verification (Medicaid Buy-In for Children);
- Form H0003, Agreement to Release Your Facts; and
- Form H5017-MBIC, Items We Need from You.

N-8350 Appeals

Revision 13-1; Effective March 1, 2013

HHSC is responsible for all appeals, including those concerning premiums and cost sharing. If premium and/or cost-sharing information is needed for an appeal, refer to the MBIC business process document.

If an individual is dissatisfied with HHSC's decision concerning his eligibility for medical assistance, he has the right to appeal through the appeal process established by HHSC. In certain circumstances, the individual is entitled to receive continued benefits or services until a hearing decision is issued. Whether an individual is entitled to continued assistance is based on requirements set forth in appropriate state or federal law or regulation of the affected program. See the Fair and Fraud Hearings Handbook.

N-9000, Notices and Forms

Body

Revision 20-2; Effective June 1, 2020

Form H1200-MBIC and new forms have been created for this program. Most of the new forms are pre-populated by the system. These forms are also available in this handbook. If a form is completed manually from this handbook, follow the instructions for that particular form.

Even though a new application has been created for this program, also accept the Form H1200, Application for Assistance – Your Texas Benefits, as an application for the Medicaid Buy-In for Children (MBIC) program.

Use the current Form H1020, Request for Information or Action, for missing information. The H1020 instructions are updated to include MBIC program-specific information.

Appendix XLIX, Medicaid Buy-In for Children Forms Chart, outlines the:

- form name;
- purpose of each form;
- naming convention of each form in TIERS; and
- naming convention of each form in this handbook.

TIERS generates Form TF0001-MBIC for all eligibility notices. The MBIC program has seven notices that will use the TF0001 format in TIERS. Because the TF0001 is a TIERS-generated form, MBIC eligibility notices have a different number in this handbook. The form content is the same.

N-9100, Replacement Medicaid Card

Body

Revision 12-1; Effective March 1, 2012

An individual will only receive one Your Texas Benefits (YTB) Medicaid card, which is intended to be the individual's permanent card. If the individual loses the card, they can get a replacement card by calling **1-800-827-3748.**

For a temporary card replacement, use H1027-A, Medicaid Eligibility Verification, or Form H1027-B, Medicaid Eligibility Verification – MQMB. Use H1027-A to replace a lost YTB Medicaid card for MBIC only. Use Form H1027-B to replace a lost YTB Medicaid card for MBIC with QMB. A Form H1027-A or Form H1027-B is provided for the current month only.

Chapter O, Waiver Programs, Demonstration Projects and All-Inclusive Care

O-1000, Waiver Programs

Body

Revision 21-3; Effective September 1, 2021

Section §1915(c) of the Social Security Act allows states to determine eligibility for certain people seeking home or community-based medical assistance as if they were living in an institution. A person can only enroll in one waiver program at a time but may be on more than one interest list. See the HHS website at https://hhs.texas.gov/about-hhs/records-statistics/interest-list-reduction.

Deeming from parents/spouses and support and maintenance are not considered for Home and Community-Based Services waiver programs. A person is not eligible for waiver services if they are subject to a transfer of assets penalty or have substantial home equity.

A person may be required to share the cost of care (co-payment).

Related Policy

Application for Waiver Programs, O-1100
Waiver Programs and 30 Consecutive Days, O-5000
Home and Community-Based Services Waiver Program Co-Payment Worksheets, Appendix XXII

O-1100, Application for Waiver Programs

Body

Revision 18-1; Effective March 1, 2018

Waiver eligibility determination involves two components:

- Waiver eligibility component
- Financial Medicaid eligibility component

HHSC is responsible for the waiver eligibility component criteria of and for the financial Medicaid eligibility component criteria of the eligibility determination for most waivers.

Intake for a waiver is also through HHSC or an HHSC contracted provider. The HHSC designee will assist with determining appropriate program services and will assist the person in the financial Medicaid eligibility component, if necessary.

In general, HHSC is responsible for ensuring that specific criteria for the waiver eligibility component have been met and that the person:

- is or will be residing in the community;
- meets the age requirement of the waiver, if applicable;
- has either a medical necessity (MN) or appropriate level of care (LOC) determination, as applicable;
- has an approved plan of care or service plan; and
- has a service begin date no later than 30 days from certification.

HHSC is normally responsible for financial Medicaid eligibility component criteria.

The financial Medicaid eligibility component criteria for most waivers are met if the person is a Supplemental Security Income (SSI) recipient or has full Medicaid coverage under another group in the Texas State Medicaid Plan.

Potentially, the financial Medicaid eligibility component criteria for most waivers are met if the person is a:

- Medicaid recipient certified under a Medicaid group within the Texas State Medicaid Plan. MEPD examples include ME – Pickle, ME – Disabled Adult Child and ME – Early Aged Widow(er);
- Medicaid recipient certified using the special income limit (see Appendix XXXI, Budget Reference Chart);
- Community Attendant Services (CAS) recipient; or
- Medicaid recipient based on a Texas Works Medicaid program.

Financial Medicaid eligibility for most waivers will require a review of the person's situation specifically relating to transfer of assets and substantial home equity. See Chapter I, Transfer of Assets, and Chapter F, Resources.

To meet the financial Medicaid eligibility component, if the person is not already a Medicaid recipient under another Texas Medicaid program or an SSI recipient, the person must apply for:

- SSI if the monthly income is less than the SSI income limit; or
- another Medicaid program under the Texas Medicaid program, such as an MEPD program.

See Section B-4000, Date of Application, for more information about the file date of an application and accepting an application.

The financial Medicaid eligibility component for the Texas Home Living (TxHmL) Program is not completed using the special income limit. More specifically, to be eligible for the TxHmL Program, the person must

already be receiving Medicaid. HHSC will not certify a person for Medicaid as a condition of the TxHmL Program.

Under the financial Medicaid eligibility component criteria when determining eligibility for waivers using special income limit, a person:

- must meet nonfinancial criteria outlined in Chapter D, Non-Financial;
- must meet resource criteria outlined in Chapter F, Resources, with specific consideration given to:
  - Chapter I, Transfer of Assets; and
  - Section F-3600, Substantial Home Equity;
- must meet income criteria outlined in Chapter E, General Income, with the understanding that:
  - deeming procedures are not used; and
  - support and maintenance is not counted as income; and
- must meet financial eligibility and payment plan budget requirements outlined in Chapter G, Eligibility Budgets, with specific consideration given to:
  - Section G-6000, Institutional Eligibility Budget Types;
  - Appendix XXII, Home and Community-Based Services Waiver Program Co-Payment Worksheets; and
  - Chapter F, Resources, for qualified income trust (QIT).

A medical effective date can be established when all the criteria are met for both the:

- waiver eligibility component; and
- financial eligibility component.

See Section R-1200, Medical Effective Date. For waiver eligibility, the medical effective date is one of the following:

- The first day of the month of entry into a nursing facility, ICF/IID or state supported living center if the applicant filed a Medicaid application during that month, then requested a program transfer before being certified and met all eligibility criteria.
- The first day of the month if the applicant met all waiver eligibility component and financial Medicaid eligibility component criteria.
- The day after the effective date of SSI denial, for recipients transferred from SSI assistance to an MEPD program (excluding any Medicare Savings Program).

Notes:

- Consider potential three months prior to the date of application if the person entered a nursing facility, ICF/IID or state supported living center and then transitioned into a waiver setting before being certified. See O-5000, Waiver Programs and 30 Consecutive Days.
- Consider potential three months prior to the date of application if the person received waiver services in the prior months period and lost waiver eligibility due to failure to return a redetermination application. See R-1200, Medical Effective Date, for examples of these situations.
- The TxHmL Program requires that the person already be eligible for Medicaid before placement in the TxHmL Program. Persons cannot be determined eligible for this waiver under the special income limit.

In addition, to comply with the federally approved waiver, co-payment must be considered for waiver recipients whose eligibility is determined under the special income limit. See Appendix XXII, Home and Community-Based Services Waiver Program Co-Payment Worksheets, for the sequence in which deductions are allowed. Allow deductions indicated on the appropriate co-pay worksheet. For many waiver recipients, the co-payment will be $0. Notify HHSC of the co-payment amount using the Medicaid Eligibility to HHSC automated communication tool.

When the person is married and applying for waiver eligibility, use spousal impoverishment policy for consideration of resources. See Chapter J, Spousal Impoverishment. Spousal impoverishment policy is not used in the TxHmL Program.

Denied SSI Due to Earned Income Impact on Waiver Eligibility

Sometimes an SSI denial is short term and an SSI recipient is reinstated. There might be a gap in SSI and Medicaid coverage. This might happen when the eligibility is based on earned weekly income, normally with four paychecks. When five paychecks are received in one month, income ineligibility might occur whether based on a recipient's earnings or deemed income that includes weekly earnings. Even though Medicaid eligibility might be established retroactively using the special income limit to cover the gap month, Medicaid waiver services may be interrupted during the gap month.

When notified that a person receiving Medicaid waiver services is being denied SSI due to income ineligibility from the receipt of an extra paycheck, send an application to the Medicaid waiver person.

Once the application is obtained, determine eligibility for the Medicaid waiver person using the special income limit. If all eligibility criteria are met, certify the Medicaid waiver person under ME-Waivers.

After receipt of the first application, it may be used for up to 12 months. A new application must be obtained yearly and processed as a redetermination.

O-1200, Community Based Alternatives Program

Body

Revision 14-4; Effective December 1, 2014

The CBA program ended Sept. 1, 2014, when it was fully transitioned into STAR+PLUS. For information on STAR+PLUS, see Section O-3200, STAR+PLUS Waiver (SPW), or visit hhsc.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/long-term-provider-resources/medicaid-managed-care-expansion.

O-1300, Community Living Assistance and Support Services

Body

Revision 18-1; Effective March 1, 2018

CLASS provides home and community-based services to persons with intellectual disability-related conditions as a cost-effective alternative to intermediate care facility for persons with intellectual disabilities (ICF/IID) institutional placement. People with related conditions are people who have a disability, other than mental illness or an intellectual disability, that affects their ability to function in daily life. Some examples of related conditions include muscular dystrophy, cerebral palsy, spina bifida, etc.

See Section O-1100, Application for Waiver Programs.

Waiver Eligibility Component

HHSC is responsible for determining if the person meets the criteria specific to CLASS for the waiver eligibility component and will communicate to HHSC that the person has:

- an ICF/IID-RC VIII level of care (LOC), which establishes that the onset of the developmental disability was before age 22;

- an approved plan of care or service plan; and
- a service begin date no later than 30 days from certification.

HHSC will determine if the person is or will be residing in the community.

If HHSC determines that the person is not residing in the community. HHSC will take appropriate action.

Financial Medicaid Eligibility Component

HHSC is responsible for determining if the person meets the criteria specific to CLASS for the financial Medicaid eligibility component. If the person is already eligible for Medicaid through another program under the Texas State Medicaid Plan, the financial Medicaid eligibility component for this waiver has already been met.

When determining financial Medicaid eligibility for CLASS, give special consideration to the following:

- Receipt of a signed and dated application. See Section O-1100, Application for Waiver Programs, and Section B-4000, Date of Application.
- Age of the person. If the person's age is less than 65 and the person does not receive a Social Security Administration (SSA), SSI or Railroad Retirement (RR) disability benefit, a disability determination by HHSC is required even if the person has received an LOC under the waiver eligibility component criteria.
- Post-DRA transfer of assets. The person is ineligible until the transfer does not appear during the look-back period. See Chapter I, Transfer of Assets, for calculation of penalty period.
- Post-DRA substantial home equity. A person with a home whose equity interest in the home exceeds the established limit is not eligible for waiver services unless the person's spouse, child or disabled adult child is also living in the home.
- Support and maintenance and deeming. Even if the person receives support and maintenance, do not develop this as income. If the person is living with parents or spouse, do not deem.
- Income limit. Use the special income limit – 300% cap limit. See Appendix XXXI, Budget Reference Chart.
- Co-payment calculation. Always determine the co-payment calculation for CLASS at initial application. Reference the appropriate worksheet from Appendix XXII, Home and Community-Based Services Waiver Program Co-Payment Worksheets, to check the calculations.
- Spousal impoverishment resources. If married, consider spousal impoverishment for a waiver. See Chapter J, Spousal Impoverishment.
- Spousal co-payment. See the appropriate worksheet from Appendix XXII to determine the spousal diversion or the dependent allowance.

Multiple Program Processing

If there is a delay in certifying the waiver services because the waiver eligibility component criteria has not been met or there is no available waiver slot, certify the person for other benefits for which the person may be entitled, such as QMB or SLMB, as soon as eligibility can be determined. If the application is due, delay of certification procedures should be used for the ME – Waiver EDG.

This allows the application to remain open for an additional 90 days.

HHSC notifies MEPD by completing and sending Form H1746-A, MEPD Referral Cover Sheet, to the Midland Data Processing Center. MEPD continues to notify HHSC of eligibility status using the MEPD communication tool (https://apps-hhsconnection.txhhsc.txnet.state.tx.us/me-to-dads/).

When all pending waiver eligibility component criteria have been met and there is an available slot, complete a disposition of the ME – Waiver EDG.

If the delay of certification period is expiring, and the waiver eligibility component criteria have not been met or there is still no available slot, proceed with denial of the ME – Waiver EDG. The MEPD specialist informs HHSC of the denial using the MEPD automated communication tool.

When a person is already a Medicaid recipient, review the case. See Section O-1100, Application for Waiver Programs, before processing a program transfer directly to the CLASS program.

Instructions for Processing the Program Transfer

- After reviewing the case, if the person is eligible for a waiver and is already an institutional (ME – Non-State Group Home, ME – State Hospital, or ME – Nursing Facility) or CAS (ME – Community Attendant) MEPD Medicaid recipient, process a program transfer directly to ME – Waivers. The QMB or SLMB coverage must be continued if the person continues to meet the QMB/SLMB eligibility criteria.
- When a program transfer for a noninstitutional MEPD Medicaid recipient is processed to ME – Waiver and waiver services have been authorized/received before the program transfer effective date, request a force change to ensure retroactive coverage of the waiver services.
- See Appendix XLV, Program Transfer with Form H1200 Guide, to determine if a Form H1200 is needed. Verify resources and income including transfer of resources and substantial home equity. If there is a community spouse, verify all income and resources and treat according to spousal policy.

Notices

When the financial Medicaid eligibility component is determined, follow established procedures on notifications.

If the applicant does not meet the financial Medicaid eligibility component criteria for CLASS Medicaid, send the appropriate denial notice to the person with a copy to the HHSC designee. Continue to send notices regarding QMB, SLMB, MQMB and MSLMB eligibility to the person with a copy to the HHSC designee.

The financial Medicaid eligibility component redeterminations follow an annual schedule. When a recipient fails to return the review form, HHSC will communicate to the designee that the recipient may be denied.

Co-Payment

To comply with the federally approved waiver, co-payment must be calculated for any person in a waiver whose eligibility is determined under the special income limit. See Appendix XXII, Home and Community-Based Services Waiver Program Co-Payment Worksheets, for the sequence in which deductions are allowed. Allow deductions indicated on the appropriate co-payment worksheet. For CLASS, the co-payment usually will be $0 unless a QIT is involved. Notify the designee of the co-payment amount using the Medicaid Eligibility to the automated communication tool, even if the co-payment is $0 at initial application. For redeterminations and reported changes, notify HHSC only if the co-payment amount changes.

See Section O-5000, Waiver Programs and 30 Consecutive Days, for information related to Medicare coverage and Medicaid coverage codes.

Medical Effective Date (MED)

An MED can be established when all the criteria are met for both the:

- waiver eligibility component, and
- financial eligibility component.

See Section R-1200, Medical Effective Date. For waiver eligibility, the effective date for medical assistance is either:

- the first day of the month of entry to a nursing facility, ICF/IID or state supported living center if the applicant filed a Medicaid application during that month, then requested a program transfer before being certified, and met all eligibility criteria;
- the first day of the month if the applicant met all waiver eligibility component and financial Medicaid eligibility component criteria. See Section O-1100, Application for Waiver Programs; or
- the day after the effective date of SSI denial for persons transferred from SSI assistance to a MEPD program (excluding any Medicare Savings Program).

Notes:

- Remember to consider eligibility for QMB and SLMB, including prior coverage for SLMB, and prior coverage if the person was in a nursing facility, ICF/IID or state supported living center before the waiver.
- A person can also be eligible under Category 2 for CLASS through Texas Works Medicaid or through the foster care program. Assist in verifying Medicaid eligibility coverage and take no further action on these cases.
- A Medicaid recipient is still eligible for Texas Health Steps until age 21.
- Restitution and reconciliation policy does not apply.

When eligibility is determined by accepting a person's statement for income and resources, obtain Form H1200 when transferring to a program that requires verification of income and resources. **Note:** The purpose of obtaining Form H1200 is to make sure all eligibility elements are addressed. If all eligibility elements have been verified before the program transfer is completed, receipt of Form H1200 is not an eligibility requirement.

Note: Verify all elements including transfer of assets and substantial home equity. If there is a community spouse, verify all elements for spousal treatment.

O-1400, Youth Empowerment Services

Body

Revision 14-4; Effective December 1, 2014

HHSC and the Texas Department of State Health Services (DSHS) received approval from the Centers for Medicare & Medicaid Services (CMS) to implement a Home and Community-Based Services Medicaid waiver, Youth Empowerment Services (YES). Section 1915(c) of the Social Security Act allows states to determine eligibility for certain persons seeking home or community-based medical assistance as if they were living in an institution. The YES waiver allows more flexibility in the funding of intensive community-based services and supports for children with serious emotional disturbances and their families. The YES waiver began Sept. 1, 2009. To find out where YES is available for individuals, go to http://hhsc.texas.gov/doing-business-hhs/vendor-contractor-informati...

See Section O-1100, Application for Waiver Programs.

Waiver Eligibility Component

DSHS is responsible for determining if the person meets the criteria specific to YES for the waiver eligibility component and will communicate to HHSC that the person has:

- an approved level of care (LOC)/medical necessity (MN) determination,
- an approved individual plan of care (IPC), and
- a service begin date no later than 30 days from certification.

HHSC will assume that DSHS has determined that the person:

- is or will be residing in the community; and
- is at least age 3, but under age 19.

If HHSC determines that the person is not residing in the community or does not meet the age requirement, communicate the discrepancy to DSHS. DSHS will take appropriate action and communicate back to HHSC.

Because Supplemental Security Income (SSI) parental deeming ends when a person reaches age 18, refer to the Social Security Administration (SSA) for an SSI determination. If certified for SSI, deny ME–Waivers. Notify the recipient of the change. Notify DSHS of the change. If the recipient never applies for SSI based on this referral, do not deny the Medicaid based on failure to apply for other benefits.

Financial Medicaid Eligibility Component

HHSC is responsible for determining if the person meets the criteria specific to YES for the financial Medicaid eligibility component and will communicate to DSHS that the person has met all eligibility factors. If the person already is eligible for Medicaid through another program under the Texas State Medicaid Plan, the financial Medicaid eligibility component for this waiver already has been met. The Disabled Adult Child (DAC) program is an exception that requires a transfer to a Medicaid waiver.

Note: Even though the DAC program is in the Texas Medicaid State Plan, the YES waiver does not recognize this Medicaid program. If a recipient currently is certified for DAC and YES services have been requested, complete a program transfer and change the recipient from DAC to ME–Waivers in the Texas Integrated Eligibility Redesign System (TIERS). **Reminder:** A person must be age 18 to be eligible for DAC, and YES waiver eligibility ends at age 19. Flag the case to restore DAC benefits once the YES waiver ends, if the recipient continues to meet all other eligibility requirements.

When determining financial Medicaid eligibility for YES, give special consideration to the following:

- Receipt of a signed and dated application. See Section O-1100, Application for Waiver Programs, and Section B-4000, Date of Application.
- The child must be age 3 to 18. If the person is under age 65 and does not receive an SSA, SSI or Railroad Retirement (RR) disability benefit, a disability determination by HHSC is required, even if the person has received an LOC determination under the DSHS waiver eligibility component criteria.
- Post-DRA transfer of assets. The person is ineligible until the transfer does not appear during the look-back period. See Chapter I, Transfer of Assets, for calculation of the penalty period.
- Post-DRA substantial home equity. A person with a home whose equity interest in the home exceeds the established limit is not eligible for waiver services unless the person's adult child with a disability, spouse or child is also living in the home.
- Support, maintenance and deeming. Even if the person receives support and maintenance, do not develop this as income. If the person is living with parents or a spouse, do not deem.
- Income limit. Use the special income limit — 300 percent cap limit. See Appendix XXXI, Budget Reference Chart.
- Co-payment calculation. Always determine the co-payment calculation for YES at the initial application. Reference the appropriate worksheet from Appendix XXII, Home and Community-Based Services Waiver Program Co-Payment Worksheets, to check the calculations made in TIERS.
- Spousal impoverishment resources. If the person is married, consider spousal impoverishment for a waiver. See Chapter J, Spousal Impoverishment.
- Spousal co-payment. See the appropriate worksheet from Appendix XXII to determine the spousal diversion or the dependent allowance.

Multiple Program Processing

If there is a delay in certifying the waiver services because the person does not meet the DSHS waiver eligibility component criteria or there is no available waiver slot, certify the person for other benefits for which the person may be entitled, such as QMB or SLMB, as soon as eligibility can be determined. If the application is due, use delay of certification procedures for the ME-Waiver eligibility determination group (EDG).

This allows the application to remain open for an additional 90 days.

DSHS notifies MEPD by completing and sending Form H1746-A, MEPD Referral Cover Sheet, to the centralized mailbox (yeswaiver@dshs.state.tx.us). MEPD continues to notify DSHS of eligibility status using the Medicaid Eligibility to DSHS centralized mailbox (yeswaiver@dshs.state.tx.us).

When the person meets all pending DSHS waiver eligibility component criteria and there is an available slot, complete a disposition of the ME-Waiver EDG.

If the delay of certification period is expiring and the person still does not meet the DSHS waiver eligibility component criteria or there is still no available slot, proceed with denial of the ME-Waiver EDG. The MEPD specialist informs DSHS of the denial using the Medicaid Eligibility to DSHS centralized mailbox (yeswaiver@dshs.state.tx.us).

Instructions for Processing the Program Transfer

- After reviewing the case, if the person is eligible for a waiver and is already an institutional (ME-Non-State Group Home, ME-State Hospital or ME-Nursing Facility) or CAS (ME-Community Attendant) and DAC MEPD Medicaid recipient, process a program transfer directly to ME-Waivers.
  The QMB or SLMB coverage must be continued if the person continues to meet the QMB/SLMB eligibility criteria.
- When a program transfer for a noninstitutional MEPD Medicaid recipient is processed to ME-Waivers and waiver services have been authorized/received before the program transfer effective date, submit a help desk ticket to override existing coverage, such as DAC, to ensure retroactive coverage of the waiver services.
- See Appendix XLV, Program Transfer with Form H1200 Guide, to determine if Form H1200, Application for Assistance — Your Texas Benefits, is needed. Verify resources and income, including transfer of resources and substantial home equity. If there is a community spouse, verify all income and resources and treat according to spousal policy.

Notices

When determining the financial Medicaid eligibility component, follow established notification procedures between the HHSC Office of Eligibility Services (OES) and DSHS.

If the applicant does not meet the financial Medicaid eligibility component criteria for YES Medicaid, send the appropriate denial notice to the person with a copy to the DSHS designee. Continue to send notices regarding QMB, SLMB, MQMB and MSLMB eligibility to the person with a copy to the DSHS designee.

Redeterminations of the financial Medicaid eligibility component follow an annual schedule. If a recipient fails to return the review form, HHSC will communicate to the DSHS designee that the recipient may be denied.

Co-Payment

To comply with the federally approved waiver, HHSC must calculate a co-payment for any person in a waiver whose eligibility is determined under the special income limit. See Appendix XXII, Home and Community-Based Services Waiver Program Co-Payment Worksheets, for the sequence in which HHSC allows deductions. Allow deductions indicated on the appropriate co-payment worksheet. For YES, the co-payment usually will be $0 unless a QIT is involved. Notify the DSHS designee of the co-payment amount using the Medicaid Eligibility

to DSHS centralized mailbox (yeswaiver@dshs.state.tx.us), even if the co-payment is $0 at the initial application. For redeterminations and reported changes, notify DSHS only if the co-payment amount changes.

Medical Effective Date (MED)

An MED can be established when the person meets all of the criteria for both the:

- waiver eligibility component, and
- financial eligibility component.

See Section R-1200, Medical Effective Date.

For waiver eligibility, the medical effective date is one of the following:

- The first day of the month of entry to a nursing facility, ICF/IID or state supported living center if the applicant filed a Medicaid application during that month, requested a program transfer before being certified, and met all eligibility criteria.
- The first day of the month if the applicant met all waiver eligibility component criteria and financial Medicaid eligibility component criteria. See Section O-1100, Application for Waiver Programs.
- The day after the effective date of SSI denial for people transferred from SSI assistance to an MEPD program (excluding any Medicare Savings Program).

Notes:

- Remember to consider eligibility for QMB and SLMB, including prior coverage for SLMB, and prior coverage if the person was in a nursing facility, ICF/IID or state supported living center before the waiver.
- A person also can be eligible under Category 2 for YES through Texas Works Medicaid. Assist in verifying Medicaid eligibility coverage and take no further action on these cases.
- A Medicaid recipient is still eligible for Texas Health Steps until age 21. Refer the person to SSI at age 18. If the recipient becomes SSI-eligible, HHSC notifies DSHS YES staff via the Medicaid Eligibility to DSHS centralized mailbox (yeswaiver@dshs.state.tx.us) that the recipient's coverage is being transferred to SSI. HHSC must then terminate ME-Waivers coverage to allow SSI eligibility to process.
- Restitution and reconciliation policy does not apply.

O-1500, Deaf Blind with Multiple Disabilities

Body

Revision 18-1; Effective March 1, 2018

This program serves persons who, in addition to deafness and blindness, have one or more other disabling conditions that result in impairment to independent functioning. Eligible persons receive home and community-based services as an alternative to institutional care.

See Section O-1100, Application for Waiver Programs.

Waiver Eligibility Component

HHSC is responsible for determining if the person meets the criteria specific to DBMD for the waiver eligibility component and will communicate to HHSC that the person has:

- an ICF/IID-RC VIII level of care (LOC);
- an approved plan of care or service plan; and
- a service begin date no later than 30 days from certification.

HHSC will determine that the person is or will be residing in the community.

If HHSC determines that the person is not residing in the community, HHSC will take appropriate action and communicate back to the appropriate person.

Financial Medicaid Eligibility Component

HHSC is responsible for determining if the person meets the criteria specific to DBMD for the financial Medicaid eligibility component and will communicate to the appropriate representative that the person has met all eligibility factors. If the person is already eligible for Medicaid through another program under the Texas State Medicaid Plan, the financial Medicaid eligibility component for this waiver has already been met.

When determining financial Medicaid eligibility for DBMD, give special consideration to the following:

- Receipt of a signed and dated application. See Section O-1100 and Section B-4000, Date of Application.
- Age of the person. If the person's age is less than 65 and the person does not receive a Social Security Administration (SSA), SSI or Railroad Retirement (RR) disability benefit, a disability determination by HHSC is required even if the person has received an LOC under the HHSC waiver eligibility component criteria.
- Post-DRA transfer of assets. The person is ineligible until the transfer does not appear during the look-back period. See Chapter I, Transfer of Assets, for calculation of penalty period.
- Post-DRA substantial home equity. A person with a home whose equity interest in the home exceeds the established limit is not eligible for waiver services unless the person's spouse, child or disabled adult child is also living in the home.
- Support and maintenance and deeming. Even if the person receives support and maintenance, do not develop this as income. If the person is living with parents or spouse, do not deem.
- Income limit. Use the special income limit – 300% cap limit. See Appendix XXXI, Budget Reference Chart.
- Co-payment calculation. Always determine the co-payment calculation for DBMD at initial application. Reference the appropriate worksheet from Appendix XXII, Home and Community-Based Services Waiver Program Co-Payment Worksheets, to check the calculations made in TIERS.
- Spousal impoverishment resources. If married, consider spousal impoverishment for a waiver. See Chapter J, Spousal Impoverishment.
- Spousal co-payment. See the appropriate worksheet from Appendix XXII to determine the spousal diversion or the dependent allowance.

Multiple Program Processing

If there is a delay in certifying the waiver services because the waiver eligibility component criteria has not been met or there is no available waiver slot, certify the person for other benefits for which the person may be entitled, such as QMB or SLMB, as soon as eligibility can be determined. If the application is due, delay of certification procedures should be used for the ME – Waiver EDG.

This allows the application to remain open for an additional 90 days.

HHSC notifies MEPD by completing and sending Form H1746-A, MEPD Referral Cover Sheet, to the Midland Data Processing Center. MEPD continues to notify HHSC of eligibility status using the Medicaid Eligibility communication tool (https://apps-hhsconnection.txhhsc.txnet.state.tx.us/me-to-dads/).

When all pending waiver eligibility component criteria have been met and there is an available slot, complete a disposition of the ME Waiver EDG.

If the delay of certification period is expiring, and the waiver eligibility component criteria have not been met or there is still no available slot, proceed with denial of the ME – Waiver EDG. The MEPD specialist informs

HHSC of the denial using the Medicaid Eligibility automated communication tool.

When a person is already a Medicaid recipient, review the case. See Section O-1100, Application for Waiver Programs, before processing a program transfer directly to the DBMD program.

Instructions for Processing the Program Transfer

- After reviewing the case, if the person is eligible for a waiver and is already an institutional (ME – Non-State Group Home, ME – State Hospital or ME – Nursing Facility) or CAS (ME – Community Attendant) MEPD Medicaid recipient, process a program transfer directly to ME – Waivers. The QMB or SLMB coverage must be continued if the person continues to meet the QMB/SLMB eligibility criteria.
- When a program transfer for a noninstitutional MEPD Medicaid recipient is processed to ME – Waivers and waiver services have been authorized/received before the program transfer effective date, request a force change to ensure retroactive coverage of the waiver services.
- See Appendix XLV, Program Transfer with Form H1200 Guide, to determine if a Form H1200 is needed. Verify resources and income including transfer of resources and substantial home equity. If there is a community spouse, verify all income and resources and treat according to spousal policy.

Notices

When the financial Medicaid eligibility component is determined, follow established HHSC Office of Eligibility Services (OES) procedures.

If the applicant does not meet the financial Medicaid eligibility component criteria for DBMD Medicaid, send the appropriate denial notice to the person with a copy to the HHSC designee. Continue to send notices regarding QMB, SLMB, MQMB and MSLMB eligibility to the person with a copy to the designee.

The financial Medicaid eligibility component redeterminations follow an annual schedule. When a recipient fails to return the review form, HHSC will communicate to the designee that the recipient may be denied.

Co-Payment

To comply with the federally approved waiver, co-payment must be calculated for any person in a waiver whose eligibility is determined under the special income limit. See Appendix XXII, Home and Community-Based Services Waiver Program Co-Payment Worksheets, for the sequence in which deductions are allowed. Allow deductions indicated on the appropriate co-payment worksheet. For DBMD, the co-payment usually will be $0 unless a QIT is involved. Notify the HHSC designee of the co-payment amount using the Medicaid Eligibility automated communication tool, even if the co-payment is $0 at initial application. For redeterminations and reported changes, notify HHSC only if the co-payment amount changes.

Medical Effective Date (MED)

An MED can be established when all the criteria are met for both the:

- waiver eligibility component, and
- financial eligibility component.

See Section R-1200, Medical Effective Date. For waiver eligibility, the effective date for medical assistance is either:

- the first day of the month of entry to a nursing facility, ICF/IID or state supported living center if the applicant filed a Medicaid application during that month, then requested a program transfer before being certified, and met all eligibility criteria;

- the first day of the month if the applicant met all waiver eligibility component and financial Medicaid eligibility component criteria. See Section O-1100, Application for Waiver Programs; or
- the day after the effective date of SSI denial for persons transferred from SSI assistance to a MEPD program (excluding any Medicare Savings Program).

Notes:

- Remember to consider eligibility for QMB and SLMB, including prior coverage for SLMB, and prior coverage if the person was in a nursing facility, ICF/IID or state supported living center before the waiver.
- A person can also be eligible under Category 2 for DBMD through Texas Works Medicaid or through the foster care program. Assist in verifying Medicaid eligibility coverage and take no further action on these cases.
- A Medicaid recipient is still eligible for Texas Health Steps until age 21.
- Restitution and reconciliation policy does not apply

O-1600, Home and Community-based Services

Body

Revision 18-1; Effective March 1, 2018

This Medicaid waiver provides various community services to people with a diagnosis of mental retardation who would otherwise be inappropriately placed in institutional facilities. Persons may apply and have their eligibility determined while residing in an institution, but must be living in the community to begin receiving waiver services.

See Section O-1100, Application for Waiver Programs.

Waiver Eligibility Component

HHSC is responsible for determining if the person meets the criteria specific to HCS for the waiver eligibility component and will communicate to HHSC that the person has:

- an ICF/IID-RC VIII level of care (LOC);
- an approved plan of care or service plan; and
- a service begin date no later than 30 days from certification.

HHSC will determine that the person is or will be residing in the community.

If HHSC determines that the person is not residing in the community HHSC will take appropriate action and communicate back to necessary parties.

Financial Medicaid Eligibility Component

HHSC is responsible for determining if the person meets the criteria specific to HCS for the financial Medicaid eligibility component and will communicate to any necessary parties that the person has met all eligibility factors. If the person is already eligible for Medicaid through another program under the Texas State Medicaid Plan, the financial Medicaid eligibility component for this waiver has already been met.

When determining financial Medicaid eligibility for HCS, give special consideration to the following:

- Receipt of a signed and dated application. See Section O-1100, Application for Waiver Programs, and Section B-4000, Date of Application.

- Age of the person. If the person's age is less than 65 and the person does not receive a Social Security Administration (SSA), SSI or Railroad Retirement (RR) disability benefit, a disability determination by HHSC is required even if the person has received an LOC under the waiver eligibility component criteria.
- Post-DRA transfer of assets. The person is ineligible until the transfer does not appear during the look-back period. See Chapter I, Transfer of Assets, for calculation of penalty period.
- Post-DRA substantial home equity. A person with a home whose equity interest in the home exceeds the established limit is not eligible for waiver services unless the person's spouse, child or disabled adult child is also living in the home.
- Support and maintenance and deeming. Even if the person receives support and maintenance, do not develop this as income. If the person is living with parents or spouse, do not deem.
- Income limit. Use the special income limit – 300% cap limit. See Appendix XXXI, Budget Reference Chart.
- Co-payment calculation. Always determine the co-payment calculation for HCS for initial applications. Reference the appropriate worksheet from Appendix XXII, Home and Community-Based Services Waiver Program Co-Payment Worksheets, to check the calculations made in TIERS.
- Spousal impoverishment resources. If married, consider spousal impoverishment for a waiver. See Chapter J, Spousal Impoverishment.
- Spousal co-payment. See the appropriate worksheet from Appendix XXII to determine the spousal diversion or the dependent allowance.

Multiple Program Processing

If there is a delay in certifying the waiver services because the waiver eligibility component criteria has not been met or there is no available waiver slot, certify the person for other benefits for which the person may be entitled, such as QMB or SLMB, as soon as eligibility can be determined. If the application is due, delay of certification procedures should be used for the ME – Waiver EDG.

This allows the application to remain open for an additional 90 days.

HHSC notifies MEPD by completing and sending Form H1746-A, MEPD Referral Cover Sheet, to the Midland Data Processing Center. MEPD continues to notify HHSC of eligibility status using the MEPD communication tool (https://apps-hhsconnection.txhhsc.txnet.state.tx.us/me-to-dads/).

When all pending waiver eligibility component criteria have been met and there is an available slot, complete a disposition of the ME – Waiver EDG.

If the delay of certification period is expiring, and the waiver eligibility component criteria have not been met or there is still no available slot, proceed with denial of the ME – Waiver EDG. The MEPD specialist informs HHSC of the denial using the MEPD communication tool.

When a person is already a Medicaid recipient, review the case.

See Section O-1100, Application for Waiver Programs, before processing a program transfer directly to the HCS program.

Instructions for Processing the Program Transfer

- After reviewing the case, if the person is eligible for a waiver and is already an institutional (ME – Non-State Group Home, ME – State Hospital or ME – Nursing Facility) or CAS (ME – Community Attendant) MEPD Medicaid recipient, process a program transfer directly to ME – Waivers. The QMB or SLMB coverage must be continued if the person continues to meet the QMB/SLMB eligibility criteria.
- When a program transfer for a noninstitutional MEPD Medicaid recipient is processed to ME – Waivers and waiver services have been authorized/received before the program transfer effective date, request a force change to ensure retroactive coverage of the waiver services.

- See Appendix XLV, Program Transfer with Form H1200 Guide, to determine if a Form H1200 is needed. Verify resources and income including transfer of resources and substantial home equity. If there is a community spouse, verify all income and resources and treat according to spousal policy.

Notices

When the financial Medicaid eligibility component is determined, follow established procedures from the HHSC Office of Eligibility Services (OES) on notifications.

If the applicant does not meet the financial Medicaid eligibility component criteria for HCS Medicaid, send the appropriate denial notice to the person with a copy to the proper designee. Continue to send notices regarding QMB, SLMB, MQMB and MSLMB eligibility to the person with a copy to the proper designee.

The financial Medicaid eligibility component redeterminations follow an annual schedule. When a recipient fails to return the review form, the recipient may be denied.

Co-Payment

To comply with the federally approved waiver, co-payment must be calculated for any person in a waiver whose eligibility is determined under the special income limit. See Appendix XXII, Home and Community-Based Services Waiver Program Co-Payment Worksheets, for the sequence in which deductions are allowed. Allow deductions indicated on the appropriate co-payment worksheet. For HCS, the co-payment usually will be $0 unless a QIT is involved. Notify the HHSC designee of the co-payment amount using the MEPD communication tool, even if the co-payment is $0 at initial application. For redeterminations and reported changes, notify HHSC only if the co-payment amount changes.

Medical Effective Date (MED)

An MED can be established when all the criteria are met for both the:

- waiver eligibility component; and
- financial eligibility component.

See Section R-1200, Medical Effective Date. For waiver eligibility, the medical effective date is one of the following:

- The first day of the month of entry to a nursing facility, ICF/IID or state supported living center if the applicant filed a Medicaid application during that month, then requested a program transfer before being certified, and met all eligibility criteria.
- The first day of the month if the applicant met all waiver eligibility component and financial Medicaid eligibility component criteria. See Section O-1100, Application for Waiver Programs.
- The day after the effective date of SSI denial for persons transferred from SSI assistance to a MEPD program (excluding any Medicare Savings Program).

Notes:

- Remember to consider eligibility for QMB and SLMB, including prior coverage for SLMB, and prior coverage if the person was in a nursing facility, ICF/IID or state supported living center before the waiver.
- A person can also be eligible under Category 2 for HCS through Texas Works Medicaid or through the foster care program. Assist in verifying Medicaid eligibility coverage and take no further action on these cases.
- A Medicaid recipient is still eligible for Texas Health Steps until age 21.
- Restitution and reconciliation policy does not apply.

O-1700, Medically Dependent Children Program

Body

Revision 18-1; Effective March 1, 2018

MDCP provides services to support families caring for children who are medically dependent and to encourage de-institutionalization of children in nursing facilities.

See Section O-1100, Application for Waiver Programs.

Waiver Eligibility Component

HHSC is responsible for determining if the person meets the criteria specific to MDCP for the waiver eligibility component and will communicate that the person has:

- a medical necessity (MN) determination;
- an approved plan of care or service plan; and
- a service begin date no later than 30 days from certification.

HHSC will determine that the person:

- is or will be residing in the community; and
- is under age 21.

If HHSC determines that the person is not residing in the community or is not under age 21, HHSC will take appropriate action.

Since Supplemental Security Income (SSI) parental deeming ends at age 18, when a person reaches age 18, refer to the Social Security Administration (SSA) for an SSI determination. If certified for SSI, deny ME – Waivers. Notify the recipient of the change. Notify HHSC of the change.

Financial Medicaid Eligibility Component

HHSC is responsible for determining if the person meets the criteria specific to MDCP for the financial Medicaid eligibility component and will communicate that the person has met all eligibility factors. If the person is already eligible for Medicaid through another program under the Texas State Medicaid Plan, the financial Medicaid eligibility component for this waiver has already been met.

When determining financial Medicaid eligibility for MDCP, give special consideration to the following:

- Receipt of a signed and dated application. Section O-1100, Application for Waiver Programs, and Section B-4000, Date of Application.
- Age of the person. If the person's age is less than 65 and the person does not receive an SSA, SSI or Railroad Retirement (RR) disability benefit, a disability determination by HHSC is required even if the person has received a level of care (LOC) determination under the waiver eligibility component criteria.
- Post-DRA transfer of assets. The person is ineligible until the transfer does not appear during the look-back period. See Chapter I, Transfer of Assets, for calculation of penalty period.
- Post-DRA substantial home equity. A person with a home whose equity interest in the home exceeds the established limit is not eligible for waiver services unless the person's spouse, child or disabled adult child is also living in the home.
- Support and maintenance and deeming. Even if the person receives support and maintenance, do not develop this as income. If the person is living with parents or spouse, do not deem.

- Income limit. Use the special income limit – 300% cap limit. See Appendix XXXI, Budget Reference Chart.
- Co-payment calculation. Always determine the co-payment calculation for MDCP at initial application. Reference the appropriate worksheet from Appendix XXII, Home and Community-Based Services Waiver Program Co-Payment Worksheets, to check the calculations made in TIERS.
- Spousal impoverishment resources. If married, consider spousal impoverishment for a waiver. See Chapter J, Spousal Impoverishment.
- Spousal co-payment. See the appropriate worksheet from Appendix XXII to determine the spousal diversion or the dependent allowance.

Multiple Program Processing

If there is a delay in certifying the waiver services because the waiver eligibility component criteria has not been met or there is no available waiver slot, certify the person for other benefits for which the person may be entitled, such as QMB or SLMB, as soon as eligibility can be determined. If the application is due, delay of certification procedures should be used for the ME – Waiver EDG.

This allows the application to remain open for an additional 90 days.

HHSC notifies MEPD by completing and sending Form H1746-A, MEPD Referral Cover Sheet, to the Midland Data Processing Center. MEPD continues to notify HHSC of eligibility status using the MEPD communication tool (https://apps-hhsconnection.txhhsc.txnet.state.tx.us/me-to-dads/).

When all pending waiver eligibility component criteria have been met and there is an available slot, complete a disposition of the ME – Waiver EDG.

If the delay of certification period is expiring, and the waiver eligibility component criteria have not been met or there is still no available slot, proceed with denial of the ME – Waiver EDG. The MEPD specialist informs HHSC of the denial using the MEPD communication tool.

Instructions for Processing the Program Transfer

- After reviewing the case, if the person is eligible for a waiver and is already an institutional (ME – Non-State Group Home, ME – State Hospital or ME – Nursing Facility) or CAS (ME – Community Attendant) MEPD Medicaid recipient, process a program transfer directly to ME – Waivers. The QMB or SLMB coverage must be continued if the person continues to meet the QMB/SLMB eligibility criteria.
- When a program transfer for a noninstitutional MEPD Medicaid recipient is processed to ME – Waivers and waiver services have been authorized/received before the program transfer effective date, request a force change to ensure retroactive coverage of the waiver services.
- See Appendix XLV, Program Transfer with Form H1200 Guide, to determine if a Form H1200 is needed. Verify resources and income including transfer of resources and substantial home equity. If there is a community spouse, verify all income and resources and treat according to spousal policy.

Notices

When the Financial Medicaid Eligibility Component is determined, follow established procedures from the HHSC Office of Eligibility Services (OES) on notifications.

If the applicant does not meet the financial Medicaid eligibility component criteria for MDCP Medicaid, send the appropriate denial notice to the person with a copy to the designee. Continue to send notices regarding QMB, SLMB, MQMB and MSLMB eligibility to the person with a copy to the designee.

The financial Medicaid eligibility component redeterminations follow an annual schedule. If a recipient fails to return the review form, HHSC will communicate to the designee that the recipient may be denied.

Co-Payment

To comply with the federally approved waiver, co-payment must be calculated for any person in a waiver whose eligibility is determined under the special income limit. See Appendix XXII, Home and Community-Based Services Waiver Program Co-Payment Worksheets, for the sequence in which deductions are allowed. Allow deductions indicated on the appropriate co-payment worksheet. For MDCP, the co-payment usually will be $0 unless a QIT is involved. Notify the designee of the co-payment amount using the MEPD communication tool, even if the co-payment is $0 at initial application. For redeterminations and reported changes, notify HHSC only if the co-payment amount changes.

Medical Effective Date (MED)

An MED can be established when all the criteria are met for both the:

- waiver eligibility component;
- and financial eligibility component.

See Section R-1200, Medical Effective Date. For waiver eligibility, the medical effective date is one of the following:

- The first day of the month of entry to a nursing facility, ICF/IID or state supported living center if the applicant filed a Medicaid application during that month, then requested a program transfer before being certified, and met all eligibility criteria.
- The first day of the month if the applicant met all waiver eligibility component and financial Medicaid eligibility component criteria. See Section O-1100, Application for Waiver Programs.
- The day after the effective date of SSI denial for persons transferred from SSI assistance to a MEPD program (excluding any Medicare Savings Program).

Notes:

- Remember to consider eligibility for QMB and SLMB, including prior coverage for SLMB, and prior coverage if the person was in a nursing facility, ICF/IID or state supported living center before the waiver.
- A person can also be eligible under Category 2 for MDCP through Texas Works Medicaid or through the foster care program. Assist in verifying Medicaid eligibility coverage and take no further action on these cases.
- A Medicaid recipient is still eligible for Texas Health Steps until age 21. Refer the person to SSI at age 18. If the recipient becomes SSI-eligible, HHSC notifies MDCP staff via the MEPD communication tool that the recipient's coverage is being transferred to SSI. HHSC must then terminate ME – Waivers coverage to allow SSI eligibility to process.
- Restitution and reconciliation policy does not apply.

O-1800, Texas Home Living

Body

Revision 21-3; Effective September 1, 2021

This program provides selected essential services and supports to people with intellectual disabilities who live with their families or in their own homes in the community. TxHmL services are intended to supplement, rather than replace, the services and supports a person may receive from other programs, such as the Texas Health Steps Program, or from family, neighbors or community organizations.

Waiver Eligibility Component

HHSC is responsible for determining if the person meets the criteria specific to TxHmL for the waiver eligibility component and that the person:

- has an ICF/IID level of care;
- has an approved plan of care or service plan;
- has a service begin date no later than 30 days from certification;
- is residing in the community; and
- is a Medicaid recipient or would be eligible under either ME – SSI, ME – Pickle, ME – Disabled Widow(er), ME – Early Aged Widow(er), ME – Disabled Adult Child or ME – Medicaid Buy-In for Children (MBIC).

Financial Medicaid Eligibility Component

The TxHmL Program requires that the person be eligible for Medicaid or would be eligible under either ME – SSI, ME – Pickle, ME – Disabled Widow(er), ME – Early Aged Widow(er), ME – Disabled Adult Child or ME – Medicaid Buy-In for Children (MBIC). A person cannot be determined eligible for this waiver under the special income limit program, and HHSC will not certify a person for Medicaid as a condition of the TxHmL Program.

Notes:

- People who are Medicaid eligible under Texas Works do not need to be redetermined eligible under an MEPD program. Assist the provider in verifying Medicaid eligibility coverage and take no further action on these cases.
- Restitution and reconciliation policy does not apply.
- Medicaid Buy-In for Children (MBIC) eligible recipients can have Texas Home Living (TxHmL) paid by MBIC systems eligibility codes.

Related Policy

Application for Waiver Programs, O-1100

O-2000, All-Inclusive Care

O-2100, Program of All-Inclusive Care for the Elderly

Body

Revision 20-4; Effective December 1, 2020

The Program of All-Inclusive Care for the Elderly (PACE) provides comprehensive health services to the frail elderly through a comprehensive service delivery system and integrated Medicare and Medicaid financing.

PACE provides community-based services for frail and elderly people who qualify for nursing facility placement. A comprehensive care approach is used to provide an array of medical, functional and day activity services for a capitated monthly fee that is below the cost of comparable institutional care.

To be eligible for PACE services, a person must:

- be age 55 and older;
- have chronic medical problems and functional impairments;
- meet nursing facility medical necessity (MN) criteria; and
- reside in a PACE service area.

The person must be eligible for Supplemental Security Income (SSI) or Medicaid under the institutional special income limit.

Currently, there are three PACE sites in Texas:

- Bienvivir Senior Health Services in El Paso;
- The Basics at Jan Werner in Amarillo; and
- La Paloma in Lubbock.

There is no co-payment for the PACE program unless the recipient is admitted to a nursing facility.

For more information about this program, see the Program of All-Inclusive Care for the Elderly (PACE) webpage on the HHS website.

O-3000, Waiver Programs and Managed Care

Body

Revision 19-1; Effective March 1, 2019

O-3100 Reserved for Future Use

Revision 11-2; Effective June 1, 2011

O-3200 STAR+PLUS Waiver (SPW)

Revision 19-1; Effective March 1, 2019

STAR+PLUS is a Texas Medicaid managed care program designed to provide health care and acute and long-term services and supports through a managed care system.

The SPW program is a Home and Community-Based Services waiver program approved for the managed care delivery system and designed to allow individuals who would otherwise require nursing home or other forms of institutionalized care to receive long-term services and supports in order to be able to live in the community.

Multiple Program Processing

If MEPD completes the financial determination and the person does not meet the HHSC waiver eligibility component criteria or there is no available waiver slot, certify the person for other benefits for which the person may be entitled, such as QMB or SLMB, as soon as eligibility can be determined. If the application is due, use delay of certification procedures for the ME-Waiver eligibility determination group (EDG).

This allows the application to remain open for an additional 90 days.

HHSC notifies MEPD by completing and sending Form H1746-A, MEPD Referral Cover Sheet, to the Austin Data Processing Center. MEPD continues to notify HHSC of eligibility status using the MEPD communication tool (https://apps-hhsconnection.txhhsc.txnet.state.tx.us/me-to-dads/) or Form H2067, Case Information.

When the person meets all pending HHSC waiver eligibility component criteria and there is an available slot, complete a disposition of the ME-Waiver EDG.

If the delay of certification period is expiring and the person still does not meet the HHSC waiver eligibility component criteria or there is still no available slot, proceed with denial of the ME-Waiver EDG. The MEPD specialist informs HHSC of the denial using Form H2067 or the MEPD communication tool.

The STAR+PLUS Support Unit (SPSU) sends Form 3676-MC, Managed Care Pre-Enrollment Assessment Authorization, to the MEPD specialist. Form 3676-MC documents medical necessity and the individual service plan (ISP). The MEPD specialist completes Section D, items 42 through 47, of Form 3676-MC and returns it to SPSU.

O-3100, Reserved for Future Use

Body

Revision 11-2; Effective June 1, 2011

O-3200, STAR+PLUS Waiver

Body

Revision 19-1; Effective March 1, 2019

STAR+PLUS is a Texas Medicaid managed care program designed to provide health care and acute and long-term services and supports through a managed care system.

The SPW program is a Home and Community-Based Services waiver program approved for the managed care delivery system and designed to allow individuals who would otherwise require nursing home or other forms of institutionalized care to receive long-term services and supports in order to be able to live in the community.

Multiple Program Processing

If MEPD completes the financial determination and the person does not meet the HHSC waiver eligibility component criteria or there is no available waiver slot, certify the person for other benefits for which the person may be entitled, such as QMB or SLMB, as soon as eligibility can be determined. If the application is due, use delay of certification procedures for the ME-Waiver eligibility determination group (EDG).

This allows the application to remain open for an additional 90 days.

HHSC notifies MEPD by completing and sending Form H1746-A, MEPD Referral Cover Sheet, to the Austin Data Processing Center. MEPD continues to notify HHSC of eligibility status using the MEPD communication tool (https://apps-hhsconnection.txhhsc.txnet.state.tx.us/me-to-dads/) or Form H2067, Case Information.

When the person meets all pending HHSC waiver eligibility component criteria and there is an available slot, complete a disposition of the ME-Waiver EDG.

If the delay of certification period is expiring and the person still does not meet the HHSC waiver eligibility component criteria or there is still no available slot, proceed with denial of the ME-Waiver EDG. The MEPD specialist informs HHSC of the denial using Form H2067 or the MEPD communication tool.

The STAR+PLUS Support Unit (SPSU) sends Form 3676-MC, Managed Care Pre-Enrollment Assessment Authorization, to the MEPD specialist. Form 3676-MC documents medical necessity and the individual service plan (ISP). The MEPD specialist completes Section D, items 42 through 47, of Form 3676-MC and returns it to SPSU.

O-4000, Demonstration Projects

Body

Revision 09-4; Effective December 1, 2009

Section 1115 of the Social Security Act allows states to waive compliance of certain sections of the Act in the case of any experimental pilot judged likely to assist in promoting the objectives of Medicaid. Such demonstration projects generally have a specific time limit, and are expected to be cost-neutral.

O-5000, Waiver Programs and 30 Consecutive Days

Body

Revision 18-1; Effective March 1, 2018

An institutional setting is a living arrangement in which a person applying for or receiving Medicaid lives in a Medicaid-certified long-term care facility or receives services under a Home and Community-Based Services waiver program. See Section G-6200, Special Income Limit for the Eligibility Budget.

To qualify for the special income limit, a person or couple must:

- have countable income that exceeds the reduced Supplemental Security Income federal benefit rate;
- receive a level of care or medical necessity determination that qualifies the person or couple for Medicaid; and
- reside in:
  - a Medicaid-certified long-term care facility for 30 consecutive days; or
  - a Medicaid-certified institution for mental diseases for 30 consecutive days, if the person is age 65 or older,

For Medicaid under a Home and Community-Based Services waiver program, the person must be approved by a Texas health and human services agency to receive services for a waiver program and receive the services within one month after approval. The count of the 30 consecutive days starts at either:

- entry into a Medicaid-certified long-term care facility and the person moves into an approval status for a waiver program; or
- an approval to receive services under a waiver program and receive the services within one month after approval.

The 30 consecutive days are not disrupted if the person:

- makes a three-day therapeutic home visit with a planned return to the facility;
- is admitted to a hospital with a planned return to the facility; or

- moves from a Medicaid-certified long-term care facility:
  - to a Home and Community-Based Services waiver program; or
  - to another Medicaid-certified facility.

If a person dies before meeting the 30-consecutive-day requirement without moving to a noninstitutional setting, the person is considered to have met the requirement for application of the special income limit.

Note: Consider potential retroactive coverage for the three months prior to the date of application if the person entered a nursing facility, ICF/ID or state supported living center and then transitioned into a waiver setting before being certified. Use the special income limit for the month of entry to the Medicaid-certified long-term care facility (Medicare-SNF, NF or ICF/ID) if it is anticipated that the person will remain in a Medicaid-certified long-term care facility for at least 30 consecutive days. When eligibility is based on the special income limit, finalization of the person's eligibility cannot be processed or disposed in the system of record until the 30 consecutive days have been met.

O-5100, Waiver Co-Payment

Body

Revision 18-1; Effective March 1, 2018

In order to comply with the federally approved waiver, co-payment must be considered for waiver persons whose eligibility is determined under the special income limit. See Appendix XXII, Home and Community-Based Services Waiver Program Co-Payment Worksheets, for the sequence in which deductions are allowed. Allow deductions indicated on the appropriate co-payment worksheet. For many waiver persons, the co-payment will be $0. Notify HHSC of the co-payment amount using Form H2067, Case Information, or use the MEPD communication tool (https://apps-hhsconnection.txhhsc.txnet.state.tx.us/me-to-dads/). If the person is married and applying for waiver eligibility, use spousal impoverishment policy for consideration of resources. Spousal impoverishment policy is not used in the TxHmL Program.

O-5200, Medicare and Co-Payment

Body

Revision 09-4; Effective December 1, 2009

Under certain limited conditions, Medicare will pay some nursing facility (NF) costs for Medicare beneficiaries who require skilled nursing or rehabilitation services. To be covered, the person must receive the services from a Medicare-certified skilled nursing facility (SNF) after a qualifying hospital stay. A qualifying hospital stay is the amount of time spent in a hospital just before entering a nursing facility. This is at least three days. Care must begin within 30 days after leaving the hospital. The person's doctor must order daily skilled nursing or rehabilitation services that the person can get only in an SNF. "Daily" means seven days a week for skilled nursing services and five days a week or more for skilled rehabilitation services.

Number of Days	Person's Responsibility	Medicare's Responsibility
1-20	Nothing	Everything
21-100	20% — the SNF care co-payment per day paid after 20 days of Care (21-100). See Appendix XXXI, Budget Reference Chart.	The rest
Over 100	Everything	Nothing

O-5210 Medicaid Coverage Code Issues

Revision 12-2; Effective June 1, 2012

- T coverage code is not a Medicaid coverage code. T indicates Community Attendant Services (CAS) coverage providing Medicaid payment for attendant care only. This coverage code does not provide for NF vendor payment, doctor visits, hospital stays, medically necessary items or prescription drug coverage.
- R coverage code is a Medicaid coverage code. R indicates regular Medicaid coverage providing Medicaid payment for NF vendor payment, doctor visits, hospital stays, medically necessary items or prescription coverage. Medicaid is the payer of last resort and a medical necessity is required for vendor payment in an NF. Vendor payment is also subject to co-payments. R coverage provides for payment of prescription drug coverage except when the person is dually eligible for both Medicare and Medicaid.
- Q coverage code is a Qualified Medicare Beneficiary coverage code. Q indicates that Medicaid pays the Medicare premiums, deductibles and co-insurance, including Medicare-covered hospital and NF stays.

Examples

Example 1: When a person with only coverage code Q (only active EDG is MC – QMB – also known as a Pure Q) enters an SNF from a hospital, Medicare will cover 100% of the SNF vendor costs for days 1-20. Medicare will cover 80 percent of the SNF vendor costs for days 21-100. As a Pure Q person, Medicaid's Q covers 100 percent of the remaining 20% of the SNF vendor costs for days 21-100. The person will not be responsible for the remaining 20% of the SNF vendor costs – the Medicare co-pay per day for days 21-100. As a Pure Q person, the person is not responsible for the amount of co-payment an MEPD-eligible individual must pay for nursing care.

Note: If the person does not remain a Pure Q person and becomes certified for MEPD, use Example 2.

Example 2: When a person living in the community enters an SNF from a hospital and is dually eligible for both Medicare and Medicaid (MQMB with both R and Q coverage), Medicare will cover 100% of the SNF vendor costs for days 1-20. Even though the person is MEPD eligible, test the person for institutional coverage that is subject to transfer of assets and excess home equity policy. The 30-day stay requirement is not necessary. If the person is eligible for MEPD and co-payment:

- retroactive adjustments to ensure the correct benefits will be necessary;
- the person will not be responsible for the remaining 20% of the SNF vendor costs – the Medicare co-pay per day for days 21-100; and
- the person will have a calculated MEPD co-payment beginning day 21.

Notify the person of the responsibility for the MEPD co-payment.

Example 3: When a CAS person (T coverage code only) who has Medicare enters an SNF from a hospital, Medicare will cover 100% of the SNF vendor payment for days 1-20. Medicare will cover 80% for days 21-100. The person's MEPD eligibility in an NF (R coverage) needs to be determined. Test the person for institutional coverage that is subject to transfer of assets and excess home equity policy. The 30-day stay requirement is necessary. If the person is eligible for MEPD with co-payment:

- retroactive adjustments to ensure the correct benefits will be necessary;
- the person will not be responsible for the remaining 20% of the SNF vendor costs – the Medicare co-pay per day for days 21-100; and
- the person will have a calculated MEPD co-payment beginning day 21.

Notify the person of the responsibility for the MEPD co-payment.

Example 4: When a CAS recipient with Qualified Medicare Beneficiary (QMB) only (T and Q coverage codes) enters an SNF from a hospital, Medicare will cover 100% of the SNF vendor payment for days 1-20. Medicare will cover 80% for days 21-100. The person's MEPD eligibility in an NF (R coverage) needs to be determined. Test the person for institutional coverage that is subject to transfer of assets and excess home equity policy. The 30-day stay requirement is necessary. If the person is MEPD eligible for vendor payment:

- retroactive adjustments to ensure the correct benefits will be necessary;
- the person will not be responsible for the remaining 20% of the SNF vendor costs – the Medicare co-pay per day for days 21-100; and
- the person will have a calculated MEPD co-payment beginning day 21.

Notify the person of the responsibility for the MEPD co-payment.

If the person is not MEPD eligible for vendor payment but is eligible for Pure Q, notify the person and use Example 1.

O-6000, Waiver Programs and Spousal Impoverishment

O-6100, Spousal Impoverishment

Body

Revision 09-4; Effective December 1, 2009

See Chapter J, Spousal Impoverishment.

O-7000, Programs and Transfer of Assets

O-7100, Transfer of Assets

Body

Revision 09-4; Effective December 1, 2009

See Chapter I, Transfer of Assets.

Chapter P, Long-term Care Partnership Program

P-1000, LTCP Overview

P-1100, Texas Administrative Code Rules

Body

Revision 12-1; Effective March 1, 2012

From Subchapter C, Financial Requirements, Division 2, Resources.

§358.35.5 Qualified Long-Term Care Partnership Program Insurance Policies.

(a) This section describes the Long-Term Care Partnership Program under which a person's resources are disregarded in the eligibility determination equal to the amount of benefits paid to or on behalf of a person by a Long-Term Care Partnership policy.

(b) The Texas Health and Human Services Commission (HHSC) administers the Long-Term Care Partnership Program.

(c) In this section, the following words and terms have the following meanings, unless the context clearly indicates otherwise:

(1) "Long-Term Care Partnership Program" means the program established under the Texas Human Resources Code, Chapter 32, Subchapter C.

(2) "Qualified plan holder" means the beneficiary of a qualified long-term care benefit plan that meets the requirements set forth in subsection (d) of this section.

(3) "Resource disregard" means the total equity value of resources not exempt under rules governing Medicaid eligibility that are disregarded in determining eligibility for Medicaid.

(4) "Resource protection" means the extension to a plan holder of an approved plan of a dollar-for-dollar resource disregard in determining Medicaid eligibility.

(5) "Dollar-for-dollar resource disregard" means a resource disregard in which the amount of the disregard is equal to the sum of benefit payments made on behalf of the approved plan holder.

(d) A Long-Term Care Partnership Program policy is one that meets all of the following requirements:

(1) On the date the policy was issued, the state in which the insured resided had in place an approved Medicaid state plan amendment under 42 U.S.C. §1396p(b).

(2) The policy meets the requirements set forth by the Texas Department of Insurance under Title 28, Part 1, Chapter 3 of the Texas Administrative Code (relating to Life, Accident and Health Insurance and Annuities).

(e) At application for long-term care services, the qualified plan holder receives a dollar-for-dollar disregard of his or her resources.

(1) HHSC determines Medicaid eligibility in accordance with this chapter.

(2) A person may apply for Medicaid before exhausting the benefits of a Long-Term Care Partnership Program policy. If a person applies for and is eligible to receive Medicaid before the Long-Term Care Partnership Program policy is exhausted, the Long-Term Care Partnership Program insurer must make payment for medical assistance to the maximum extent of its liability before Medicaid funds may be used to pay providers for covered services as established in this chapter.

(3) If a person has applied for and been found eligible to receive Medicaid and subsequently receives additional resources, the person continues to be eligible for Medicaid if the total resources do not exceed the individual resource limit after applying the dollar-for-dollar resource disregard.

(f) If the Long-Term Care Partnership Program is discontinued, a person who purchased a Long-Term Care Partnership Program policy before the date the program is discontinued remains eligible to receive the dollar-for-dollar resource exclusion.

P-1200, Program Overview

Body

Revision 18-1; Effective March 1, 2018

The Long-Term Care Partnership (LTCP) is a public-private partnership between state agencies and private insurance providers to encourage individuals to plan for their long-term care needs. Specifically, the LTCP involves collaboration among private long-term care insurers, long-term care insurance producers (agents and brokers), Texas Department of Insurance (TDI), the Health and Human Services Commission (HHSC).

Owning an LTCP policy does not guarantee access to Medicaid, even if the policy holder exhausts his or her benefits. A person must still meet all Medicaid eligibility requirements in order to be eligible for Medicaid. The LTCP benefits a person by disregarding countable resources in an amount equal to the value of benefits paid by a qualified LTCP policy on the person's behalf at the time of Medicaid eligibility determination and at Medicaid estate recovery.

If the LTCP policyholder needs to rely on Medicaid for payment of long-term care services, the person may qualify for various Medicaid long-term care programs and still own countable resources in excess of the statutory resource limit. Additionally, at the time of death, resources designated for an LTCP disregard will not be subject to Medicaid Estate Recovery Program (MERP) for the person's Medicaid costs.

Current policy in D-7600, Long-Term Care Insurance Policies, remains in effect for policies that are not LTCP **qualified**.

To participate in the LTCP, a person must have utilized some or all of the benefits of a **qualified** LTCP policy. A **qualified** LTCP policy must meet all the rules set out by the TDI including a specific amount of inflation protection based on the person's age at the time the person purchases the policy.

P-1210 Resource Protection Under the LTCP

Revision 12-1; Effective March 1, 2012

A policy holder is considered an LTCP participant when a person:

- requests and is eligible for Medicaid payment of long-term care services, or
- is receiving Medicaid payment of long-term care services, **and**
- has received some or all of the long-term care benefits paid out under a qualified LTCP policy.

A person participating in the LTCP may designate countable resources for a dollar-for-dollar disregard in an amount equal to the value of benefits paid out by a qualified LTCP policy on the person's behalf. Once the countable resource is designated, the LTCP provides the person with the following benefits:

- disregards the value of the designated countable resource in the resource limit calculation.
- allows the person to transfer a designated non-income producing countable resource without penalty.

However, Medicaid will not **pay for long-term care services that are paid by the LTCP policy until such time as these same benefits under the person's LTCP policy have been exhausted. This is consistent with federal law that Medicaid is the payer of last resort.**

A person must provide a written resource designation and must verify the value of the designated countable resource(s). Form H0056, Notice of Opportunity to Designate Countable Resources, is used to allow the person an opportunity to designate a countable resource for the LTCP disregard. Once designated, a person must:

- report any sale, transfer or conversion of a designated resource(s) and verify the value of the designated resource(s) as of the date the reported transaction took place.

- document and verify any designated resource(s) still owned by the person at the time of each Medicaid redetermination. (Special reviews may be performed periodically before each annual redetermination.)

Note: If a designated countable resource is expended, no additional countable resource designation is allowed as a replacement for the expended countable resource.

Medicaid Eligible Persons, who secure additional resources and have not designated resources up to the amount of LTCP benefits paid, may then designate additional countable resources up to the amount of LTCP benefits paid.

P-1220 Interaction of LTCP Disregard with other Medicaid Policies

Revision 12-1; Effective March 1, 2012

The LTCP affects the following Medicaid policies:

- TPR: Benefits under an LTCP policy that are available while a person is receiving Medicaid are considered as a TPR. Medicaid is the payer of last resort.
- Resource division under spousal impoverishment policy: The Spousal Protected Resource Amount (SPRA) for a married couple is established before designation of countable resource(s) for the LTCP disregard. Any available LTCP disregard is applicable to the countable resource(s) owned by the eligible spouse only. The following should be considered:
    - Who owns the LTCP policy?
    - Who does the LTCP policy cover?
    - Who did the LTCP policy pay benefits for?
    - Who is the disregard allowed for?
    - What are the eligible spouse's countable resource(s)?

Note: If the designated countable resource is income-producing, the income is still potentially countable for eligibility and co-payment purposes according to current MEPD policy. For example, if the person designates rental property for the LTCP disregard, any countable rental income (as calculated under existing policy) is still considered in the eligibility and co-payment budget. If the income-producing designated countable resource is transferred, there is no transfer penalty for the resource; however, a potential transfer of income may exist, which could result in a penalty period.

All other eligibility and co-payment criteria for MEPD eligibility are still applicable.

P-1230 Policy Concepts for Resource Disregards

Revision 12-1; Effective March 1, 2012

Only countable resources may be designated for the LTCP disregard in the eligibility determination.

The allowable LTCP resource disregard amount is equal to the amount the qualified LTCP policy has paid for the person applying for or receiving Medicaid.

If a designated countable resource declines in value for reasons other than tampering, additional countable resources may be designated up to the LTCP pay-out amount.

If a designated countable resource increases in value for any reason, consider the current fair market value (FMV) against the current amount of LTCP benefits paid.

A person may expend a designated countable resource, however no additional LTCP designation is allowed in this circumstance.

Transferred countable resources may be designated for the LTCP disregard to eliminate or reduce a transfer penalty.

The LTCP disregard may not be applied to excess home equity value.

The LTCP disregard is applicable only to the person who has received the LTCP benefits.

When an LTCP participant has fewer countable resources than the amount the LTCP policy has paid, the full LTCP disregard amount will be disregarded after death when MERP becomes applicable.

Texas intends to participate in reciprocal recognition with other participating LTCP states.

P-1240 LTCP Scenarios

Revision 12-1; Effective March 1, 2012

Example 1: At application a person has purchased and exhausted a $100,000 qualifying LTCP policy.

The person's only resource is a homestead with equity value of $600,000. The person is not eligible for vendor payment as the equity value of the homestead exceeds the limit ($525,000).

Can the person designate the amount of $75,000, which exceeds the $525,000 home equity limit, as an LTCP disregard?

Response: The person cannot designate the available $75,000 as an LTCP disregard.

Example 2: At application a person has purchased and exhausted an LTCP policy in the amount of $100,000. The person has a $100,000 transfer.

Can the $100,000 transfer be nullified by the allowable $100,000 LTCP disregard or are only available countable resources eligible for the LTCP disregarded?

Response: The LTCP disregard may be applied dollar-for-dollar to the transfer amount.

Example 3: At application a person has purchased and exhausted a $100,000 qualifying LTCP policy.

The person owns a home valued at $200,000. The home is an excluded resource based on the person's declared intent to return to the home. The home cannot be designated for the LTCP disregard because it is not a countable resource. The person designates a $100,000 savings account, which is a countable resource, as the LTCP disregarded resource.

When the person dies, what is disregarded for estate recovery?

Response: Whatever countable resource is designated at application for the LTCP disregard is the countable resource disregarded at estate recovery. The person's LTCP designated $100,000 savings account is the resource disregarded at estate recovery.

Example 4: At application a person has a $100,000 qualifying LTCP policy that has paid out $50,000. At application the person has $50,000 in countable resources, which is designated for the LTCP disregard. At review, the LTCP policy has paid out the remaining $50,000.

How is the additional LTCP disregard applied? Will the additional $50,000 the LTCP policy paid out after the client was determined eligible be applied to the homestead FMV and be disregarded at estate recovery?

Response: The LTCP disregard continues to be applied to the designated $50,000 in countable resources at review. The full amount the LTCP policy paid out is disregarded at estate recovery.

Example 5: At application a person has purchased and exhausted an LTCP policy in the amount of $100,000. The person designates countable real property, FMV $90,000 for the LTCP disregard. At review the designated countable real property FMV increased to $110,000.

Is the remaining LTCP disregard balance of $10,000 ($100,000 – $90,000 = $10,000) applied to the FMV increase? Is the person now over the resource limit as the allowable LTCP designation ($100,000) is not enough to cover the increase in the FMV ($110,000) of the countable LTCP designated resource?

Response: At review the FMV of the countable resource is verified. If the FMV is over the allowed LTCP disregard amount, the amount over the LTCP disregard amount is considered a countable resource. ($110,000 [FMV] – $100,000 [LTCP disregard] = $10,000 countable)

Example 6: At application a person has purchased and exhausted an LTCP policy in the amount of $100,000. The person designates countable real property, FMV $100,000 for the LTCP disregard. At review, the designated countable real property FMV decreased to $90,000 and the person has acquired other countable resources.

Are the newly acquired countable resources allowed for LTCP designation and disregard at review?

Response: At review, if the person has an unused LTCP disregard amount, the person may designate other newly acquired countable resources dollar-for-dollar up to the amount of the unused LTCP disregard amount.

Example 7: At application a person has purchased and exhausted an LTCP policy in the amount of $100,000. The person designates countable rental property, FMV $100,000.

Is the income from the rental property countable?

Response: Although the FMV of the countable rental property is disregarded in the eligibility determination, the rental income is considered countable income.

Example 8: At application a person has purchased and exhausted a $100,000 qualifying LTCP policy in Kansas. The person then moves to Texas and applies for Medicaid.

Is an LTCP disregard allowable for the usage of a $100,000 LTCP policy in Kansas?

Response: Due to reciprocity, Texas honors the Kansas LTCP policy and allows an LTCP disregard of $100,000 of countable resources.

Example 9: A person resides in Kansas and has purchased and exhausted a $100,000 qualifying LTCP policy. The person is eligible in Kansas for their Medically Needy program.

Since the person was on a Medically Needy program in Kansas, would the person automatically be eligible for Medicaid in Texas?

Response: Kansas and Texas have different eligibility criteria for their Medicaid programs. If the person moves to Texas it does not guarantee Texas Medicaid eligibility. Due to reciprocity, Texas honors the Kansas LTCP policy and allows an LTCP disregard of $100,000 of countable resources.

Example 10: Mr. and Mrs. each purchase and exhaust a qualifying LTCP policy for $100,000. Mr. and Mrs. have $150,000 in countable resources. Mr. and Mrs. have a homestead FMV of $200,000. The $150,000 in countable resources is designated.

Is the remaining LTCP disregard balance of $50,000 disregarded at estate recovery?

Response: The full $200,000 LTCP disregard amount will be disregarded at estate recovery.

Example 11: Mr. and Mrs. each purchase and exhaust a qualifying LTCP policy for $100,000. Mrs. dies. At application for Medicaid Mr. has $150,000 in countable resources.

Can Mr. count the $100,000 Mrs.'s LTCP policy paid toward the cost of her care in his countable resource LTCP designation?

Response: No, Mr. can only designate countable resources up to the amount **his** LTCP policy has paid out, which is $100,000. Mr.'s remaining $50,000 in countable resources is countable towards the resource limit.

Example 12: Mr. and Mrs. each purchase and exhaust a qualifying LTCP policy for $100,000. Mr. enters a nursing facility and applies for Medicaid. Total countable resources are $250,000. The SPRA protects $113,640 (maximum SPRA) for the wife. They do not qualify for an expanded SPRA.

$250,000
– $113,640 (SPRA Mrs.)
$136,360
– $100,000 (LTCP disregard designation Mr.)
= $ 36,360 Countable amount

Can they designate the countable amount using her LTCP disregard?

Response: No, the institutionalized spouse is the applicant and the only one eligible for the LTCP disregard.

P-2000, Program Resources

P-2100, Notices and Forms

Body

Revision 12-1; Effective March 1, 2012

Form H0055, Verification of Long-Term Care Partnership Policy, is used to request and verify information about a person's LTCP insurance policy.

Form H0056, Notification of Opportunity to Designate Countable Resources, is used to provide a person an opportunity to select the countable resource(s) and the amount of the countable resource(s) the person wishes to designate for the LTCP disregard. It also serves as the written resource designation for any available LTCP disregard.

Form H0057, Long-Term Care Partnership Resource Worksheet, is used as the LTCP resource calculation worksheet.

The **LTCP Tracking Spreadsheet** is used to track LTCP information for HHSC purposes and to meet federal reporting requirements. This spreadsheet is available on the internal OES MEPD website at http://reg03.dhs.state.tx.us/mepd/.

P-2200, Inquiries

Body

Revision 17-4; Effective December 1, 2017

Refer any LTCP non-Medicaid eligibility related inquiries to the following:

- LTCP and MERP inquiries: merp@hhsc.state.tx.us
- LTCP insurance policy and related inquiries: TDI Consumer Help Line 800-252-3439, Austin 512-463-6515
- Other general LTCP inquiries: LTC Partnership Coordinator at the Medicaid Chip Division 512-491-1803

Chapter Q, Medicare Savings Program

Q-1000, Medicare Savings Programs Overview

Body

Revision 21-1; Effective March 1, 2021

This chapter describes the Medicare Savings Programs. The Medicare Savings Programs use Medicaid funds to help eligible persons pay for all or some of their out-of-pocket Medicare expenses, such as premiums, deductibles or coinsurance.

HHSC manages the Medicare Savings Programs, which consists of the following:

- Qualified Medicare Beneficiary (QMB) Program
- Specified Low-Income Medicare Beneficiary (SLMB) Program
- Qualifying Individual (QI) Program
- Qualified Disabled and Working Individual (QDWI) Program

Countable resource limits for Medicare Savings Programs (except QDWI) are updated annually based on the Consumer Price Index. QDWI requires a person to have countable resources equal to or less than twice the limits for the SSI program to be eligible based on resources. The treatment of income and resources is based on policy in Chapter E, General Income, and Chapter F, Resources. Application and redetermination policies for Medicare Savings Programs adhere to policy and procedure in Chapter B, Applications and Redeterminations. Transfer of assets, spousal impoverishment and co-payment policy and procedures are not used in the Medicare Savings Programs.

All Medicare Savings Programs require a person to meet non-financial eligibility requirements described in Chapter D, Non-Financial.

A person is not eligible for MSP coverage if they:

- are in the custody of penal authorities; or
- are over age 20 and under age 65 and lives in an institution for mental diseases (IMD).

Related Policy

Medicare Savings Program Information, Appendix IX
Medicare Savings Programs, A-8000

Q-1100, Texas Administrative Code Rules

Body

Revision 09-4; Effective December 1, 2009

§359.101. Purpose and Scope.

(a) This chapter describes the assistance available and eligibility requirements for the Medicare Savings Program. Authorized under 42 U.S.C. §1396a(a)(10)(E), the Medicare Savings Program uses Medicaid funds to help eligible persons pay for all or some of their out-of-pocket Medicare expenses, such as premiums, deductibles, or coinsurance.

(b) The Texas Health and Human Services Commission (HHSC) manages the Medicare Savings Program, which consists of the following:

(1) the Qualified Medicare Beneficiary (QMB) Program;

(2) the Specified Low-Income Medicare Beneficiary (SLMB) Program;

(3) the Qualified Individual (QI) Program; and

(4) the Qualified Disabled and Working Individual (QDWI) Program.

(c) Nothing in these rules shall be construed to violate the maintenance of eligibility requirements of section 5001 of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5) and make eligibility standards, methodologies, or procedures under the Texas State Plan for Medical Assistance (or any waiver under section 1115 of the Social Security Act (42 U.S.C. §1315)) more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) that were in effect on July 1, 2008.

§359.103. Qualified Medicare Beneficiary Program.

(a) Authorized under 42 U.S.C. §1396a(a)(10)(E)(i), the Qualified Medicare Beneficiary (QMB) Program pays Medicare premiums, deductibles, and coinsurance for a person who meets the requirements of this section. A person receiving Medicaid may also receive QMB benefits if the person meets the requirements of this section.

(b) To be eligible for QMB coverage, a person must:

(1) be entitled to benefits under Medicare Part A; and

(2) meet income and resources requirements in 42 U.S.C. §1396d(p).

(c) A person is not eligible for QMB coverage if the person:

(1) is in the custody of penal authorities as defined in 42 C.F.R. §411.4(b); or

(2) is over 20 years of age and under 65 years of age and resides in an institution for mental diseases.

(d) A person's QMB eligibility begins on the first day of the month after the month the person is certified for QMB benefits.

(e) A person with QMB coverage is not eligible for three months prior medical coverage.

§359.105. Specified Low-Income Medicare Beneficiary Program.

(a) Authorized under 42 U.S.C. §1396a(a)(10)(E)(iii), the Specified Low-Income Medicare Beneficiary (SLMB) Program pays only Medicare Part B premiums for a person who meets the requirements of this section. A person receiving Medicaid may also receive SLMB benefits if the person meets the requirements of this section.

(b) To be eligible for SLMB coverage, a person must meet the eligibility criteria for QMB coverage in §359.103(b) of this chapter (relating to Qualified Medicare Beneficiary Program), except the person must have an income that is greater than 100% but less than 120% of the federal poverty level.

(c) A person is not eligible for SLMB coverage if the person:

(1) is in the custody of penal authorities as defined in 42 C.F.R. §411.4(b); or

(2) is over 20 years of age and under 65 years of age and resides in an institution for mental diseases.

(d) A person's SLMB eligibility may begin with the month of application.

(e) A person with SLMB coverage is eligible for three months prior medical coverage, if all criteria are met.

§359.107. Qualifying Individual Program.

(a) Authorized under 42 U.S.C. §1396a(a)(10)(E)(iv) the Qualifying Individual (QI) Program pays only Medicare Part B premiums to a person who meets the requirements of this section. A person cannot be eligible for regular Medicaid and QI coverage at the same time.

(b) To be eligible for QI coverage, a person must meet the eligibility criteria for Qualified Medicare Beneficiary coverage in §359.103(b) of this chapter (relating to Qualified Medicare Beneficiary Program), except the person must have income that is at least 120% but less than 135% of the federal poverty level.

(c) Eligibility for QI coverage is determined for each calendar year.

(d) A person's QI eligibility may begin with the month of application.

(e) A person with QI coverage is eligible for three months prior medical coverage if all criteria are met. The three-month prior period cannot extend back into the previous calendar year.

§359.109. Qualified Disabled and Working Individual Program.

(a) Authorized under 42 U.S.C. §1396a(a)(10)(E)(ii), the Qualified Disabled and Working Individual (QDWI) Program pays only Medicare Part A premiums for a person who meets the requirements of this section. A person cannot be eligible for regular Medicaid and QDWI coverage at the same time.

(b) To be eligible for QDWI coverage, a person must:

(1) be under 65 years of age;

(2) be entitled to benefits under Medicare Part A;

(3) not otherwise be eligible for Medicaid;

(4) have a monthly income equal to or less than 200% of the federal poverty level; and

(5) have no more than twice the countable resources allowed under the Supplemental Security Income (SSI) program, as described in §1611 of the Social Security Act (42 U.S.C. §1382).

(c) A person's QDWI eligibility begins in accordance with the coverage period described in §1818A of the Social Security Act (42 U.S.C. §1395i-2a(c)).

Q-1200, Medicare Improvement for Patients and Providers Act of 2008

Body

Revision 20-4; Effective December 1, 2020

MIPPA added requirements for processing MSP applications for people applying through the Social Security Administration (SSA) for the Low Income Subsidy (LIS) program, also referred to as the Extra Help program. LIS provides prescription assistance for Medicare beneficiaries enrolled in Medicare Part D who have limited income and resources. The MSP programs included in MIPPA are:

- Qualified Medicare Beneficiary (QMB) Program;
- Specified Low-Income Medicare Beneficiary (SLMB) Program; and
- Qualified Individual (QI) Program.

The Qualified Disabled and Working Individual (QDWI) Program is not part of MIPPA.

Texas receives a list of people who applied for LIS from SSA. The list includes whether the people were approved or denied. The date the Texas Health and Human Services Commission (HHSC) receives the list is the application date for MSP and starts the 45-day clock for timely processing of the applications for each person on the list. The date the application was made with SSA is a protected file date for MSP eligibility. Form H1200EZ-MSP is sent to each person on the list. HHSC sends denied LIS applicants a denial notice with the right to appeal if they are denied because they:

- live outside the United States;
- have excess resources; or
- have excess income (couples will not auto deny).

Additionally, TIERS will deny anyone identified as living outside of Texas.

Processing instructions on the MIPPA applications are on the LOOP.

Q-1300, MSP Resource Limits

Body

Revision 21-1; Effective March 1, 2021

QMB, SLMB and QI Resource Limits

The resource limits for the following Medicare Savings Programs (MSP) are based on the annual consumer price index (CPI) and are updated in January of each year:

- QMB;
- Specified Low-Income Medicare Beneficiary (SLMB); and
- Qualified Individual (QI).

Use the following resource limits when determining eligibility for these programs.

Date Range	Individual	Couple
Jan. 1, 2021 to present	**$7,970**	**$11,960**
Jan. 1, 2020 to Dec. 31, 2020	$7,860	$11,800
Jan. 1, 2019 to Dec. 31, 2019	$7,730	$11,600
Jan. 1, 2018 to Dec. 31, 2018	$7,560	$11,340
Jan. 1, 2017 to Dec. 31, 2017	$7,390	$11,090
Jan. 1, 2016 to Dec. 31, 2016	$7,280	$10,930
Jan. 1, 2015 to Dec. 31, 2015	$7,280	$10,930
Jan. 1, 2014 to Dec. 31, 2014	$7,160	$10,750
Jan. 1, 2013 to Dec. 31, 2013	$7,080	$10,620
Jan. 1, 2012 to Dec. 31, 2012	$6,940	$10,410
Jan. 1, 2011 to Dec. 31, 2011	$6,680	$10,020
Jan. 1, 2010 to Dec. 31, 2010	$6,600	$9,910
Jan. 1, 1989 to Dec. 31, 2009	$4,000	$6,000

QDWI Resource Limits

The resource limits for QDWI are twice the resource limits for the SSI program.

Use the following resource limits when determining eligibility for the QDWI program:

- $4,000 for an individual; and
- $6,000 for a couple.

Related Policy

Resource Limits, F-1300
Medicare Savings Program Information, Appendix IX
Budget Reference Chart, Appendix XXXI

Q-1400, MSPs and Cost-of-Living Adjustments

Body

Revision 20-3; Effective September 1, 2020

The income limits for QMB, SLMB and QI are based on the federal poverty level (FPL), which is adjusted annually. The Social Security cost-of-living adjustment (COLA) is excluded through the month in which the annual revision of the FPL is published. To determine eligibility for applications and redeterminations, use the pre-COLA benefit amount during those months.

For example, if the FPL is published in February, exclude the RSDI COLA for the months of January and February.

Reminder: The COLA exclusion does not apply when determining eligibility for the QDWI program.

Related Policy

Deeming Income, E-7000
QDWI Cost-of-Living Adjustment, Q-6300

Q-2000, Qualified Medicare Beneficiaries – MC-QMB

Body

Revision 21-2; Effective June 1, 2021

The Qualified Medicare Beneficiary (QMB) Program pays Medicare premiums, deductibles and coinsurance for a person who meets the requirements of this section.

To be eligible for QMB coverage, a person must:

- be entitled to benefits under Medicare Part A; and
- meet income and resources requirements.

The income limits for QMB are based on 100 percent of the federal poverty level (FPL), and are updated annually.

The resource limits are based on the consumer price index and are updated annually.

The person must provide proof of Medicare Part A entitlement to enroll for Medicare Part A. They may have a Medicare card or an enrollment letter from the Social Security Administration (SSA) showing entitlement to Part A.

If the person has no proof of entitlement, refer them to SSA for Part A enrollment if they:

- are 65;
- have a disability (as determined by SSA); or
- have chronic renal disease.

The person must enroll themselves. HHSC is not allowed to enroll the person for Part A as it can for Part B.

A person receiving Medicaid may also be eligible for QMB benefits if they meet the requirements of this section, including the following recipients:

- people of any age residing in a state supported living center;
- people 65 or older residing in a state hospital; and
- people of any age residing in an intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID).

Related Policy

Medicare Savings Program Information, Appendix IX
Qualified Medicare Beneficiary (QMB), A-8100
Medicare Savings Programs Overview, Q-1000
MSP Resource Limits, Q-1300
QMB Income Limits, Q-2500
QMB Medical Effective Date, Q-2700
Qualified Disabled and Working Individuals (QDWI) – MC-QDWI, Q-6000

Q-2100, Verification and Documentation for QMB

Body

Revision 09-4; Effective December 1, 2009

Acceptable verification for Medicare enrollment for Part A includes:

- Wire Third Party Query (WTPY);
- State On line Query (SOLQ);
- Medicare card;
- an enrollment letter from the Social Security Administration documenting enrollment in Part A; and
- presumptive eligibility (persons age 65 years and older receiving RSDI or Railroad Retirement can be presumed enrolled in Medicare Part A, unless their Social Security claim number suffix ends in J3, J4, K3, K4, K7, K8, KB, KC, KF, KG, KL and KM).

Q-2200, Conditional QMB

Body

Revision 09-4; Effective December 1, 2009

Texas is a "buy-in" state. There is no restricted enrollment period. HHSC can automatically "add on" a person's Medicare Part A entitlement and pay the Medicare Part A premium at any time during the year. In other words, if the applicant has Part A, is enrolling for Part A or is entitled to Part A, the applicant may be certified for QMB.

Q-2210 Upon Certification of QMB

Revision 09-4; Effective December 1, 2009

- If the person has Part B only (or is enrolling for Part B), the state will add on the person's Part A entitlement.
- If the person has Part A only, the state will automatically add on the Part B entitlement.
- The state will not pay any expenses until Part A and B premiums begin.

The only "conditional" left is if a person does not have Part A or B. However, we do not have to wait to put the person on QMB.

Q-2300, Social Security Administration QMB Referral Procedures

Body

Revision 10-4; Effective December 1, 2010

Although most people who are eligible for Medicare Part A receive free Part A coverage, some are required to pay a monthly premium.

A person is entitled to Medicare Part A if the person meets one of the following conditions:

- The person does not have to pay Medicare Part A, and is receiving Medicare Part A services as of the QMB determination.

  Example: Mrs. Smith applies for QMB benefits Aug. 15. She has a Medicare card with a Part A begin date of June 1. Since Medicare will pay for Part A services as of June 1, she is entitled to Part A at the time of the QMB determination.

- The person is a Medicaid recipient or QMB or Specified Low-Income Medicare Beneficiary (SLMB) or Qualified Disabled and Working Persons (QDWI) applicant and has never been enrolled in the federal Medicare system. In this case the person must apply at the local Social Security Administration (SSA) office for Part A Medicare eligibility. The person will receive a receipt that entitles the person to enrollment in Part A on the condition that the person is found eligible for QMB or SLMB. The receipt from SSA will have a Part A begin date on it. QMB or SLMB or QDWI eligibility cannot begin before the Part A begin date.

  Example: Mrs. Brown was never enrolled in the federal Medicare system. She applies for QMB. The eligibility specialist takes her application and pends it. Before she can become QMB eligible she must obtain a receipt for conditional eligibility for Part A Medicare. She contacts SSA and is conditionally determined eligible for Part A. Her QMB application is completed.

The eligibility specialist may receive a referral from SSA. An application will be sent to a person with conditional Part A enrollment if there is not a current pending QMB application already on file.

The person's Wire Third Party Query (WTPY) verifies conditional Part A enrollment when the Social Security claim number ends in M **and**:

- the Part A payment code status is Z99 **and** there is an entitlement date to Medicare Part B; **or**
- there is no entitlement date for Part A **and** there is an entitlement date to Part B.

Proof of conditional enrollment in Part A fulfills the QMB eligibility requirement of entitlement to Medicare Part A.

Note: Do not presume that a person enrolled in Medicare Part B is also enrolled in Medicare Part A. Persons drawing early retirement (RSDI) (usually at the age of 62) are not eligible for Medicare Part A or B. Persons determined disabled by SSA and under age 65 are not eligible to enroll in Medicare until they have been disabled for 24 consecutive months or reach their 65th birthday, whichever comes first.

Q-2400, QMB Benefits

Body

Revision 12-2; Effective June 1, 2012

QMB recipients do not receive regular Medicaid benefits. HHSC sends these persons a Your Texas Benefits Medicaid Card that reflects QMB status.

Medicaid pays out-of-pocket Medicare cost-sharing expenses for QMB recipients. Medicaid does not limit deductible or coinsurance payments to services covered by the State Plan.

Q-2500, QMB Income Limits

Body

Revision 21-2; Effective June 1, 2021

Monthly income must be not more than 100 percent FPL.

Use the couple income range when both spouses are applying for the same program.

Monthly Income Limits for the QMB Program

Date Range	Individual	Couple	Deeming*
March 1, 2021 to Present	**$1074**	**$1452**	**$378**
March 1, 2020 to Feb. 28, 2021	$1064	$1437	$373
March 1, 2019 to Feb. 29, 2020	$1041	$1410	$369
March 1, 2018 to Feb. 28, 2019	$1012	$1372	$360
March 1, 2017 to Feb. 28, 2018	$1005	$1354	$349
March 1, 2016 to Feb. 28, 2017	$990	$1,335	$345
March 1, 2015 to Feb. 29, 2016	$981	$1,328	$347
March 1, 2014 to Feb. 28, 2015	$973	$1,311	$338
March 1, 2013 to Feb. 28, 2014	$958	$1,293	$335
March 1, 2012 to Feb. 28, 2013	$931	$1,261	$330
March 1, 2011 to Feb. 29, 2012	$908	$1,226	$318
March 1, 2009 to Feb. 28, 2011	$903	$1,215	$312

*The deeming allowance is the couple limit minus the individual limit.

Note: These amounts do not include the $20 disregard.

Related Policy

MSP Resource Limits, Q-1300
Budget Reference Chart, Appendix XXXI

Q-2600, Reserved for Future Use

Body

Revision 20-3; Effective September 1, 2020

Q-2700, QMB Medical Effective Date

Body

Revision 12-4; Effective December 1, 2012

QMB eligibility begins on the first day of the month following the month the person is determined eligible for QMB benefits. The disposition date in the system of record is the date the eligibility decision is completed. For example, if the MC – QMB is signed and disposed on Jan. 2, QMB eligibility would begin on Feb.1.

There is no QMB coverage in the three months prior to the QMB application date or coverage for months up to the QMB effective date. The only exception is if the individual is eligible for continuous QMB. See details listed in Section Q-2800, Ensuring Continuous QMB.

Q-2710 Prior Coverage Under SLMB/QI-1

Revision 12-2; Effective June 1, 2012

Institutional living arrangement (including persons residing in state supported living centers and ICF/ID facilities, and persons age 65 and over residing in institutions for mental diseases (IMDs)).

Situation 1

A person does **not** reside in the institution during the entire three prior months.

An applicant who is QMB eligible ongoing may be eligible for SLMB or QI-1 in the three prior months when the individual's income exceeds the QMB limits in the prior months. This situation occurs when there has been a decrease in countable ongoing income or when deemed income or support and maintenance was countable in the prior months.

Situation 2

A person does reside in the institution during the entire three prior months.

An applicant who is QMB eligible ongoing may be eligible for SLMB in the three prior months when the individual's income exceeds the QMB limits in the prior months. This situation occurs when there has been a decrease in countable ongoing income, such as additional income was received in the prior months.

Note: Deeming and support and maintenance is not applicable to institutional or Home and Community-Based Services waiver programs but is applicable to QMB, SLMB, and QI-1.

Living in the community, including persons applying for Community Attendant Services (CAS) and persons residing at home and applying for Home and Community-Based Services waiver programs:

Situation

An applicant who is QMB eligible ongoing may be eligible for SLMB or QI-1 in the three prior months when the individual's income exceeds the QMB limits in the prior months. This situation occurs when there has been a decrease in countable ongoing income or when deemed income or support and maintenance was countable in the prior months.

Reminder

QI-1 persons cannot be eligible for regular Medicaid and QI-1 benefits at the same time. Always give applicants the opportunity to choose which benefit they prefer to receive and document the person's verbal or written choice of preferred benefit, including a choice between QI-1 and CAS benefits. For QI-1, the three months prior period cannot extend back into the previous calendar year unless the application was filed in that calendar year. The application file date and prior coverage months must be in the same calendar year.

Example 1: February is the application month, which makes January the only possible prior coverage month.

Example 2: December is the application month; thus, the three months prior would be September, October and November. Applicant could be potentially eligible for the three months prior, the application month of December and for January and ongoing.

Note: Refer to Section Q-3400, SLMB Medical Effective Date, for policy regarding the prior months.

Q-2800, Ensuring Continuous QMB

Body

Revision 13-4; Effective December 1, 2013

If a denied SSI recipient applies for Medicaid under an MEPD program, verify whether the individual was also receiving QMB benefits at the time of the SSI denial by viewing the individual's Medicaid History or Eligibility History in TIERS Inquiry. Verification also can be obtained by SOLQ/WTPY.

If a person is eligible for QMB and is applying for MC-QMB, enter the Continuous QMB Begin Month in the Program – Individual page in the system of record. This ensures continuous QMB coverage.

Examples:

- The last day of SSI with QMB coverage is Jan. 31, 20XX. The person is being certified under ME-Pickle and MC-QMB.
- The last day of SSI with QMB coverage is Jan. 31, 20XX. The person is certified under MC-QMB.

Technically, there is no limit as to how far back continuous QMB coverage may be given. However, system limitations will not allow Medicare Part B buy-in reimbursement to begin any earlier than two full fiscal years (with September considered the start of a fiscal year). The earliest buy-in date is based on the date that the buy-in process is successfully completed (not the eligibility specialist's decision date, the person's medical effective date [MED], or QMB effective date).

Examples:

- SSI/QMB coverage denied Dec. 31, 2007
  Form H1200, Application for Assistance – Your Texas Benefits, filed April 7, 2010
  Eligibility determined on May 15, 2010, for continuous QMB; QMB MED = Jan. 1, 2008; buy-in process completed on July 15, 2010; buy-in effective January 2008 (current full fiscal year does not end until August 2010; earliest full fiscal year began September 2007)
- SSI/QMB coverage denied Dec. 31, 2007
  Form H1200 filed Aug. 15, 2010
  Eligibility determined on Sept. 11, 2010, for continuous QMB; QMB MED = Jan. 1, 1998; buy-in process completed on Nov. 15, 2010; buy-in effective September 2008 (current full fiscal year began September 2010; earliest full fiscal year began September 2008)

If the QMB medical effective date precedes the earliest available buy-in date, the person can receive Medicaid coverage for Medicare co-payments and deductibles for the entire period established by the medical effective date. Buy-in coverage would begin later. A person may elect not to have continuous coverage if the medical effective date will not provide buy-in for the entire period and the person does not have any claims to cover or be reimbursed.

What is not considered continuous QMB:

- QMB recipient was denied in error because income was incorrectly counted in the budget. The case needs to be corrected to add the missing coverage the recipient is entitled to receive.
- QMB recipient was correctly denied for exceeding the income or resource limits. This is a valid denial and a break in coverage. These individuals cannot have continuous coverage if they reapply and are again eligible for QMB. The QMB effective date would be the first of the month after disposition.
- QMB recipient was denied because the redetermination packet was lost or misrouted in the task list manager queue. The case needs to be corrected to add the missing coverage the recipient is entitled to receive.
- QMB recipient was denied at redetermination for no packet received. At reapplication, this is not a continuous QMB, as the denial was valid. The QMB effective date would be the first of the month after disposition.

Q-2900, QMB Eligibility and Supplemental Security Income

Body

Revision 13-4; Effective December 1, 2013

Persons receiving Medicaid benefits under SSI also may qualify for QMB. QMB status is automatically added to the Medicaid coverage when the person also receives Medicare Part A. QMB eligibility is effective the month after the tape match from SSA is received.

Example: The tape match with SSA is received in September 20XX indicating the SSI recipient is Medicare Part A eligible August 20XX. QMB eligibility will begin in October 20XX.

In situations where the SSI recipient should have QMB coverage but does not, the eligibility specialist emails all inquiries or necessary updates to CCC_Data_Integrity_Program@hhsc.state.tx.us. The turnaround time is 24 to 36 hours, depending on the number of inquiries received. Send the following information with your request:

- Individual's number
- Individual's name
- Case number and EDG number
- Medical coverage requested, including certification period
- Add or delete coverage requested
- Any special instructions that have to do with Medicaid coverage

Q-3000, Specified Low-Income Medicare Beneficiaries – MC-SLMB

Body

Revision 21-2; Effective June 1, 2021

The Specified Low-Income Medicare Beneficiary (SLMB) program is an extension of QMB.

A person receiving Medicaid may also receive SLMB.

Note: ME-Pickle and ME-Disabled Adult Child recipients cannot be dually eligible for SLMB as the Medicare Part B premium is already paid.

To be eligible for SLMB, a person must meet the eligibility criteria for QMB (see Section Q-2000), except the person must have an income that is greater than 100% but less than 120% of the federal poverty level.

The following may be certified for SLMB if all eligibility criteria are met:

- people 65 or older residing in an institution for mental diseases (IMD);
- people of any age residing in state supported living centers;
- people residing in intermediate care facilities for individuals with an intellectual disability or related condition (ICF/IID); and
- people residing in state supported living centers.

Related Policy

Medicare Savings Program Information, Appendix IX
Specified Low-Income Medicare Beneficiaries (SLMB), A-8200
Medicare Savings Program Overview, Q-1000
MSP Resource Limits, Q-1300

Q-3100, SLMB Benefits

Body

Revision 09-4; Effective December 1, 2009

For SLMB-eligible persons, Medicaid pays only Medicare Part B premiums. However, enrollment in Medicare Part B is not an eligibility criterion.

Q-3200, SLMB Income Limits

Body

Revision 21-2; Effective June 1, 2021

Monthly income must be more than 100 percent FPL and less than 120 percent FPL.

Use the couple income limit when both spouses are applying for the same program.

Monthly Income Limits for the SLMB Program

Time Period	Range/Limit for Individuals	Range/Limit for Couple	Deeming*
March 1, 2021 to Present	**$1,074.01 to $1,288**	**$1,452.01 to $1,742**	**$454**
March 1, 2020 to Feb. 28, 2021	$1,064.01 to $1,276	$1,437.01 to $1,724	$448
March 1, 2019 to Feb. 29, 2020	$1,041.01 to $1,249	$1410.01 to $1,691	$442
March 1, 2018 to Feb. 28, 2019	$1,012.01 to $1,214	$1,372.01 to $1,646	$432
March 1, 2017 to Feb. 28, 2018	$1,005.01 to $1,206	$1,354.01 to $1,624	$418
March 1, 2016 to Feb. 28, 2017	$990.01 to $1,188	$1,335.01 to $1,602	$414
March 1, 2015 to Feb. 29, 2016	$981.01 to $1,177	$1,328.01 to $1,593	$416
March 1, 2014 to Feb. 28, 2015	$973.01 to $1,167	$1,311.01 to $1,573	$406
March 1, 2013 to Feb. 28, 2014	$958.01 to $1,149	$1,293.01 to $1,551	$402
March 1, 2012 to Feb. 28, 2013	$931.01 to $1,117	$1,261.01 to $1,513	$396
March 1, 2011 to Feb. 29, 2012	$908.01 to $1,089	$1,226.01 to $1,471	$382

*The deeming amount is the couple limit minus the individual limit.

Note: These amounts do not include the $20 disregard. There must be at least a one cent unmet need for SLMB (MC-SLMB) eligibility.

SLMB uses the same resource limits as QMB and QI.

Related Policy

MSP Resource Limits, Q-1300
Budget Reference Chart, Appendix XXXI

Q-3300, Reserved for Future Use

Body

Revision 20-3; Effective September 1, 2020

Q-3400, SLMB Medical Effective Date

Body

Revision 13-3; Effective September 1, 2013

A person's SLMB eligibility may begin with the month of application. A person with SLMB coverage is eligible for three months prior medical coverage, if all criteria are met.

Do not grant SLMB coverage for QMB applicants whose monthly income is equal to or less than the QMB limit during the three months prior through the QMB eligibility effective date.

SLMB in the three prior months is allowed with ongoing QMB if the individual's income exceeds the QMB limits in the prior months. This situation occurs when there has been a change in countable ongoing income.

Q-3500, SLMB Eligibility and Other Programs

Body

Revision 12-2; Effective June 1, 2012

When a Specified Low-Income Medicare Beneficiary (MC-SLMB) recipient becomes eligible for Supplementary Security Income (SSI), the MC-SLMB EDG in TIERS is automatically denied since SLMB is not allowed with SSI.

ME – Pickle, ME – SSI Prior, ME – Disabled Adult Child, and ME – A and D – Emergency cannot be dually eligible for SLMB. Even though ME – Pickle and ME – Disabled Adult Child may meet SLMB eligibility requirements, the Medicare Part B premium is already paid

Notes:

- ME – Early Aged Widow(er) and Disabled Widow(er) cannot be entitled to Medicare; therefore, not eligible for any MSP Program.
- A person is not eligible for SLMB coverage if the person is:
  - in the custody of penal authorities; or
  - over 20 years of age and under 65 years of age and resides in an institution for mental diseases (IMD).
- Persons age 65 or older residing in an IMD may be certified for SLMB, if all eligibility criteria are met. Persons of any age residing in state supported living centers may be certified for SLMB, if all eligibility criteria are met. SLMB ongoing and prior coverage is available for ICF/ID and state supported living center residents.
- SLMB ongoing and prior coverage is allowed with ME – Nursing Facility, which includes individuals on Mason Manor.
- SLMB ongoing and prior coverage is allowed with ME – Waivers.

Q-4000, Medicare Savings Programs and Dual Eligibility

Q-4100, SLMB Dual Eligibility and Medicare Buy-In

Body

Revision 13-4; Effective December 1, 2013

Programs ME-Pickle, ME-SSI Prior, ME-Temp Manual SSI, ME-SSI, ME-Disabled Adult Child, MC-QMB, and ME-A and D-Emergency cannot be dually eligible for SLMB. Even though ME-Pickle and ME-Disabled Adult Child recipients may meet SLMB eligibility requirements, the Medicare Part B premium is already paid because they are on Medicaid.

Q-4200, Texas Works Medicaid and QMB or SLMB Dual Eligibility

Body

Revision 20-2; Effective June 1, 2020

Persons receiving Medicaid benefits through Texas Works Medical Programs also may qualify for QMB benefits.

These programs include the following:

- MA – Earnings Transitional (TP 07)
- MA – Parents and Caretaker Relatives (TP08)
- MA – Pregnant Women (TP 40)
- MA – Children Under 1 (TP 43)
- MA – Newborn Children (TP 45)
- MA – Children 1-5 (TP 48)
- MA – Children 6-18 (TP 44)
- MA – Former Foster Care Children (FFCC) (TA 82)

The above programs cannot be dually eligible for SLMB. Even though these programs may meet SLMB eligibility requirements, the Medicare Part B premium is already paid.

A person receiving (TP-56) MA-Medically Needed Spend Down can be eligible for MC-SLMB.

Note: There is no prior coverage for QMB unless income during a specific prior month is over the QMB limit and is within the SLMB income limit criterion.

Related Policy

Medicare Savings Programs, A-8000

Q-4210 Breast and Cervical Cancer Services Program

Revision 12-2; Effective June 1, 2012

Do not certify a person for a Medicare Savings Program if that person is receiving services through the Breast and Cervical Cancer Services (BCCS) program.

To receive services through the BCCS program, a person must be uninsured. As a result, insurance coverage from another Medicaid program or Medicare would stop that person from receiving services through the BCCS program.

The MSP EDG will be pended until MBCC denial is disposed by the TW advisor. The TW advisor will be notified of the pended MSP EDG by an Alert.

Q-4220 Reserved for Future Use

Revision 12-2; Effective June 1, 2012

Q-4230 Reserved for Future Use

Revision 12-2; Effective June 1, 2012

Q-4240 Reserved for Future Use

Revision 12-2; Effective June 1, 2012

Q-4250 Reserved for Future Use

Revision 12-2; Effective June 1, 2012

Q-5000, Qualifying Individuals (QIs)

Body

Revision 21-2; Effective June 1, 2021

The Qualifying Individuals (QIs) program is an extension of QMB.

A person cannot be certified for any other Medicaid-funded program and the QI program at the same time. A person must be given the opportunity to choose which benefit they prefer to receive.

Because a person cannot receive both Medicaid and QI benefits at the same time, document their oral or written choice of preferred benefit in case comments, including the person's choice between QI and Community Attendant Services (CAS) benefits.

Note: ME-Pickle and ME-Disabled Adult Child recipients cannot be dually eligible for QI as the Medicare Part B premium is already paid.

To be eligible for QI, a person must meet the eligibility criteria for QMB (see Section Q-2000), except the person must have an income that is greater than 120% but less than 135% of the federal poverty level.

Related Policy

Medicare Savings Program Information, Appendix IX
Qualifying Individuals (QIs), A-8300

Medicare Savings Programs Overview, Q-1000
MSP Resource Limits, Q-1300

Q-5100, QI Benefits

Body

Revision 09-4; Effective December 1, 2009

Authorized under 42 U.S.C. §1396a(a)(10)(E)(iv), the QI Program pays only Medicare Part B premiums to a person who is eligible for QI.

Q-5200, QI Income Limit

Body

Revision 21-2; Effective June 1, 2021

Monthly income must be at least 120 percent FPL and less than 135 percent FPL.

Use the couple income limit when both spouses are applying for the same program.

Monthly Income Limits for the QI-1 Program

QI-1s	Individuals (income at least, but less than)	Couples (income at least, but less than)	Deeming*
March 1, 2021 to Present	**$1,288 to $1,449**	**$1,742 to $1,960**	**$511**
March 1, 2020 to Feb. 28, 2021	$1,276 to $1,436	$1,724 to $1,940	$504
March 1, 2019 to Feb. 29, 2020	$1,249 to $1,406	$1,691 to $1,903	$497
March 1, 2018 to Feb. 28, 2019	$1,214 to $1,366	$1,646 to $1,852	$486
March 1, 2017 to Feb. 28, 2018	$1,206 to $1,357	$1,624 to $1,827	$470
March 1, 2016 to Feb. 28, 2017	$1,188 to $1,337	$1,602 to $1,803	$466
March 1, 2015 to Feb. 29, 2016	$1,177 to $1,325	$1,593 to $1,793	$468
March 1, 2014 to Feb. 28, 2015	$1,167 to $1,313	$1,573 to $1,770	$457
March 1, 2013 to Feb. 28, 2014	$1,149 to $1,293	$1,551 to $1,745	$452
March 1, 2012 to Feb. 28, 2013	$1,117 to $1,257	$1,513 to $1,703	$446
March 1, 2011 to Feb. 29, 2012	$1,089 to $1,226	$1,471 to $1,655	$429

*The deeming allocation amount is based on the difference between the couple and individual income limits.

Note: These amounts do not include the $20 disregard. There must be at least a one cent unmet need for SLMB (MC-SLMB) eligibility.

Related Policy

MSP Resource Limits, Q-1300
Budget Reference Chart, Appendix XXXI

Q-5300, Reserved for Future Use

Body

Revision 20-3; Effective September 1, 2020

Q-5400, QI Medical Effective Date

Body

Revision 09-4; Effective December 1, 2009

Eligibility for QI coverage is determined for each calendar year. A person's QI eligibility may begin with the month of application. A person with QI coverage is eligible for three months prior medical coverage if all criteria are met. The three-month prior period cannot extend back into the previous calendar year.

The application file date and prior coverage months must be in the same calendar year. **Example:** If the application is filed in February, the only possible prior coverage month is January.

Q-5500, Reserved for Future Use

Body

Revision 12-2; Effective June 1, 2012

Q-5600, QI-2

Body

Revision 12-2; Effective June 1, 2012

Authority for the QI-2 program under Public Law 105-33 expired on Dec. 31, 2002.

Q-6000, Qualified Disabled and Working Individuals – MC-QDWI

Body

Revision 21-2; Effective June 1, 2021

SSI policy is used to determine eligibility for the Qualified Disabled and Working Individuals (QDWI) Program – MC-QDWI. To be eligible for QDWI coverage, a person must:

- be under 65 years old;
- be entitled to benefits under Medicare Part A;
- not otherwise certified under any other Medicaid-funded program;
- have a monthly income equal to or less than 200% of the federal poverty level; and
- have no more than twice the countable resources allowed under the SSI program.

Resource Limits

- **Individual** – $4,000
- **Couple** – $6,000

Q-6100, QDWI Benefits

Body

Revision 12-2; Effective June 1, 2012

Authorized under 42 USC §1396a(a)(10)(E)(ii), the QDWI Program pays only Medicare Part A premiums. A person cannot be eligible for regular Medicaid and QDWI coverage at the same time. The person does not receive a Your Texas Benefits Medicaid Card or Form H1027, Medical Eligibility Verification.

A person's QDWI eligibility begins in accordance with the coverage period described in §1818A of the Social Security Act (42 USC §1395i-2a(c)).

Q-6200, QDWI Income Limit

Body

Revision 21-2; Effective June 1, 2021

A person with a disability who gets Social Security disability payments and free Medicare may work. If the person's earnings exceed a certain amount over a time-period, the Social Security Administration (SSA) may stop the person's Social Security benefits and free Medicare. Under Section 1818A of the Social Security Act, a person may pay the Medicare Part A premium if SSA denies the person's free Medicare because of earnings.

Monthly Income Limits for the QDWI Program

Time Period	Person	Couple	Deeming*
March 1, 2021 to Present	**$2,147**	**$2,904**	**$757**
March 1, 2020 to Feb. 28, 2021	$2,127	$2,874	$747
March 1, 2019 to Feb. 29, 2020	$2,082	$2,819	$737
March 1, 2018 to Feb. 28, 2019	$2,024	$2,744	$720
March 1, 2017 to Feb. 28, 2018	$2,010	$2,707	$697
March 1, 2016 to Feb. 28, 2017	$1,980	$2,670	$690
March 1, 2015 to Feb. 29, 2016	$1,962	$2,655	$693
March 1, 2014 to Feb. 28, 2015	$1,945	$2,622	$677
March 1, 2013 to Feb. 28, 2014	$1,951	$2,585	$670
March 1, 2012 to Feb. 28, 2013	$1,862	$2,522	$660
March 1, 2011 to Feb. 29, 2012	$1,815	$2,452	$637
March 1, 2009 to Feb. 28, 2011	$1,805	$2,429	$624
March 1, 2008 to Feb. 28, 2009	$1,734	$2,334	$600
April 1, 2007 to Feb. 29, 2008	$1,702	$2,282	$580
April 1, 2006 to March 31, 2007	$1,634	$2,200	$566
April 1, 2005 to March 31, 2006	$1,595	$2,139	$544
April 1, 2004 to March 31, 2005	$1,552	$2,082	$530
Jan. 1, 2003 to March 31, 2004	$1,497	$2,020	$523
Jan. 1, 2002 to Dec. 31, 2002	$1,477	$1,990	$513
Jan. 1, 2001 to Dec. 31, 2001	$1,432	$1,935	$503
Jan. 1, 2000 to Dec. 31, 2000	$1,392	$1,875	$483
Jan. 1, 1999 to Dec. 31, 1999	$1,374	$1,844	$470
Jan. 1, 1998 to Dec. 31, 1998	$1,342	$1,809	$467

Time Period	Person	Couple	Deeming*
Jan. 1, 1997 to Dec. 31, 1997	$1,315	$1,769	$454
Jan. 1, 1996 to Dec. 31, 1996	$1,290	$1,727	$437
Jan. 1, 1995 to Dec. 31, 1995	$1,245	$1,672	$427
Jan. 1, 1994 to Dec. 31, 1994	$1,227	$1,640	$413
Jan. 1, 1993 to Dec. 31, 1993	$1,162	$1,572	$410
Jan. 1, 1992 to Dec. 31, 1992	$1,136	$1,532	$396
Jan. 1, 1991 to Dec. 31, 1991	$1,104	$1,480	$376
Jul 1, 1990 to Dec. 31, 1990	$1,047	$1,404	$357

* The deeming amount is the couple limit minus the person limit.

Note: These amounts do not include the $20 disregard.

Related Policy

MSP Resource Limits, Q-1300
Budget Reference Chart, Appendix XXXI

Q-6300, QDWI Cost-of-Living Adjustment

Body

Revision 16-2; Effective June 1, 2016

Recipients of QDWI do not receive Social Security benefits, therefore the cost-of-living adjustment (COLA) does not apply.

Q-6400, QDWI Medical Effective Date

Body

Revision 09-4; Effective December 1, 2009

The medical effective date is influenced by whether the person enrolls for Medicare coverage during the initial enrollment period but before his present Medicare entitlement ends, after the initial enrollment period begins but after his entitlement ends, or following the initial enrollment period. Consider the date the person enrolled for continuation of his/her Medicare entitlement when determining the medical effective date (MED). The MED does not precede the earliest date the person is entitled to reinstatement of his Part A coverage. Otherwise, use the same procedures for determining the MED for all other MEPD programs (including three months prior coverage).

Example: The following chart may be used as a reference for the MED determination policies and examples.

Enrollment Period	Month	Activities
Initial Enrollment Period	April May	Person notified his free Part A entitlement will end
	June	End of person's free entitlement

Enrollment Period	Month	Activities
	July August September	First month person meets QDWI criteria
General Enrollment Period	January February	QDWI coverage effective July 1
	March	End of general enrollment period

The following applies when determining the MED:

- The initial enrollment period for a person who has been notified that his free entitlement to Medicare Part A coverage will end is seven months. The enrollment period begins the month the person is notified.

  Example: A person is notified in April that his free entitlement to Part A coverage ends at the end of June. His initial enrollment period begins in the month of notification (April) and ends at the end of October. To reinstate his Part A coverage, he must enroll with SSA before the end of October. He then must apply with the department for QDWI benefits.
- In the case of a person who enrolls in an initial enrollment period before meeting QDWI criteria and applies for QDWI benefits, the medical effective date is the first day of the month he meets the QDWI criteria.

  Example: A person is notified in April that his free entitlement to Medicare Part A coverage ends at the end of June. He enrolls for reinstatement of his Part A coverage with SSA in April and applies for and is determined eligible for QDWI benefits with the department in May. The earliest MED he can have for QDWI benefits is July 1 because it is the first month he meets QDWI criteria and is allowed to purchase Part A coverage.
- If the person enrolls in the first month that he meets all QDWI criteria except for reinstatement (fourth month of the initial enrollment period), and applies for QDWI benefits, the MED is effective the first of the following month.

  Example: A person is notified in April that his free entitlement to Medicare Part A coverage ends at the end of June. He enrolls for reinstatement of his Part A coverage with SSA in July and applies for and is determined eligible for QDWI benefits in July. The earliest medical effective date he can have for QDWI benefits is Aug. 1 because that is the first month he is entitled to reinstatement of his Part A coverage.
- If the person enrolls in the second month that he meets all QDWI criteria except for reinstatement (fifth month of the initial enrollment period) and applies for QDWI benefits, the MED is effective the second month after enrollment.

  Example: A person is notified in April that his free entitlement to Medicare Part A coverage ends at the end of June. He enrolls for reinstatement of his Part A coverage with SSA in August and applies for and is determined eligible for QDWI benefits in September. The earliest MED he can have for QDWI benefits is Oct. 1 because that is the first month he is entitled to reinstatement of his Part A coverage.
- If the person enrolls in the third or fourth month that he meets all QDWI criteria except for reinstatement (sixth or seventh month of the initial enrollment period) and applies for QDWI benefits, the medical effective date is effective the first day of the third month following the month he enrolled.

  Example: A person is notified in April that his free entitlement to Medicare Part A coverage ends at the end of June. He enrolls for reinstatement of his Part A coverage with SSA in September and applies for and is determined eligible for QDWI benefits in October. The earliest MED he can have for QDWI benefits is Dec. 1 because that is the first month he is entitled to reinstatement of his Part A coverage.
- If the person enrolls during the general enrollment period, the medical effective date is always effective July 1.

Example: A person is notified in April that his free entitlement to Medicare Part A coverage ends at the end of June. He does not enroll during the initial enrollment period and decides to enroll during the general enrollment period, from January through March 31, of the next year. The earliest MED date he is allowed is the July 1 following his enrollment.

Q-6500, General SSA Procedures Involving Potential QDWIs

Body

Revision 09-4; Effective December 1, 2009

The Social Security Administration notifies disabled persons whose Social Security disability payments have ceased and whose Medicare coverage is about to cease because of earnings. A seven-month initial enrollment period begins with the month of notification. During this period, the person may enroll to pay the Medicare premium himself or he may contact the department to have his eligibility determined for QDWI benefits. If he does not take either of these actions, his Medicare coverage ends and he must wait until the next general enrollment period to enroll for Medicare coverage.

Reminder: Remember that entitlement to Medicare Part A is one of the eligibility criteria for receiving QDWI benefits.

Q-6600, QDWI Application Procedures

Body

Revision 09-4; Effective December 1, 2009

Q-6610 Medicare Part A Entitlement

Revision 09-4; Effective December 1, 2009

Ask the person if he/she is entitled to Medicare Part A benefits.

- If the person is currently enrolled, verify by checking:
  - the person's Medicare card;
  - a TPQY inquiry; or
  - the letter from the Social Security Administration (SSA) notifying the person of the imminent termination of Part A.
- If the person has been entitled but is not currently enrolled, determine when his/her entitlement ended.
  - If entitlement has ended, but the person can still enroll during his/her initial enrollment period, refer him to SSA to begin enrollment procedures. He/She must obtain proof of enrollment from SSA.
  - If both entitlement and the initial enrollment period have ended, the person cannot be eligible for QDWI benefits until after enrolling with SSA during the general enrollment period (January through March of each year). QDWI benefits begin in July of the year of enrollment.

Q-6700, Reserved for Future Use

Body

Revision 12-2; Effective June 1, 2012

Chapter R, Case Disposition

R-1000, Medical Effective Date and Notices

R-1100, Texas Administrative Code Rules

Body

Revision 09-4; Effective December 1, 2009

§358.540. Medical Effective Date.

(a) If a person is eligible for a Medicaid-funded program for the elderly and people with disabilities (MEPD), the Texas Health and Human Services Commission (HHSC) includes in the notice of eligibility the date that the person's Medicaid benefits will begin, which is known as the medical effective date.

(b) HHSC determines the medical effective date:

(1) in accordance with 42 CFR §435.914, as the first day of the month in which a person meets all eligibility criteria, which may be up to three months before the date of application if:

(A) during the three months before the month of application, the person received MEPD services covered under the Texas State Plan for Medical Assistance; and

(B) would have been eligible for MEPD at the time the services were received if the person had applied (or someone had applied on behalf of the person), regardless of whether the person is alive when application for MEPD is made; or

(2) as approved by the Centers for Medicare and Medicaid Services for a §1915(c) waiver program.

§358.535. Notice of Eligibility Determination.

(a) After making an initial eligibility determination, the Texas Health and Human Services Commission (HHSC) sends the applicant, in accordance with 42 CFR §435.912:

(1) a written notice of eligibility, including notice of any co-payment the person must pay and the medical effective date described in §358.540 of this subchapter (relating to Medical Effective Date); or

(2) a written notice of ineligibility, explaining the reason for the decision and the specific provision supporting the decision.

(b) After making an eligibility redetermination, HHSC sends the recipient a written notice of any change in eligibility or co-payment.

(c) The written notice informs the applicant or recipient of the right to request a hearing to appeal the eligibility determination. The hearing is held in accordance with 42 CFR Part 431, Subpart E and HHSC's fair hearing rules in Chapter 357 of this title (relating to Hearings).

R-1200, Medical Effective Date

Body

Revision 19-2; Effective June 1, 2019

The medical effective date (MED) is the first day of the month an applicant meets all eligibility criteria. The MED may be up to three months before the date of application, in which:

- the applicant had unpaid or reimbursable medical expenses, regardless if the person is alive when the application is made; or
- the applicant entered a nursing facility, intermediate care facility for persons with intellectual disabilities (ICF/IID), or state supported living center.

For persons transferring from Supplemental Security Income (SSI) to an MEPD program (excluding Medicare Savings Program recipients), the MED is the day after the effective date of the SSI denial (under ME – SSI).

The MED is used to initiate all medical benefits to the person and payments to providers.

The MED for Community Attendant Services (formerly 1929(b)) may be the first of the month in which:

- the application was received; or
- an eligibility decision was made.

MED for Home and Community-Based Waiver Services after a Denial of No Renewal Packet

Prior months' eligibility and ongoing eligibility for the financial Medicaid eligibility component is contingent upon verification of receipt of waiver services when re-establishing an MED for Home and Community-Based Services waiver services following a denial due for non-receipt of redetermination packet.

Coordinate financial case actions with a waiver case manager.

The following examples are for the financial Medicaid eligibility component for waivers and are not intended to address any situation with continuous Q benefits.

- **Example 1:** A case is denied because of non-receipt of the redetermination packet effective June 30. In October, the redetermination packet is received. The redetermination is treated as an application. The person met all financial eligibility criteria for October and all months since the denial. Verification is received indicating that waiver services were provided continuously since June. The MED is July 1 and there is no break in coverage.
- **Example 2:** A case is denied because of non-receipt of the redetermination packet effective March 31. In October, the redetermination packet is received. The redetermination is treated as an application. The person met all financial eligibility criteria for October and all months since denial. Verification is received indicating that waiver services were provided continuously since March. The MED is July 1. This is a break in coverage because the MED is the first day of the month up to three months before the receipt of the application or redetermination.
- **Example 3:** A case is denied because of non-receipt of the redetermination packet effective Jan 31. In June, the redetermination packet is received. The redetermination is treated as an application. The person met all financial eligibility criteria for February and all months since denial. Verification is received indicating that waiver services stopped effective Feb. 28. The MED is June 1 or the first day of the month waiver services begin. There is a break in coverage.

Related Policy

Administrative Denials, B-9100
Qualified Disabled and Working Individuals (QDWI), R-1230
Qualified Medicare Beneficiary (QMB)-MC-QMB, Q-2000
QMB Medical Effective Date, Q-2700

R-1210 Medicare Skilled Nursing Facilities

Revision 12-2; Effective June 1, 2012

The medical effective date for a person in a Medicare skilled nursing facility (SNF) potentially can be as early as the first day of the month of entry to the nursing facility or the first day of a prior month. If eligible, this will ensure payment of any other medical expenses (including returns to the hospital during the initial 20 days of full Medicare coverage). At certification, the eligibility worker must verify and document in TIERS case comments section that the individual:

- remains in the SNF section; or
- has been discharged to a Medicaid-certified facility.

Medicare approval of the applicant for the SNF bed meets the medical necessity (MN) requirement. If the MED is prior to the applicant's move to the Medicaid-only bed, the MN requirement has been met.

Note: If the person remains in the SNF when the case is certified, it is recommended that a special review be scheduled to monitor for the completed MN determination when SNF does end.

See Chapter H, Co-Payment, for issues related to the 30 consecutive day stay requirement and the appropriate income limit.

Examples:

- Marsha Ford is admitted to an SNF as full Medicare on 11-15-XX. The 21st SNF day is 12-05-XX. The application is received 12-14-XX. Application is ready to certify 01-03-XX. The eligibility worker verifies that Ms. Ford has unpaid/reimbursable hospital bills for 11-XX. Ms. Ford is still in the SNF bed and has met all eligibility criteria as of 12:01 a.m. 11-01-XX. MED = 11-01-XX. Co-payment begins 12-05-XX.
- Fred McDaniel is admitted to an SNF as full Medicare on 03-24-XX. The 21st SNF day is 04-13-XX. The application is received 04-05-XX. He is discharged from the SNF to a Medicaid bed on 05-20-XX. Application is ready to certify 06-15-XX. Mr. McDaniel meets all eligibility criteria as of 12:01 a.m. 03-01-XX. MED = 03-01-XX. Co-payment begins 04-13-XX. MN is not necessary, as MED is prior to discharge to Medicaid-only bed.

R-1220 Out-of-State Transfers

Revision 12-2; Effective June 1, 2012

If a person from another state declares an intention to live in Texas and meets Texas eligibility requirements, contact the Medicaid agency of the former state of residence. Request that the agency notify HHSC about Medicaid eligibility and the denial, including its effective date. The denial effective date is the last day for which the person's former state of residence will pay Medicaid claims. This is not necessarily the denial effective date on the former state's computer system.

Texas residency is met the first day of the month of move to Texas with the intent to remain in Texas.

If the person did not receive any form of Medicaid in the former state of residence, the earliest MED is the first day of the month of move to Texas, regardless of the actual date of the move. Follow MED policy for month of application and three months prior.

Exception: For QMB, coverage begins the first of the month after eligibility is determined.

If the person did receive Medicaid in the former state of residence, the MED for the person in Texas is no earlier than the day following the date his/her former state of residence will pay Medicaid claims.

If an out-of-state person receives SSI and indicates that he/she intends to live in Texas, refer him/her to a Social Security office. That office makes the SSI (and Medicaid) residence determination.

Examples:

1. A person was not receiving any form of Medicaid in another state, moved to Texas on July 7 and applied to have the Medicare premium paid. The application for Medicare Savings Programs was filed on July 28. The person met all eligibility criteria in July for Specified Low Income Medicare Beneficiaries (SLMB).

   The MED for SLMB is July 1. Prior months would not be applicable in this situation because the person did not reside in Texas before July.
2. A person was not receiving any form of Medicaid in another state, moved to Texas on July 30 and entered a nursing facility (NF) that day. An application for MEPD was filed on Aug. 14. The individual met all eligibility criteria in July for Medicaid and QMB.

   In this situation, July is a prior month. Because coverage for a prior month must begin the first day of that month, the MED is July 1. The MED for QMB in Texas is the first day of the month following the month in which QMB eligibility is determined.
3. A person was receiving Medicaid in another state, moved to Texas on Jan. 15 and entered an NF that day. The application for ME – Nursing Facility was filed on Feb. 10. Medicaid coverage in the other state ended on Jan. 15. The individual met all eligibility criteria in January.

   In this situation, January is a prior month. Because coverage for a prior month must begin the first day of that month, the MED would normally be Jan. 1. If the MED were reported as Jan. 1, there would be federal financial participation (FFP) for two states for the same time period (Jan. 1-15), which is prohibited by federal regulations. Because the correct MED in this case is Jan. 16, the file date must be adjusted to reflect the date following Medicaid closure in the other state, or Jan. 16. Case comments should explain the file date discrepancy.
4. A person was an SSI recipient in another state and moved to Texas on July 7.

   Because the Social Security Administration (SSA) determines SSI entitlement, HHSC uses the effective date in Texas as communicated by the State Data Exchange (SDX) tape. This date should be the first day of the month following the month in which the SSI recipient moves to Texas.
5. A person who was a QMB recipient in another state, moved to Texas on July 7 and applied to have the Medicare premium paid. The application for Medicare Savings Programs was filed on July 28.

   If QMB coverage in the other state ended during July, the effective date of QMB coverage in Texas should be no earlier than Aug. 1. The other state is payer of record for Medicare buy-in for July 1993 and receives FFP for that purpose. Any buy-in attempt by Texas for that month will be rejected by the federal system. Because of the prohibition against dual FFP, QMB eligibility cannot be divided between two states for a given month.
6. The person received ME – Nursing Facility with Q benefits in a Texas NF, but moved out-of-state in April and began receiving Medicaid in the other state. The person returned to a Texas NF on Nov. 15 and applied for MEPD on Nov. 15. The person never received QMB benefits in the other state, although he/she appears to have been eligible since leaving Texas.

The other state will pay no claims after Nov. 15; therefore, the MED for ME – Nursing Facility with may be no earlier than Nov. 16, because November is the month of application. In this situation, there is no continuous Q to ensure. The person did not have QMB coverage in the other state, and HHSC cannot grant QMB coverage for the period of time he/she lived out of state, as he/she was not a Texas resident. The effective date of QMB coverage in Texas is the first day of the month following the month in which QMB eligibility is determined.

R-1230 Qualified Disabled and Working Individuals (QDWI)

Revision 09-4; Effective December 1, 2009

The MED is influenced by whether a person enrolls for Medicare coverage during the initial enrollment period (IEP) but before his/her present Medicare entitlement ends, after the IEP begins but after his entitlement ends, or following the IEP. HHSC considers the date the person enrolled for continuation of his Medicare entitlement when determining the MED. The MED does not precede the earliest date the person is entitled to reinstatement of his/her Part A coverage. Otherwise, use the same procedures for determining the MED for all other MEPD non-institutional groups (including retroactive coverage).

The following chart may be used as a reference for the MED determination policies and examples.

Enrollment Period	Month	Activities
Initial Enrollment Period (IEP)	April May	Client notified his free Part A entitlement will end.
	June	End of client's free entitlement.
	July August September	First month client meets QDWI criteria.
General Enrollment Period (GEP)	January February	QDWI coverage effective July 1.
	March	End of GEP.

The following apply when determining the MED:

- The IEP for a person who has been notified that his free entitlement to Medicare Part A coverage will end is a seven-month period. The enrollment period begins the month the person is notified.

  Example: A person is notified in April that his free entitlement to Part A coverage ends at the end of June. His initial enrollment period begins in the month of notification (April) and ends at the end of October. To reinstate his Part A coverage, he must enroll with SSA before the end of October. He then must apply with the department for QDWI benefits.
- In the case of a person who enrolls in an IEP before meeting QDWI criteria and applies for QDWI benefits, the MED is the first day of the month he meets the QDWI criteria.

  Example: A client is notified in April that her free entitlement to Medicare Part A coverage ends at the end of June. She enrolls for reinstatement of her Part A coverage with SSA in April and applies for and is determined eligible for QDWI benefits with HHSC in May. The earliest MED she can have for QDWI benefits is July 1 because it is the first month she meets QDWI criteria and is allowed to purchase Part A coverage.
- If a person enrolls in the first month that he meets all QDWI criteria except for reinstatement (fourth month of the initial enrollment period), and applies for QDWI benefits, the medical effective date is

effective the first of the following month.

Example: A person is notified in April that his free entitlement to Medicare Part A coverage ends at the end of June. He enrolls for reinstatement of his Part A coverage with SSA in July and applies for and is determined eligible for QDWI benefits in July. The earliest MED date he can have for QDWI benefits is August 1 because that is the first month he is entitled to reinstatement of his Part A coverage.

- If a person enrolls in the second month that she meets all QDWI criteria except for reinstatement (fifth month of the IEP) and applies for QDWI benefits, the medical effective date is effective the second month after enrollment.

  Example: A person is notified in April that her free entitlement to Medicare Part A coverage ends at the end of June. She enrolls for reinstatement of her Part A coverage with SSA in August and applies for and is determined eligible for QDWI benefits in September. The earliest MED she can have for QDWI benefits is October 1 because that is the first month she is entitled to reinstatement of her Part A coverage.
- If a person enrolls in the third or fourth month that he meets all QDWI criteria except for reinstatement (sixth or seventh month of the IEP) and applies for QDWI benefits, the MED is effective the first day of the third month following the month he enrolled.

  Example: A person is notified in April that his free entitlement to Medicare Part A coverage ends at the end of June. He enrolls for reinstatement of his Part A coverage with SSA in September and applies for and is determined eligible for QDWI benefits in October. The earliest MED he can have for QDWI benefits is December 1 because that is the first month he is entitled to reinstatement of his Part A coverage.
- If a person enrolls during the general enrollment period (GEP), the MED is always effective July 1.

  Example: A person is notified in April that her free entitlement to Medicare Part A coverage ends at the end of June. She does not enroll during the IEP and decides to enroll during the GEP, from January through March 31, of the next year. The earliest MED she is allowed is the July 1 following her enrollment.

R-1300, Notices

Body

Revision 21-4; Effective December 1, 2021

When processing an application, redetermination or change, the applicant or recipient, and the authorized represented (AR) must be notified of the eligibility determination and co-payment if applicable.

Mail the written notice to the applicant or recipient, and AR within two business days after the date of the eligibility decision. All information on notices must be accurate.

For Eligibility:

On the eligibility notice, include the MED and any co-payment amount.

Note: For Mason Manor cases, see Appendix XXIII, Procedure for Designated Vendor Number to Withhold Vendor Payment, for the appropriate forms and explanation to send.

For Ineligibility:

On the ineligibility notice, explain the reason for the decision and the appropriate chapter of this handbook that supports the decision.

See below for more information on each notice and its purpose:

Form H0090-I, Notice of Admission, Departure, Readmission or Death of an Applicant/Recipient of Supplemental Security Income and/or Medical Assistance Only in a State Institution

Provides notice to the state institution of the:

- action taken on the application; and
- amount of income available to be applied to the vendor rate for the applicant or recipient's maintenance, support and treatment.

Form H1226, Transfer of Assets/Undue Hardship Notification

Provides advance notice to applicants and recipients who have transferred assets for less than the fair market value or who have home equity that exceeds the limit. The form notifies the person of the:

- amount of the uncompensated transfer and the length of the penalty period;
- possible effect of the transfer of assets on Medicaid services or eligibility;
- possible effect of excess home equity on Medicaid services or eligibility;
- process for claiming undue hardship; and
- opportunity to provide more information about the transfer that may reduce the penalty period.

Send the form within three business days of determining the uncompensated value of any assets transferred for less than the fair market value or excess home equity, if unable to notify the person verbally within the three-day period.

Form TF0001, Notice of Case Action

Notifies a person of:

- eligibility;
- ineligibility;
- copayment amount (if applicable); and
- right to appeal.

If benefits have been approved, the notice informs the person of:

- the date benefits begin (Medicaid effective date); and
- the amount of benefits.

If benefits have been denied, terminated or reduced, the notice informs the person of:

- the reason for denial;
- the effective date of the action;
- the person's right to appeal;
- the address and phone number of free legal services available in the area; and
- that information from a credit report was used, if the information resulted in denial or termination of benefits.

The following forms must also be sent at initial certifications with the eligibility notice Form TF0001:

- HIPAA — Notice of Privacy Practices;
- Form 8001, Medicaid Estate Recovery Program Receipt Acknowledgement.
- Form H1019, Report of Change (with a prepaid envelope); and
- Form H1204, Long Term Care Options

Form H1247, Notice of Delay in Certification

Provides notice to an applicant or recipient and a facility administrator of a delay in certification and the right to appeal.

Form H1259, Correction of Applied Income

Provides notice to an institutionalized applicant or recipient of retroactive changes in their co-payment. Includes the following information:

- the calendar months involved;
- the adjusted co-payment amount for each month, based on a comparison of projected variable income or incurred medical expenses with actual variable income or incurred medical expenses received;
- totals for the projection period of the amount the facility owes the applicant or recipient and the amount the applicant or recipient owes the facility; and
- the right to appeal.

Form H1274, Medicaid Eligibility Resource Assessment Notification

Provides notice of a couple's protected resource amount.

Form H1277, Notice of Opportunity to Designate Funds for Burial

Provides notice to applicants or recipients with excess resources that they can designate liquid resources as burial funds and have up to $1,500 in burial funds excluded from the eligibility determination.

Send Form H1277 to the applicant or recipient before denying for excess resources.

Form H1279, Spousal Impoverishment Notification

For spousal impoverishment applications, Form H1279 provides notice to the applicant or recipient of the initial eligibility period and the following:

- At the end of the initial eligibility period, only the resources in the name of the institutionalized spouse will be tested against the resource limit.
- Interspousal transfers are permitted.
- A transfer-of-assets penalty may be incurred if resources are transferred to anyone other than the spouse.

MEPD Communication Tool

Provides notice of a financial eligibility determination on a referral for Community Attendant Services (CAS) or waiver services.

Provide the following:

- financial eligibility determination from MEPD or Texas Works eligibility staff;
- information requested on a pending application or ongoing case;
- case information not involving an eligibility determination such as a change in address or the authorized representative; and
- changes in co-payment.

Send to the:

- Community Care Services Eligibility (CCSE) case manager for CAS cases; or
- HHSC Program Support Unit (PSU) for waiver cases. Include the co-payment amount, if applicable.

Granted Applications and Redeterminations

Community Programs	Notice(s) Sent
ME-Pickle, ME-SSI Prior, ME-Disabled Adult Child, ME-Early Aged Widow(er), MC-QMB, MC-SLMB, MC-QI-1, MC-QDWI, ME-A and D-Emergency	Form TF0001
ME-Community Attendant	MEPD Communication Tool
ME-Community Attendant with MC-QMB or MC-SLMB	Form TF0001 and the MEPD Communication Tool
ME-Medicaid Buy-In (MBI)	Form H0053, Medicaid Buy-In Potential Eligibility Notice, must include each eligible month listed in reverse chronological order, each premium amount, total of all premium amount(s) and premium due date.

Institutional Programs	Notice(s) Sent
ME-Nursing Facility, ME-Non-State Group Home (ICF/IID), ME-State School (State Supported Living Center)	Form TF0001, Form TF0001P to facility
Changes in Co-Pay Amount (Raised or Lowered)	Form TF0001, Form TF0001P to facility

Waiver Programs	Notice(s) Sent
ME-Waivers (SPW, MDCP, CLASS, HCS, DBMD)	Form TF0001 and MEPD Communication Tool (must include co-pay information on this form)
ME-Waivers with MC-QMB or MC-SLMB	Form TF0001 and MEPD Communication Tool (must include co-pay information on this form)

Denied Applications and Redeterminations

Community Programs	Notice(s) Sent
ME-Pickle, ME-SSI Prior, ME-Disabled Adult Child, ME-Early Aged Widow(er), ME-Disabled Widow(er), MC-QMB, MC-SLMB, MC-QI-1, MC-QDWI, ME-A and D-Emergency	Form TF0001
ME-Community Attendant	Form TF0001 and MEPD Communication Tool

Institutional Programs	Notice(s) Sent
ME-Nursing Facility, ME-Non-State Group Home (ICF/IID), ME-State School (State Supported Living Center)	Form TF0001, Form TF0001P to facility

Waiver Programs	Notice(s) Sent
ME-Waivers (SPW, MDCP, CLASS, HCS, DBMD)	Form TF0001 and MEPD Communication Tool

Medicaid Buy-In	Notice(s) Sent
ME-Medicaid Buy-In (MBI)	Form TF0001. **Note:** Staff must confirm the Form TF0001 includes the correct MBI denial reason. If the incorrect reason is listed, manually add the correct reason for denial in the comments section before generating the Form TF0001.

Changes

Institutional Programs	Notice(s) Sent
Changes in Co-Pay Amount (Raised or Lowered)	Form TF0001, TF0001P to facility
Anytime reconciliation is done	Include Form H1259

Note: Ensure all notices generated outside of TIERS are imaged for the case record. If generated in TIERS, correspondence history will retain the notice(s) and date generated.

R-2000, Other Actions and Notifications

R-2100, Persons Discharged to Hospitals from Institutional Settings

Body

Revision 09-4; Effective December 1, 2009

When a recipient in a long-term care facility is discharged to a Medicaid-certified hospital, the recipient continues to be eligible during his/her absence. Redetermine eligibility if the recipient does not re-enter the nursing facility after discharge from the hospital.

To monitor a recipient in a nursing facility who is discharged to a hospital, use a tracking system. This ensures prompt awareness of a change in the recipient's status, such as death or a return to the community after he/she is discharged to a hospital.

The following procedures are recommended for establishing a tracking system:

- Immediately upon receipt of Form 3618, Resident Transaction Notice, showing discharge to a hospital, establish a control record for the recipient. Use Form 3618 as the control record or prepare a card file record. The control file may be maintained separately by each eligibility specialist or centrally for all eligibility specialists in an office.
- At least every 15 calendar days, confirm the recipient's status and location. Contact the nursing facility first because the recipient may have been readmitted. If he/she has not returned to the facility, the facility may supply the name of the hospital or the authorized representative to determine if the recipient is still a patient. Follow up with the hospital or authorized representative every 15 days until the recipient returns to the nursing facility, is discharged to another living arrangement or dies.
- If the recipient is no longer in the hospital, remove the control record from the file and take action to update the case, if required.

R-2200, Reserved for Future Use

Body

Revision 12-2; Effective June 1, 2012

R-2300, Your Texas Benefits Medicaid Card

Body

Revision 19-4; Effective December 1, 2019

When a person is certified for ongoing Medicaid benefits, a Your Texas Benefits Medicaid card is mailed, which should:

- be carried and protected like a driver license or credit card; and
- used when visiting a Medicaid provider (i.e., doctor, dentist, or pharmacy).

The Your Texas Benefits Medicaid card is plastic, like a driver's license or credit card, and includes the following information printed on the front:

- person's name and Medicaid ID number;
- managed care program name (if STAR Health);
- date the card was issued; and
- billing information for pharmacies.

The back of the card includes the statewide toll-free phone number where people can get more information on the Your Texas Benefits Medicaid card.

Each person certified for Medicaid in a household receives a Your Texas Benefits Medicaid card. It is intended to be the person's permanent card.

If a person loses:

- Medicaid coverage but later regains coverage, the person can use the same Your Texas Benefits Medicaid card.
- Their Your Texas Benefits Medicaid card, they can request a replacement:
  - By logging onto their YourTexasBenefits.com account;
  - Calling 2-1-1 (after selecting language, select Option 2, and then Option 1); or
  - Calling 855-827-3748.

If the person forgets their Your Texas Benefits Medicaid card, a provider (i.e., doctor, dentist or pharmacy can) verify Medicaid coverage by:

- calling the Texas Medicaid and Healthcare Partnership's (TMHP) Contact Center at **800-925-9126;** or
- visiting Texas Medicaid and Healthcare Partnership's (TMHP's) TexMedConnect website using the person's Medicaid ID number or one of the following combinations for the person:
  - Social Security Number (SSN) and last name;
  - SSN and date of birth (DOB); or
  - last name, first name, and DOB.

If a person needs quick proof of eligibility they can:

- log in to their www.YourTexasBenefits.com account to print a temporary card; or
- go to a local benefits office to request a card. Staff in the office will:
  - assist the person in accessing and printing a Medicaid card from the person's www.YourTexasBenefits.com account from the office's lobby computer; or
  - generate a temporary Form H1027, Medicaid Eligibility Verification via TIERS if the person prefers not to or has trouble accessing their Medicaid card online.

A Your Texas Benefits Medicaid card is not issued for residents of a state supported living center because Medicaid state institutions are responsible for all medical care for Medicaid-eligible residents. Each state institution is sent a monthly listing of all Medicaid individuals currently shown on computer files as living in that facility.

Note: A Your Texas Benefits Medicaid card is not issued to Community Attendant Services (CAS) recipients. A person with CAS receives a Your Texas Benefits Medicaid card only if they are also eligible for the Qualified Medicare Beneficiary Program (QMB). No other Medicare Savings Program (MSP) generates a Medicaid card.

Related Policy

Issuance of Form H1027, Medicaid Eligibility Verification, R-2400

R-2400, Issuance of Form H1027, Medicaid Eligibility Verification

Body

Revision 16-3; Effective September 1, 2016

Occasionally, a recipient who needs medical services may lack current medical care identification.

HHSC may issue a Medicaid verification letter to an eligible Medicaid recipient who lacks a Your Texas Benefits Medicaid ID card if the:

- recipient is newly certified and has not received the initial card; or
- current card has been lost or destroyed.

Note: Do not issue Form H1027 to Community Attendant Services, SLMB or QDWI individuals (ME-Community Attendant with no QMB, MC-SLMB and MC-QDWI).

Form H1027 is issued in three versions. Issuance of the appropriate version of Form H1027 is dependent on the benefits the recipient is currently eligible for and receiving. Following is a brief description of each version of Form H1027.

Form H1027-A, Medicaid Eligibility Verification, is issued to recipients who are eligible for and receiving Medicaid benefits only.

Form H1027-B, Medicaid Eligibility Verification – MQMB, is issued to recipients who are eligible for and receiving both Medicaid and Qualified Medicare Beneficiary (QMB) benefits.

Form H1027-C, Medicaid Eligibility Verification – QMB, is issued to recipients who are eligible for and receiving QMB benefits only. Do not issue Form H1027-C to recipients who are receiving Medicaid benefits.

Reference: For additional information regarding client eligibility for QMB, see Chapter Q, Medicare Savings Programs.

Reminder: To ensure that the appropriate form is issued to an eligible person, only intake screeners and TANF, Medicaid, LTC (ME/CCAD), foster care or adoption assistance eligibility specialists and supervisors are authorized to complete the form.

Form H1027-A, Form H1027-B or Form H1027-C must be issued only to eligible persons who need verification of their current eligibility for benefits and who have no access to a current Your Texas Benefits Medicaid ID card. The forms are issued only for the current month and never for retroactive periods of eligibility.

Verify a recipient's current eligibility by:

- contacting Data Integrity; or
- checking inquiry in TIERS.

Note: If unable to verify the recipient's eligibility because of computer problems, follow regional procedures to verify eligibility.

After verifying eligibility, complete the appropriate Form H1027.

After completing the appropriate Form H1027, have the form approved, signed and dated by the unit supervisor. The supervisor may also approve the form by telephone. If obtaining the supervisor's approval by telephone,

note "by telephone" on the approval line. If the unit supervisor is not available, the lead eligibility specialist in the locality may approve the form.

Reference: For additional information about issuing Form H1027, refer to the instructions. See Chapter B, Applications and Redeterminations, for emergency manual certification procedures.

R-2500, Explanation of Benefits

Body

Revision 12-2; Effective June 1, 2012

Form H3086, Explanation of Benefits (EOB), is mailed each month to a random sample of Medicaid recipients. The EOB is a statement of all Medicaid services that were billed and paid on the recipient's behalf in the preceding month.

The EOB is mailed with a return envelope. If a recipient has a question about reported Medicaid services, the recipient circles the service in question, enters a contact telephone number and returns the EOB to state office. The recipient can call 1-800-252-8263 if questions arise about the EOB information.

If a recipient contacts HHSC about a questionable EOB, explain the purpose of the EOB. If a question still exists, instruct the recipient to mail the EOB to:

Office of Inspector General/Medicaid Provider Integrity
Mail Code 1361
P.O. Box 82500
Austin, TX 78708-9920

If the EOB is readily available, record on the EOB the recipient statement about the discrepancy. (**Example:** "Client states she has never seen a Dr. Jones.")

After an EOB is returned to state office, the EOB analyst checks the service in question for possible billing errors. If a billing error is found, appropriate action is taken to correct the files. The EOB analyst notifies the recipient that correction has been made. If no billing error can be found, the EOB is referred to the appropriate local office for a contact with the recipient.

When an EOB from state office is received, attempt to contact the recipient and discuss the reason for returning the EOB. The contact may be by telephone, office visit or home visit. Do not contact the provider of service under any circumstance.

If the recipient did not understand the purpose of the EOB, or if the problem can be resolved by talking to him/her, check the appropriate box on the EOB-Form Letter (FL) 1 and return the EOB-FL 1 and EOB to state office.

If the recipient alleges that the service in question was not received, reports an additional charge or reports other problems in relation to the service questions, check the appropriate box, record the recipient's statement in the space provided on the EOB-FL 1 and return the EOB-FL 1 and EOB to state office. (A cover memorandum is not necessary.) After the EOB is returned to state office, the EOB is referred to the Texas Medicaid and Healthcare Partnership (TMHP) for further investigation, and no further action on the part of the eligibility specialist is required.

If a provider of services has questions about an EOB, explain the purpose of the EOB. If additional information is requested, or a service listed is in question, ask the provider to telephone TMHP using the provider contact information below:

- Automated Inquiry System (AIS) – 1-800-925-9126
- TMHP Contact Center – 1-800-925-9126

Reminder: Only services billed and paid appear on the monthly EOB.

R-2600, Reserved for Future Use

Body

Revision 14-1; Effective March 1, 2014

R-2700, Notification of Pre-Screening Result for Medicaid

Body

Revision 12-2; Effective June 1, 2012

Occasionally, for purposes of receiving assistance from drug companies or other private entities, a person will request a pre-screening for Medicaid in conjunction with a request for a letter to substantiate the results of the pre-screening.

Form H1035, Pre-Screening Result for Medicaid, is used to notify an interested person of the pre-screening results for Medicaid if:

- the notice is requested by the person;
- the pre-screening is based on a verbal conversation;
- an official determination of eligibility is not conducted; and
- the person does not appear eligible for Medicaid.

R-3000, Automated Systems

R-3100, Establish Processing Deadlines

Body

Revision 12-2; Effective June 1, 2012

When taking an application, designated staff complete Application Registration. Applications are tracked using TIERS and Data Mart reports.

When the application is for a person who is younger than 65 and has never had a disability determination, the eligibility specialist must pend for Disability on the Disability – Details page and run Eligibility Determination and Benefit Calculation (EDBC) to override the application due date default of 45 days. The application due date will be 90 days from the file date. If the application is not pended appropriately, the application will be delinquent in 45 days.

Sometimes an application cannot be certified before the 45th/90th day. In these cases complete Form H1215, Report of Delay in Certification, and submit the form for approval. Once approval for the delay is received, send Form H1247, Notice of Delay in Certification, to the applicant and the facility administrator. Enter appropriate information in TIERS to initiate the delay in certification.

Note: Do not send Form H1247 if certification is delayed because Home and Community-Based Services waiver services are pending. No notification is required for those cases because services have not yet begun.

Applications for which delay-in-certification procedures have been followed are excluded from the delinquent count in timeliness reports. However, the exclusion is only for a specific period of time, as follows:

- Applications for persons age 65 or older are excluded for 135 days (45 + 90-day extension); however, if the application is still pending on the 136th day, it will be counted as delinquent.
- Applications for persons under age 65 who have never had a disability determination are excluded for 180 days (90 days + 90-day extension); however, if the application is still pending on the 181st day, it will be counted as delinquent.

Applications that cannot be certified within the normal 45/90-day limit, plus the 90-day extension, must be denied. A new application will be necessary to reconsider eligibility.

TIERS Delay Reasons Drop-down

- 30-day consecutive requirement not met
- Medical necessity decision is pending
- Level of care decision is pending
- Disability determination pending
- Home and Community-Based Services waiver services pending
- Nursing facility pending certification
- New resource/information received after 30th day
- Resource spend-down
- Miscellaneous
- CC Pending
- Documentation of citizenship and identity
- Legal review of documents

R-3200, Case Number

Body

Revision 12-2; Effective June 1, 2012

When an application for assistance is entered into the system for the first time a unique 10-digit application number is assigned. The application number begins with the letter T. The letter T changes to the number one when the application moves to Data Collection and becomes a case. The case number is unique to that household. The household members may consist of more than one individual on more than one HHSC programs including Texas Works as well as MEPD programs.

If a certified member of the household leaves the household and establishes a new household, a new case is created and a new case number is assigned for the member who left the original household.

R-3210 Association of Case Number

Revision 12-2; Effective June 1, 2012

When a former recipient reapplies for assistance during File Clearance, determine if the individual should be associated to a former case number. This includes associating a former case number to a person who applies for

ME – A and D-Emergency.

R-3300, Client/Individual Number

Body

Revision 12-2; Effective June 1, 2012

The first time a person is certified by HHSC, a unique client/individual number is automatically assigned by state office. Once assigned, the number must be used by all program areas. The client/individual number is used in the system to locate identification information, certain types of income, Medicaid coverage and the numbers for all Edges in which the person appears.

Individuals certified under the legacy system (SAVERR) had their client numbers changed to nine-digit individual numbers at TIERS conversion.

R-3310 Association of Client/Individual Number

Revision 12-2; Effective June 1, 2012

During application registration, a procedure called File Clearance is performed on each individual that is recorded on the Individual Logical Unit of Work (LUW).

File Clearance is a process that compares the demographic information for an applicant (SSN, name, date of birth, gender and so on) against information in the Master Client Index (MCI). The MCI is a database containing information on all individuals known to the agency. **Known to the agency** means the individual has been on an application or case in either TIERS or the SAVERR legacy system.

File Clearance identifies and displays individuals whose information may match the application individual. If a match occurs, staff must investigate the matches to determine whether the applicant is in fact one of these people, or is a person completely new to the agency. The purpose of this process is to avoid duplicate individual information and duplicate cases or applications by reassigning the existing client/individual number.

Note: TIERS scores a match at 100% only when the first name, last name, SSN, DOB and gender are provided and that information matches an existing individual. Many instances exist where no Social Security number is available, and it sometimes is not required; therefore, staff should not assume the person is new to the system when the score is not a 100% match. Staff must be sure the person is new to the system before creating a new client/individual number and avoid creating multiple client/individual numbers for the same person.

When an individual is a match for an applicant, staff have various options that depend on whether the need is to match the application to an entire case or only to selected individuals. Associate the application to an existing TIERS case or application, or add TIERS individuals from an existing case to the new application.

R-3400, Merge and Separate Client/Individual Numbers

Body

Revision 12-2; Effective June 1, 2012

Situations may arise when a person is erroneously assigned more than one client/individual number or when two or more people are assigned the same client/individual number. Eligibility specialists must resolve the situation

by requesting the client/individual numbers be merged or separated, depending on the situation.

Staff use the TIERS functional area on the left navigation bar named **Merge/Separate** to request a merge or separate and the following procedures.

Merge

Use **Request Merge** when more than one Individual number has been assigned to a single person.

- Enter a minimum of two, up to 10 Individual numbers to be merged and enter the mandatory comments explaining the reason for the merge request.
- Upon entry of the Individual number in the **Individual number** field and clicking on the **Add** button, the demographic information associated with that Individual number will be displayed in the **Selected Individuals** section. If it is not the correct person, delete the entry using the delete icon or use the binoculars icon to search for the individual using demographic data. This is similar to the individual search in **Inquiry**.
- Once all of the Individual numbers and mandatory comments are entered, click the **Submit** button to send the request to Data Integrity.

Separate

Use **Request Separate** when more than one person is assigned to a single Individual number.

- Enter one **Shared Individual number** and up to three Individual numbers to be separated. Enter mandatory comments explaining the reason for the separate request.
- Upon entry of the Individual number in the **Shared Individual number** field **or** demographic information and clicking on the **Add** button, the demographic information associated with that Individual number will be displayed in the **Selected Shared Individuals** and **Shared ID above is to be separated to these individuals** sections if it is not the correct person. Delete that entry using the delete icon or use the binoculars icon to search for the individual using demographic data, similar to the individual search in **Inquiry**.
- Once all of the Individual numbers and mandatory comments are entered, click the **Submit** button to send the request to Data Integrity.

When the eligibility specialist enters an Individual number that already exists on a merge or separate request, it cannot be requested again and a validation message will be displayed. When TIERS displays a validation message, staff must either correct the information, if entered incorrectly, or use **Search Merge/Separate** to determine if the Individual number(s) on the request are associated with the same Individual number.

Tracking Progress

Use **Search Merge/Separate** to track the progress of the request. Some requests will take longer than others. This may occur when the Individual received MEPD coverage in addition to the Texas Works benefits they receive in TIERS. These requests are placed on hold until the request can be processed in TIERS.

Data Integrity staff can mark an Individual number as a potential duplicate (PD) when a merge or separate request is made. Staff cannot select an Individual number for addition to new cases if it is marked as **PD,** which limits the potential for the wrong Individual number to be awarded benefits or coverage in error.

Questions about a merge or separate request should be sent to the Data Integrity mailbox at tiers_statepaidmedicaid@hhsc.state.tx.us

R-3500, Information Maintained in Automated System

Body

Revision 12-2; Effective June 1, 2012

When a person is certified for assistance, the following information is kept electronically:

- Identification data
- Client/Individual number
- Name
- Birth date
- Sex
- Race
- Social Security account number
- Social Security claim number
- Client Residence County Code

The county related to the person's home address is used. For residents of a long-term care facility, record the county for the facility address. The person's residence county should be updated whenever there is a change of address involving a new county. This entry is used to identify a person who is eligible or required to enroll in managed care. It is also used by the Service Authorization System Online (SASO).

R-3600, Reserved for Future Use

Body

Revision 12-2; Effective June 1, 2012

R-3700, Automated Verification Systems

Body

Revision 12-2; Effective June 1, 2012

Through interagency agreements, several automated verification systems have become available to staff. This has allowed staff to obtain necessary verifications in a more efficient and timely manner. All systems require specific password permission for access.

R-3710 Automated Status Verification Index

Revision 12-2; Effective June 1, 2012

The Automated Status Verification Index (ASVI) is a Department of Homeland Security (DHS) online system used to verify immigration status of non-citizens applying for benefits. The system is accessed through UNISCOPE EMULATION. Information is obtained using the individual's Alien Registration Number. Result response time is generally immediate.

If the Alien Registration Number is found by the system, the following information will be displayed:

- Alien number
- Last name
- First name

- Middle name
- Date of birth
- Country of birth
- Alternate ID
- Social Security number
- Date of entry
- USCIS (formerly INS) status
- Verification number

Residency status is reported with one of the following messages:

- Lawful Permanent Resident/Employment Authorized
- Institute Secondary Verification
- Temporary Resident/Temporary Employment Authorized

Refer to Section D-8000, Alien Status, for additional policy and verification information.

A user guide, ASVI/SAVE System, contains detailed information regarding access and data interpretation. The guides are available through unit supervisors.

R-3720 Reserved for Future Use

Revision 20-2; Effective June 1, 2020

R-3730 State Online Query/Wire Third Party Query

Revision 12-2; Effective June 1, 2012

State Online Query (SOLQ) is a Social Security Administration (SSA) automated system used to verify Social Security and Supplemental Security Income (SSI) benefits. The system is Windows-based. It uses the individual's name, Social Security number (SSN) or Social Security claim number (SSCN) and date of birth to identify and provide the appropriate records. When an inquiry match occurs, the response provides all available benefit information attributable to a particular claim number. SOLQ responses are not to be printed. SOLQ responses provide current information and are available immediately after request in the system.

If the individual has entitlement under more than one SSCN, those numbers will be identified. You must submit separate inquiries to obtain data related to those claims.

Information includes:

- Standard Response — individual name, date of birth, verified SSN and error messages regarding any discrepancies between inquiry and response match.
- Title II (RSDI) — individual demographics, enrollment in Medicare Part A and/or Part B, supplementary medical income benefits (SMIB) premium deduction, benefit amounts and dates, unearned income, disability onset dates, etc.
- Title XVI (SSI) — individual demographics, Medicaid, SSI payment history, benefit amount, payment status code, resource and earned income leads, etc.

Note: The SOLQ system is available only in TIERS. The response only includes information for individuals in TIERS.

If more detailed information is needed, it is recommended to request a WTPY.

Wire Third Party Query (WTPY) is an SSA automated overnight batch process system used to verify Social Security and SSI benefits. Information is obtained using the person's name, SSN or SSCN, and date of birth. Response is usually received on the next business day following transmittal of the inquiry, provided the request is transmitted by 2:30 p.m. If the request is transmitted after that time, the response will be delayed one day.

If an inquiry match occurs, the response will provide all available benefit information attributable to a particular claim number. If a person has entitlement under more than one SSCN, those numbers will be identified. Separate inquiries are not necessary. The programming logic within the WTPY system will do an automated request within three business days on the newly discovered SSCNs. Staff do not have to create additional requests to obtain data related to those claims.

Information will include:

- Standard Response — Name, date of birth, verified SSN and error messages regarding any discrepancies between inquiry and response match.
- Title II (RSDI) — Demographics, enrollment in Medicare Part A and/or Part B, SMIB premium deduction, benefit amounts and dates, unearned income, disability onset dates, etc.
- Title XVI (SSI) — Demographics, Medicaid, SSI payment history, benefit amount, payment status code, resource and earned income leads, etc.
- 40 Quarters — Used for legal permanent residents, their spouses or parents. Response will provide employment history, identify the qualifying quarters and give the type income received during that period. **Note:** Response time for this data is within two days of transmittal (rather than one day as with other WTPY information).
- Citizenship Verification — Effective Feb. 1, 2011. WTPY makes citizenship verification available, and is available for use by HHSC to verify citizenship for Texas Works and MEPD applicants.

The Wire Third Party Query User Guide contains detailed information regarding data interpretation. The 40 Quarters Operations Guide and 40 Quarters Response contain information outlining inquiry and response interpretation of 40 Quarters data.

Reminder: Federal tax information is provided through SOLQ and WTPY. Federal tax information is confidential. It is not to be shared with unauthorized individuals. SOLQ and WTPY responses should not be printed.

R-3740 Asset Verification System (AVS)

Revision 18-2; Effective June 1, 2018

The Asset Verification System (AVS) is an automated system used to request information from banking institutions on people applying for certain MEPD programs. The AVS is available through the Data Broker system and is accessed through TIERS. Use a person’s name and Social Security number to identify and provide information on the appropriate financial records.

AVS information must be requested for the following MEPD programs at application, renewal, add a person, and program transfer requests only when consent is provided:

- State Group Home (TA 12 ME);

- State Supported Living Center (TP 10 ME);
- Non-State Group Home (TP 15 ME);
- State Hospital (TP 16 ME);
- Nursing Facility (TP 17 ME);
- Waiver Program (TA 10 ME);
- Program of All-Inclusive Care for the Elderly (PACE) (TA 10 ME);
- Pickle (TP 03 ME);
- Disabled Adult Child (TP 18 ME);
- Disabled Widow(er) (TP 21 ME);
- Early Aged Widow(er) (TP 22 ME); and
- Medicaid Buy-In (MBI) Program (TP 87 ME).

R-3741 AVS Consent

Revision 18-2; Effective June 1, 2018

Consent to access AVS is required for a person whose assets are considered in the eligibility determination for AVS applicable MEPD Programs. Individuals who must provide consent are:

- the applicant or recipient (or the individual's legal guardian, power of attorney, or authorized representative);
- parents whose resources are deemed to a minor child;
- a spouse whose resources are deemed to the applicant or recipient; or
- the community spouse for spousal impoverishment cases.

A person provides consent by submitting a signed application or renewal form that contains the asset verification consent language. If the application or renewal form does not contain the AVC language, or does not contain the signature of the person whose assets are considered in the eligibility determination, staff must pend for a signed Form H0003, Agreement to Release Your Facts. Only request AVS information for someone who has provided consent.

Deny an applicant or recipient if consent is not provided from all people whose assets are considered in the eligibility determination or if a written request to revoke consent to access AVS is received. Do not run AVS if consent is not provided or after a request to revoke consent is received.

R-3742 AVS Requests

Revision 18-2; Effective June 1, 2018

When consent is provided, run the determination to process eligibility but do not dispose the case.

- If all eligibility requirements are met, initiate the AVS request.
- If a person does not meet all eligibility requirements, do not initiate the AVS request; process the denial.

For initial applications, request 60-months of AVS information. For reapplications, annual redeterminations, and program transfers, request AVS information only for the months between the last AVS response and the current transaction. If AVS was not previously requested, request 60-months of AVS information.

R-3743 AVS Responses

Revision 18-2; Effective June 1, 2018

AVS responses provide information on both disclosed and undisclosed financial accounts.

Initial AVS responses are received immediately and include information from the major banking institutions.

In addition to the immediate initial responses, Data Broker will also provide enhanced AVS responses when financial information is identified for additional banking institutions not included in the immediate AVS response. The enhanced AVS response is available on the Data Broker report a minimum of 15 days after the initial AVS request. Do not delay disposing the case when an enhanced AVS response is pending if all other information needed to make an eligibility determination is provided. Regardless of when the agency receives an enhanced AVS response, the response is treated as an agency reported change.

R-3744 Consideration of AVS Information

Revision 18-2; Effective June 1, 2018

Determine eligibility based on the AVS response received via Data Broker.

For both immediate and enhanced AVS responses, if the AVS information is consistent with the client-provided information, complete the eligibility determination.

If the AVS information is new or inconsistent, but does not affect eligibility, do not pend for verification. Enter the new information in TIERS and complete the eligibility determination.

If the AVS information is new or inconsistent and the applicant or recipient is potentially ineligible, pend the case and request verification from the applicant or recipient before completing the eligibility determination.

If the applicant or recipient fails to provide verification of new or inconsistent AVS information, enter the AVS information in the case and deny the case using the appropriate AVS denial reason code.

R-3800, Data Broker

Body

Revision 20-2; Effective June 1, 2020

HHSC contracts with a Data Broker vendor to provide financial and other background information about applicants and recipients applying for both Texas Works and MEPD programs. The vendor collects and combines information from several data sources into one report. This report is called a Data Broker Combined Report.

Within each Data Broker Combined Report, there is an option to request a credit report on the person for whom the Data Broker report was requested. Federal law limits the use of credit reports.

Note: Credit reports are not requested for MEPD programs.

The Data Broker Combined Report includes information from several data sources such as:

- Department of Public Safety (DPS)

- United States Citizenship and Immigration Services (USCIS)
- Texas Department of Motor Vehicles (DMV)
- Office of the Attorney General (OAG)
- Texas Workforce Commission (TWC)
- Texas Lottery
- Department of State Health Services (DSHS)
- SNAP Electronic Disqualified Recipient System (EDRS)
- Electronic Benefits Transfer (EBT)
- Texas Department of Criminal Justice (TDCJ)

These agencies provide information on:

- people search information (name, address, driver license/ID and neighbors);
- alien verification;
- vehicle search (name, address, license plate, vehicle identification number and vehicle valuation);
- income search (new hire, quarterly wages and unemployment insurance benefits, child support, current earned income and Texas lottery winnings);
- marriage and divorce; and
- TWC wages/benefits.

Staff must view Data Broker reports to accurately determine eligibility and resolve any discrepancies between Data Broker information and information the applicant or recipient provided. Failure to view the report may result in eligibility errors.

Before beginning denial procedures based on information obtained in a Data Broker report, always:

- make a phone contact and request the information needed to explain the discrepancy and document the results of the phone contact; or
- send a written request for information or proof to resolve the discrepancy.

Refer to the TWH sections C-820-829 for more information about Data Broker and available reports.

Related Policy

Documentation and Verification Guide, MEPD Appendix XVI
Data Broker, TWH C-820

R-4000, Automated Data Exchanges and Tape Matches

Body

Revision 21-3; Effective September 1, 2021

HHSC periodically receives information through a data exchange with the Social Security Administration via electronic files. Some exchanges automatically update data in TIERS, while others provide potentially new income or resource information. The more common exchanges and tape matches are described in the following sections.

R-4100, Beneficiary and Earnings Data Exchange

Body

Revision 12-2; Effective June 1, 2012

The Beneficiary and Earnings Data Exchange (BENDEX) is an automated data information exchange received from SSA. HHSC initiates the process by sending SSA a tape containing a person's identifying information. The BENDEX data is SSA's response. The data exchange is performed twice per month.

BENDEX data matches SSA recipient information against the TIERS information. Data matches include recipient's name, sex, date of birth, Social Security number, Social Security claim number and RSDI amount. Should there be a discrepancy in data, an ALERT will be generated for the individual case in the Task List Manager (TLM) and sent to the eligibility specialist for clearance.

At the time of SSA's annual Cost of Living Adjustment (COLA), HHSC receives a BENDEX that is used to update RSDI amounts on all current cases.

R-4110 Social Security Administration Deceased Individual Report

Revision 12-3; Effective September 1, 2012

The Deceased Individual Report from SSA identifies individuals receiving benefits from both SSA and HHSC who have been reported as deceased to SSA. SSA provides the date of death reported to their agency.

R-4200, State Data Exchange

Body

Revision 12-2; Effective June 1, 2012

The State Data Exchange (SDX) is an automated data information exchange received from SSA. The SDX tape contains all newly certified Texas SSI recipients and current SSI recipients with updated/changed information. HHSC normally receives SDX data five to six times per month, but not necessarily weekly.

SDX data matches SSI recipient information against all case and client information.

R-4210 Contacting Data Integrity

Revision 12-2; Effective June 1, 2012

Incorrect SSI information can be temporarily changed or corrected by the Office of Eligibility Services (OES), Business Services, Data Integrity area. Processing of the next SDX tape with updated information on that person will override temporary information entered by Data Integrity. Permanent corrections or changes must be completed by SSA and will be reflected on subsequent SDX tapes.

Staff can request the Data Integrity area make a temporary correction. Staff must also inform the person of the need to make a permanent correction at the local SSA office. A person should never be told to contact the Data Integrity area directly. Follow local procedures for contacting Data Integrity.

R-4300, Income and Eligibility Verification System

Body

Revision 21-3; Effective September 1, 2021

The Income and Eligibility Verification System (IEVS) was established to conduct data matches as part of the verification process for Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP) and Medicaid programs. IEVS data includes taxable income reported to the Internal Revenue Service (IRS). Income may have been earned through existing resources or generated by the liquidation of a resource. IEVS data also includes unemployment insurance benefits (UIB), wage information from the Texas Workforce Commission (TWC) and self-employment and earned data from the Social Security Administration (SSA).

An annual IRS data match is processed on all active recipients in August or September to obtain data from the last tax year. The system receives quarterly wage data from TWC and the annual self-employment and earned data from SSA. The files are run against the system of record using the Social Security number and first four letters of the recipient's last name. If a match occurs, the Automated System for Office of Inspector General (ASOIG) application will create, assign and distribute an IEVS worksheet to the designated MEPD specialists for review

The Deficit Reduction Act of 1984 and IEVS regulations require state agencies to safeguard the IEVS match data.

Related Policy

Safeguarding Federal Income Data, C-2400
System Generated IEVS Worksheets Legends for IRS Tax Data, Appendix XVII

R-4400, Employees and Teacher Retirement System

Body

Revision 20-1; Effective March 1, 2020

HHSC matches the names of active recipients with the benefits records of the Texas Teachers Retirement System (TRS) and the Employees Retirement System (ERS). The TRS/ERS tape match is conducted quarterly and generates a report with the gross and net income amount and any deductions. TIERS automatically updates the appropriate income record. If unable to update the income record automatically, TIERS creates tasks for staff to verify the income.

Matches are conducted during the first week of the following months:

- March;
- June;
- September; and
- December.

The system will also provide information when ERS/TRS issues a one-time supplemental payment (13th check) for cost-of-living increases or other adjustments of benefits. This one-time payment (13th check) from ERS/TRS is countable income and considered an irregular payment.

The ERS/TRS match is considered acceptable verification. If the information received differs from the information in the case record, TIERS will generate alerts indicating additional action is needed from staff to clear the discrepancy.

To verify income for new applicants, send Form H1297, Request for Information from Teacher Retirement System of Texas, to request verification of the TRS income or Form H1214, Request for Pension Information, to

request verification of ERS income. The form must be annotated to indicate the person is a new applicant.

Related Policy

Documentation and Verification Guide, Appendix XVI
Other Annuities, Pensions and Retirement Plans, E-4400
Infrequent or Irregular Income, E-9000
When to Apply the Infrequent or Irregular Exclusion, E-9300

R-4500, Reserved for Future Use

Body

Revision 20-1; Effective March 1, 2020

R-4600, Public Assistance Reporting Information System

Body

Revision 21-3; Effective September 1, 2021

HHS uses the Public Assistance Reporting Information System (PARIS) data match. This use ensures people enrolled in Medicaid or other public assistance benefits in one state are not receiving duplicate benefits based on simultaneous enrollment in the Medicaid program or other public benefit programs in another state.

The Office of the Inspector General's (OIG's) clearance action on interstate worksheets must have the recipient's residency verified by the verification letter OIG 5079, Request for Verification of Residence.

HHS IEVS staff performing clearance action on PARIS matches related to MEPD Programs use the manual Form H1020, Request for Information or Action, for verification of residence requests.

Selection of "Interstate" allows authorized staff access to PARIS worksheets.

ASOIG allows authorized users to access reports, view and clear worksheets, create referrals, create interstate referrals, view and add comments, search and transfer worksheets, view related worksheets and generate correspondence.

HHS IEVS staff do not print the OIG 5079.

Glossary

Body

Revision 21-4; Effective December 1, 2021

A B C D E F G H I J K L M N O P Q R S T U V W Y

Account holder (owner) — Person who establishes an account for the purpose of paying for the beneficiary's qualified higher education expenses at an eligible educational institution. Any person, including the designated beneficiary, can contribute to an educational savings account. Organizations, such as corporations and trusts, also can contribute to a tuition savings account.

Account transfer — The way in which an applicant's information moves between the Marketplace and the Texas Health and Human Services Commission (HHSC) when applying for medical assistance. The account transfer from the Marketplace to HHSC and from HHSC to the Marketplace will include most of the information the applicant submitted through the Marketplace application and HHSC applications, along with information on any verifications performed by either the Marketplace or HHSC.

Admission Stamp — The U.S. Department of Homeland Security (DHS) places the admission stamp on the alien's passport, on the alien's machine-readable immigrant visa (MRIV) or on an I-94. The stamp shows:

- "DEPARTMENT OF HOMELAND SECURITY U.S. CUSTOMS AND BORDER PROTECTION";
- information about the DHS Customs and Border Protection (CBP) field office with jurisdiction over the port of entry;
- information about the alien's port of entry and date of admission; and
- a four-digit stamp identification number.

The alien's class of admission and the validity date (that is, the date admitted until) are endorsed in ink by the admitting inspector.

Advanced authentication — Personal security questions generated by third-party software to perform authentication of an applicant's identity before granting the person an account through the Self-Service Portal with Case Visibility.

Adverse action — A termination, suspension or reduction of Medicaid eligibility or covered services.

Alien — A person who is not a citizen or national of the U.S.

Alien Category — A category based on the date of the alien status (date of entry) and the alien's classification.

Alien Classification — A classification code on the I-94 or I-551 that identifies the terms and conditions of the person's admission to the U.S.

Alien Sponsor — A person who signed an affidavit of support (USCIS Form I-864 or Form I-864-A) on or after Dec. 19, 1997, agreeing to support an alien as a condition of the alien's entry into the U.S.

> **Note:** Not all aliens must obtain a sponsor before being admitted into the U.S.

Annual review — The process of redetermining a person's continued eligibility for Medicaid.

Appeal — A request for a review of an action or failure to act by HHSC that may result in a fair hearing.

Applicant — A person seeking benefits under MEPD who is not currently receiving MEPD services.

Application for assistance — A form prescribed by HHSC that a person uses to apply for MEPD or to have MEPD eligibility redetermined.

Application Visibility — Type of Self-Service Portal account given to an applicant who has selected not to go through advanced authentication. Those with Application Visibility accounts may only apply for benefits and view and modify applications created under their user name.

Assets — All items a person owns that have monetary value. Assets include both income and resources.

Asylee — An alien already in the U.S. or at a port of entry who is granted asylum in the U.S. Asylum may be granted to non-citizens who are unable or unwilling to return to their countries of nationality, or to seek the protection of those countries, because of persecution or a well-founded fear of persecution.

Authorized representative — For medical programs, a person who is familiar with the applicant and knowledgeable of the applicant's financial affairs and designated by the applicant or recipient to:

- sign an application on the applicant's behalf;
- complete and submit a renewal form;
- receive copies of the applicant's or recipient's notices and other communications from the agency; and
- act on behalf of the applicant or recipient in all other matters with the agency.

Automobile — Includes, passenger cars and other vehicles used to provide necessary transportation.

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BCIS — Bureau of Citizenship and Immigration Services

BENDEX — Beneficiary Data Exchange. Computer tape from the Social Security Administration giving Retirement, Survivors, and Disability Insurance (RSDI) and Medicare information about HHSC's applicants and recipients.

Beneficiary — A designated individual (student or future student) whose qualified higher education expenses are expected to be paid for from a tuition savings program. The designated beneficiary can be changed to another member of the account.

Benefits office — A local HHSC office.

Blind — A person who meets SSI program requirements for blindness, as defined in 42 U.S.C. §1382c(a)(2).

Bona Fide Agent — A person acting responsibly on behalf of a deceased applicant, who is familiar with the applicant, has knowledge of the applicant's financial affairs, and who can, under penalty of perjury, provide information required for an eligibility determination.

Brother — See definition of sibling.

Budget group — A group consisting of members of the family unit whose income is countable in the eligibility determination.

Budgeting — The process of determining a person's financial eligibility for MEPD or for calculating a co-payment.

Burial space — A burial plot, grave site, crypt, mausoleum, urn, casket, niche or other repository customarily and traditionally used for a deceased person's bodily remains. The term also includes necessary and reasonable improvements or additions to these spaces, including vaults, headstones, markers or plaques; burial containers; arrangements for opening and closing the grave site; and contracts for care and maintenance of the grave site. Contracts for care and maintenance are sometimes referred to as endowments or perpetual care.

Business day — Monday through Friday from 8 a.m. to 5 p.m. local time. Business day excludes Saturday, Sunday, and federal, state, or agency-designated holidays.

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CAS — Community Attendant Services.

Case Visibility — Type of YourTexasBenefits.com account access given to an applicant who has been through advanced authentication and therefore granted a Case Visibility level account. With this type of access, people

can view and modify an application created under their user name and any case data for cases in which they are the head of household, an adult member within the household or an authorized representative.

Certification — HHSC's official authorization of approved eligibility.

Child — An unmarried person under 19.

CFR — Code of Federal Regulations.

COLA — Cost of living adjustment.

Common law marriage — Relationship in which the parties 18 or older:

- are free to marry;
- live together; and
- hold out to the public that they are married.

A minor child in Texas is not legally allowed to enter a common law marriage unless the claim of common law marriage began before Sept. 1, 1997.

Note: Same-sex common law marriages are considered valid effective June 26, 2015.

Community spouse — The spouse of an institutionalized spouse who is not living in a setting that provides medical care and services.

Compacts of Free Association (COFA) — Agreements or treaties between the United States and the Federated States of Micronesia (FSM), the Republic of Palau, and the Republic of the Marshall Islands (RMI) which allow citizens of those nations to live and legally work in the U.S. without a visa.

Compact of Free Association Citizens — A permanent nonimmigrant who is residing in the U.S. under the provisions of the Compact of Free Association Act of 1985. Under this act, citizens of the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Palau may enter, reside, and work in the U.S. without restriction.

Conditional Resident Alien — An alien granted a two-year period of permanent resident status based on a “qualifying” marriage to a U.S. citizen or national, or to a permanent resident alien. A conditional resident alien has the same immigration documents as a lawful permanent resident (LPR), except that the I-551 expires after two years.

Co-payment — The amount of personal income a person must pay toward the cost of his or her care. Co-payment was formerly known as applied income.

Cost-share — The amount a person pays out of their own pocket for health care.

Cost-share limit amount — The total amount a family must pay out of its own pocket for the applicant's or recipient's medical care. This amount can change if there is an income change.

Cost-share period — A time period for tracking the cost-share limit. It begins the first day of the disposition month. This period is 12 months and reset every 12 months.

Countable income — The amount of a person's income that is not exempt or excluded.

Countable resource — A resource owned by and accessible to a person that is not exempt or excluded.

Coverage group — A group of people who are categorically eligible for MEPD under the Texas State Plan for Medical Assistance.

Current market value — The amount of money an item would bring if sold in the current local market.

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DAC — Disabled adult child.

Date of application — The date when HHSC receives an application for assistance or when an application for SSI is filed with the Social Security Administration. If an application for assistance is received after the close of business, the date of application is the next working day. See Section B-4000, Date of Application.

DDU — Disability Determination Unit.

Deeming — Counting all or part of the income or resources of another person (for example, a parent or spouse) as income or resources available to an applicant or recipient.

DHS — U.S. Department of Homeland Security. Effective March 1, 2003, DHS absorbed the Immigration and Naturalization Service (INS).

DIC — Dependency and Indemnity Compensation.

Disabled — A person who meets SSI program requirements as defined in 42 U.S.C. §1382c(a)(3).

DRA — Deficit Reduction Act of 2005.

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Earned income — Income a person receives for services performed as an employee or from self-employment.

Earned income tax credit (EITC) — A special tax credit that reduces the federal tax liability of certain low-income working taxpayers.

Eligible sibling — A sibling who is eligible for regular Medicaid. See definition of sibling.

Eligibility determination — A decision made by HHSC concerning a person's initial eligibility for MEPD. This term does not include any functional or other assessment required for some MEPD services, unless the context clearly indicates otherwise.

Eligible educational institution — Generally any college, university, vocational school or other postsecondary educational institution eligible to participate in a student aid program administered by the Department of Education.

Eligibility redetermination — A decision made by HHSC concerning a person's continued eligibility for MEPD. This term does not include any functional or other assessment required for some MEPD services, unless the context clearly indicates otherwise.

Enhanced Life Estate Deeds — A legal document (sometimes known as a Lady Bird Deed) in which one transfers property to their heirs while at the same time retaining a life estate with powers including the right to sell the property in their lifetime.

Since the life estate holder retains the power to sell the property, its value as a resource is its full equity value. If you see a document that appears to transfer property to heirs while retaining a life estate with powers, contact the regional attorney to determine the value of any transfer. The full value of the asset is treated as a countable resource to the individual, unless it is a resource that is otherwise excluded, such as a home to which the individual intends to return.

All Enhanced Life Estate Deeds must be reviewed by the regional attorney.

Equity value — The value of a resource based on its fair market value or current market value minus all money owed on the resources and, if sold, any costs usually associated with the sale.

ESI — Employer-sponsored health insurance. This is health insurance someone gets through their job.

Excluded — Income or resources not counted for the purpose of determining eligibility only.

Exempt — Income or resources not counted for the purpose of determining eligibility or calculating a co-payment.

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Fair hearing — An informal proceeding held before an impartial hearings officer where a person or the person's representative appeals an action taken on the person's case.

Fair market value (FMV) — The current market value of a resource at the time of its sale or transfer.

Family member — An applicant's or recipient's spouse, minor child, adult child, stepchild, adopted child, brother, sister, parent or adoptive parent. A spouse of the applicant's or recipient's minor child, adult child, stepchild, adopted child, brother, sister, parent or adoptive parent.

Family unit — A unit consisting of an applicant or recipient and the applicant's or recipient's parents and siblings who live in the same household as the applicant or recipient.

FBR — Federal benefit rate.

Federal poverty level (FPL) — A guideline for a household's yearly income used to determine eligibility for certain benefit programs. It is published each year by the U.S. Department of Health and Human Services.

FFP — Federal financial participation.

Fiduciary agent — A person or organization acting on behalf of or with the authorization of another person under circumstances that involve a high degree of confidence, good faith and honesty. The term applies to anyone who acts in a financial capacity, whether formal or informal, regardless of title, such as representative payee, guardian or conservator.

Financial Duress — Not having enough funds to meet living expenses because of debts incurred for medical expenses for the institutionalized spouse, community-based spouse or dependent, or because of replacement of a resource lost through theft or acts of God.

Foreign-born Alien — A person born outside the 50 states, District of Columbia, American Samoa, Swains Island, Guam, Northern Mariana Islands, Puerto Rico or the U.S. Virgin Islands.

Fraud — Deliberate misrepresentation or willful withholding of information for the purpose of obtaining public assistance, either for self or another person.

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Good Cause — A term used to indicate that a person has an acceptable reason for not complying with a program requirement.

Green Card — A vernacular term for the Alien Registration Receipt Card (I-551, I-151, AR-3 or AR-3a). The current version of the card is not green.

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Health Insurance Premium Payment Program (HIPP) — A Medicaid program that pays for the cost of medical premiums. The program reimburses recipients or employers for private health insurance payments for Medicaid-eligible persons when it is cost-effective to do so.

HHSC — The Texas Health and Human Services Commission.

HIPAA — Health Insurance Portability and Accountability Act.

Home — A structure in which a person lives (including a mobile home, a houseboat and a motor home), other buildings on the home property and all adjacent land (including land separated by a road, river or stream) in which the person has an ownership interest and that serves as his or her principal place of residence.

Home and Community-Based Services waiver program — A home or community-based service authorized for use in Texas by the Centers for Medicare and Medicaid Services in accordance with Sections §1115 and §1915 of the Social Security Act.

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Illegal Alien (undocumented alien) — A foreign national who entered the U.S. without inspection or with fraudulent documentation or who, after entering legally as a nonimmigrant, violated status and remained in the U.S. without authorization.

Immigrant — A person who abandons residence in a foreign country to live in the U.S as a permanent resident. A lawful permanent resident (LPR) is an example.

Immigrant Visa — A document on security paper, issued by a U.S. consul abroad, that permits a foreign national to apply to DHS for admission into the U.S. as a permanent resident.

Immigration and Naturalization Service (INS) — On March 1, 2003, the former Immigration and Naturalization Service officially became the Bureau of Citizenship and Immigration Services (BCIS), operating under the Department of Homeland Security.

Immigration Reform and Control Act (IRCA) — IRCA of 1986. This is public law (P.L. 99-603) that amended and repealed certain sections of the INA. The IRCA provides for the legalization of certain illegal aliens and updates the registry date that allows DHS to process certain illegal aliens differently.

Immigration Status — The legal status conferred on an alien by immigration laws.

INA — Immigration and Nationality Act.

Income Eligibility Verification System (IEVS) — Computer tape matches required by federal law.

Income — Any item a person receives in cash or in-kind that can be used to meet their need for food or shelter. For purposes of determining MEPD financial eligibility, income includes the receipt of any item that can be applied, either directly or by sale or conversion, to meet the basic needs of food or shelter.

Ineligible sibling — A sibling who is not eligible for regular Medicaid. See definition of sibling.

Inheritance — Cash, other liquid resources, noncash items, or any right in real or personal property received as the result of someone's death. A person may not have access to their inheritance pending legal action or the discovery of the inheritance.

Initial eligibility period — The time from a person's certification date to the person's first annual review.

In-kind — Consisting of something such as food, shelter or replacement of a resource that is not cash.

Institution for mental diseases (IMD) — A hospital, nursing facility or other institutional setting of more than 16 beds. It is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. An IMD includes a state mental health facility operated by the Texas Department of State Health Services.

Institutional care — Long-term nursing care, treatment or services received in a Medicaid-certified long-term care facility.

Institutional setting — A living arrangement in which a person applying for or receiving Medicaid lives in a Medicaid-certified long-term care facility or receives services under a Home and Community-Based Services waiver program. Formerly known as a vendor living arrangement.

Insurance — The following terms apply to the definition of insurance:

- "The insured" means the person named in a life insurance policy whose death affects the proceeds and distribution of the policy.
- "The beneficiary" means the person or entity named in a contract to receive the proceeds of the policy upon the death of the insured.
- "The owner" means the person with the right to change the policy as the person sees fit. The owner is the only person who can receive the cash surrender value of the policy.
- "The insurer" is the company that contracts with the owner.
- "Cash surrender value" means the amount that the insurer pays the owner if the policy is cancelled before death or before it has matured. The cash surrender value usually increases with the age of the policy.
- A "participating life insurance policy" is one in which dividends are distributed to the policyholder.
- "Term life insurance" means life insurance that has no cash, loan or dividend value, nor the potential for cash, loan or dividend value.
- "Dividend" means a share of surplus funds allocated to the policyholders of a participating insurance policy. A dividend generally represents a previous overpayment of premiums.

Intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID) — A Medicaid-certified facility that provides care in a 24-hour specialized residential setting for people with an intellectual disability or related condition. An ICF/IID includes a state supported living center and a state center.

Inter vivos trust — A trust established while the person creating the trust is still living.

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LAPR — Lawfully admitted for permanent residence.

Lawfully Admitted but Not for Permanent Residence — An alien (non-citizen) who is lawfully admitted to the U.S. but not a permanent resident.

Lawful Permanent Resident (LPR) — An alien (non-citizen) who is lawfully authorized to live permanently within the United States.

Note: The Immigration Act of 1990 also grants permanent resident status to alien entrepreneurs who enter the U.S. to engage in a new commercial enterprise and meet certain criteria for investment. These persons must apply for termination of conditional status or the LPR status terminates.

Level of care (LOC) — The type of care required by a Medicaid applicant or recipient based on an assessment of the person's need for care.

Level of care determination — An assessment to determine the appropriate level of care required based on a person's medical or related needs.

Life estate — A right to real property conferred in a legal instrument on a person who is a beneficiary. The right is conferred for the duration of the beneficiary's lifetime or the lifetime of another person. The beneficiary usually has the right to possess, use, and receive profits from the real property during his or her possession.

Liquid resource — Cash or other property that can be converted to cash within 20 working days.

Long-term care facility — A nursing facility, ICF/IID or IMD where medical services are provided.

Look-back period — The time-period HHSC uses to determine if a person transferred, gave away, disposed of or otherwise reduced their countable resources and income without receiving equal value in return and with the intent to qualify for MEPD.

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MAGI — Modified Adjusted Gross Income. The rules used to determine financial eligibility for certain medical programs. These rules are based on Internal Revenue Service tax rules.

Marketplace — The governmental entity that makes qualified health plans available to qualified individuals and/or qualified employers. The Marketplace in Texas is operated by the United States Department of Health and Human Services. Also known as the Exchange, Health Insurance Marketplace, and Federally Facilitated Marketplace (FFM).

Marriage — A legal union between two people recognized under federal law.

Note: Same-sex marriages that occurred before June 26, 2015, are considered valid effective June 26, 2015, and same-sex marriages that occurred on or after June 26, 2015, are considered valid on the date they occurred.

MAO — Medical assistance only.

Medicaid — A state and federal cooperative program, authorized under Title XIX of the Social Security Act (42 U.S.C. §1396 et seq.) and Chapter 32 of the Texas Human Resources Code, that pays for certain medical and health care costs for people who qualify. Also known as the medical assistance program.

Medical care identification card — The Your Texas Benefits Medicaid card is a plastic card with a magnetic strip, like a credit card, that holds the individual's Medicaid ID number and verification of coverage. Also referred to as the Medicaid card.

Medical effective date (MED) — The date a person's Medicaid coverage begins.

Medical necessity (MN) — The determination that a person requires the services of a licensed nurse in an institutional setting to carry out a physician's planned regimen for total care.

Medical services — Services that are directed toward diagnostic, preventive, therapeutic or palliative treatment of a medical condition and that are performed, directed or supervised by a state-licensed health professional.

Medicare — Medical coverage available under Title XVIII of the Social Security Act to people age 65 or older and to certain people with disabilities under age 65.

MEPD — Medicaid for the Elderly and People with Disabilities. A public assistance program providing medical assistance, institutional and community-based health-related care, and Medicare cost-sharing assistance for the elderly and people with disabilities. MEPD does not provide cash assistance. Examples of MEPD services and programs are:

- primary home care services;
- Home and Community-Based Services waiver programs, which provide community-based care as an alternative to institutional care;
- care in a Medicaid-certified long-term care facility;
- the Program of All-Inclusive Care for the Elderly (PACE);
- Medicaid Buy-In programs; and
- Medicare Savings Programs.

MERP — Medicaid Estate Recovery Program.

Mineral rights — Ownership interest in the oil, gas or minerals beneath the surface of a piece of property.

MMMNA — Minimum monthly maintenance needs allowance.

Month of application — The month in which the date of application falls.

MQMB — Medicaid Qualified Medicare Beneficiary.

MSP — Medicare Savings Programs.

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Non-immigrant — An alien temporarily in the U.S. for a specific purpose other than permanent residency. This includes foreign government officials, religious workers, visitors, students and temporary employees.

Non-immigrant Visa — A travel document issued to foreign nationals who wish to enter the U.S. on a temporary basis. Reasons for entry include tourism, business, medical treatment and certain types of temporary work or study.

Non-institutional setting — A living arrangement where a person applying for or receiving Medicaid does not live in a long-term care facility or receive services under a Home and Community-Based Services waiver program. Formerly known as a nonvendor living arrangement.

Nursing facility (NF) — An entity that provides organized and structured nursing care and services, and is subject to licensure under Texas Health and Safety Code, Chapter 242.

A B C D E F G H I J K L M N O P Q R S T U V W Y

OBRA — Omnibus Budget Reconciliation Act (also COBRA, Consolidated Omnibus Budget Reconciliation Act, and SOBRA, Sixth Omnibus Budget Reconciliation Act).

OSS — Office of Social Services

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Parent — A child's natural or adoptive parent or the spouse of the natural or adoptive parent.

Parolee — An alien who appears to be inadmissible to the inspecting DHS officer, but who is legally allowed to enter the U.S. under emergency conditions or when that alien's entry is in the public interest. Although parolees are required to leave when the conditions supporting their parole cease to exist, sometimes they adjust their immigration status to stay in the U.S.

PEI — Protected earned income.

Pension funds — Monies held in a retirement fund under a plan administered by an employer or union, or an individual retirement account (IRA) or Keogh account as described in the Internal Revenue Code.

Permanent Release — Release from a correctional facility such as a jail, prison, reformatory or holding facility when a person is no longer considered to be under the control of that institution.

Personal needs allowance (PNA) — An amount of the recipient's income that a recipient in an institutional setting may retain for personal use.

Preadmission screening and annual resident review (PASARR) — Federally mandated screening for mental illness, intellectual or developmental disabilities (IDD) and related conditions before admission to a nursing facility. Helps determine if placement is appropriate.

Premium — A monthly payment made by a family to HHSC or its designee to buy MBI or MBIC coverage.

Premium processing vendor (PPV) — HHSC's designee that handles premium processing for MBIC.

Primary home care services — Medicaid-funded, in-home attendant services provided to a person with a medical need for specific tasks to delay or prevent the person's need for institutional care.

Principal place of residence — The home where a person resides, occupies and lives.

Provider — A person, group or agency contracted to provide a Medicaid-funded service to a person for a fee.

Public institution — An institution that has 17 or more residents. It is operated or controlled by the federal or state government, or by a political subdivision of a state such as a city or county, including a jail, prison, reformatory or other correctional or holding facility for prisoners or for people pending trial. Examples of public institutions include county jails, city jails, Texas Department of Criminal Justice (TDCJ) facilities or Federal Bureau of Prisons (BOP) facilities.

Publicly Operated Community Residence — A community residence that has 16 or fewer residents. It is operated or controlled by the federal or state government, or a political subdivision of a state such as a city or county designed to serve no more than 16 residents and to provide some services beyond food and shelter, such as social services, training in socialization and life skills. An example of a publicly operated community residence is a county homeless shelter with a capacity of no more than 16 people. Residents of a publicly operated community residence are not considered inmates of a public institution.

A B C D E F G H I J K L M N O P Q R S T U V W Y

QDWI — Qualified disabled working individual.

QI — Qualifying individual.

QIT — Qualifying income trust.

QMB — Qualified Medicare Beneficiary Program.

Qualified higher education expenses — Tuition, fees or expenses for books, supplies and equipment required for the enrollment or attendance of an individual at an eligible educational institution, including the costs of room and board, and any other higher education expenses that may be permitted under Section 529 of the Internal Revenue Code.

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Railroad Retirement (RR) — Retirement and disability benefits for qualified U.S. railroad workers as well as spousal and survivor benefits for qualified family members. Benefits are administered by the Railroad Retirement Board.

Real property — Land and improvements, including buildings and structures. Real property may also include a mine or quarry, standing timber or minerals.

Recipient — A person receiving benefits under MEPD, including a person whose Medicaid eligibility is being redetermined.

Redetermination — See eligibility redetermination.

Refugee — A status granted to a person who is outside their country of nationality and who is unable or unwilling to return to that country because of persecution or a well-founded fear of persecution. Unlike asylees, refugees apply for and receive this status prior to entry into the U.S.

Representative payee — A person or an organization selected to receive benefits on behalf of a recipient, if the recipient is not able to manage or direct the management of benefit payments in their own interest.

Reasonable opportunity — The 95-day period following the date on which a notice is sent to a person to provide another source of citizenship or alien status verification.

Resources — Cash, other liquid assets, or any real or personal property, that a person, spouse or parent, as appropriate:

- owns;
- has the right, authority or power to convert to cash (if not already cash); and
- is not legally restricted from using for his or her support and maintenance.

Restitution — Securing payment from a recipient when fraud is not indicated or pursued and when the recipient's co-payment has been undercharged or a recipient is ineligible because of previously unreported or underreported monthly income or resources.

Retirement, Survivors, and Disability Insurance (RSDI) — Federal benefits provided under Title II of the Social Security Act to workers, their dependents and survivors. Also known as "Old Age, Survivors and Disability Insurance Program" (OASDI).

Retroactive coverage — Payment for Medicaid-reimbursable medical services received up to three months before the month of application. Also known as three months prior.

Review — The process of redetermining a client's continued eligibility for Medicaid.

A B C D E F G H I J K L M N O P Q R S T U V W Y

SASO — Service Authorization System Online.

SAVERR — System for Application, Verification, Eligibility, Referrals and Reports.

Self-Service Portal (SSP) — A web-based application available to applicants and community partners assisting applicants to:

- perform initial self-screening to check for potential eligibility;
- apply for benefits online;
- check application status;
- check benefit and appointment status; and
- view general benefit program information.

Note: This is now referred to as YourTexasBenefits.com.

Severance pay — Payment made by an employer to an employee whose employment is terminated independently of their wishes or payment is made due to voluntary early retirement.

Sibling — A child's unmarried brother or sister (natural, adoptive or step) who is under 18 or under 22, if a student.

Sister — See definition of sibling.

SMIB — Supplemental medical insurance benefits.

SNF — Skilled nursing facility.

Social Security — A federal system of retirement and disability insurance for various categories of employed and dependent persons, funded through dedicated payroll taxes.

Social Security Act — The federal statute that provides the authority for various programs referenced in this chapter, including Medicare and Medicaid. Also see the definition in this section for certain titles in the Social Security Act.

Social Security Administration (SSA) — The federal agency that issues Social Security numbers, administers Social Security benefit programs, and manages the Supplemental Security Income program.

Social service — A service, other than a medical service, intended to assist a person with a physical disability or social disadvantage to function in society on a level comparable to a person who does not have a disability or disadvantage. No in-kind items are expressly identified as social services.

SOLQ/WTPY — State Online Query/Wire Third-Party Query.

Special Agricultural Worker (SAW) — Seasonal agricultural workers residing in the U.S. who qualify for legalization under Section 302 or 303 of IRCA. SAWs are treated as LPRs for Medicaid purposes.

Special income limit — The income limit used to test MEPD eligibility for a person or couple in an institutional setting in accordance with Section 358.433 of this chapter (relating to Special Income Limit). Formerly known as institutional income limit.

Specified Low-Income Medicare Beneficiary (SLMB) — A Medicare Savings Program (MSP) that assists people under a specific federal income limit with paying their Medicare Part B premiums.

Spousal impoverishment — Provision implemented under Section 1924 of the Social Security Act (42 USC Section 1396r-5) designed to prevent the impoverishment of a family, usually a couple, when one spouse needs care in an institutional setting.

Spouse — A person who:

- is married; or
- lives with another person and they represent themselves to the community as married.

Spousal Protected Resource Amount (SPRA) The portion of a couple's combined countable resources reserved for the community spouse and deducted from the couple's combined countable resources in determining eligibility.

SSI federal benefit rate (FBR) — The maximum monthly payment amount for an eligible person in the SSI program.

State center — A facility operated by the Texas Department of State Health Services that HHSC contracts with. It provides services to people with intellectual or developmental disabilities who live in the facility.

State Data Exchange (SDX) — An automated data information system received from the SSA that provides eligibility, benefit, and demographic data for SSI recipients.

State Medicaid claims administrator — Company contracted with HHSC to serve as the insuring agent in providing health benefits to Medicaid clients. The current state Medicaid claims administrator is the Texas Medicaid and Healthcare Partnership (TMHP).

State mental health facility — A facility operated by the Texas Department of State Health Services that provides care for people with mental illness who need the safety, structure and resources of an in-patient setting.

State Plan — See Texas State Plan for Medical Assistance.

State supported living center — A facility that provides residential services and 24-hour supervision and active treatments to assist people with an intellectual or developmental disability. State supported living centers were formerly known as state schools.

Student — A person who regularly attends school, college or job training, as determined by HHSC.

Supplemental Nutrition Assistance Program (SNAP) — A program that provides nutrition benefits to low-income people, so they can purchase healthy food. Previously known as the Food Stamp Program.

Supplemental Security Income (SSI) — A federally funded program that provides monthly cash assistance to people with limited income and resources who are 65 or older, blind or have a disability. Eligibility for SSI is determined by the SSA. SSI recipients are automatically eligible for Medicaid.

Support and maintenance (S/M) — The term used for the countable value of food and shelter a person receives.

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Temporary Assistance for Needy Families (TANF) — A program that provides temporary benefits (cash assistance) and work opportunities to families with needy dependent children, authorized under Title IV of the Social Security Act.

Temporary Protected Status (TPS) — DHS grants TPS to persons living in the U.S. who are from certain countries where unsafe conditions make it a hardship to return to that country. Persons who qualify for TPS are authorized to remain in the U.S. for a specified period of time and are eligible for an I-766, Employment Authorization Document (EAD). Initial TPS aliens are issued an approval notice and EAD with “A-12” or “C-19” category; re-registered TPS aliens receive an approval notice and EAD only if requested.

Testamentary trust — A trust established by a will.

Texas Health Steps (THSteps) — Services offered under Medicaid for eligible children. This program is known federally as EPSDT (Early and Periodic Screening, Diagnosis and Treatment). Find information at www.dshs.state.tx.us/thsteps/default.shtm.

Texas Medicaid and Healthcare Partnership (TMHP) — The current state Medicaid claims administrator.

Texas State Plan for Medical Assistance — Document describing the Medicaid-funded services provided in Texas, in accordance with Section 1902 of the Social Security Act (42 U.S.C. Section 1396a).

Third-party resource (TPR) — A source of payment for medical expenses other than Medicaid.

Three months prior — The three calendar months before the month of application. Also known as retroactive coverage.

TIERS — Texas Integrated Eligibility Redesign System. A computer system that:

- stores case information as well as information about applicants and recipients;
- processes eligibility determinations for multiple programs based on data provided through direct input and interfaces with other systems;
- generates benefit issuance;
- assists users in monitoring and managing workload; and
- creates correspondence and reports based on system- and user-requested criteria.

Titles to Social Security Act — Divisions of the Social Security Act. Titles referenced in this chapter are:

- Title II, which governs RSDI benefits;
- Title XVI, which governs the SSI program;
- Title XVIII, which governs Medicare; and
- Title XIX, which governs Medicaid.

Trust — A trust includes any legal instrument, device or arrangement which may not be called a trust under state law, but is like a trust. That is, it involves a grantor who transfers property to a person or entity with fiduciary obligations intending it be held, managed or administered by the person or entity for the benefit of the grantor or others. This includes, but is not limited to, escrow accounts, investment accounts, pension funds, irrevocable burial trusts, limited partnerships and other similar entities managed by a person or entity with the fiduciary obligations.

Tuition savings programs (also referred to as a Qualified Tuition Plans [QTP], Educational Savings Accounts [ESA] or Section 529 Plans) — Tax-deferred savings plans that allow contributors to save money in an account for the purpose of paying the qualified education expenses of a designated beneficiary.

- Any fund or plan established under Subchapter G, H or I, Chapter 54, Education Code, including an interest in a savings trust account, prepaid tuition contract or related matching account; or
- Any qualified tuition program of any state that meets the requirements of Section 529, Internal Revenue Code of 1986.

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Unearned income — Income that is not earned.

U.S. — United States of America.

U.S.-born Alien — A person born in the U.S. who, because of international law, is not subject to the jurisdiction of the U.S. This occurs when a person is born to a parent who is a foreign diplomatic officer such as ambassador, minister, chargé d' affaires, counselor, secretary or attaché of an embassy, legation or European Economic Community delegation.

U.S.C. — United States Code.

U.S. Citizenship and Immigration Services (USCIS) — USCIS is the government agency that oversees lawful immigration to the U.S. The former Immigration and Naturalization Service (INS) was dismantled and separated into three components within the Department of Homeland Security:

- USCIS provides immigrant services;

- Immigration and Customs Enforcement handles immigration enforcement; and
- Customs and Border Protection is responsible for border security functions.

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VA — U.S. Department of Veterans Affairs.

Vendor — See provider.

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Waiver — See Home and Community-Based Services waiver program.

Working day — Any day except Saturday, Sunday, a state holiday or a federal holiday.

WTPY — Wire Third-Party Query

A B C D E F G H I J K L M N O P Q R S T U V W Y

Your Texas Benefits Medicaid ID card — A plastic card with a magnetic strip, like a credit card, that holds the individual's Medicaid ID number and verification of coverage.

Appendices

Appendix I, MAO Action Codes

Body

Revision 07-1; Effective January 1, 2007

1. Reasons for Opening Aged, Blind, or Disabled MAO Cases

The code selected should represent the occurrence, during the six months preceding the date of approval for assistance, which had the greatest effect in producing the need for assistance.

When two or more reasons apply in a case, use the code for the reason primarily responsible for the need for assistance. If a reduction in income or resources and an increase in need are of equal importance, the code reflecting the reduction in income or resources should be used. If the increase in need is considerably greater than the reduction in income, the increased need becomes the primary reason.

Computer-printed reasons to the applicant will be initiated by use of the appropriate opening code. The statements that are to be computer-printed to the applicant are listed after each opening code for informational purposes.

The appropriate opening code should be taken from the following list and entered on the Form H1000-A.

Reasons Relating to Material Change in Income or Resources During Six Months Preceding Approval for Assistance

A change in income or resources should be regarded as material only if the amount of the reduction or loss of income is substantial in relation to the need for assistance. A loss of income that is based on need, such as assistance from a public or private agency, is not regarded as a material change in income. (Cases transferred from another assistance program will be coded 047.)

Earnings Lost or Reduced

Code 028 (TP03, 14) — Use this code if the applicant lost employment or had a reduction in earnings during the six months preceding application.

Computer-printed reason to applicant:

"Your earnings are less due to loss of or decrease in employment."

Support From Other Person

Code 038 (TP03, 14) — Use this code if the needs of the applicant have been met wholly or in part through contributions from a person and such contributions have been discontinued or reduced during the six months preceding application.

Computer-printed reason to applicant:

"Income available to you from another person is less."

Other Income

Code 041 (TP03, 14) — Use this code if the applicant suffered a loss of or reduction in income during the six months preceding application from some source other than those specified in Codes 028 or 038. Examples of such income are RSDI; an allowance, pension, or other payment connected with military service; unemployment benefits; workmen's compensation; and rental income. Do not include the loss of any income that was based on need.

Computer-printed reason to applicant:

"Income available to you is less."

Assets Depleted or Reduced

Code 044 (TP03, 14) — Use this code if the assets of the applicant have been depleted or reduced during the six months preceding application to an amount permitted under Department policy.

Computer-printed reason to applicant:

"Your financial resources have been reduced."

No Material Change in Income or Resources During Six Months Preceding Approval for Assistance

If the need for assistance is caused primarily by some change other than a loss of or reduction in income or assets of the applicant, use one of codes 045 through 055.

Such a change may result, for example, if the allowance for a standard budget item is raised; if an eligibility requirement such as residence is liberalized; or if an applicant's needs increased without a material change in income or assets.

Increased Medical Needs

Code 045 (TP 03, 14) — Use this code if the requirements of the applicant increased during the six months preceding application as a result of need for medical care without a corresponding increase in income or resources. The term medical care is used in the generic sense, that is, it embraces all items usually considered medical or remedial care, including care in a nursing facility.

Computer-printed reason to applicant:

"You have increased medical expense."

"Sins cuentas médicas han aumentado."

Miscellaneous

Code 047 (TP 03, 14) – Program Transfer — Use this code if the recipient receiving assistance is being transferred from a non-DHS assistance program to a DHS assistance program.

Computer-printed reason to applicant:

"You have changed from one type of assistance program to another."

"Su caso ha sido traspasado de inn programa de asistencia a otro."

Codes 048-052 (TP 03, 14) – Attained Technical Eligibility — If the applicant has been living below Department standards and the only change during the last six months is that the applicant has now fulfilled some technical eligibility requirement, enter the appropriate code for the particular requirement from the following codes (048-052). Do not use these codes if the applicant was eligible during the six months period but postponed applying. In such circumstances, code 053 should be used.

Code 048 — Age

Computer-printed reason to applicant:

"You now meet the age requirement."

"Ahora usted cumple con el requisito de edad."

Code 049 — Residence

Computer-printed reason to applicant:

"You now meet residence requirement."

"Ahora usted cumple con el requisito de residencia."

Code 050 — Citizenship or Legal Entry

Computer-printed reason to applicant:

"You now meet the citizenship requirement."

"Ahora usted cumple con el requisito de ciudadanía."

Code 051 — Blindness or Disability

Computer-printed reason to applicant:

Blind – "You now meet the agency's definition of economic blindness."

Ciego – "Ahora esta agencia considera que la condición de usted es ceguedad económica."

Disabled – "You now meet the agency's definition of disability."

Incapacitado – "Ahora esta agencia le considera a usted incapacitado(a)."

Code 052 — Other Technical Eligibility Requirement

Computer-printed reason to applicant:

"You now meet eligibility requirements."

"Ahora cumple usted con los requisitos de elegibilidad."

Code 053 (TP 03, 14) – Needy and Eligible — Use this code if the applicant has been needy and eligible over an extended period of time (more than six months prior to application) but postponed applying and during this period lived at a level below the Department standards.

Computer-printed reason to applicant:

"You meet all eligibility requirements."

"Usted cumple con todos los requisitos de elegibilidad."

Code 055 (TP 03, 14, 18, 19, 22, 23, 24, 51) – Denied in Error — Use this code if a case is reopened after having been closed by mistake, either as a result of an erroneous report of death or an erroneous denial, including a denial made on presumptive ineligibility. Reassign the previous case number. Make the medical effective date as the date after the denial.

Use this code to open MQMB and QMB coverage in order to prevent a gap in QMB coverage. Code 055 will allow QMB eligibility to begin prior to the application file date.

Computer-printed reason to applicant:

"Your case was closed by mistake."

"Su caso fue cerrado por error."

2. Reasons for Denial of Aged, Blind, and Disabled MAO Applications and Cases

Reasons for denying applications or closing cases are classified into four major groups: (1) death of applicant or recipient; (2) ineligible with respect to need; (3) ineligible with respect to requirements other than need; and (4) miscellaneous reasons.

Select the code reflecting the primary reason for denial. If a reason producing ineligibility with respect to need and reason producing ineligibility with respect to some requirement other than need occur at the same time, use the code for need. If several events occur simultaneously, none of which, alone, would produce ineligibility with respect to need, but collectively they do make the recipient ineligible, use the code for the reason having the greatest effect.

Although the applicant or recipient will receive a card explaining action taken on his/her case, the worker should make an adequate interpretation of the decision to the applicant or recipient.

Computer-printed reasons to the applicant or recipient will be initiated by use of the appropriate closing code and the computer will automatically print out the appropriate reason to the recipient corresponding to the code used.

The statements that are to be computer-printed to the applicant or recipient are listed after each closing code. The Spanish translations are to assist workers in completing FL-4 (MAO) and Form h1801. The Spanish translation will not be included on the Form H1029 mailed by the State Office.

The appropriate denial code should be taken from the following list and entered on the Forms H1000-A/B. These codes may be used on both Forms H1000-A and H1000-B with any type program unless otherwise specified.

Death

Code 059 – Death — Use this code if an application is denied because of death of applicant, or active case is closed because of death or the recipient.

Do not use this code for deceased applications that are simultaneously opened and closed.

Computer-printed reason to applicant or recipient:

No reason necessary — no notice will be sent to applicant or recipient.

Ineligible with Respect to Need: Material Change in Income or Resources During Last Six Months

A change in income or resources should be regarded as material only if the additional income is substantial in relation to the need for assistance. A material change in income or resources may result from the conversion of nonliquid assets into cash or other non-income producing assets into income producing assets, as well as from earnings or other direct income. A material change in income or resources does not necessarily mean a change with respect to cash income. For example, a recipient who has been keeping house may go to live with another person who provides food, clothing, and shelter.

Earnings

Code 060 – Earnings of Applicant or Recipient — Use this code if an application is denied because of applicant's earnings from employment, or active case is denied because of a material change in income as a result of recipient's employment or increased earnings. The change in earnings must have occurred during the preceding six months. Earnings may be from self-employment, seasonal employment, increased employment, or higher wages.

Computer-printed reason to applicant or recipient:

"Your employment earnings meet needs that can be recognized by this agency."

"Su salario es suficiente para cubrir las necesidades que esta agencia puede reconocer."

Code 061 – Earnings of Spouse — Use this code if an applicant is denied because of earnings of his or her spouse, or active case is denied because of a material change in income as a result of employment or increased earnings of spouse. The change in earnings must have occurred during the preceding six months. Earnings may be from self-employment, seasonal employment, increased employment, or higher wages.

Computer-printed reason to applicant or recipient:

"Employment earnings of your husband or wife meet needs that can be recognized by this agency."

"El salario de su esposo o esposa es suficiente para cubrir las necesidades que esta agencia puede reconocer."

Support From Other Person

Code 066 — Use this code if an application is denied because of support from another person, or active case is denied because of the receipt of or increase in support from another person. The change must have occurred during the preceding six months.

Computer-printed reason to applicant or recipient:

"Income available to you from another person meets needs that can he recognized by this agency."

"El dinero que recibe de otra persona es suficiente para cubrir las necesidades que esta agencia puede reconocer."

Benefits – Pensions

Code 067 – RSDI — Use this code for applicants or recipients denied if the material change in income resulted, or will result from the receipt of or increase in benefits under the Federal RSDI program during the preceding six months.

Computer-printed reason to applicant or recipient:

"Income available to you from Social Security Benefit meets needs that can be recognized by this agency."

"La entrada que tiene a su disposición de los Beneficios del Seguro Social es suficiente para cubrir las necesidades que esta agencia puede reconocer."

Code 068 – Other Federal — Use this code if an application is denied because of receipt of a Federal benefit or pension other than RSDI, or active case is denied because of receipt of or increase in a Federal benefit or pension other than RSDI, during the preceding six months. Examples of such income include Veterans' Administration, Federal Civil Service Retirement, or SSI.

Computer-printed reason to applicant or recipient:

"Income available to you from other Federal benefit or pension meets needs that can be recognized by this agency."

"La entrada que tiene a su disposición de otros beneficios o pensiones federales es suficiente para cubrir las necesidades que esta agencia puede reconocer."

Code 069 – State or Local — Use this code if an application is denied because of receipt of a benefit or pension administered by a state or local government, or active case is denied because of receipt of or increase in a benefit or pension administered by a state or local government during the preceding six months. Examples include workmen's compensation benefits, State employees', teachers' or policemen's retirement.

Computer-printed reason to applicant or recipient:

"Income available to you from state or local benefit or pension meets needs that can be recognized by this agency."

"La entrada que tiene a su disposición de beneficios o pensiones locales o del estado es suficiente para cubrir las necesidades que esta agencia puede reconocer."

Code 070 – Non-Governmental — Use this code if an application is denied because of receipt of a non-governmental pension or benefit, or active case is denied because of receipt of or increase in a non-governmental benefit or pension during the preceding six months. Examples are pensions from United Auto Workers Union and other pensions financed by private industry.

Computer-printed reason to applicant or recipient:

"Income available to you from pension or benefit meets needs that can be recognized by this agency."

"La entrada que tiene a su disposiciòn de beneficios o pensiones es suficiente para cubrir las necesidades que esta agencia puede reconocer."

Code 071 – Other Income — Use this code if an application is denied because of receipt of, or active case is denied because of receipt of or increase in income during the preceding six months other than that covered by codes 060-070. Examples are income from investments or real property.

Computer-printed reason to applicant or recipient:

"Income available to you meets needs that can be recognized by this agency."

"La entrada que tiene a su disposición es suficiente para cubrir las necesidades que esta agencia puede reconocer."

Excess Assets

Code 072 — Use this code if an application is denied because of excess resources, or active case is denied because of receipt of or increase in resources during the preceding six months. Examples are cash, savings bonds, inheritance of money or property, and increase in income from investments or real property.

Computer-printed reason to applicant or recipient:

"Resources available to you from other property meets needs that can be recognized by this agency."

"Los recursos de otra propiedad que tiene a su disposición son suficientes para las necesidades que esta agencia puede reconocer."

Ineligible with Respect to Need: No Material Change in Income or Resources During Last Six Months

Decreased Medical Needs

Code 073 — Use this code if an applicant or recipient is ineligible because the need for medical or remedial care (available under the department's program) decreased during the preceding six months.

Computer-printed reason to applicant or recipient:

"Your need for medical care expenses that can be recognized by this agency is less."

"Se ha reducido la necesidad que esta agencia puede reconocer de gastos médicos."

Ineligible With Respect to Requirement(s) Other Than Need

If two or more reasons apply, code the one occurring first. If the occurrences were simultaneous, code the reason appearing first on the list.

Refusal To

Code 076 – Furnish Information — Use this code if an application or active case is denied because of refusal to comply with department policy or to furnish information necessary to determine eligibility. This code does not apply to applicants or recipients who fail to return their client-completed form. Code 091, Failure To Furnish Information, should be used in this circumstance.

Computer-printed reason to applicant or recipient:

"You did not wish to furnish enough information for this agency to establish eligibility for assistance."

"Usted no quiso darnos suficiente información para que esta agencia pudiera establecer su calificación para asistencia."

Code 077 (Form H1000-B Only) – Follow Agreed Plan — Use this code for those situations in which a recipient was granted assistance with the understanding that he would take certain steps to utilize resources that were not actually available at time of application but could be made available through recipient's efforts.

Computer-printed reason to applicant or recipient:

"You did not wish to follow agreed plan so that eligibility for assistance could be continued."

"Usted no quiso cumplir con el plan convenido para continuar su calificación para asistencia."

Other Requirements

Code 080 – Blind (Not Blind) Disabled (Not Disabled) — Use this code if a blind applicant does not meet the definition of economic blindness or a blind recipient is denied because his vision has been restored. Also, enter if a disabled applicant does not meet the definition of total and permanent disability or a disabled recipient is no longer totally disabled. If recovery from the incapacity is accompanied by employment or increased earnings, use codes 060 or 061.

Computer-printed reason to applicant or recipient:

Blind – "You do not meet the agency's definition of economic blindness."

Disabled – "You do not meet the agency's definition of total and permanent disability."

Blind – "Usted no cumple con la definición de ceguedad económica de la agencia."

Disabled – "Usted no cumple con la definición de incapacidad total y permanente de la agencia."

Code 081 – Not Enrolled in Medicare Part A — Use this code if the applicant is not enrolled for Medicare Part A benefits and therefore cannot qualify for Qualified Medicare Beneficiary (QMB) or the Qualified Disabled Working Individuals (QDWI) programs. Use the code to deny a QMB or QDWI case if the client becomes unenrolled in Medicare Part A.

Computer-printed reason to applicant or recipient:

"You do not have Medicare Part A benefits."

"Usted no tiene los beneficios de la Parte A de Medicare."

Code 083 (Form H1000-A Only) – 30 Consecutive Days Requirement — Use this code if an applicant has been denied because he does not meet the 30 consecutive day requirement.

Computer-printed reason to applicant:

"You have not lived in a Medicaid-certified long-term care facility for 30 consecutive days."

"Usted no tiene 30 días consecutivos de vivir en un establecimiento certificado por Medicaid para proveer atención de largo plazo."

Code 086 – Admitted to Institution — Use this code if an applicant or recipient has been denied because he is an inmate of or has been admitted to an institution.

Computer-printed reason to applicant or recipient:

"You have been admitted to an institution."

"Usted fue admitido en una institución."

Code 087 – Age — Use this code if an application or active case is denied because evidence proves ineligibility on the basis of age. This code does not apply to disabled recipients transferred to aged assistance on becoming 65 years old. In these cases use code 122, Category Change.

Computer-printed reason to applicant or recipient:
"You do not meet the age requirement."
"Usted no cumple con el requisito de edad."

Code 088 – Residence — Use this code if evidence proves applicant is ineligible on the basis of residence, or if a recipient is known to have moved out of the state or remained out of the state longer than the minimum time allowed. If a recipient has moved out of the state to obtain employment, support from relatives, or for other known reason, use the code for that reason, rather than code 088. If an applicant or recipient cannot be located, use code 095.

Computer-printed reason to applicant or recipient:

"You do not meet residence requirements for assistance."

"Usted no cumple con los requisitos de residencia para asistencia."

Code 089 – Citizenship or Legal Entry — Use this code if an applicant or recipient is ineligible because he is not a citizen nor a noncitizen lawfully admitted for permanent residence in the United States nor residing in the United States under color of law.

Computer-printed reason to applicant or recipient:

"You do not meet legal United States entry or citizenship requirement for assistance."

"Usted no cumple con el requisito para asistencia de entrada legal en los E.U., ni de naturalización."

Code 090 (Form H1000-A Only) – Prior Eligibility (Used for Simultaneous Open and Close Only) — Use this code if an applicant is either deceased or currently ineligible for assistance but was eligible for Medicaid coverage during a prior period.

Computer-printed reason to applicant:

"Medical assistance was granted during a prior period, but you are not eligible now for medical or financial assistance."

"Consiguió asistencia médica durante un periodo anterior, pero ahora no califica para asistencia médica ni financiera."

Code 091 – Failure to Furnish Information — Use this code only when an applicant or recipient fails to execute and return the completed eligibility form.

Computer-printed reason to applicant or recipient:

"You failed to complete and return the necessary eligibility form."

"No devolvió usted debidamente completada la forma necesaria para calificar."

Code 092 – Other Eligibility Requirement — Use this code if an application or active case is denied because applicant or recipient does not meet an eligibility requirement other than need not covered by codes 076-089.

Computer-printed reason to applicant or recipient:

"You do not meet eligibility requirements for assistance."

"Usted no cumple con los requisitos para calificar para asistencia."

Code 136 – Failure to Provide Proof of U.S. Citizenship — Use this code if an application or active case is denied because applicant or recipient is a U.S citizen or national and fails to provide proof of U.S. citizenship.

Computer-printed reason to applicant or recipient:

“(Last, First) is not eligible for Medicaid because proof of U.S. citizenship was not provided. As soon as this information is provided, this person may be eligible for Medicaid.”

“(Last name, first name) no llena los requisitos de Medicaid porque no presentó prueba de ciudadanía estadounidense. Una vez que esta persona presente la información, es posible que llene los requisitos de Medicaid.”

Miscellaneous Reasons

Code 094 – Appointment Not Kept — Use this code when an applicant or recipient is denied because: (1) he/she has failed to keep an appointment, and (2) he/she has made no response within 10 days to a follow-up inquiry.

Computer-printed reason to applicant or recipient:

"You failed to keep your appointment."

"Usted no vino a la cita qine tenía."

Code 095 – Unable to Locate — Use this code if an applicant or recipient is denied because he/she cannot be located.

Computer-printed reason to applicant or recipient:

"You cannot be located."

"No lo podemos localizar a usted."

Code 096 (Form H1000-A Only) – Application Filed in Error — Use this code if an application is to be denied because of being filed or pending in error or to deny a duplicate application, that is, more than one application filed for an individual in the same category.

Computer-printed reason to applicant:

No reason necessary - no notice will be sent to applicant.

Code 097 – Transfer of Property — Use this code if an application or active case is denied because of transfer of property, either real or personal, for purpose of qualifying for or increasing the need for assistance.

Computer-printed reason to applicant or recipient:

"You transferred property that has an effect on your eligibility for assistance."

"Usted transfirió propiedad que afecta su calificació; para asistencia."

Code 098 – Voluntary Withdrawal — Use this code only if an applicant does not wish to pursue his/her application further, or if a recipient requests that his/her grant be discontinued and the underlying cause for the withdrawal request cannot be determined. If a specific reason for the withdrawal can be determined, always use the applicable code. Do not use for applicant/recipients who have moved out-of-state. Code 088 will be used for this reason.

Computer-printed reason to applicant or recipient:

"You have requested that your application for or your grant of assistance be withdrawn."

"Usted ha pedido que su aplicación para, o su concesión de asistencia sea retirada."

Code 099 – Other Miscellaneous — Use this code only if an application or active case is denied for a reason which cannot be related in some respect to one of the preceding codes. Include under this code cases closed because the applicant or recipient is incarcerated, or was originally ineligible.

Computer-printed reason to applicant or recipient:

"You do not presently meet eligibility requirements."

"Al presente usted no cumple con los requisitos para calificar."

3. Reasons for Sustaining Aged, Blind, and Disabled MAO Cases

Notices to recipients for all redeterminations are computer-printed on special forms. These notices are "triggered" by the action code entered on the Form H1000-B. Since the reason is general, an adequate interpretation should be made to the recipient for any action taken to sustain the case.

Code

110 – "You remain eligible for medical coverage."

121 – Type Program Transfer — "You have been transferred to another type of medical assistance."

122 – **Category Change** — "You continue to be eligible for medical assistance."

(**Note:** Use Code 122 if both type program and category change.)

Appendix II, Reserved for Future Use

Body

Revision 20-3; Effective September 1, 2020

Appendix III, Reserved for Future Use

Body

Revision 20-3; Effective September 1, 2020

Appendix IV, Reserved for Future Use

Body

Revision 20-2; Effective June 1, 2020

Appendix V, Levels of Evidence of Citizenship and Acceptable Evidence of Identity Reference Guide

Body

Revision 07-4; Effective October 1, 2007

Important: Current SSI recipients and individuals entitled to or enrolled in Medicare are exempt from the citizenship documentation requirement for Medicaid. This includes individuals determined disabled for Social Security benefits and in the 24-month period before receiving Medicare.

Primary Evidence of Citizenship and Identity

Primary Evidence of Citizenship and Identity

- U.S. passport
- Certificate of naturalization
- Certificate of U.S. citizenship
- SDX for denied SSI recipients when the denial is for any reason other than citizenship (N13)
- SOLQ/WTPY and documentation of reason for Medicare denial

If primary evidence of citizenship is not available, the individual must provide **two** documents – one to establish U.S. citizenship and one to establish identity. Acceptable evidence of identity documents is outlined last at the end of this reference guide.

When primary evidence of citizenship is not available, begin with the second level of evidence of citizenship and continue through the levels to locate the best available documentation.

Second Level of Evidence of Citizenship
(Use only when primary evidence is not available.)

- A U.S. public birth certificate showing birth in one of the 50 states, the District of Columbia, Puerto Rico (if born on or after Jan. 13, 1941), Guam (on or after April 10, 1899), the Virgin Islands of the U.S. (on or after Jan. 17, 1917), American Samoa, Swain's Island or the Northern Mariana Islands (after Nov. 4, 1986). Conduct Bureau of Vital Statistics (BVS) inquiry for an individual born in Texas. If an individual's date of birth is earlier than 1903 or if the birth was out of state, accept a legible/non-questionable copy. For a birth out of state, individuals may obtain a birth certificate through the following: BirthCertificate.com; vitalchek.com; or usbirthcertificate.net. Individuals may also contact usbirthcertificate.net toll-free at:1-888-736-2692.
- Report of Birth Abroad of a U.S. Citizen (FS-240)
- Certification of Birth Abroad (FS 545 or DS-1350)
- U.S. Citizen Identification card (Form I-179 or I-197)
- Northern Mariana Identification card (I-873)
- American Indian card (I-872) issued by Department of Homeland Security with classification code "KIC"
- Final adoption decree showing the child's name and U.S. place of birth
- Evidence of U.S. Civil Service employment before June 1, 1976
- U.S. Military record showing a U.S. place of birth (**Example:** DD-214)

Third Level of Evidence of Citizenship
(Use only when primary and second level evidence is not available.)

- Hospital record of birth showing a U.S. place of birth
- Life, health or other insurance record showing a U.S. place of birth
- Religious record of birth recorded in the U.S. or its territories within three months of birth that indicates a U.S. place of birth showing either the date of birth or the individual's age at the time the record was made
- Early school record showing a U.S. place of birth, name of the child, date of admission to the school, date of birth, and name(s) and place(s) of birth of the applicant's/recipient's parents

Fourth Level of Evidence of Citizenship
(Use only when primary, second level and third level evidence is not available.)

Any listed documents used must include biographical information, including U.S. place of birth.

- Federal or state census record showing U.S. citizenship or a U.S. place of birth and the individual's age (generally for individuals born 1900-1950)
- Seneca Indian Tribal census record showing a U.S. place of birth
- Bureau of Indian Affairs Tribal census records of the Navajo Indians showing a U.S. place of birth
- Bureau of Indian Affairs Roll of Alaska Natives
- U.S. State Vital Statistics official notification of birth registration showing a U.S. place of birth
- Statement showing a U.S. place of birth signed by the physician or midwife who was in attendance at the time of birth
- Institutional admission papers from a nursing facility, skilled care facility or other institution showing a U.S. place of birth
- Medical (clinic, doctor or hospital) record, excluding an immunization record, showing a U.S. place of birth
- Affidavits from two adults regardless of blood relationship to the individual; **use only as a last resort when no other evidence is available**

Evidence of Identity

Evidence of Identity

- Driver's license issued by a state either with a photograph or other identifying information such as name, age, sex, race, height, weight or eye color
- School identification card with a photograph
- U.S. Military card or draft record
- Identification card issued by the federal, state or local government with the same information included on driver's license
- Department of Public Safety identification card with a photograph or other identifying information such as name, age, sex, race, height, weight or eye color
- Birth certificate
- Hospital record of birth
- Military dependent's identification card
- Native American Tribal document
- U.S. Coast Guard Merchant Mariner card
- Certificate of Degree of Indian Blood or other U.S. American Indian/Alaskan Native and Tribal document with a photograph or other personal identifying information
- Data matches with other state or federal government agencies (**Example:** Employee Retirement System and Teacher Retirement System)
- Three or more corroborating documents, such as marriage license, divorce decrees, high school diplomas and employer ID cards. **Use only with second and third levels of evidence of citizenship.**
- Adoption papers or records
- Work identification card with photograph
- Signed application for Medicaid (accept signature of an authorized representative or a responsible person acting on the individual's behalf)
- Health care admission statement
- For children under 16, school records may include nursery or day care records
- For children under 16, clinic, doctor or hospital records
- For children under 16, an affidavit signed by a parent or guardian stating the date and place of birth of the child; **use as a last resort when no other evidence is available and if an affidavit is not used to establish citizenship**
- For disabled individuals in residential care facilities, an affidavit signed by the facility director or administrator attesting the identity of the individual when the individual does not have or cannot get any document on this list. **Use as a last resort when no other evidence is available and if an affidavit is not used to establish citizenship.**

Appendix VI, SSA Claim Number Suffixes

Body

Revision 21-1; Effective March 1, 2021

BIC Code	Type of Beneficiary
A	Primary Claimant
B	Wife, 62 or older (1st claimant)
B1	Husband, 62 or older (1st claimant)
B2	Young wife with a child in her care (1st claimant)
B3	Wife, 62 or older (2nd claimant)
B4	Husband, 62 or older (2nd claimant)

BIC Code	Type of Beneficiary
B5	Young wife with a child in her care (2nd claimant)
B6	Divorced wife, 62 or older (1st claimant)
B7	Young wife with a child in her care (3rd claimant)
B8	Wife, 62 or older (3rd claimant)
B9	Divorced wife, 62 or older (2nd claimant)
BA	Wife, 62 or older (4th claimant)
BD	Wife, 62 or older (5th claimant)
BG	Husband, 62 or older (3rd claimant)
BH	Husband, 62 or older (4th claimant)
BJ	Husband, 62 or older (5th claimant)
BK	Young wife with a child in her care (4th claimant)
BL	Young wife with a child in her care (5th claimant)
BN	Divorced wife, 62 or older (3rd claimant)
BP	Divorced wife, 62 or older (4th claimant)
BQ	Divorced wife, 62 or older (5th claimant)
BR	Divorced husband, 62 or older (1st claimant)
BT	Divorced husband, 62 or older (2nd claimant)
BW	Young husband with a child in his care (2nd claimant)
BY	Young husband with a child in his care (1st claimant)
C1-C9	Child (minor, disabled or student)
CA-CK	Child (minor, disabled or student) CA = C11, CB = C12, etc. See Note 1.
D	Widow, 60 or older (1st claimant)
D1	Widower, 60 or older (1st claimant)
D2	Widow, 60 or older (2nd claimant)
D3	Widower, 60 or older (2nd claimant)
D4	Widow (remarried after turning 60) (1st claimant)
D5	Widower (remarried after turning 60) (1st claimant)
D6	Surviving divorced wife, 60 or older (1st claimant)
D7	Surviving divorced wife, 60 or older (2nd claimant)
D8	Widow, 60 or older (3rd claimant)
D9	Widow (remarried after turning 60) (2nd claimant)
DA	Widow (remarried after turning 60) (3rd claimant)
DC	Surviving divorced husband, 60 or older (1st claimant)
DD	Widow, 60 or older (4th claimant)
DG	Widow, 60 or older (5th claimant)
DH	Widower, 60 or older (3rd claimant)
DJ	Widower, 60 or older (4th claimant)
DK	Widower, 60 or older (5th claimant)
DL	Widow (remarried after turning 60) (4th claimant)
DM	Surviving divorced husband, 60 or older (2nd claimant)

BIC Code	Type of Beneficiary
DN	Widow (remarried after turning 60) (5th claimant)
DP	Widower (remarried after turning 60) (2nd claimant)
DQ	Widower (remarried after turning 60) (3rd claimant)
DR	Widower (remarried after turning 60) (4th claimant)
DS	Surviving divorced husband, 60 or older (3rd claimant)
DT	Widower (remarried after turning 60) (5th claimant)
DV	Surviving divorced wife, 60 or older (3rd claimant)
DW	Surviving divorced wife, 60 or older (4th claimant)
DX	Surviving divorced husband, 60 or older (4th claimant)
DY	Surviving divorced wife, 60 or older (5th claimant)
DZ	Surviving divorced husband, 60 or older (5th claimant)
E	Mother (widow) (1st claimant)
E1	Surviving divorced mother (1st claimant)
E2	Mother (widow) (2nd claimant)
E3	Surviving divorced mother (2nd claimant)
E4	Father (widower) (1st claimant)
E5	Surviving divorced father (1st claimant)
E6	Father (widower) (2nd claimant)
E7	Mother (widow) (3rd claimant)
E8	Mother (widow) (4th claimant)
E9	Surviving divorced father (2nd claimant)
EA	Mother (widow) (5th claimant)
EB	Surviving divorced mother (3rd claimant)
EC	Surviving divorced mother (4th claimant)
ED	Surviving divorced mother (5th claimant)
EF	Father (widower) (3rd claimant)
EG	Father (widower) (4th claimant)
EH	Father (widower) (5th claimant)
EJ	Surviving divorced father (3rd claimant)
EK	Surviving divorced father (4th claimant)
EM	Surviving divorced father (5th claimant)
F1	Father
F2	Mother
F3	Stepfather
F4	Stepmother
F5	Adopting father
F6	Adopting mother
F7	Second alleged father
F8	Second alleged mother
G1-G9	Claimants of lump-sum death payments
J1	Primary PROUTY entitled to HIB (less than 3 Q.C.) (General Fund) See Note 2
J2	Primary PROUTY entitled to HIB (over 2 Q.C.) (RSI Trust Fund)
J3	Primary PROUTY not entitled to HIB (less than 3 Q.C.) (General Fund)

BIC Code	Type of Beneficiary
J4	Primary PROUTY not entitled to HIB (over 2 Q.C.) (RSI Trust Fund)
K1	PROUTY wife entitled to HIB (less than 3 Q.C.) (General Fund)
K2	PROUTY wife entitled to HIB (over 2 Q.C.) (RSI Trust Fund)
K3	PROUTY wife not entitled to HIB (less than 3 Q.C.) (General Fund)
K4	PROUTY wife not entitled to HIB (over 2 Q.C.) (RSI Trust Fund)
K5	PROUTY wife entitled to HIB (less than 3 Q.C.) (2nd claimant) (General Fund)
K6	PROUTY wife entitled to HIB (over 2 Q.C.) (2nd claimant) (RSI Trust Fund)
K7	PROUTY wife not entitled to HIB (less than 3 Q.C.) (2nd claimant) (General Fund)
K8	PROUTY wife not entitled to HIB (over 2 Q.C.) (2nd claimant) (RSI Trust Fund)
K9	PROUTY wife entitled to HIB (less than 3 Q.C.) (3rd claimant) (General Fund)
KA	PROUTY wife entitled to HIB (over 2 Q.C.) (3rd claimant) (RSI Trust Fund)
KB	PROUTY wife not entitled to HIB (less than 3 Q.C.) (3rd claimant) (General Fund)
KC	PROUTY wife not entitled to HIB (over 2 Q.C.) (3rd claimant) (RSI Trust Fund)
KD	PROUTY wife entitled to HIB (less than 3 Q.C.) (4th claimant) (General Fund)
KE	PROUTY wife entitled to HIB (over 2 Q.C.) (4th claimant) (RSI Trust Fund)
KF	PROUTY wife not entitled to HIB (less than 3 Q.C.) (4th claimant) (General Fund)
KG	PROUTY wife not entitled to HIB (over 2 Q.C.) (4th claimant) (RSI Trust Fund)
KH	PROUTY wife entitled to HIB (less than 3 Q.C.) (5th claimant) (General Fund)
KJ	PROUTY wife entitled to HIB (over 2 Q.C.) (5th claimant) (RSI Trust Fund)
KL	PROUTY wife not entitled to HIB (less than 3 Q.C.) (5th claimant) (General Fund)
KM	PROUTY wife not entitled to HIB (over 2 Q.C.) (5th claimant) (RSI Trust Fund)
LM	Black lung miner (1st claimant)
LW	Black lung miner's widow (1st claimant)
M	Beneficiary not entitled to Title II or monthly benefits (Not qualified for automatic free Part A – HIB)
M1	Similar to M, but qualified for automatic free Part A – HIB, but elects to file for Part B – SMIB only
T	• Fully insured beneficiaries who have elected entitlement only to HIB (usually but not always along with SMIB) • End Stage Renal Disease (ESRD) filing for Medicare only • Deemed insured (hospital insurance only)
T2-T9	Multiple eligible children (Medicare Qualified Government Employment (MQGE) childhood disability benefits) (2nd – 9th claimant)
TA	MQGE primary beneficiary
TB	MQGE aged spouse (1st claimant)
TC	MQGE childhood disability benefits (1st claimant)
TD	MQGE aged widow or widower (1st claimant)
TF	MQGE father
TG, TH, TJ, TK	Multiple eligible MQGE aged spouses
TL, TM, TN, TP	Multiple eligible MQGE aged widow(er)s
TQ	MQGE mother

BIC Code	Type of Beneficiary
TE, TR, TS, TT , TU	Multiple eligible MQGE young widow(er)s
TV, TW, TX, TY, TZ	Multiple eligible MQGE disabled widow(er)s
W	Disabled widow, 50 or older (1st claimant)
W1	Disabled widower, 50 or older (1st claimant)
W2	Disabled widow, 50 or older (2nd claimant)
W3	Disabled widower, 50 or older (2nd claimant)
W4	Disabled widow, 50 or older 3rd claimant)
W5	Disabled widower, 50 or older 3rd claimant)
W6	Disabled surviving divorced wife (1st claimant)
W7	Disabled surviving divorced wife (2nd claimant)
W8	Disabled surviving divorced wife (3rd claimant)
W9	Disabled widow, 50 or older (4th claimant)
WB	Disabled widower, 50 or older (4th claimant)
WC	Disabled surviving divorced wife (4th claimant)
WF	Disabled widow, 50 or older (5th claimant)
WG	Disabled widower, 50 or older (5th claimant)
WJ	Disabled surviving divorced wife (5th claimant)
WR	Disabled surviving divorced husband (1st claimant)
WT	Disabled surviving divorced husband (2nd claimant)

Note 1: Youngest child is assigned suffix "1." If there are more than nine children in an Eligibility Determination Group (EDG), the 10th child is coded with an A rather than 10, the 11th child is coded with a B, etc.

Note 2: Quarters of covered employment.

Appendix VII, County Names, Codes and Regions

Body

Revision 12-1; Effective March 1, 2012

All Programs

A B C D E F G H I J K L M N O P R S T U V W Y Z

County	Code	Region
Anderson	001	04
Andrews	002	09
Angelina	003	05
Aransas	004	11

County	Code	Region
Archer	005	02
Armstrong	006	01
Atascosa	007	08
Austin	008	06

A B C D E F G H I J K L M N O P R S T U V W Y Z

County	Code	Region
Bailey	009	01
Bandera	010	08
Bastrop	011	07
Baylor	012	02
Bee	013	11
Bell	014	07
Bexar	015	08
Blanco	016	07
Borden	017	09
Bosque	018	07
Bowie	019	04
Brazoria	020	06
Brazos	021	07
Brewster	022	10
Briscoe	023	01
Brooks	024	11
Brown	025	02
Burleson	026	07
Burnet	027	07

A B C D E F G H I J K L M N O P R S T U V W Y Z

County	Code	Region
Caldwell	028	07
Calhoun	029	08
Callahan	030	02
Cameron	031	11
Camp	032	04
Carson	033	01
Cass	034	04
Castro	035	01
Chambers	036	06
Cherokee	037	04
Childress	038	01
Clay	039	02
Cochran	040	01

County	Code	Region
Coke	041	09
Coleman	042	02
Collin	043	03
Collingsworth	044	01
Colorado	045	06
Comal	046	08
Comanche	047	02
Concho	048	09
Cooke	049	03
Coryell	050	07
Cottle	051	02
Crane	052	09
Crockett	053	09
Crosby	054	01
Culberson	055	10

A B C D E F G H I J K L M N O P R S T U V W Y Z

County	Code	Region
Dallam	056	01
Dallas	057	03
Dawson	058	09
Deaf Smith	059	01
Delta	060	04
Denton	061	03
DeWitt	062	08
Dickens	063	01
Dimmit	064	08
Donley	065	01
Duval	066	11

A B C D E F G H I J K L M N O P R S T U V W Y Z

County	Code	Region
Eastland	067	02
Ector	068	09
Edwards	069	08
Ellis	070	03
El Paso	071	10
Erath	072	03

A B C D E F G H I J K L M N O P R S T U V W Y Z

County	Code	Region
Falls	073	07

County	Code	Region
Fannin	074	03
Fayette	075	07
Fisher	076	02
Floyd	077	01
Foard	078	02
Fort Bend	079	06
Franklin	080	04
Freestone	081	07
Frio	082	08

A B C D E F G H I J K L M N O P R S T U V W Y Z

County	Code	Region
Gaines	083	09
Galveston	084	06
Garza	085	01
Gillespie	086	08
Glasscock	087	09
Goliad	088	08
Gonzales	089	08
Gray	090	01
Grayson	091	03
Gregg	092	04
Grimes	093	07
Guadalupe	094	08

A B C D E F G H I J K L M N O P R S T U V W Y Z

County	Code	Region
Hale	095	01
Hall	096	01
Hamilton	097	07
Hansford	098	01
Hardeman	099	02
Hardin	100	05
Harris	101	06
Harrison	102	04
Hartley	103	01
Haskell	104	02
Hays	105	
Hemphill	106	01
Henderson	107	04
Hidalgo	108	11
Hill	109	07

County	Code	Region
Hockley	110	01
Hood	111	03
Hopkins	112	04
Houston	113	05
Howard	114	09
Hudspeth	115	10
Hunt	116	03
Hutchinson	117	01

A B C D E F G H I J K L M N O P R S T U V W Y Z

County	Code	Region
Irion	118	09

A B C D E F G H I J K L M N O P R S T U V W Y Z

County	Code	Region
Jack	119	02
Jackson	120	08
Jasper	121	05
Jeff Davis	122	10
Jefferson	123	05
Jim Hogg	124	11
Jim Wells	125	11
Johnson	126	03
Jones	127	02

A B C D E F G H I J K L M N O P R S T U V W Y Z

County	Code	Region
Karnes	128	08
Kaufman	129	03
Kendall	130	08
Kenedy	131	11
Kent	132	02
Kerr	133	08
Kimble	134	09
King	135	01
Kinney	136	08
Kleberg	137	11
Knox	138	02

A B C D E F G H I J K L M N O P R S T U V W Y Z

County	Code	Region
Lamar	139	04

County	Code	Region
Lamb	140	01
Lampasas	141	07
LaSalle	142	08
Lavaca	143	08
Lee	144	07
Leon	145	07
Liberty	146	06
Limestone	147	07
Lipscomb	148	01
Live Oak	149	11
Llano	150	07
Loving	151	09
Lubbock	152	01
Lynn	153	01

A B C D E F G H I J K L M N O P R S T U V W Y Z

County	Code	Region
Madison	154	07
Marion	155	04
Martin	156	09
Mason	157	09
Matagorda	158	06
Maverick	159	08
McCulloch	160	09
McLennan	161	07
McMullen	162	11
Medina	163	08
Menard	164	09
Midland	165	09
Milam	166	07
Mills	167	07
Mitchell	168	02
Montague	169	02
Montgomery	170	06
Moore	171	01
Morris	172	04
Motley	173	01

A B C D E F G H I J K L M N O P R S T U V W Y Z

County	Code	Region
Nacogdoches	174	05
Navarro	175	03

County	Code	Region
Newton	176	05
Nolan	177	02
Nueces	178	11

A B C D E F G H I J K L M N O P R S T U V W Y Z

County	Code	Region
Ochiltree	179	01
Oldham	180	01
Orange	181	05

A B C D E F G H I J K L M N O P R S T U V W Y Z

County	Code	Region
Palo Pinto	182	03
Panola	183	04
Parker	184	03
Parmer	185	01
Pecos	186	09
Polk	187	05
Potter	188	01
Presidio	189	10

A B C D E F G H I J K L M N O P R S T U V W Y Z

County	Code	Region
Rains	190	04
Randall	191	01
Reagan	192	09
Real	193	08
Red River	194	04
Reeves	195	09
Refugio	196	11
Roberts	197	01
Robertson	198	07
Rockwall	199	03
Runnels	200	02
Rusk	201	04

A B C D E F G H I J K L M N O P R S T U V W Y Z

County	Code	Region
Sabine	202	05
San Augustine	203	05
San Jacinto	204	05
San Patricio	205	11

County	Code	Region
San Saba	206	07
Schleicher	207	09
Scurry	208	02
Shackelford	209	02
Shelby	210	05
Sherman	211	01
Smith	212	04
Somervell	213	03
Starr	214	11
Stephens	215	02
Sterling	216	09
Stonewall	217	02
Sutton	218	09
Swisher	219	01

A B C D E F G H I J K L M N O P R S T U V W Y Z

County	Code	Region
Tarrant	220	03
Taylor	221	02
Terrell	222	09
Terry	223	01
Throckmorton	224	02
Titus	225	04
Tom Green	226	09
Travis	227	07
Trinity	228	05
Tyler	229	05

A B C D E F G H I J K L M N O P R S T U V W Y Z

County	Code	Region
Upshur	230	04
Upton	231	09
Uvalde	232	08

A B C D E F G H I J K L M N O P R S T U V W Y Z

County	Code	Region
Val Verde	233	08
Van Zandt	234	04
Victoria	235	08

A B C D E F G H I J K L M N O P R S T U V W Y Z

County	Code	Region

County	Code	Region
Walker	236	06
Waller	237	06
Ward	238	09
Washington	239	07
Webb	240	11
Wharton	241	06
Wheeler	242	01
Wichita	243	02
Wilbarger	244	02
Willacy	245	11
Williamson	246	07
Wilson	247	08
Winkler	248	09
Wise	249	03
Wood	250	04

A B C D E F G H I J K L M N O P R S T U V W Y Z

County	Code	Region
Yoakum	251	01
Young	252	02

A B C D E F G H I J K L M N O P R S T U V W Y Z

County	Code	Region
Zapata	253	11
Zavala	254	08

Appendix VIII, Summary of Effects of Institutionalization on Supplemental Security Income (SSI) Eligibility

Body

Revision 21-4; Effective December 1, 2021

Appendix is available for staff use on the LOOP.

Appendix IX, Medicare Savings Program Information

Body

Revision 21-2; Effective June 1, 2021

Note: The following information is effective March 1, 2021.

Eligibility as a Qualified Medicare Beneficiary (QMB)

Medicare Entitlement

Must be entitled to Medicare Part A.

Income — Maximum gross monthly income

- $1,074 Individual
- $1,452 Couple

Income can equal the maximum gross monthly income or be less than this limit. Use the couple income limit when both spouses are applying for the same program. If both are not eligible, use the individual income limit to test eligibility for each spouse separately. A portion of the spouse's income may also be considered as part of the applicant's income.

Income limit amounts do not include the $20 general income disregard.

What counts as income?

- Social Security benefits
- Railroad retirement benefits
- State or local retirement benefits
- Interest or dividends
- Gifts or contributions
- Civil service annuities
- Veterans benefits
- Private pension benefits
- Royalty and rental payments
- Earnings or wages
- Value of food, clothing or shelter paid by someone else

Resources — Maximum countable resources

- $7,970 Individual
- $11,960 Couple

What is a resource?

- Bank accounts and certificates of deposit (CDs)
- Real property
- Life insurance policies
- Burial funds
- Individual retirement accounts (IRAs)
- Stocks and bonds
- Oil, gas or mineral rights
- Jewelry and antiques
- Cars and other vehicles
- Boats and recreational vehicles

What can be excluded?

- Texas homestead where a person lives that they consider their principal place of residence
- Life insurance, if the face value is $1,500 or less
- Separately identifiable burial funds of $1,500 (less any excluded life insurance or irrevocable arrangement for burial) for the applicant and the applicant's spouse
- Car
- Burial spaces

Benefits

QMB covers Medicare premiums (both Parts A and B), deductibles and coinsurance fees for Medicare services. As a QMB, a person does not get regular Medicaid benefits. The state sends a special identification card to people who are eligible for QMB for them to show their medical service providers.

Eligibility as Specified Low-Income Medicare Beneficiaries (SLMB)

Medicare Entitlement

Must be entitled to Medicare Part A.

Income

The income range for a person is equal to a minimum monthly amount of $1,074.01 to a maximum monthly amount of less than $1,288.

The income range for a couple is equal to a minimum monthly amount of $1,452.01 to a maximum monthly amount of less than $1,742.

Use the couple income range when both spouses are applying for the same program. If both are ineligible, use the individual income range to test eligibility for each spouse separately. A portion of the spouse's income may also be considered as part of the applicant's income.

Income limit amounts do not include the $20 general income disregard.

What counts as income?

- Social Security benefits
- Railroad retirement benefits
- State or local retirement benefits
- Interest or dividends
- Gifts or contributions
- Civil service annuities
- Veterans benefits
- Private pension benefits
- Royalty and rental payments
- Earnings or wages
- Value of food, clothing or shelter paid by someone else

Resources — Maximum countable resources

- $7,970 Individual
- $11,960 Couple

What is a resource?

- Bank accounts and CDs
- Real property
- Life insurance policies
- Burial funds
- IRAs
- Stocks and bonds
- Oil, gas or mineral rights
- Jewelry and antiques
- Cars and other vehicles
- Boats and recreational vehicles

What can be excluded?

- Texas homestead where a person lives that they consider their principal place of residence
- Life insurance, if the face value is $1,500 or less
- Separately identifiable burial funds of $1,500 (less any excluded life insurance or irrevocable arrangement for burial) for the applicant and the applicant's spouse
- Car
- Burial spaces

Benefits

SLMB covers only the payment of Medicare Part B premiums. An SLMB-eligible person does not get regular Medicaid benefits or a monthly medical identification card.

Eligibility for the Qualifying Individuals Program (QI-1)

Entitlement

- Must be entitled to Medicare Part A.
- Must not otherwise be receiving Medicaid.

Income

The income range for a person is equal to a minimum monthly amount of $1,288 to a maximum monthly amount of less than $1,449.

The income range for a couple is equal to a minimum monthly amount of $1,742 to a maximum monthly amount of less than $1,960.

Use the couple income range when both spouses are applying for the same program. If both are not eligible, use the individual income range to test eligibility for each spouse separately. A portion of the spouse's income may also be considered as part of the applicant's income.

Income limit amounts do not include the $20 general income disregard.

What counts as income?

- Social Security benefits
- Railroad retirement benefits
- State or local retirement benefits
- Interest or dividends
- Gifts or contributions
- Civil service annuities

- Veterans benefits
- Private pension benefits
- Royalty and rental payments
- Earnings or wages
- Value of food, clothing or shelter paid by someone else

Resources — Maximum countable resources

- $7,970 Individual
- $11,960 Couple

What is a resource?

- Bank accounts and CDs
- Real property
- Life insurance policies
- Burial funds
- IRAs
- Stocks and bonds
- Oil, gas or mineral rights
- Jewelry and antiques
- Cars and other vehicles
- Boats and recreational vehicles

What can be excluded?

- Texas homestead where a person lives that they consider their principal place of residence
- Life insurance, if the face value is $1,500 or less
- Separately identifiable burial funds of $1,500 (less any excluded life insurance or irrevocable arrangement for burial) for the applicant and the applicant's spouse
- Car
- Burial spaces

Benefits

QI-1 covers only the payment of Medicare Part B premiums. A QI-1-eligible person does not get regular Medicaid benefits or a medical identification card. A person cannot receive QI-1 benefits if receiving benefits under any other Medicaid-funded program.

Qualified Disabled and Working Individuals Program (QDWI)

Entitlement

- Must be entitled to enroll in Medicare Part A.
- Must be under age 65 and not otherwise receiving Medicaid.

Income — Maximum gross monthly income

- $2,147 Individual
- $2,904 Couple

Income can be less than or equal to the maximum limit. Use the couple income limit when both spouses are applying for the same program. If both are ineligible, use the individual income limit to test eligibility for each spouse separately. A portion of the spouse's income may also be considered as part of the applicant's income.

Income limit amounts do not include the $20 general income disregard.

What counts as income?

- Social Security benefits
- Railroad retirement benefits
- State or local retirement benefits
- Interest or dividends
- Gifts or contributions
- Civil service annuities
- Veterans benefits
- Private pension benefits
- Royalty and rental payments
- Earnings or wages
- Value of food, clothing or shelter paid by someone else

Resources — Maximum countable resources

- $4,000 Individual
- $6,000 Couple

What is a resource?

- Bank accounts and CDs
- Real property
- Life insurance policies
- Burial funds
- IRAs
- Stocks and bonds
- Oil, gas or mineral rights
- Jewelry and antiques
- Cars and other vehicles
- Boats and recreational vehicles

What can be excluded?

- Texas homestead where a person lives that they consider their principal place of residence
- Life insurance, if the face value is $1,500 or less
- Separately identifiable burial funds of $1,500 (less any excluded life insurance or irrevocable arrangement for burial) for the applicant and the applicant's spouse
- Car
- Burial spaces

Benefits

QDWI covers only Medicare Part A premiums. A QDWI-eligible person does not get regular Medicaid benefits or a medical identification card.

Appendix X, Life Estate and Remainder Interest Tables

Body

Revision 12-3; Effective September 1, 2012

Age	Life Estate	Remainder
0	.97188	.02812
1	.98988	.01012
2	.99017	.00983
3	.99008	.00992
4	.98981	.01019
5	.98938	.01062
6	.98884	.01116
7	.98822	.01178
8	.98748	.01252
9	.98663	.01337
10	.98565	.01435
11	.98453	.01547
12	.98329	.01671
13	.98198	.01802
14	.98066	.01934
15	.97937	.02063
16	.97815	.02185
17	.97700	.02300
18	.97590	.02410
19	.97480	.02520
20	.97365	.02635
21	.97245	.02755
22	.97120	.02880
23	.96986	.03014
24	.96841	.03159
25	.96678	.03322
26	.96495	.03505
27	.96290	.03710
28	.96062	.03938
29	.95813	.04187
30	.95543	.04457
31	.95254	.04746
32	.94942	.05058
33	.94608	.05392
34	.94250	.05750
35	.93868	.06132
36	.93460	.06540
37	.93026	.06974
38	.92567	.07433
39	.92083	.07917
40	.91571	.08429
41	.91030	.08970
42	.90457	.09543

Age	Life Estate	Remainder
43	.89855	.10145
44	.89221	.10779
45	.88558	.11442
46	.87863	.12137
47	.87137	.12863
48	.86374	.13626
49	.85578	.14422
50	.84743	.15257
51	.83674	.16126
52	.82969	.17031
53	.82028	.17972
54	.81054	.18946
55	.80046	.19954
56	.79006	.20994
57	.77931	.22069
58	.76822	.23178
59	.75675	.24325
60	.74491	.25509
61	.73267	.26733
62	.72002	.27998
63	.70696	.29304
64	.69352	.30648
65	.67970	.32030
66	.66551	.33449
67	.65098	.34902
68	.63610	.36390
69	.62086	.37914
70	.60522	.39478
71	.58914	.41086
72	.57261	.42739
73	.55571	.44429
74	.53862	.46138
75	.52149	.47851
76	.50441	.49559
77	.48742	.51258
78	.47049	.52951
79	.45357	.54643
80	.43659	.56341
81	.41967	.58033
82	.40295	.59705
83	.38642	.61358
84	.36998	.63002
85	.35359	.64641

Age	Life Estate	Remainder
86	.33764	.66236
87	.32262	.67738
88	.30859	.69141
89	.29526	.70474
90	.28221	.71779
91	.26955	.73045
92	.25771	.74229
93	.24692	.75308
94	.23728	.76272
95	.22887	.77113
96	.22181	.77819
97	.21550	.78450
98	.21000	.79000
99	.20486	.79514
100	.19975	.80025
101	.19532	.80468
102	.19054	.80946
103	.18437	.81563
104	.17856	.82144
105	.16962	.83038
106	.15488	.84512
107	.13409	.86591
108	.10068	.89932
109	.04545	.95455

Appendix XI, Reserved for Future Use

Body

Revision 20-3; Effective September 1, 2020

Appendix XII, Nursing Facility and Home and Community-Based Services Waiver Information

Body

Revision 21-1; Effective March 1, 2021

Note: The following information is effective January 1, 2021.

Medicaid Eligibility for the Nursing Facility Program and the Home and Community-Based Services Waiver Programs

Income — Maximum gross monthly income

- $2,382 Individual
- $4,764 Couple

Note: The income of parents and spouses are not considered for determining eligibility.

What counts as income?

- Social Security benefits
- Certain veterans benefits
- Private pensions
- Interest or dividends
- Royalty and rental payments
- Federal employee annuities
- Railroad benefits
- State or local retirement benefits
- Gifts or contributions
- Earnings and wages

Resources — Maximum countable resources

- $2,000 Individual
- $3,000 Couple

What is a resource?

- Bank accounts and certificates of deposit (CDs)
- Real property
- Life insurance policies
- Burial funds
- Individual retirement accounts (IRAs)
- Stocks and bonds
- Oil, gas or mineral rights
- Jewelry and antiques
- Cars and other vehicles
- Boats and recreational vehicles

What can be excluded?

- A homestead in Texas to which the person intends to return.
- Life insurance, if the face value is $1,500 or less per insured person.
- Separately identifiable burial funds of $1,500 (less any excluded life insurance) or more, if irrevocable, for the applicant and the applicant's spouse.
- One vehicle is excluded, regardless of value.

Protected resources amount for a spouse in the community

$26,076 minimum to $130,380 maximum (excludes value of homestead, household goods, personal goods, one car and burial funds)

Other Eligibility Requirements

Nursing Facility

- Be 65 or older or meet SSA's definition of disability.
- Meet medical necessity criteria.
- Be a resident of Texas and a U.S. citizen or alien with approved status (for example, a legalized or permanent resident alien).
- Live in a Medicaid-contracted long-term care facility for at least 30 consecutive days.

Co-payment

Individual — Total gross income, less $60 for personal needs.

Individual with a spouse in the community — Total gross couple income, less $60 for personal needs; less amount up to $3,259.50 for community spouse; less certain amount for dependents living with community spouse.

Couple — Total gross income, less $120 for personal needs.

Certain other expenses (such as health insurance premiums, guardianship fees and incurred medical expenses if the Medicaid program does not cover direct payment for the services) may be deducted if the person meets program policy requirements.

Home and Community-Based Services

- Be 65 or older or meet SSA's definition of disability.
- Meet nursing facility medical criteria or ICF/IID-RC level of care criteria.
- Be a resident of Texas and a U.S. citizen or alien with approved status (for example, a legalized or permanent resident alien).
- Have an approved plan of care within the cost ceiling.
- Meet waiver requirements.

Co-payment

In certain situations, a recipient may be required to pay a co-payment based on income.

Appendix XIII, Reserved for Future Use

Body

Revision 19-3; Effective September 1, 2019

Appendix XIV, In-Kind Support and Maintenance Charts A through E; Worksheets A through D

Body

Revision 16-4; Effective December 1, 2016

Appendix is available for staff use, here.

Appendix XV, Notification to Provide Proof of Citizenship and Identity

Body

Revision 07-3; Effective July 1, 2007

Insert for Application and Redetermination Packets

Beginning July 1, 2006, each U.S. citizen eligible for Medicaid will be required to provide proof of citizenship and identity. This is due to a new federal law.

You will not have to provide any additional documents to prove citizenship and identity if you:

- Receive SSI or have received SSI in the past.
- Are entitled to and/or enrolled in Medicare currently or have been in the past.
- Are a newborn to a mother who is Medicaid eligible.

If you are required to provide documents to prove citizenship and identity, the lists below will help you decide the best way to do this.

For individuals born in Texas, we may be able to get the birth certificate electronically, and you will not need to provide it to prove citizenship. However you will need to provide proof of identity.

The following documents prove both citizenship and identity. You need to provide only **one** of these documents.

- U.S. passport
- Certificate of Naturalization
- Certificate of U.S. citizenship

If you do not have one of the documents listed above, then you will need to provide one document from each of the lists below. This means you will need to provide **two** documents with your application or recertification.

To Verify Citizenship

- U.S. birth certificate
- U.S. citizen identification card

To Verify Identity

- Current driver license with picture

- American Indian card with a classification code "KIC"
- Northern Mariana identification card
- Hospital record of birth
- Religious record of birth with date and place of birth, such as baptismal record
- Affidavit from two adults, regardless of blood relationship to the individual, establishing the date and place of birth in the United States
- Department of Public Safety identification card with picture
- Work or school identification card with picture

There may be other documents we can accept to prove citizenship or identity. Please contact your local office to discuss other possibilities. If you are currently receiving Medicaid and are unable to provide proof of citizenship, you may be given extra time to obtain and provide proof before your Medicaid benefits are denied.

You may use an affidavit only as a last resort if you cannot provide any other proof. If you want to provide an affidavit to prove citizenship or identity, you can get a form at your local HHSC benefits office or online at www.hhsc.state.tx.us. You can dial 2-1-1 and request the location of the nearest HHSC benefits office.

Anexo para los paquetes de solicitud y de redeterminación

A partir del 1 de julio de 2006, todos los ciudadanos estadounidenses que reúnan los requisitos para recibir Medicaid deberán presentar pruebas de ciudadanía e identidad. Esto se debe a una nueva ley federal.

No tendrá que presentar ningún documento adicional para demostrar su ciudadanía e identidad si:

- Recibe SSI o ha recibido SSI en el pasado.
- Tiene derecho a Medicare o está o estuvo inscrito en él antes.
- Es un recién nacido cuya madre llena los requisitos de Medicaid.

Si tiene que presentar algún documento para demostrar su ciudadanía e identidad, las siguientes listas le ayudarán a determinar cuál es la mejor manera de hacerlo.

Quizás podamos obtener un acta de nacimiento electrónica de las personas que nacieron en Texas y usted no necesite presentarla para demostrar su ciudadanía. Sin embargo, deberá presentar pruebas de identidad.

Los siguientes documentos demuestran tanto la ciudadanía como la identidad. Solo tendrá que presentar uno de estos documentos.

- Pasaporte de Estados Unidos
- Certificado de naturalización
- Certificado de ciudadanía estadounidense

Si no tiene ninguno de los documentos de la lista anterior, tendrá que presentar un documento de cada una de las siguientes listas. Esto significa que tendrá que presentar dos documentos con su solicitud o recertificación.

Para verificar la ciudadanía

- Acta de nacimiento de Estados Unidos
- Tarjeta de identificación de ciudadanía de Estados Unidos
- Tarjeta de indio americano con un código de clasificación de "KIC"
- Tarjeta de identificación de Mariana del Norte
- Registro de nacimiento del hospital
- Registro religioso de nacimiento con fecha y lugar de nacimiento, como la fe de bautismo
- Declaración jurada de dos adultos, sin importar el parentesco con la persona, que establezcan la fecha y el lugar del nacimiento en Estados Unidos

Para verificar la identidad

- Licencia para manejar vigente con foto
- Tarjeta de identificación del Departamento de Seguridad Pública, con foto
- Tarjeta de identificación del trabajo o la escuela con foto

Puede haber otros documentos que se acepten para demostrar la ciudadanía o la identidad. Por favor, llame a la oficina local para hablar sobre otras posibilidades. Si está recibiendo Medicaid en este momento y no puede presentar la prueba de ciudadanía, es posible que reciba un plazo adicional para obtenerla y presentarla antes de negarle los beneficios de Medicaid.

Solo puede utilizar la declaración jurada como último recurso si no puede proporcionar otra prueba. Si quiere presentar una declaración jurada para demostrar su ciudadanía o identidad, puede conseguir la forma en la oficina local de beneficios de la Comisión de Salud o Servicios Humanos (HHSC) o en línea en www.hhsc.state.tx.us. Puede marcar el 2-11 y pedir la dirección de la oficina de beneficios de la HHSC más cercana.

Appendix XVI, Documentation and Verification Guide

Body

Revision 18-1; Effective March 1, 2018

This guide gives documentation expectations and suggested sources for obtaining information that have proven to result in quality, accurate cases. This document is comprehensive, but not all-inclusive and is subject to change. When supervisor approval is suggested, written or documented, verbal contact is acceptable.

Casework Hints: Hints are good, proven casework practices.

State/Medicaid Eligibility Specialist Judgment Call: Case record documentation based on eligibility specialist judgment or knowledge is an option, **but is not** a requirement.

Case Record Documentation: The Case Record Documentation column in the chart below includes information entered via Texas Integrated Eligibility Redesign System (TIERS) data entry screens. Use case comments only as needed for information not covered by TIERS data entry or to clarify TIERS entries.

Verification and Sources: Each bullet in the Verification and Sources column is an acceptable source of verification unless otherwise stated. Remember, documents the specialist receives or generates in the local office must be sent for imaging in order for them to become part of the case record.

Electronic Data Verifications: Staff must attempt to verify eligibility criteria using information from electronic sources. Staff may not request additional information or documentation from individuals unless such information is not available electronically or the information obtained electronically is not consistent with the information on the application.

Element Policy Section	Case Record Documentation	Verification and Sources
General Acceptable Documentation	Documentation must be sufficient to support the eligibility determination and give enough detail that someone not familiar with the case will understand computations and eligibility decisions. **Client Statement:** When selecting "client statement" as a verification source, the information must be on the application/renewal form, imaged documents or telephone/in person contact documentation and must be documented in case comments. **Third-Party Contacts by Telephone or In Person (including client and authorized representative [AR] contacts):** **Telephone** Document the following: • Telephone number called • Person(s) contacted, including title (authority to release information being requested) • Date of call • Reported information, including dates, values and/or balances, descriptions, and source(s) the responder references **In Person** Document the following: • Date • Reported information, including dates, values and/or balances, descriptions, and source(s) the responder references **Other Acceptable:**	Only one type of verification is required unless noted otherwise. **Example:** If all required information is on the bank statement, there is no need to request Form H1239, Request for Verification of Bank Accounts.

Element Policy Section	Case Record Documentation	Verification and Sources
	Document in case comments the source used to verify the element if there is no field to enter information on the individual TIERS Logical Unit of Work (LUW) page. **Note**: Other forms of verification may be acceptable with proper, complete documentation and program approval. For example, use of Kelly Blue Book, savings bond verification, etc. **Blanks on Most Recent Application/Review:** Documentation must address how items left blank on the most recent application or review are cleared. **Note:** If an application has only client identifying information and a valid signature, telephone contact may be needed to get an explanation of the incomplete items. It is not sufficient to assume a client has no income or resources or that none of the questions apply and to request only a State Online Query (SOLQ) inquiry.	
Case Comments	Document the following in case comments: • Complete name and area (MEPD) of the person making the comments. • Any open tickets, including the ticket number, date of ticket and the reason for the ticket. • The reason for reopening the application, with an explanation of the new file date. If a denial was made in error or the previous worker did not clearly document the denial reason, then document the reason for denial. The reviewer (supervisor/worker III) must document the reason when approving the reopening of an application with a protected file date. • Explain the file date chosen if there are several dates stamped or written on the application form or if an incorrect file date was used. If email correspondence is received, image the email.	

Element Policy Section	Case Record Documentation	Verification and Sources
	• If eligibility cascades to an incorrect program, document the reason eligibility is denied for the correct program. (For example: Application for waiver Medicaid denied due to excess income, cascaded to TANF Level Family. Sent to Texas Works for disposal.) • The reason for using the override function. • When the second-party reviewer does not approve whatever is being reviewed, then the reviewer (supervisor/worker III) would need to document why it is not approved. • Enough detail to explain the use of a contingency processing method (CPM) when one is needed due to a defect or because the policy has not yet been programmed into TIERS. If the CPM gives instructions on specific information to include in the explanation, then document the information. Document the CPM number. • Resolutions to any discrepancies, questionable information or special situations for any eligibility element. • The person's response to clear discrepant Data Broker information, or a notation that the person disagrees with the information, as required by policy in Appendix IV, Data Broker. • If an application indicates the person requested interpreter services, document when the services were provided and how they were provided, as required by policy indicated on Form H1200, Application for Assistance — Your Texas Benefits. Document the name of the interpreter. • Any contact made with the applicant/recipient or his authorized representative, including the date of the call, the name of the person contacted, that person's relationship to the applicant/recipient and authority to release information, and the phone number called.	

Element Policy Section	Case Record Documentation	Verification and Sources
	• Document the reasons for delays in processing an application and the eligibility specialist's actions, as explained in Section B-6420, Missing Information Due Dates, specifically in the subsection titled "Delay in Certification."	
SOLQ/WTPY **Use and Documentation**	SOLQ/Wire Third-Party Query (WTPY) can verify several things regarding an applicant's/recipient's eligibility and co-payment. **Examples:** • Name on Social Security Administration (SSA) record • Date of birth (DOB) • Citizenship • Medicare Parts A, B, C and D • Social Security amounts • Dual entitlement to Medicare and Medicaid This list is not all-inclusive. Use SOLQ as the primary verification tool when possible. To comply with SSA safeguarding requirements, **do not** print (and/or send for imaging) or copy and paste SOLQ data directly into case comments. In case comments, document the date or dates SOLQ was viewed. If SOLQ does not provide all information needed, request a WTPY. To comply with SSA safeguarding requirements, **do not** print (and/or send for imaging) or copy and paste WTPY data directly into case comments. In case comments, document the need for a WTPY, the WTPY request number, date viewed and information verified by WTPY rather than SOLQ.	**SOLQ/WTPY** Record SOLQ/WTPY correctly on screens where using SOLQ/WTPY as a verification source. (Since SOLQ is the primary source of verification and TIERS treats SOLQ/WTPY as one verification source, document in case comments when WTPY was used instead of SOLQ.)

Element Policy Section	Case Record Documentation	Verification and Sources
Streamlining Methods for Community-Based Applications	Use this procedure for community-based programs, including: • all cost-of-living adjustment (COLA) disregard programs, such as Pickle, Disabled Adult Child (DAC), and Widow/Widower; • all Medicare Savings Programs; and • the Community Attendant Services (CAS) program. Do not use this procedure when a person is applying for or requesting a program transfer to: • an institution, • a Home and Community-based Services waiver, • Medicaid Buy-In, or • Medicaid Buy-In for Children.	This procedure is available online on the Office of Social Services (OSS) website for Medicaid for the Elderly and People with Disabilities (MEPD). Look for the bulleted item **State Processes** under **Policy** on the left side of the webpage. The title of the document is Simplification for Community Based Programs.
Streamlining Methods for Redeterminations **B-8440**	Apply the three options to redeterminations for both institutional cases and community-based cases.	
Customized Redetermination Driver Flow (CRDF)	CRDF can be used for MEPD redeterminationswhen the case is active and in ongoing mode and the packet received date is on or before the redetermination date.	CRDF does not preclude the requirement for documentation and verification of eligibility elements.
Guardians and Other Agents **F-1231, B-3220, B-3300**	If there is no guardian or power of attorney (POA), determine if there is any other fiduciary agent. If there is no family, friends or attorney, Form H0003, Agreement to Release Your Facts, should be completed. **Note:** When a guardianship exists, only that person can act on the individual's behalf to sign applications and review forms.	Obtain a copy of the guardianship or POA document.

Element Policy Section	Case Record Documentation	Verification and Sources
Citizenship/Identity, Residence, Alien Status **D-3000, D-5000, D-8000**	If Level 1 evidence of citizenship is not used, document the reason a more reliable source is not used. If citizenship is verified by sources other than SOLQ: • Bureau of vital statistics (BVS) — Document the birth certificate number, as TIERS does not automatically retain the certificate number. • Birth certificate, naturalization papers or other sources used — Ensure the image is available in the portal. If viewing the original document, be sure to send a copy for imaging and return the original document to the individual. Alien status needs to be verified through Systematic Alien Verification for Entitlements (SAVE) in Data Broker. Identity verification must also be documented. Copies of documents are acceptable if they are legible and not questionable. **Hint:** Ensure copies of alien status cards are legible by adjusting the print quality on the copier.	See Appendix V, Levels of Evidence of Citizenship and Acceptable Evidence of Identity Reference Guide, for acceptable documentation. If citizenship or alien status verification is the only information that is not provided, do not delay certification or deny the application. Form TF0001, Notice of Case Action, informs the applicant that citizenship or alien status verification will be required within 95 days and lists the name of each individual who must provide citizenship or alien status verification.

Element Policy Section	Case Record Documentation	Verification and Sources
	Hint: The notification of denial should explain that denial is based on applicant/recipient declaration. Document the name and type of contact, date, time and any additional comments to substantiate the decision.	
Excess Income or Resources	**Excess Resources:** • If excess resources can be designated as burial funds, allow the person the opportunity to do so. See Section F-4227, Burial Funds. • If a person is determined ineligible because of excess funds in a joint account, allow the person an opportunity to disprove the presumed ownership of all or part of the funds. The person must also be allowed to disprove ownership of joint accounts that do not currently affect eligibility, but may in the future. See Section F-4121, Joint Bank Accounts. **Excess Income:** See the following: • Section G-6200, Special Income Limit for the Eligibility Budget • Section F-6800, Qualified Income Trust (QIT) • Appendix XXXVI, Qualified Income Trusts (QITs) and Medicaid for the Elderly and People with Disabilities (MEPD) Information • Section B-2500, Explaining Policy vs. Giving Advice **Hint:** If denial is based on applicant/recipient declaration, both the notification of denial and case comments should include the name and type of contact, date and any additional comments to substantiate the decision.	

Element Policy Section	Case Record Documentation	Verification and Sources
Third-Party Resources **D-7000**	Ensure that the TPR LUW is completed fully and accurately to ensure correct information is submitted to Provider Claims. **State/MEPD Specialist Judgment Call:** Assignability of the policy may be pursued on a follow-up basis if it appears reasonable that the policy is assignable. **Casework Hints:** • Check bank drafts for premiums for third-party resource (TPR) policies. • Check employment history/retirement income for possible TPRs.	Verify the names, addresses and policy numbers of insurance policies (assignability). Sources for verifying insurance policies: • Copy of policy • Form H1253, Verification of Health Insurance Policy • Copy of insurance card Verify the amount of the premium and obtain proof that premiums are being paid and that the policy is in force. Copies of canceled checks are very good proof of payment of an insurance premium.
Incurred Medical Expenses **Chapter H, Co-Payment**	Incurred medical expenses (IMEs) should be properly determined (co-payment issue). • Is the IME being paid by the applicant/recipient? • Do not allow an IME deduction if there is no proof that the applicant/recipient paid the insurance premium and/or incurred other medical expenses. • If someone else has been paying the insurance premium and/or medical expenses and the applicant/recipient clearly plans to make the payment, schedule a special review to consider the IME deduction. Obtain a completed, signed and dated Form H1263, Certification of Medical Necessity. See Appendix XXXII, Incurred Medical Expenses (IME) Deductions for Medicare Rx Drugs, for information about IME treatment and processes.	Verify the names, addresses and policy numbers of insurance policies. Verify the names and addresses of other medical providers the applicant/recipient may be paying, such as a dentist. For what is the charge? Is it for an allowable medical expense? How many payments will be required for complete payoff? How much has been agreed to be paid? Is there any private health insurance that might pay the expenses? If there is no documentation field present in TIERS, use case comments to record this information. Verify the name and address of any other source of payment. Copies of canceled checks are very good proof of payment of a medical bill. Do not allow deductions for nonassignable health or nonassignable dental insurance policies. Assignable insurance policies must be reported on Form H1039, Medical Insurance Input, and sent to the Office of Inspector General (OIG), Third-Party Resources Unit. Remember to set a special review date to monitor IMEs.

Case Record Documentation

Evaluate that the transfer took place. Document the when, what, how much was it worth as of 12:01 a.m. on the first day in the month of transfer, how much was received, and the "from(s)" and "to(s)."

Document the date of transfer.

Establish the look-back period. Were assets transferred within the look-back period?

Presume the transfer took place for Medicaid eligibility. Is there any value that is uncompensated?

Evaluate the transfer for exceptions. Document applicable exceptions as needed.

Document the value of the resource at the time of transfer and the amount of income being transferred.

Offer an opportunity for rebuttal.

Document the compensation received to offset the value transferred.

Document that an opportunity for rebuttal was offered and record the time frames observed. Were the rebuttal notices properly sent? If the individual attempts a rebuttal, document the evidence used during the rebuttal process.

Document the factors used to determine the validity of the rebuttal.

Document supervisor concurrence of the rebuttal decision.

Bank statements that are provided or requested need to be reviewed for possible transfers. If transfers are noted, additional bank statements and other verification can be requested to determine and verify whether additional transfers have occurred.

See Section I-3000, Exceptions to the Transfer of Assets.

See also:

Verification and Sources

Sources for verifying validity of a transfer:

- Copies of documents transferring assets. (Documentation from viewing documents is acceptable if copies cannot be obtained. Document the reason a copy could not be obtained.)
- Contact with companies or firms, such as a financial institution, that are knowledgeable of the transfer. (The contact must be documented using telephone contact documentation.)
- Verify the fair market value according to handbook requirements for the asset transferred.
- Can request up to 60 months of bank statements or other verification if a transfer has occurred.

Sources for verifying the amount of compensation offered:

- If compensation is other than cash, document the formula used for determining the value of the tendered compensation.
- Verification should include a copy of the sales document or agreement. If an oral agreement was made, obtain a written statement from the applicant/recipient and the person who received the transferred asset.
- If more than one source of verification is required (for example, one to verify transfer and another to verify compensated value), document the additional sources and pertinent information in case comments.

Receipts used to verify compensation: Bank deposit slips or bank statements (for verification of the amount only).

Element Policy Section	Case Record Documentation	Verification and Sources
	• Section F-6500, Irrevocable Trusts • Section F-6800, Qualified Income Trust (QIT) • Section F-7000, Annuities • Section E-4400, Other Annuities, Pensions and Retirement Plans • Section E-3320, Alimony and Support Payments • Section E-3370, Gifts and Inheritances • Section E-3372, Effective Date of Receipt of Inheritance; Disclaimers	
Cash **F-4110**	Cash is a countable resource. Accept the person's statement as to the amount of cash on hand. Address the amount as of 12:01 a.m. on the first day of the month.	Accept the person's statement as verification.
Bank Accounts **F-4120**	Document the name of the financial institution, complete account number and account accessibility by the applicant/recipient. Document the account balance as of 12:01 a.m. on the first day of the appropriate month(s). Give consideration to encumbered funds. Give consideration to the timing of consistent income deposits. Is interest being paid on the account? If so, document the amount and frequency of payment and the source of verification. For information about the treatment of interest paid, see the Interest and Dividends section of this chart, as well as handbook sections regarding the treatment of interest in eligibility and co-payment budgets. Identify the source of all deposits. All questionable deposits should be verified. Identify withdrawals that reoccurred at least three times a month. Identify the payees of all bank drafts. Do not develop a transfer penalty when the total amount of all transfers per month is **$200 or less,** as outlined in Section I-3600, Administrative Procedures of Transfers of Nominal	Verify an applicant's/recipient's bank account balance using one of the following methods: • Bank statements or a completed Form H1239, Request for Verification of Bank Accounts. Payment for completion of the form cannot be made by the Texas Health and Human Services Commission (HHSC). • Letter from the financial institution. • Telephone contact with an employee of the financial institution, using telephone contact documentation. • Pursue written follow-up if unable to obtain information by telephone call or if this information results in the applicant/recipient being ineligible. The following three pieces of information must be in the case record: • Name of the financial institution • Account number(s) • Amount of the balance as of 12:01 a.m. for the appropriate month(s) If the verification that the person provides does not meet the three criteria above, ask specifically for the information that is missing. For example, request a copy of the bank statement that will indicate (1) the name of the financial institution, (2) the account number, and (3) the balance as of 12:01 a.m. for [the appropriate] month(s).

Element Policy Section	Case Record Documentation	Verification and Sources
	Amounts. Document information in case comments on all deposits and withdrawals, as identified above. If these deposits and withdrawals are numerous, it may be advisable to document on a separate sheet the identity of each deposit and withdrawal (bank, date and amount). Be sure to send the completed sheet to be imaged. **Applications:** Obtain bank statements covering the month of application and the three prior months to substantiate financial flow/management and statements regarding potential transfers of assets. If transfers have occurred, request as many bank statements as needed (up to 60 months) to determine how far back the transfers may go. **Reviews:** Verify resources as of 12:01 a.m. on the first day of the month that Form H1200, Application for Assistance — Your Texas Benefits/Form H1200-A, Medical Assistance Only (MAO) Recertification, was received; the preceding two months; or any month up to the month the review is completed. **Reminder:** All resources must be verified as of 12:01 a.m. on the same month.	**Hint:** For institutional cases, including waiver cases, bank statements are preferred over Form H1239 for verification purposes due to possible transfers and drafts.

Element Policy Section	Case Record Documentation	Verification and Sources
Joint Bank Accounts **F-4121**	Document the name of the financial institution and the complete account number. Document the name of the person(s) with access to the account. If disproving ownership, obtain a completed Form H1299, Request for Joint Bank Account Information, or a written statement by the applicant/recipient (or from the applicant's/recipient's authorized representative if not listed as an owner of the account) as to the applicant's/recipient's ownership of the funds in the account. (An authorized representative's statement can be accepted if no other statement is available and there is additional evidence to support the statement, such as deposits and canceled checks.) Whose funds were used to establish the account? Whose income was used to make subsequent deposits, and who made withdrawals? Use case comments to document how and when ownership is disproved. Obtain written statements from co-holders of the account verifying the applicant's/recipient's statement. A third party's statement may be necessary if either party is mentally incompetent. Obtain evidence that a change has been made to restrict the applicant's/recipient's accessibility to the account (funds) or to establish separate accounts. If the account is not disproved, follow the guidelines for case record documentation for bank accounts. If all monies belong to the applicant/recipient, no Form H1299 is required. Follow the guidelines for case record documentation for bank accounts.	Verify the name of the financial institution and account number. Verify the name of the owner (or owners) of the account. The applicant/recipient must be given the opportunity to disprove or prove ownership of part or all funds/income in the account, before denial.

Element Policy Section	Case Record Documentation	Verification and Sources
Trusts **F-6100 through F-6900**	Document the type of trust. Is the trust revocable or irrevocable? Document whether the trust is revocable or irrevocable. If it is irrevocable, review the transfer of assets treatment in Section F-6500, Irrevocable Trusts; Section F-6713, Transfer of Assets; and Chapter I, Transfer of Assets. Is the trust a qualifying income trust (QIT)? Are deposits being made to a trust account? Determine the source(s) of deposits to the account. Who is the beneficiary? Document the value of the trust corpus. Document the amount and frequency of income being produced by the trust, and the amount of the corpus and income available to the applicant/recipient. Determine and document the countability of the corpus and income being produced. Document the source of verification.	**Send copies of trusts to regional legal staff for interpretation.** Sources for verifying trusts: • Copy of the trust agreement. • For special needs trusts, the source of the assets used to fund the trust. • Copy of the will, if the trust is a testamentary trust. • For wills, a copy of the Order Probating the Will or a copy of the Letters Testamentary issued when the will was probated. This is actually needed for any resource type where the individual may have inherited an interest in property, for example, a will granting a life estate or other interest in property. • Statement from the financial institution, trust management company or attorney. • Legal staff interpretation. (Contact with legal staff should occur via designated procedures.) **Note:** If the trust is exempt, document the basis for the exemption.
Patient Trust Funds **F-4123**	Document whether the applicant/recipient maintains a trust fund at the facility and the balance in the account as of 12:01 a.m. on the first day of appropriate month(s). Is interest being paid on the account? If so, document the amount and frequency of payment and the source of verification. For information about the treatment of interest paid, see the Interest and Dividends section of this chart. If the applicant/recipient resided in another nursing facility and indicates that a trust fund was maintained at the previous facility, contact must be made with that facility to determine if the applicant/recipient owns a trust fund at that facility and to verify that funds have been transferred to the current facility.	Use one of the verification sources listed below: • Documented viewing of the facility's records • Copy of the statements provided by the facility • Contact with a knowledgeable representative at the facility, such as a telephone call to the facility bookkeeper, using telephone contact documentation

Element Policy Section	Case Record Documentation	Verification and Sources
Stocks **F-4130**	Document the following: Name of the company, number of shares and type of shares. Document in case comments the: • number of shares, • type of shares, and • calculations of countable value. Market value as of 12:01 a.m. on the first day of the appropriate month. Source of verification.	Use one of the following sources for verifying the closing prices of stocks: • Newspaper • Statement from a brokerage firm • Research department of a local library • Documented contact with the issuing company, using telephone contact documentation Use one of the following sources to verify ownership of stock: • Copies of stock certificates • Written statement from an authorized employee of the brokerage firm or issuing company • Documented contact with the brokerage firm or issuing company, using telephone contact documentation

Element Policy Section	Case Record Documentation	Verification and Sources
Bonds **F-4140**	Document the following: Name of the company, type of bond and the serial number. The serial number is required to verify the face value. Document the serial number in case comments. Market value as of 12:01 a.m. on the first day of the appropriate month. Source of verification. **Note:** There is no need to redetermine the value of a bond if there is evidence that the value will not change from year to year.	Verify ownership by examining the front of a bond. Use one of the following sources for verifying the cash value of municipal, corporate and government bonds: • Newspaper (closing price on the last day of the month before the appropriate month[s]) • Statement from an authorized employee of a savings or banking institution or a brokerage or securities firm • Research department of a local library Use one of the following sources for verifying the cash value of U.S. savings bonds: • Table of redemption values for U.S. savings bonds (the table may be available at a savings or banking institution) • Statement from an authorized employee of a savings or banking institution • Copy of bond

Element Policy Section	Case Record Documentation	Verification and Sources
Promissory Notes, Loans and Property Agreements **F-4150 (for resource treatment)** **I-6200 (cross reference for transfer of assets)**	Document the following: Ownership of the note. Accessibility by the applicant/recipient. Whether the note is negotiable. If non-negotiable, why? Does a transfer of assets exist? Whether the note is an excluded resource. If the note is excluded, the reason for exclusion. If the note is a countable resource, the current market value of the note. Amount of income (interest) generated by the note. Source of verification. **State/MEPD Specialist Judgment Call:** If the appraisal value is $0, based on the reason given by the appraising entity, document your evaluation of the validity of the appraisal. **Note:** The applicant/recipient must own the note. Notes that the applicant/recipient owes are not a resource.	**Send copies of notes, loans and property agreements to legal for interpretation.** Use one of the following sources for verifying ownership of a promissory note, loan or property agreement: • Copy of the instrument (note, mortgage or agreement) • Statements from the purchaser and noteholder Use one of the following sources for verifying negotiability of a promissory note, loan or property agreement: • Copy of the instrument that indicates whether it is negotiable • Statement from a bank or other financial institution, private investor, or real estate agent Use one of the following sources for verifying the value of a promissory note, loan or property agreement: • Copy of the instrument • Amortization schedule For a statement from a bank or other financial institution, private investor, or real estate agent (if the fair market value is being rebutted), the following information must be included: • Current principal owed • Appraised market value (if value is $0, document the reason) • Date the original instrument was signed • Interest rate • Payment schedule **Note:** If the appraisal value is not likely to change, there is no need to reverify the value each year unless circumstances involving the resource change.

Element Policy Section	Case Record Documentation	Verification and Sources
Home as an Excluded Resource **F-3000**	Document the address or location description of the home. Verify and document one of the following reasons for exclusion: • Principal place of residence • Spouse residing in home • Dependent relative residing in home • Home is placed for sale • Life estate/remainder interest (also see the Life Estates and Remainder Interests section in this chart) • Intent to return The primary evidence of an applicant's/recipient's intent to return home is the applicant's/recipient's statement, as documented on a signed Form H1245, Statement of Intent to Return to Home, or a written statement from the applicant's/recipient's spouse or authorized representative. Document the source of verification. **Remember,** a home placed in an irrevocable trust loses its homestead exclusion. A home placed in a revocable trust loses its homestead exclusion, but if it is removed from the trust, it can once again be excluded as a homestead if it meets the exclusion reasons. See Section F-3200, The Home and Resources in a Trust, through Section F-3300, The Home as a Countable Resource.	Verify the current residence address of the applicant/recipient and/or spouse (prior to nursing facility admission). Sources for verifying the exclusion are as follows: For a spouse/dependent relative residing in the home: Document the person's statement establishing the residence as the spouse's/dependent relative's primary residence. Use case comments for documentation. For intent to return: Form H1245 or comparable written statement on intent to return to the described residence. Document receipt of the form in case comments. For a home placed for sale: • Copy of the real estate listing agreement • Newspaper ad • Picture of a visible "for sale" sign on the property • Collateral contact with someone viewing a visible "for sale" sign on the property, using telephone contact documentation Document these sources in case comments. Review the status of a home placed for sale at each annual review. If a shorter time frame is referenced in the real estate listing agreement, set a special review to monitor at the specified time.

Element Policy Section	Case Record Documentation	Verification and Sources
The Home as a Countable Resource **F-3300**	Document the location and ownership of the homestead. If the property does not meet exclusion requirements, determine the current equity value of the homestead or the applicant's/recipient's equity interest in the homestead. Document in case comments the applicant's/recipient's ownership interest, if less than 100 percent, and the formula used for determining the countable equity value. Document the source of verification. See Section I-3000, Exceptions to the Transfer of Assets. See Section F-3800, The Home and Transfer of Assets.	Use one of the following sources for verifying location, ownership and current market value of a home: • Tax statement with the current assessment, if using 100 percent evaluation • Copy of the appraisal from the local taxing authority or appraisal district • Statement from a local knowledgeable source (for example, a realtor) • Telephone contact with a previously listed source, using telephone contact documentation Use one of the following sources for verifying the equity value of a home: • Copy of a lien, note or other outstanding debt • Statement from the mortgage company or a copy of the amortization schedule • Statement from the tax office (if taxes are in arrears) In TIERS, “court record or other legal document” includes a copy of a lien, note or other outstanding debt, a statement from the mortgage company, or a copy of the amortization schedule.

Element Policy Section	Case Record Documentation	Verification and Sources
Proceeds from Sale of Home or Other Real Property **F-3400, F-4260**	Determine the type of resource sold and whether the recipient received the current market value. If the current market value was not received, follow transfer-of-resources policy. Document the following: Selling price of the home or other real property. Gross amount received from and the expenses involved in the sale of the home/property. Itemize the expenses involved. Whether the applicant/recipient is purchasing a replacement home and the time frame for excluding the proceeds from the sale of the original home. Set a special review to monitor.	Sources for verifying the sale and amount received include: • Copy of the deed • Real estate contract or agreement • Statement from the mortgage company or a copy of the amortization schedule • Statement from the tax office (if taxes are in arrears) • Copy of the appraisal from the local taxing authority or appraisal district • Statement from a local knowledgeable source (for example, a realtor) • Sales receipt or contract • Bank deposit slip or copy of check/form of payment Sources for verifying expenses related to the sale of a resource include: • Bill for repairs or services • Copy of a lien or note that had to be paid to effect the sale (the copy should show the final settlement)
Home Equity **F-3600**	Treatment of a homestead as a resource in Section F-3000, Home, continues, but it does not impact the determination of disqualification for vendor payment in an institution or denial of waiver services due to substantial home equity. Evaluation of the substantial home equity is required for institutional or waiver services at application and redetermination. Consider reverse mortgage and home equity loans when determining the equity value. Consider undue hardship.	Obtain verification of the home equity value, including a copy of the reverse mortgage or home equity loan, if applicable, for the case record. Thoroughly document in case comments the home equity value and information about the reverse mortgage or home equity loan, if applicable.

Element Policy Section	Case Record Documentation	Verification and Sources
Continuing Care Retirement Community (CCRC) **F-3700**	The entrance fee in a continuing care retirement community or life care community must be evaluated for consideration as a resource if certain criteria are met. Document the following: • CCRC contract date • CCRC facility name • CCRC entry date • Is the resource accessible? (yes/no) • Does the contract specify that the fee be used to pay for care? (yes/no) • Is the person eligible for a refund upon termination of the contract or departure from the CCRC? (yes/no) • CCRC entrance fee value • Amount of entrance fee spent on care • Refundable amount	Obtain a copy of the CCRC contract.

Element Policy Section	Case Record Documentation	Verification and Sources
		Sources for verification include: • Ownership interest in the property • Tax statement with the current assessment, if using 100 percent evaluation • Copy of the appraisal from the local taxing authority or appraisal district • Statement from a local knowledgeable source about the value (for example, a realtor) • Telephone contact with a previously listed source with knowledge of the property in the area, using telephone contact documentation • Copy of the deed or will to verify ownership
Other Real Property **F-4210**	Document the following: Location and description of the property. Ownership interest in the property. Whether the property is excluded. If the property is excluded, the reason for exclusion. Current equity value of the applicant's/recipient's interest in the property. If the applicant's/recipient's ownership interest is less than 100 percent, document in case comments the percentage of ownership and the formula used for determining the value of the applicant’s/recipient’s interest. Source of verification.	**State/MEPD Specialist Judgment Call:** If the property is inherited via descent and distribution, the recipient's statement on the degree of ownership may be used if no other documentation is available. Obtain the assistance of legal staff to determine the degree of ownership. Sources for verifying the equity value of other real property are as follows: • Copy of a lien, note or other outstanding debt • Statement from the mortgage company or a copy of the amortization schedule • Statement from the tax office (if taxes are in arrears) In TIERS, “court record or other legal document” includes a copy of a lien, note or other outstanding debt, a statement from the mortgage company, or a copy of the amortization schedule.

Element Policy Section	Case Record Documentation	Verification and Sources
Life Estates and Remainder Interests **F-4212**	Document the location of the life estate property. Document whether the life estate is excluded as a resource, such as a home. In TIERS, for a remainder interest, use life estate as the real property type and document this action in case comments. If the resource is excludable, document the reason for exclusion. If the resource is countable, document the current equity value. See Appendix X, Life Estate and Remainder Interest Tables, for information about calculating life estate and remainder interest values. Calculate the equity value and document in case comments the formula used for determining the value. Document the source used to verify the value. **Note:** Clearance of a life estate is required for subsequent reviews if the recipient is over the resource limit and older than when the value was initially determined. Record whether the applicant/recipient chooses to rebut the value, the basis of the rebuttal, the value from a knowledgeable source used for the rebuttal, and the verification used to support the rebuttal. For the purchase of a life estate, see Section I-6100, Purchase of a Life Estate. See Section F-3800, The Home and Transfer of Assets.	Sources for verifying ownership of a life estate or remainder interest: • Copy of the deed. • Copy of the will, court record or other legal document showing that the applicant/recipient has been granted a life estate or remainder interest. If the terms of the will, court record or other legal document are difficult to understand, obtain the assistance of legal staff. Sources for verifying the current market value of a life estate or remainder interest: • If a statement from a knowledgeable source is obtained, the MEPD formula for determining value is not necessary. • Current tax statement or assessment notice. • Statement from a local appraisal district office. • Statement from a realtor or an authorized employee of a savings or banking institution. Sources for verifying the equity value of a life estate or remainder interest: • Copy of a lien, note or other outstanding debt • Statement from the mortgagee or a copy of the amortization schedule • Statement from the tax office (if taxes are in arrears) • Copies of bills for essential repairs • Copy of a bill for legal fees • For rebuttals, written verification from a knowledgeable source **Note:** Life estates cannot be inherited via descent and distribution, as the life estate would end at death. One cannot inherit another person's life estate.

Element Policy Section	Case Record Documentation	Verification and Sources
Life Settlement Contract **F-4225.1**	For the life insurance policy, document the following: • Name of the life insurance company, the policy number and the face value • Date the life insurance policy was converted to a life settlement contract For the life settlement contract, document the following: • Name of the life settlement company • Amount of proceeds from the life settlement contract • Irrevocable/revocable assignment • Name of the financial institution • Account number • Any allowable disbursements, as indicated in the account agreement • Amount of funds reserved for the death benefit After certification, send an encrypted email to OESMEPDIC@hhsc.state.tx.us (listed as HHSC OES MEPD IC in the Outlook Global Address List) and document in case comments the date the email was sent. Title the email "LIFE SETTLEMENT" in all caps. In the body of the email, include all of the following: • Case name • Case number • Document Control Number (DCN) for the life settlement contract and supporting documentation • Disposition date • Result of the disposition (certified or denied) • Total proceeds of the life settlement contract	Sources of verification include: • Copy of a contract or written agreement from the life settlement company • Copy of the account agreement from the bank • Bank account statement indicating deposits and withdrawals • Written statement from the life insurance company indicating change of ownership
Life Insurance **F-4223**	Document the following: Name of the insurance company, the policy number and the face value.	Sources of verification include: • Copy of the insurance policy • Completed Form H1238, Verification of Insurance Policies

Element Policy Section	Case Record Documentation	Verification and Sources
	Type of insurance coverage. Whether or not the insurance is excluded as a resource. If the insurance is excluded, the reason for exclusion. Whether or not the insurance is a participating policy. If an applicant/recipient has a participating policy, determine and document whether the dividends are used to: • Purchase additional insurance — Treat as an additional life insurance policy. • Increase the value of existing insurance policy coverage — Verify whether the face value or cash value is increased. • Apply toward the payment of premiums — Disregard the dividends as income or resources. • Pay cash to the policyholders — Verify how often cash is paid, the amount of the payment and how the cash is used. Balance of any dividend accumulation and interest. For TIERS, if dividends are accumulating and are considered in eligibility, add the countable value of the dividends to the cash value of the policy and enter this total in the cash value section of the life insurance screen. Use case comments to document the actual value of the policy and the value of the dividends separately. Do not utilize the interest/dividend field on the life insurance screen. If the insurance is a countable resource, the current cash value. Source used to verify the value. **Casework Hints:** • Check the bank drafts for life insurance premiums.	• Letter from the insurance company • Telephone contact with the insurance company's representative, using telephone contact documentation **Note:** For term insurance, no further verification is necessary. **Note:** On reviews, if a total face value equal to or less than $1,500 was previously verified and the policy is not participating, no further verification is needed.

Element Policy Section	Case Record Documentation	Verification and Sources
	• Check the insurance policy for an Application for Life Insurance page for indicators of other life insurance policies.	
Burial Spaces **F-4214**	Document the name of the cemetery and the number of spaces. All burial spaces are excluded regardless of designation. However, if the person acknowledges that the spaces are purchased as an investment, count the equity value. Ownership of a burial plot in another state does not affect residency requirements or excludability.	If the burial spaces are not an investment, accept the person's statement as verification. If the burial spaces are an investment, sources for verifying the location and number of spaces include: • Applicant's/recipient's statement • Cemetery association • Funeral home (if associated with a particular cemetery or if it sells plots) Review the purchase contract for the burial spaces.
Burial Funds **F-4227, F-4228, F-4229** **Preneed Contracts** **F-4160, F-4170**	Document the type of resource being designated. Document the total amount of assets being designated. Document the amount of the asset that is excludable under the designated burial fund exclusion. Unless the designated resource is a prepaid burial contract or a bank account styled "for burial," obtain a written statement from the applicant/recipient or his authorized representative designating the assets for burial. Verbal designation is acceptable when the applicant/recipient or authorized representative is designating life insurance insuring the applicant/recipient (or spouse) and the case is due. The recipient/authorized representative must follow up with a written statement, however, to continue the burial fund designation. For preneed contracts, document: • the name of the funeral home or insurance company; • how the policy is funded (e.g., life insurance, cash);	Use one of the following sources for verifying the designation of burial funds: • Form H1252, Designation of Burial Funds. • A written statement from the applicant/recipient or his authorized representative containing the same information requested on Form H1252. • For a life insurance designation, a verbal statement from the applicant/recipient or his authorized representative containing the same information requested on Form H1252 can be utilized to certify a case on a timely basis when a written statement or a completed Form H1252 is not received prior to the certification deadline. The case also must reflect a special review to follow up for the written statement of designation. If the written verification is not received by the due date, redetermine eligibility based on the resource not being designated. • Copy of the ownership papers or the financial institution's record showing the burial fund designation.

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- whether the policy is revocable or irrevocable;
- the face value of the contract and who owns it;
- the cash value, if it is owned by the applicant/recipient;
- the face value, if it is irrevocable or owned by someone else;
- the reason for exclusion, if it is excluded; and
- the source of verification.

May substitute another source of verification.

See Appendix XXXIV, Burial Resources, for information about calculating the countable amount of preneed.

Burial spaces can be excluded for anyone. However, only allow the designated burial fund exclusion for the person and the person's spouse.

Verification and Sources

If the designated burial funds are in the form of an irrevocable trust or arrangement, obtain a copy of the burial trust or agreement document.

Note: Burial space items are not excludable on insurance-funded burial contracts. However, if the insurance-funded burial contract is irrevocable and fully paid, the value of the burial space item is disregarded when determining the amount of the irrevocable arrangement that reduces the burial fund designation.

Exception: If the irrevocable burial contract is owned by someone other than the applicant/recipient, do not make a deduction for the burial space items regardless of whether the contract is paid in full or not; reduce the burial fund designation by the face value of the contract.

For preneed contract verification, obtain one of the following:

- Completed Form H1238-A, Verification of Pre-Need Information
- Copy of the contract or a letter from the funeral home, or document verbal contact with a funeral home representative using telephone contact documentation

Although contact with a funeral home representative can be used to complete a case near the delinquency deadline, immediately follow up with verification by obtaining a copy of the contract or a letter from the funeral home.

For insurance-funded preneeds, verification, including irrevocable assignment, must come from the insurance company, not the funeral home.

Element Policy Section	Case Record Documentation	Verification and Sources
Automobiles **F-4221**	Document the year, make and model of all vehicles. • Exclude one vehicle regardless of value. • If the household is made up of more than one person and the additional member of the household **requires** an additional vehicle for transportation to and from work, exclude the additional vehicle for that member for work transportation. • If the household is made up of more than one person and there is an additional member of the household who **requires** handicap-accessible transportation, exclude an additional vehicle if the vehicle is specially equipped for that additional member of the household. For all other vehicles, use the current market value. If the applicant/recipient still owes on the vehicle, consider the current market value and equity value. If the equity value is less than the market value, document the formula used to determine the countable value. Indicate the source used to verify the current market value and equity value.	Verify the market value of a vehicle in any of the following situations: • The applicant's/recipient's statement is not reasonable. • The applicant/recipient owns more than one the vehicle. Sources for verifying the value of a vehicle include: • Kelley Blue Book or NADA guidebook (trade-in wholesale value) • Hearst Corporation Black Book • Statement from an automobile dealer • Newspaper ads • Source knowledgeable about antique cars (in TIERS, use “other acceptable” and document in case comments) **Note:** If the vehicle is being declared as "junk" (not running or fixable), a $0 default value may be assigned.

Element Policy Section	Case Record Documentation	Verification and Sources
Land Resources **F-4213, E-3333** **This includes:** **Mineral Rights (oil, gas, etc.)** **Surface Rights (grass, timber, etc.)**	Document the following: Location/address of the property (document in case comments). Percentage of ownership interest in the land resources (document in case comments). Applicant's/recipient's accessibility to the interest in the land resources. Whether the land resources are excluded as a resource. If the land resources are excluded, the reason for exclusion. If the land resources are not excluded, the current equity value of the applicant's/recipient's interest in the land resources. Document in case comments the calculation of countable equity value. Source of verification. **Notes:** • Clearance of value is not required for subsequent reviews unless circumstances occur that may change the countability or value. • If the mineral rights are non-producing, assign a $100 "default value." Document in case comments the reason for the $100 default value. • If the default value negatively impacts eligibility, verify a specific value.	Sources for verifying the value of land resources: • Tax statement, if assessed. • Contact with a knowledgeable source in the community, using telephone contact documentation. (Sources include oil and gas producers, tax assessors/collectors, and petroleum lease agents/ landmen.) • Form H1242, Verification of Mineral Rights, completed by an authorized employee of the producing company. • Internal Revenue Service formula for assessing the value of mineral rights for inheritance purposes — 40 times the average monthly payout (to be used only when no other source is available). In TIERS, use "other acceptable" and document this information in case comments. Sources to verify ownership include: • Copies of deeds, wills or leases. If the terms of the deeds, wills or leases are difficult to understand, obtain the assistance of legal staff. • Copy of royalty statement. • Division order, if the mineral rights are producing. • Statement from the applicant/recipient about the amount of interest (ownership). • Completed Form H1242.

Element Policy Section	Case Record Documentation	Verification and Sources
Sources of Earned Income **E-3100 (includes royalties from book publications)**	Document the following: Gross earned income (if income fluctuates, use amounts for the previous six months or the number of months available). Source of earnings. Calculations used to determine average earned income, if appropriate. Amount of the protected earned income allowance, if appropriate. Source of verification. Date of special review, if appropriate. Amount of mandatory payroll deductions. In TIERS, identify these payroll deductions on the expenses screen using case comments.	Use one of the following sources for verifying the gross earned income for the immediately preceding six months (or less, depending on the review schedule): • Statement from the employer about wages (signed and dated) • Copies of check stubs (for the entire period if there is fluctuating earned income) • Written statement furnished by the ICF/IID provider, only if verification cannot be obtained from the employer • Completed and signed Form H1028, Employment Verification
In-kind Support and Maintenance (Non-Vendor Only) Situations **E-8000**	Document the name of the person(s) who provided the support and maintenance and the type of in-kind benefit given to the applicant/recipient. Document the amount of any payment or contribution made or received by the applicant/recipient. If the applicant/recipient rebuts the presumed maximum value, document the countable value of the in-kind benefit and any calculations used to determine the countable value. Verify the stated income is sufficient to provide for known living expenses. If manipulating entries on the detail screens in order to calculate in-kind support and maintenance (ISM) correctly, thoroughly document the ISM details in case comments.	Sources of verification include: • Statement from the owner as to the current market rental value • Statements from the applicant/recipient and the head of household or authorized representative (use statement from Form H1200, Application for Assistance — Your Texas Benefits, if reasonable) • Copies of checks for payments made by the applicant/recipient • Copies of household bills (utilities, rent, etc.)

Element Policy Section	Case Record Documentation	Verification and Sources
Farm Income **E-3130**	Document the type of farm income, the applicant's/recipient's interest in the farm income, and the accessibility of the income to the applicant/recipient. If not fully owned by the applicant/recipient, document in case comments the applicant's/recipient's ownership interest. Obtain the most recent income tax return, including Schedule F. **Note:** Project income based on the countable income declared on the most recent income tax return; depreciation is not an allowable expense. A review should be scheduled for six months to determine if the farm income for the period has changed significantly. If not, the projected income from the tax return should be continued until the annual review. A special review may be scheduled to obtain the next income tax return and put the annual review cycle in line with the filing of the return. In the absence of a recent (previous year) income tax return, use the amount of gross income and allowable expenses from the previous six months. Obtain this information from records provided by the applicant/recipient. If the amount of income is expected to change, document in case comments the reason for the difference in income. Document the amount of net countable income and the calculations used to arrive at countable income. See Section E-3120, Self-Employment, and Section E-6000, Self-Employment Income, for allowable expenses/deductions. Itemize these expenses/deductions and document them in case comments. Document the source of verification.	Verify gross annual income and expenses, as appropriate. If the farmland is not part of the applicant's/recipient's homestead, verify that the income is at least 6 percent of the equity value to ensure the farmland is exempt. **Note:** If the farm qualifies as the applicant's/recipient's business, it can be excluded regardless of the value or the rate of return (see Section F-4300, Resources Essential to Self-Support). Sources of verification include: • Income tax return • Receipts, payments and statements from other knowledgeable sources (for example, a county agent or a co-op)

Element Policy Section	Case Record Documentation	Verification and Sources
Self-Employment Income **E-3120, E-6000**	Document the following: • type of self-employment income; • most recent income tax return; and • amount of gross income and expenses from the previous months (if income tax return is not available or earnings are expected to be significantly different). If staff is determining earnings using the applicant's/recipient's tax return, identify if the earnings are anticipated to change significantly. Continue to use the earnings determined from the income tax return for the following six months or until the next income tax return is filed. If staff is determining earnings using the applicant's/recipient's IRS Schedule C form, staff will be directed to the Schedule C page in TIERS to enter the applicable fields from the applicant's/recipient's IRS Schedule C form. TIERS will calculate the monthly expense amount automatically. **Note:** An income tax return should not be used for projecting income for more than one year. If the applicant/recipient fails to file a timely tax return, projected income must be determined based on the income and expenses from the previous six months. If the amount of income is expected to change, explain the reason. Document this information in case comments. Document in case comments the amount of net countable income and the calculations used to arrive at countable income if not using a tax return, an IRS Schedule C form, or an IRS Schedule F form. Document the source of verification. Set a six-month special review for variable earnings income.	Verify gross earnings and expenses for the past six months. (See Section E-5000, Variable Income, and Section E-6000, Self-Employment Income, regarding the averaging of earned income every six months. For treatment in the eligibility budget, see Section G-2200, Variable Income, and for treatment in the co-payment budget, see Section H-3400, How to Budget at Reviews. Note the income tax return exception.) • Sources for verification include: • most recent year's income tax return; • IRS Schedule C, Form 1040- Profit or Loss from Business; • IRS Schedule F, Form 1040- Profit or Loss from Farming; and • receipts maintained by the applicant/recipient **Note:** Reconciliation must be done when a new tax return, an IRS Schedule C form, or an IRS Schedule F form is used for projecting the recipient's income or a change in the recipient's income is noted at the six-month review. **Hint:** If the applicant/recipient cannot provide income records (income tax receipts, etc.), have the applicant/recipient provide a written self-declaration of projected income, or use Form H1049, Client's Statement of Self-Employment Income. Use that statement to project income for one month. Explain to the applicant/recipient the information needed to establish the applicant's/recipient's true income; set a one-month special review to obtain the necessary information. Use the information gathered at the special review to project the applicant’s/recipient's earnings for six months.

Element Policy Section	Case Record Documentation	Verification and Sources
	Document the gross benefit amount and, if appropriate, the supplemental medical insurance benefits (SMIB) premium amount. If, according to SOLQ/WTPY, the difference between the RSDI gross and net benefit amounts is greater than the Medicare Part B premium, document the amount of and reason for the difference (e.g., overpayment, child support, etc.).	
Social Security Benefits **E-4100**	Document the claim number. Document the source of verification. For applications, verify gross benefits. For reviews, if the recipient's statement agrees with the conversion amount and there is no indication that the RSDI benefit has changed, no further verification is needed. Document in case comments the date SOLQ/WTPY was viewed. **Helpful Hint:** Check for dual entitlement.	Verify the amount of Social Security benefits by one or more of the following methods: • View or obtain a copy of the applicant's/recipient's award notice (letter) from the SSA. • Obtain an SOLQ/WTPY. • Contact a representative of the Social Security Administration, using telephone contact documentation. • View or obtain a copy of the applicant’s/recipient's most recent benefit check or direct deposit slip. This method is least desirable, because the check/direct deposit slip may not show the gross benefit amount. • At review, use the conversion amount in the system of record if there is no indication that the RSDI benefit is different from the converted amount.

Element Policy Section	Case Record Documentation	Verification and Sources
Railroad Retirement Benefits **E-4200**	Document the gross benefit amount and, if appropriate, the SMIB premium amount. In TIERS, document deductions on the expenses screen and utilize case comments to explain the deductions. Check the deductions for potential life/health insurance. If a deduction is for health/life insurance, then pursue verifying and documenting the insurance policy. (See the Third-Party Resources and Life Insurance sections of this chart.) Document the railroad retirement claim number. Document the source of verification. If a special review is needed for an annual cost-of-living increase (not automated) or an anticipated change in the health insurance premium, document the date of the special review.	Verification sources include: • Obtain a completed Form H1026, Verification of Railroad Retirement Benefits, to furnish information. • View or obtain a copy of the applicant's/recipient's award notice issued by the Railroad Retirement Board. • Contact a representative of the Railroad Retirement Board, using telephone contact documentation. • View or obtain a copy of the applicant's/recipient's most recent benefit check or direct deposit slip. This method is least desirable, because the check/direct deposit slip may not show the gross benefit amount. Send a follow-up letter to the payor.

Element Policy Section	Case Record Documentation	Verification and Sources
Department of Veterans Affairs (VA) Compensation and Pensions **E-4300**	Document the gross benefit amount and, if appropriate, the amount of any VA allowance not considered in the eligibility and co-payment budgets (i.e., aid and attendance [A&A], housebound benefits, or reimbursements for unusual or continuing medical expenses). In TIERS, if the pension is not full A&A, make two entries for VA income: one entry for the VA pension and the other entry for A&A. Document the VA claim number. Document the source of verification. **Note:** If the recipient's VA compensation is capped at $90, there is no need to reverify it at the recipient's review or at the COLA review. There is no need to reverify old-law benefits at the review if the recipient or authorized representative indicates there has been no change. If a special review is needed for an annual cost-of-living increase (not automated), document the date of the special review.	Verify VA benefits by one or more of the following methods: • Obtain a completed Form H1240, Request for Information from Bureau of Veterans Affairs and Client's Authorization. • Contact an appropriate VA representative, using telephone contact documentation. • View or obtain a copy of the applicant's/recipient's award notice issued by the VA. • View or obtain a copy of the most recent benefit check or direct deposit slip. This method is least desirable, because the check/direct deposit slip may not show whether the funds include aid and attendance, a housebound allowance, or reimbursements for unusual or continuing medical expenses. Send a follow-up letter to the payor.

Element Policy Section	Case Record Documentation	Verification and Sources
	Document the source of payments.	
	Document the gross benefit amount and the amounts of any deductions from the gross benefit. In TIERS, document deductions on the expenses screen and utilize case comments to explain the deductions.	Verify payments by one or more of the following methods: • Obtain a letter from the organization providing the payments. • Contact a representative of the organization, using telephone contact documentation. • Obtain a completed Form H1243, Verification of Civil Services Benefits, if the payments are from that source. • Obtain a completed Form H1297, Request for Information from Teacher Retirement System of Texas, if the payments are from that source. • Obtain a completed Form H1214, Request for Pension Information, for other types of pensions. • View or obtain a copy of the applicant's/recipient's award notice. • View or obtain a copy of the applicant's/recipient's most recent check or direct deposit slip. This method is least desirable, because the check/direct deposit slip may not show the gross benefit amount and/or deductions. Send a follow-up letter to the payor. • View tape matches, such as ERS or TRS.
	Check the deductions for potential life/health insurance. If a deduction is for health/life insurance, then pursue verifying and documenting the insurance policy. (See the Third-Party Resources and Life Insurance sections of this chart.)	
Other Annuities, Pensions and Retirement Plans **E-4400**	If the source of payment is a civil service annuity, document the claim number.	
	Document tape matches. Additional verification is not needed if the tape matches agree with the recipient's statement.	
	Document the source of verification.	
	If a change in the health insurance premium or an increase in benefits is anticipated (e.g., a cost-of-living increase for civil service annuities or a potential raise in Teacher Retirement System [TRS] or Employee Retirement System [ERS] benefits), document the date of the special review.	
	See Section F-7000, Annuities.	

Element Policy Section	Case Record Documentation	Verification and Sources
	If the applicant/recipient enters a Medicaid nursing facility, the administrator of the facility must notify SSA to initiate an application for Supplemental Security Income (SSI). See Section H-6260, Facility Administrator Responsibilities.	
Application for Other Benefits **D-6300**	Inquire about and document the following for potential entitlement to other benefits: • Military service time for applicant, spouse or child • Applicant's employment history • Applicant's previous marriages **Note:** If there is any indication the applicant/recipient may be entitled to other benefits (e.g., VA benefits), the applicant/recipient must apply for the benefits and provide proof of application for and/or receipt of the benefits within 30 days of receiving written notice from HHSC. The caseworker must set a special review to check whether the applicant/recipient has made application to the VA or other benefit provider. See Section D-6300, Application for Other Benefits Requirement, for information about monitoring applications for and/or receipt of benefits.	Check with the facility administrator and system of record. The applicant's/recipient's declaration is acceptable. For complete policy regarding the verification and documentation of potential benefits, refer to the appropriate sections of this documentation guide and the MEPD Handbook.

Element Policy Section	Case Record Documentation	Verification and Sources
Interest and Dividends **E-3330**	Document the following: Name of the financial institution, company or other source of interest or dividend income. If the income is received from a financial institution, the account number. If the income is received from an insurance company, the policy number. The information used for projecting income, including the interest amount and dates paid (must be verified at each review subject to variable income review policy). If the income is excludable, the reason for exclusion. If the income is countable, any calculations used to arrive at an average amount. Source of verification. If a special review is needed, the date of the special review.	Sources of verification include: • Copies of bank statements • Written statement from the company or financial institution making the payments • Copies of dividend check stubs • Completed Form H1239, Request for Verification of Bank Accounts • Contact with a representative of the company or financial institution, using telephone contact documentation • Completed Form H1238, Verification of Insurance Policies, if received from an insurance company

Element Policy Section	Case Record Documentation	Verification and Sources
	Document the type of rental income, the applicant's/recipient's interest in the rental income, and the accessibility of the income to the applicant/recipient. Document in case comments the applicant's/recipient's interest in the income. Obtain the most recent year's income tax return (depreciation is not allowable) for persons who have established rent records. **Note:** Income may be projected using the most recent year's income tax return, but a review is required at six months to determine if there has been a significant change in the applicant’s/recipient's income.	Sources for verification include: • Income tax return • Receipts, payments, bank deposit slips and canceled checks • Statements from the applicant/recipient and the renter
Rents **E-3340**	If not using the income tax return to project income, use the amount of gross income and expenses from the previous six months to project the income and expenses for the next six months. If the amount of income is expected to change, document in case comments the reason for the difference in income. Document the amount of net countable income and the calculations used to arrive at countable income. Document in case comments the types of expenses or deductions. Document the source of verification. If a special review is needed, document the date of the special review.	

Element Policy Section	Case Record Documentation	Verification and Sources
Royalties (from land resources) **E-3330**	Document the following; Name of the payor and the reason for payment. Verification of the amounts and receipt dates used in the calculation of average income. If the royalties are excludable, the reason for exclusion. If the royalties are countable, the calculations used to arrive at an average amount. Source of verification. If a special review is needed, the date of the special review.	Use one of the following methods of verification: • Copies of check stubs. • Completed Form H1242, Verification of Mineral Rights. Ensure the reported payments reflect when royalties were received and not when they were earned. • Contact with a representative of the lease company (must be documented using telephone contact documentation). Automated telephone information is acceptable and a very good source of information, but it must be documented using telephone contact documentation.
Gifts, Inheritances, Support and Alimony **E-3320, E-3370** **Cross reference: Chapter I, Transfer of Assets**	Document the following: Amount of the gift, support, alimony or inheritance. Whether the income will be treated as a lump-sum payment, infrequent or irregular income, or regular and predictable income. Source of the income. Frequency the income is received. Whether the income is expected to continue.	Verify a gift, an inheritance, or support and alimony payments by one or more of the following methods: • Obtain a statement from the person or organization providing the item. Use “other acceptable” in TIERS and document in case comments. • View or obtain copies of the court order, court records or will. If the terms and/or conditions of the agreement do not clearly identify income, obtain the assistance of legal staff. • Obtain a fair market value of gift items from a knowledgeable source or through newspaper advertisement. • Use other appropriate methods, depending on the nature of the item.

Element Policy Section	Case Record Documentation	Verification and Sources
Notes and Mortgages **E-1750, E-3331, F-4150**	Document the following: Name of the person making the note payments and whether the income is accessible to the applicant/recipient. Document in case comments the name of the person making the note payments. Amount of the note payment and the frequency of payments. Whether or not the note is negotiable. Whether or not payments are countable as income and, if so, the portion of the note payment that must be considered as income. Source of verification. If a special review is needed, the date of the special review. See Section I-6200, Purchase of a Promissory Note, Loan or Mortgage.	Sources of verification include: • Amortization schedule. • Copy of contract. • Copy of note or mortgage document giving the terms of repayment. If the terms and/or conditions of the agreement do not clearly identify income, obtain the assistance of legal staff. • Statements from the applicant/recipient and the person who makes the payments. Use "purchaser/noteholder" in TIERS. • Contact with the bank, using telephone contact documentation.
Prizes and Awards **E-3360**	Document in case comments the type of prize or award and the name of the awarding company. Document on the expense screen or in case comments any legal or medical expenses involved in obtaining the award. Document the value of the prize or award.	Verify prizes and awards by one or more of the following methods: • Obtain a copy of the applicant's/recipient's notice of the prize or award. • Contact a representative of the organization, using telephone contact documentation. • View or obtain a copy of the applicant's/recipient's check. • Obtain estimates of the value if the prize or award is not cash. • Obtain proof of any legal or medical expenses involved in obtaining an award.

Element Policy Section	Case Record Documentation	Verification and Sources
Medical Necessity (MN)/Level of Care (LOC) Determination for Applications **B-7420** **Hospice** **A-5200**	In TIERS, the interface auto-populates MN/LOC information. If the interface is not responding, the caseworker can populate TIERS screens with information verified by the Texas Medicaid and Healthcare Partnership (TMHP) or by the nursing facility (NF) if the person is receiving Medicare. If a person has elected hospice care, Form 3071, Individual Election/Cancellation/Update, serves as verification of MN.	Use one of the following methods for verification: • Long-term Services and Supports (LTSS) summary screen in TIERS, populated by the interface • Telephone contact with TMHP or the NF, documenting the name of the person and the date and time of contact
Thirty-Consecutive Day-Stay Rule **G-6000, G-6200, O-1100, O-5000**	Document in case comments that an applicant/recipient has met the 30-consecutive-days requirement, including verification and sources. If the person is eligible only because of the special income limit, the person must be admitted to a Medicaid-approved long-term care facility (Medicare-SNF, NF or ICF/IID) for the 30-consecutive-day time frame to begin. **Note:** A full or regular Medicaid recipient who enters a Medicaid-approved long-term care facility does not have to meet the 30-consecutive-day time frame.	Verify the applicant's/recipient's stay using one of the following methods: • Contact with facility staff no sooner than the 31st day of the applicant's/recipient's stay, using telephone contact documentation • Proof of admission and/or discharge due to death via the LTSS summary screen interface • Contact with TMHP, using telephone contact documentation • Contact with providers, using telephone contact documentation • Contact with waiver staff, using telephone contact documentation
Special Review Requirement **B-8200, B-8430**	**Hint:** This list is not all-inclusive. Special reviews are set for many reasons depending on the information needed. Monitor eligibility at least every three months if the applicant's/recipient's total countable income is within $10 of the income limit. Monitor eligibility at least every three months if the applicant's/recipient's countable resources are within $100 of the resources limit. Special reviews are needed every six months for the following: • All IMEs • Variable income	

Element Policy Section	Case Record Documentation	Verification and Sources
	Other situations requiring a special review include the following: • Potential benefits — Set a special review 30 days from the date of notice to apply for other benefits. • Known changes, such as an increase in income or TPR amount, loss of benefits, etc. Enter in case comments the following information: • Date of the special review • Why a special review is being set • What information needs to be requested to complete the special review The following information must be included in the case record documentation: • Whether a special review is needed • Specific details regarding the special review • Months and source of verification relevant to the special review • Date the special review will be conducted **All special reviews must be entered into TIERS.**	

Appendix XVII, System Generated IEVS Worksheet Legends for IRS Tax Data

Body

Revision 21-4; Effective December 1, 2021

Appendix is available for staff use on the LOOP.

Appendix XVIII, IRS Tax Code, Sections 7213, 7213A, and 7431

Body

Revision 16-4; Effective December 1, 2016

Appendix is available for staff use, here.

Appendix XIX, Reserved for Future Use

Body

Revision 19-2; Effective June 1, 2019

Appendix XX, Deeming Noninstitutional Budgets – Couple Living in the Same Household

Body

Revision 16-4; Effective December 1, 2016

Appendix is available for staff use, here.

Appendix XXI, Reserved for Future Use

Body

Revision 09-4; Effective December 1, 2009

Appendix XXII, Home and Community-Based Services Waiver Program Co-Payment Worksheets

Body

Revision 21-2; Effective June 1, 2021

Note: This information is effective March 1, 2021.

Appendix is available for staff use, here.

Appendix XXIII, Procedure for Designated Vendor Number to Withhold Vendor Payment

Body

Revision 18-1; Effective March 1, 2018

Appendix is available for staff use, here.

Appendix XXIV, Reserved for Future Use

Appendix XXV, Accessibility to Income and Resources in Joint Bank Accounts

Body

Revision 16-4; Effective December 1, 2016

Appendix is available for staff use, here.

Appendix XXVI, ICF/ID Vendor Payment Budget Worksheets

Body

Revision 16-4; Effective December 1, 2016

Appendix is available for staff use, here.

Appendix XXVII, Worksheet for Expanded SPRA on Appeal

Body

Revision 16-4; Effective December 1, 2016

Appendix is available for staff use, here.

Appendix XXVIII, Worksheet for Spouse's Income (Post-Expanded SPRA Appeals)

Body

Revision 16-4; Effective December 1, 2016

Appendix is available for staff use, here.

Appendix XXIX, Special Deeming Eligibility Test for Spouse to Spouse

Body

Revision 21-2; Effective June 1, 2021

Note: The following information is effective March 1, 2021.

Step	Spouse-to-Spouse Procedure	Budget		Budget		Budget	
Pretest	Applicant or recipient must first be eligible based on the applicant's or recipient's own income in the pretest. Determine if the applicant or recipient meets the pretest. Use G-5100, Individual and Couple Noninstitutional Budgets, or G-7000, Prior Coverage, as appropriate. If eligible as an individual in the pretest, use the following steps when deeming from an ineligible spouse to the applicant or recipient.						
1	Determine the appropriate income limit.			QMB		SLMB	
2	Determine the nonexempt and non-excludable gross earned and unearned income of the **ineligible** spouse; Reference E-1700, Things That Are Not Income, E-2440, Certain Health-Related Payments, E-3170, Census Bureau Wages, E-4300, VA Benefits, E-4318, VA Contracts, E-7200, When Deeming Procedures Are Not Used, and E-7300, When Deeming Procedures Begin.	gross earned	unearned	gross earned	unearned	gross earned	unearned
3	Determine the number of children. If no ineligible children and countable income is less than the program-specific living allowance allocation, skip to 4a.						

Step	Spouse-to-Spouse Procedure	Budget	Budget	Budget
	Program-Specific Living Allowance Allocation: Community MEPD $397; CA $397; QMB $378; SLMB $454; QI-1 $511; QDWI $757; Determine the non-exempt income of the **ineligible** children. See MEPD references in Step 2.			
4a	Deduct from the ineligible spouse's **countable income** the program-specific living allowance for each ineligible child reduced by the ineligible child's gross amount of income. If the child's own income exceeds the allowance, there is no deduction and the child and their income is disregarded in the budget. **The living allowance allocations are FIRST deducted from the ineligible spouse's UNEARNED income. If the ineligible spouse does not have enough unearned income to cover the allocation, the balance of the allocation is deducted from the ineligible spouse's earned income.** Reference Appendix XXXI, Budget Reference Chart. If remaining income (unearned or earned) of the ineligible spouse is no greater than the program-specific living allowance, **stop.** No income is deemed.			
4b	If remaining income (both earned and unearned) of the ineligible spouse exceeds the program-specific living allowance allocation, the applicant or recipient and the ineligible spouse are treated as an eligible couple in the deeming process. Continue with Step 5.			
5	Determine applicant's or recipient's monthly gross earned income and monthly unearned income, including the applicant's or recipient's support and maintenance. Because support and maintenance is exempt for the ineligible spouse, use the appropriate companion amount in Appendix XXXI. Reference E-8000, Support and Maintenance. Combine the remainder of the ineligible spouse's unearned income with the applicant's or recipient's unearned income and the ineligible spouse's earned income with the applicant's or recipient's earned income.	gross earned unearned	gross earned unearned	gross earned unearned
6	From the combined unearned income, deduct $20. If there is less than $20 unearned income, the remaining portion of the $20 exclusion is applied to earned income; **Note:** The $20 disregard is not applicable for Special Income Limit cases Spouse-to-Spouse Deeming (CAS, institutional and Waiver programs). Reference G-4110, Twenty-Dollar General Exclusion.			

Step	Spouse-to-Spouse Procedure	Budget	Budget	Budget
	From the combined earned income, deduct up to $65 plus half of the remaining earned income. Note: not applicable for Special Income Limit cases for Spouse-to-Spouse Deeming (CAS, Institutional and Waiver programs). Reference G-4120, Earned Income Exclusion.			
7	Deduct **applicant's or recipient's** COLA(s) for Pickle, DAC or Widow or Widowers. G-4300, Special RSDI Income Exclusions.			
	Deduct **applicant's or recipient's** Social Security COLA(s) for January and February of each year if the current countable budgeted income exceeds the appropriate QMB, SLMB, QI-1 Income Limit. See Q-1400, MSPs and Cost-of-Living Adjustments (COLAs).			
	Remainder is countable income.			
8	Compare to the appropriate income limit for an eligible **couple**.			
	If an unmet need of 1 cent or more exists, the **individual** is eligible.			
	For the **Special Income Limit** or the **QMB Limit**, if the income is no greater than these limits, the individual is eligible.			

Reference Appendix XXXI for income, resource and budget amounts. If eligible on individual pretest for QMB but not eligible for QMB in the special deeming eligibility test, re-budget appropriate programs for SLMB or QI-1. The minimum income requirement for SLMB or QI-1 does not apply when the applicant is ineligible due to deeming. For parent-to-child deeming, see G-2312, Parent-to-Child Noninstitutional Deeming.

Appendix XXX, Medical Effective Dates (MEDs)

Body

Revision 19-1; Effective March 1, 2019

Note: This document is effective Jan. 1, 2012.

Community Based

Type Program	MED
ME – Pickle	For ME - SSI to medical assistance only (MAO) program overlays or program transfers, the MED may be the first day of the month following the last month of Supplemental Security Income (SSI) eligibility. 3MP constraints apply (Form H1200, Application for Assistance – Your Texas Benefits, file date).

Type Program	MED
ME – Disabled Adult Child	For ME - SSI to MAO program overlays or program transfers, the MED may be the first day of the month following the last month of SSI eligibility. 3MP constraints apply (Form H1200, Application for Assistance – Your Texas Benefits, file date).
ME – Disabled/Early Aged Widow(er)	For ME - SSI to MAO program overlays or program transfers, the MED may be the first day of the month following the last month of SSI eligibility. 3MP constraints apply (Form H1200, Application for Assistance – Your Texas Benefits, file date).
ME – SSI Prior	• For **certified** SSI clients, Medicaid coverage **automatically** begins with the month prior to the first month of SSI **payment**. For ME – SSI Prior applications, the MED may be as early as the first day of the month, two months prior to the SSI **gap** month. (SSI Begin Date = Payment Month) • For **denied** SSI applicants, the MED may be as early as the three months prior to the SSI **application** month.
ME – Waivers	For waiver eligibility, the effective date for medical assistance is either: • the first day of the month of nursing facility (NF), intermediate care facility for individuals with intellectual disabilities or related conditions (ICF/IID) or state supported living center entry if the applicant filed a Medicaid application during that month, then requested a program transfer **before** being certified, and met all eligibility criteria; • the first day of the month if the applicant met all Waiver Eligibility Component and Financial Medicaid Eligibility Component criteria. See Section O-1100, Application for Waiver Programs; or • the day after the effective date of denial (under ME - SSI), for people transferred from SSI assistance to MAO (excluding qualified Medicare beneficiaries). **Notes:** • Consider potential three months prior to the application file date if the individual entered an NF, ICF/IID or state supported living center and then transitioned into a waiver setting before being certified. See **Institutional Based** section of this appendix. Also, see Section B-6300, Institutional Living Arrangement; Section B-7400, Application for Institutional Care; and Section J-4310, Determining the Assessment Date for a Home and Community-Based Services Waiver. • The MED information for waivers would not apply if the waiver required Medicaid eligibility prior to waiver services consideration (for example, Texas Home Living Waiver).
ME – Community Attendant	Use the: • first day of the month that the application was filed, if the provider started services during that month; • first day of the month services started, if the application was filed by that date; or • first day of the month that the eligibility decision was made.
MC – SLMB	MED is the first day of the month in which the application is filed as long as all eligibility factors are met. MED can be the first of any of the three months prior.

Type Program	MED
MC – Qualifying Individuals (QI-1)	MED is the first day of the month in which the application is filed as long as all eligibility factors are met. MED can be the first of any of the three months prior. 3MP cannot include previous calendar year unless the application was filed in the previous year.
MC – QMB	MED is the first day of the month following the month the case is processed and disposed in TIERS unless ensuring continuous Q.
ME – A and D - Emergency	MED is the date the emergency condition started. Use the date the practitioner entered on Form H3038, Emergency Medical Services Certification. There is also an end date. The practitioner will have also listed it on Form H3038. These are open/close cases.

Institutional Based

ME – Nursing Facility, ME – State School, ME – Non-state Group Home, ME – State Group Home, ME – State Hospital

Situation	Determination
Apply and Enter Nursing Facility (NF) in Same Month	Must meet 30 consecutive days in the facility. MED is the first day of the month of the month of entry to the facility.
Apply in Month following Month of Entry (Prior Months)	MED is potentially the first day of any of the three months prior to the application file date. Use the SSI income limit unless entry to a facility is during the month. If facility entry is in a prior month, use institutional income limit.
Subsequent Month	If individual is not resource eligible, the MED is the first day of the subsequent month in which all eligibility factors are met.

What to do if:

Situation	Determination
Applicant enters extended care facility (ECF) section of NF:	MED is the first day of the month of entry to ECF. ECF serves as the medical necessity (MN). At whatever point applicant moved from ECF or no longer meets Medicare care definition of skilled nursing facility, then MN is required. If time in ECF is in any prior months, the MED is the first day of any of the three months prior.
SSI client enters facility **and** SSI is denied:	MED is the first of the month following the last month of SSI eligibility.
SSI client enters facility **and** SSI is still active:	MED is the first of the month after the month SSI is denied. Email Data Integrity (DI) giving information of entry date. Once SSI shows denied the MEPD specialist can enter information for the applicable institutional EDG. If stay is temporary less than 90 days no change is needed. See Section B-7200 for specific details.
Individual enters NF **from** the community:	MED is potentially the first day of any of the three months prior to the application file date. Use the **SSI income limit** for income eligibility purposes if the individual was **not** in the facility any part of the month.

Situation	Determination
Individual enters facility **from** the hospital:	MED is potentially the first day of any of the three months prior to the application file date. Use the special income limit for the month of entry to the facility.

Continuous Coverage

Type Program	Time Frame
ME – Pickle	Continuous coverage is ensured if the application is filed by the end of April or the end of the fourth month after denial, if client continues to meet eligibility criteria and has unpaid or reimbursable medical bills during this prior time period.
ME – Disabled Adult Child	Continuous coverage is ensured if the application is filed by the end of April or the end of the fourth month after denial, if client continues to meet eligibility criteria and has unpaid or reimbursable medical bills during this prior time period.
ME – Disabled/Early Aged Widow(er)	Continuous coverage is ensured if the application is filed by the end of April or the end of the fourth month after denial, if client continues to meet eligibility criteria and has unpaid or reimbursable medical bills during this prior time period.
QMB	Continuous Qualified Medicare Beneficiary (QMB) Program coverage must be ensured, as well as Medicaid coverage. Retroactivity for continuous QMB may be as early as 24 months prior to the beginning of the current fiscal year (with September considered the start of a fiscal year), if appropriate.

Appendix XXXI, Budget Reference Chart

Body

Revision 21-3; Effective September 1, 2021

Community-Based Programs Using SSI Limits (DAC, Pickle, Widow(er)s)

Income — Effective Jan. 1, 2021, total countable income must be less than the Supplemental Security Income (SSI) federal benefit rate (FBR) with the exclusion of certain increases in Social Security benefits:

- Individual — $794
- Couple — $1,191
- Deeming amount — $397

Resources — Total countable resources must be no more than the limit:

- Individual — $2,000
- Couple — $3,000
- Companion — $3,000

In-Kind Support and Maintenance (Community Living Arrangement)

The value of food, shelter or both that a person receives from someone else.

Effective Jan. 1, 2021:

- One-third of the SSI FBR:
  - Individual — $264.66
  - Couple — $397
- One-third of the SSI FBR + 20:
  - Individual — $284.66
  - Couple — $417
- One-half of the couple 1/3 SSI FBR:
  - Companion — $198.50
- One-half of the couple 1/3 SSI FBR + 10:
  - Companion — $208.50

All Living Arrangements

Effective Jan. 1, 2021, the special income exemption for a student's earned income (regardless of living arrangement).

- Monthly earnings — $1,930
- Annual earnings — $7,770

Related Policy

Student Earnings, E-2220

Medicare Savings Programs (MSP)

Income limits are based on the federal poverty level (FPL).

Income — Effective March 1, 2021, total countable income must be:

- **QMB** — Not more than 100 percent FPL:
  - Individual — $1,074
  - Couple — $1,452
  - Deeming amount — $378
  - Medicaid benefits are:
    - Part A premiums
    - Part B premiums
    - Deductibles
    - Coinsurance
- **SLMB** — Greater than 100 percent FPL, but less than 120 percent FPL:
  - Individual — $1,074.01 to < $1,288
  - Couple — $1,452.01 to < $1,742
  - Deeming amount — $454
  - Medicaid benefits are:
    - Part B premiums
- **QI-1** — At least 120 percent FPL, but less than 135 percent FPL:
  - Individual — $1,288 to < $1,449

    - Couple — $1,742 to < $1,960
    - Deeming amount — $511
    - Medicaid benefits are:
        - Part B premiums
- **QDWI** — No more than 200 percent FPL:
    - Individual — $2,147
    - Couple — $2,904
    - Deeming amount — $757
    - Medicaid benefits are:
        - Part A premiums

Note: These income limits do not include the $20 disregard for MSP.

Resources — Effective Jan. 1, 2021, total countable resources must be:

- **QMB, SLMB, QI-1** — No more than the limit:
    - Individual — $7,970
    - Couple — $11,960
- **QDWI** — No more than twice the SSI resource limit:
    - Individual — $4,000
    - Couple — $6,000

Medicaid Buy-In (MBI) Program

Income — Effective March 1, 2021:

- Income eligibility is based on earnings.
- Countable earned income must be less than the limit:
    - 250 percent of FPL — $2,684

Resources — Total countable resources must be no more than the limit of $2,000.

MBI Monthly Premiums: Countable Unearned Income Minus (−) SSI FBR of $794 Plus (+) Earned Income Premium

Unearned Income Premium
Countable Unearned Income **Minus (−)** SSI FBR of $794

Earned Income Premium

	Countable Earned Income Based on FPL Range	
FPL	**Dollar Range**	**Earned Income Premium**
	Less than or equal to **$1,610**	$0
150%–185% of FPL	Greater than **$1,610** up to and including **$1,986**	$20
>185%–200% of FPL	Greater than **$1,986** up to and including **$2,147**	$25
>200%–250% of FPL	Greater than **$2,147** up to and including **$2,684**	$30

Countable Earned Income Based on FPL Range

FPL	Dollar Range	Earned Income Premium
>250% of FPL	Greater than **$2,684**	$40

If the unearned income premium amount plus the earned income premium amount equals or exceeds $500, then the total monthly premium remains at $500.

Medicaid Buy-In for Children (MBIC) Program

Resources — No resource test for MBIC.

Income — Effective March 1, 2021:

- MBIC income exclusion — $85 plus one-half of the remaining income.
- Eligibility — No more than 150 percent FPL based on family size.

These amounts **do not** include the MBIC income exclusion.

FPL Amounts for Income Eligibility

Family Size	150% FPL
1	$1,610
2	$2,178
3	$2,745
4	$3,313
5	$3,880
6	$4,448
7	$5,015
8	$5,583

Ineligible sibling exclusion amount (150% FPL x 2 + $85) — $3,305

FPL Amounts for Premium Determination

Family Size	150% FPL	200% FPL	300% FPL
1	$1,610	$2,147	$3,220
2	$2,178	$2,904	$4,355
3	$2,745	$3,660	$5,490
4	$3,313	$4,417	$6,625
5	$3,880	$5,174	$7,760
6	$4,448	$5,930	$8,895
7	$5,015	$6,687	$10,030
8	$5,583	$7,444	$11,165

MBIC Premiums — No Employer-Sponsored Insurance (ESI)

Family Income	Family of 1 or 2 Premium Amount	Family of 3 or More Premium Amount
At or below 150% FPL	$0	$0

MBIC Premiums — No Employer-Sponsored Insurance (ESI)

Family Income	Family of 1 or 2 Premium Amount	Family of 3 or More Premium Amount
151–200% FPL	$90	$115
201–300% FPL	$180	$230

MBIC Premiums — ESI with State-Paid Health Insurance Premium Program (HIPP)

Family Income	Family of 1 or 2 Premium Amount	Family of 3 or More Premium Amount
At or below 150% FPL	$0	$0
151–200% FPL	$25	$35
201–300% FPL	$50	$70

MBIC Premiums — ESI and No State-Paid HIPP

No MBIC premium.

Medicare Premiums

Effective Jan. 1, 2021

Part A Premium (Hospital Insurance):

- **$0** — Most people do not pay a monthly Part A premium because they or a spouse has 40 or more quarters of Medicare-covered employment.
- **$471** — Standard Medicare Part A monthly premium cost — The monthly Part A premium for people who are not otherwise eligible for premium-free hospital insurance and who have less than 30 quarters of Medicare-covered employment.
- **$259** — Reduced Medicare Part A premium — The monthly Part A premium for people who have 30–39 quarters of Medicare-covered employment.

Part B Premium (Medical Insurance):

- **$148.50** — 2021 standard Medicare Part B monthly premium.

Staff must use the Medicare Part B amount as verified in the State Online Query (SOLQ).

Related Policy

Medicare Part B Premium, H-1800

Community Attendant Services (CAS)

Income — Effective Jan. 1, 2021, total countable income must be no more than the special income limit:

- Individual — $2,382
- Couple — $4,764

Resources — Total countable resources must be no more than the limit:

- Individual — $2,000
- Couple — $3,000

Institutional Living Arrangement (Individuals residing in a Medicaid certified long-term care facility or receiving Home and Community Based Waiver services)

Individual or Couple Eligibility Budget

Special income limit — The special income limit for an individual is equal to or less than 300% of the SSI federal benefit rate.

Income — Effective Jan. 1, 2021, total countable income must be no more than the special income limit:

- Individual — $2,382
- Couple — $4,764

Resources —Total countable resources must be no more than the limit:

- Individual — $2,000
- Couple — $3,000
- Substantial home equity — $603,000.00
- Transfer of assets (TOA) divisor — $237.93 daily rate (effective Sept. 1, 2021)

Note: The Transfer of Assets daily rate is reviewed every other year.

Co-Payment

Individual or Couple Co-Payment Budget:

- Personal Needs Allowance (PNA) —
  - $60 (nursing facility recipient)
  - $60 plus the Protected Earned Income (PEI) amount (recipient in an ICF/IID facility)
  - $85 (recipient in foster care or assisted living)
  - $2,382 (HCBS waiver recipient)
- Guardianship Fees — Varies
- Dependent Allowance — $794
- Incurred Medical Expenses — Varies
- Deduction for Home Maintenance — Up to $794

Spousal Co-payment Budget:

- Personal Needs Allowance (PNA) —
  - $60 (nursing facility recipient)

    - $60 plus the Protected Earned Income (PEI) amount (recipient in an ICF/IID facility)
    - $85 (recipient in foster care or assisted living)
    - $2,382 (HCBS waiver recipient)
- Guardianship Fees — Varies
- Minimum Monthly Maintenance Needs Allowance (MMMNA) (Spousal allowance) — $3,259.50
- Spousal Impoverishment Dependent Allowance — $2,178 (effective July 1, 2021)
- Incurred Medical Expenses — Varies

Calculation of the Spousal Protected Resource Amount (SPRA):

- SPRA is the greater of:
    - one-half of the couple's combined countable resources; or
    - the minimum resource amount set by federal law (SPRA minimum — $26,076.00); but
    - SPRA is not to exceed the maximum resource amount set by federal law (SPRA maximum — $130,380.00).

Income-first minimum monthly maintenance needs allowance (MMMNA) for SPRA expansion (Spousal Allowance) — $3,259.50

Related Policy

Personal Needs Allowance (PNA), H-1500
Guardianship Fees, H-1550
Dependent Allowance, H-1600
Deduction for Home Maintenance, H-1700
Incurred Medical Expenses, H-2000
Spousal Impoverishment Dependent Allowance, J-7400

Appendix XXXII, Reserved for Future Use

Body

Revision 16-2; Effective June 1, 2016

Appendix XXXIII, Medicaid for the Elderly and People with Disabilities Information

Body

Revision 21-1; Effective March 1, 2021

Introduction

Assistance is available to help pay for medical care and supportive services for people with limited income and resources. The following information explains some of the requirements used to determine if you are eligible for help and what must be done to get help.

If you are interested in getting Medicaid to pay for medical and supportive services, you need to file an application. Depending on your income, you will file an application with either the Social Security Administration for Supplemental Security Income (SSI) or with the Texas Health and Human Services Commission (HHSC). If the Social Security Administration determines you are eligible for SSI, you will also be eligible for Medicaid without having to file a separate application with HHSC.

At HHSC, eligibility staff are responsible for determining the financial eligibility for Medicaid. This Medicaid assistance is available for those who do not have SSI and need care:

- in a nursing facility;
- in an intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID);
- in an institution for mental diseases (IMD); or
- through a home and community-based waiver program (these programs offer services and supports to help you live in the community).

Depending on your income, assistance is also available to help pay for your Medicare premiums (Part A, Part B or both), deductibles and coinsurance costs through a Medicare Savings Programs, Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB) or Qualifying Individuals-1 (QI-1).

You or your representative must complete an application for Medicaid and furnish the proof needed to make an eligibility determination. HHSC will determine your eligibility for Medicaid based on the information you provide on the application, documents you send in, and information that you orally explain.

By federal law, HHSC must also use your Social Security number to compare information with other state and federal agencies, such as the Internal Revenue Service, Social Security Administration, Texas Workforce Commission, and any others to ensure that your benefits are correctly determined. If you meet all eligibility requirements, HHSC is required to completely review your circumstances at least once a year to make sure you are still eligible for help.

You have the responsibility to let HHSC know, within 10 days, of any changes in your circumstances, including changes in your address and living arrangements, your income and resources, and your private health insurance premium amounts.

Non-Financial Eligibility

- **Age and Disability** — You must be at least 65 or older **or**, if under 65, you must get Social Security or Railroad Retirement disability benefits. If you are not getting a disability benefit, HHSC will complete a disability determination using your medical, education, and work history information.
- **Citizenship** — You must be a U.S. citizen or a qualified legal alien. Qualified legal aliens include those who have been lawfully admitted for permanent residence, active-duty military or honorably discharged veterans (or the spouses or dependent children of veterans), certain refugees or asylees, and certain people for whom deportation has been deferred. Unless you already have Medicaid or Medicare, a U.S. public birth certificate showing birth in one of the 50 states, the District of Columbia, Puerto Rico (if born on or after Jan. 13, 1941), Guam (on or after April 10, 1899), the Virgin Islands of the U.S. (on or after Jan. 17, 1917), American Samoa, Swain's Island or the Northern Mariana Islands (after Nov. 4, 1986) may be necessary to prove your citizenship. You may also need proof of earning 40 quarters of Social Security credit or proof of 10 years of verifiable work credit to prove your alien status.
- **Residence** — You must be a resident of the U.S. and Texas.
- **Medicare Savings Programs** — You must be entitled to Medicare Part A for QMB, SLMB and QI-1. You will need a Medicare card, award letter, or some other document from the Social Security Administration as proof of your Medicare Part A entitlement.

- **Medical Necessity, Level of Care for Nursing Facility, ICF/IID and Waiver Programs** — Your need for medical care available in a Medicaid facility or a Medicaid waiver program will need to be determined.
- **30 Consecutive Days in an Institution** — This applies after admission to a nursing facility, ICF/IID or IMD (if 65 or older). If you want help paying for care in a facility, you must stay in a facility that has a Medicaid contract for 30 consecutive days. If you must go to the hospital before the end of 30 days, but return directly to a Medicaid facility, the hospital stay counts toward the 30 days. If you meet all other eligibility criteria from the day you are first admitted to a facility, Medicaid can pay for care beginning the day of admission, once 30 days has passed.

Income

HHSC must consider your income from all sources. Gross income is usually used for the eligibility determination. Therefore, when comparing your income to the income limit for a program, deductions that are withheld from your income before you get it may be included.

If you get your income less frequently than monthly, it may or may not be countable. An example of income that may not be countable is a small amount of interest you receive quarterly.

Certain types of income may be exempt or excluded for the eligibility determination. An example of exempt income is a refund of federal income taxes relating to the earned income tax credit a person receives from the Internal Revenue Service (IRS).

Proof of Income

HHSC requires proof of income and deductions from income, such as award letters, check stubs from pension checks, check stubs from mineral rights payments, amortization schedules, bank statements listing interest or dividend payments, rent receipts (tax, insurance, and repair expense receipts), and copies of checks.

It may take some time to gather all the needed proof and more proof may be needed to verify your eligibility. Any of the above items that you send in with an application may speed up the eligibility decision.

If you are determined to be eligible, proof of your income may also be needed whenever there is a change in the amounts and at least once a year when your circumstances must be completely reviewed.

Resources

Resources are things that you own or are buying. The resources of both you and your spouse must be reported, regardless if the resources are owned by your or your spouse individually or together. The total value of resources that must be counted cannot exceed certain resource limits. Resource values are determined as of 12:01 a.m. on the first day of the month(s) that eligibility is determined. Some resources may not be counted.

For a waiver program, resources of a parent(s) are not considered.

Examples of Excluded Resources — The following are examples of some resources that HHSC does not count when determining eligibility:

- **Homestead** — If you, your spouse, or a dependent relative live in the home, the value of the home is not counted. Absence from a homestead may result in loss of its homestead status and exclusion unless you have an intent to return. If you have an intent to return to a homestead in another state, you do not meet the Texas residency requirement. If the value of your home exceeds a certain amount, you may not qualify for payment of nursing facility or waiver services.
- **Vehicle** — One vehicle is excluded, regardless of value. If your household has more than one person and the additional member of the household requires an additional vehicle for transportation to and from work, the additional vehicle is excluded for that member for work transportation. If your household has more than one person and there is an additional member of the household who requires disability accessible transportation, an additional vehicle is excluded if the vehicle is specially equipped for that additional member of the household. For all other vehicles, HHSC counts the current market value or, if you still owe on the vehicle, the current equity value as a resource.
- **Life Insurance** — Life insurance policies that you own with a total face value of $1,500 or less **per insured person** are excluded. If the face value of all policies per person exceeds $1,500, the cash value is counted as a resource. Term insurance is excluded.
- **Burial Spaces** —All burial spaces are excluded, unless you purchased them as an investment, in which case the equity value is counted.
- **Burial Funds** —Up to $1,500 of the funds identified for burial may be excluded, if kept separate from other resources. **This exclusion is only for you and your spouse.** This amount is reduced by the face value of any excluded life insurance and the value of any irrevocable arrangements for the individual's burial.

Examples of Countable Resources — The following are examples of resources you may own that are counted when determining eligibility:

- Checking accounts, savings accounts, certificates of deposit, money market accounts, individual retirements accounts (IRAs), stocks, bonds, land, lots or houses (other than homestead), and oil, gas, and mineral rights.
- Prepaid Burial Contracts — Prepaid burial contracts may or may not be excluded depending on the terms of the contract, how the contract is paid, ownership of life insurance, and the value of any other burial arrangements you own or another person owns that is for you.
- Other resources may or may not be countable depending on ownership and the use of items. Examples are antiques, jewelry, livestock, promissory notes, loans, property agreements, annuities, and trusts.

Spousal Impoverishment

The term "spousal impoverishment" is used to identify a federal law that allows a spouse still living at home to keep additional income and resources so they can continue to live independently.

If you apply for Medicaid in a nursing facility, ICF/IID, IMD or for a waiver program and have a spouse living in the community, a Spousal Protected Resource Allowance (SPRA) is determined for your spouse. The SPRA is determined as of the month you are admitted to a facility or the month you apply for waiver services.

The value of all resources owned by you and your spouse is combined and divided in half. The value of a homestead, one vehicle, personal goods, and certain burial funds for both you and your spouse is not included in the resource total. Your spouse who continues to live in the community is allowed to keep up to half of the total countable resources subject to the minimum and maximum allowable amounts, which change annually.

The amount of resources not protected for your spouse is your countable resource amount. Your countable resources cannot exceed the $2,000 resource limit to be eligible for medical assistance.

The SPRA exclusion ends at the first annual redetermination of your circumstances. At that time, all resources that remain in your name are considered in determining eligibility. Your total countable resources cannot exceed the $2,000 resource limit for you to stay eligible for medical assistance.

Proof of Resources

Proof of the ownership and value of resources is required. Examples of proof include bank statements, copies of notes, stocks, bonds, property deeds, loans, mortgages, insurance policies, prepaid burial contracts, annuities, letters from appraisers, and trust instruments.

It may take some time to gather all the needed proof and additional proof may be needed to determine the resource amount for specific months. Any of the above items that you send in with your application may help to speed up the eligibility decision. Proof of your resources will also be needed whenever there is a change in the ownership or the value of items you own and at least once a year when your circumstances must be completely reviewed.

Transfer of Assets

Giving away things you own for no compensation or refusing to accept income or reducing income you could receive may result in a penalty of non-payment for nursing facility services, ICF/IID facility services, or ineligibility for waiver program services or state supported living center services.

For income and resources that you transfer, the look-back time is up to 60 months before you apply for institutionalization or waiver services.

Cost of Care Responsibility

If you are eligible for Medicaid in a nursing facility, ICF/IID facility, IMD (if 65 or older) or for waiver program services, you may have to pay toward the cost of your care. This is referred to as your copayment. From your total income, you are allowed to keep a standard personal needs allowance. The amount of this allowance is different for different programs. Certain medical expenses you may pay, such as general health insurance premiums, Medicare premiums, deductibles and coinsurance, certain dental fees or prescription drug costs, may also be deducted. HHSC staff will calculate your copayment and notify you and your case manager or your service provider of the amount. The arrangement for your portion of the payment is between you, your case manager or the service provider. Medicaid payments for your care will be made directly to the service provider.

To access the Medicaid eligibility rules on the Internet, follow the steps below:

- Go to www.sos.state.tx.us/tac.
- Under **Points of Interest**, select **View the current Texas Administrative Code**.
- A menu will appear entitled **Texas Administrative Code: Titles**. Select **Title 1, Administration**.
- Select **Part 15, Texas Health and Human Services Commission**.
- Select **Chapter 358, Medicaid Eligibility for the Elderly and People with Disabilities**.
- Select the subchapter you desire.

This information is a general overview about Medicaid financial eligibility determinations and may not specifically cover your situation. The information is dated because the eligibility policies may be changed by federal, state, and agency rules. If you have questions about your situation, please contact 211.

Current Income and Resource Limits

Current budget limits are available in Appendix XXXI, Budget Reference Chart, of the Medicaid for the Elderly and People with Disabilities Handbook.

Appendix XXXIV, Burial Resources

Body

Revision 16-4; Effective December 1, 2016

Appendix is available for staff use, here.

Appendix XXXV, Treatment of Insurance Dividends

Body

Revision 16-4; Effective December 1, 2016

Appendix is available for staff use, here.

Appendix XXXVI, Qualified Income Trusts (QITs) and Medicaid for the Elderly and People with Disabilities (MEPD) Information

Body

Revision 21-1; Effective March 1, 2021

This information is offered by the Texas Health and Human Services Commission (HHSC). It helps prospective Medicaid applicants and their attorneys by describing basic information about the use of a qualifying income trust (QIT) (sometimes referred to as a "Miller" Trust) in meeting **MEPD** eligibility requirements. A model instrument is included at the end of this document. It shows an example of a QIT that meets MEPD requirements when properly completed. This form meets the basic MEPD requirements for a QIT, but it is not the only acceptable QIT form, and it may have consequences beyond Medicaid eligibility that an applicant would want to consider.

HHSC attorneys are prohibited from giving legal advice to the public. MEPD eligibility specialists, supervisors and other HHSC non-attorneys are prohibited from advising anyone by recommending

specific actions to become eligible for Medicaid as doing so may constitute the unauthorized practice of law.

HHSC staff has an obligation to inform applicants and other people of MEPD requirements. This information is not intended as legal advice and people seeking information on the legal consequences of these documents are encouraged to consult a lawyer of their choosing. HHSC will only review trust documents connected with the processing of a Medicaid application. The review by HHSC is limited to a determination of whether the trust meets the requirements for a Medicaid QIT.

People with low or limited income may be able to get legal counsel through their local legal aid office, local area agency on aging, local bar association, National Academy of Elder Law Attorneys, lawyer referral service, Advocacy Inc. or the State Bar of Texas.

Background

Eligibility for Medicaid institutional or home and community-based waiver services in Texas includes a requirement that the applicant's countable income not exceed the special income limit. The special income limit for a person is equal to or less than 300 percent of the full individual Supplemental Security Income (SSI) benefit rate. The special income limit for a couple is twice the special income limit for an individual. Effective Jan. 1, 2021, the special income limit is $ 2,382 per month for an individual and $ 4,764 per month for a couple. HHSC's current estimate of the average daily cost of a private pay nursing home stay in Texas for an individual is $213.71 — an amount that is significantly more than the individual special income limit.

Thus, Texas residents who require nursing home care and who have monthly income above the special income limit but below the private pay cost of the care, may have insufficient funds to pay for the needed care. To address this problem, Congress in 1993 amended Section 1917 of the Social Security Act to provide for an income diversion trust, or QIT (see 42 USC § 1396p(d)(4)(B)). The proper use of a QIT allows a person to legally divert the individual's income into a trust, after which the income is not counted for purposes of the MEPD institutional and home and community-based waiver special income limit.

Caution

A QIT should not be confused with other types of trusts that are commonly used in connection with the receipt of Medicaid or other public benefits. This information does not address these other types of trusts, such as a "Special Needs" trust that may be created for a person with a disability under age 65 who wishes to shelter assets to become or stay eligible for Medicaid or other public benefits.

HHSC does not count income that is properly diverted through a QIT in determining Medicaid eligibility for institutional or home and community-based waiver services. However, this income is not disregarded in determining eligibility for other Medicaid benefits, such as non-institutional assistance other than home and community-based waiver services, or Medicare Savings Programs. Such income also may not be disregarded in determining eligibility for non-Medicaid public benefits programs.

Although the use of a QIT can overcome the special income limit for Medicaid eligibility as explained above, a QIT will not address other eligibility requirements for institutional and home and community-based waiver services, such as citizenship, residency, medical necessity and the applicant's countable resources. A person with more than $2,000 in countable resources is not eligible for benefits, and the use of a QIT does not affect this resource eligibility requirement.

This information is based in part on informal guidance by the federal Centers for Medicare & Medicaid Services

(CMS). CMS has not adopted any federal regulations relating to QITs. Therefore, CMS' guidance and interpretations could change without advance public notice or any opportunity for advance public comment.

Necessity

The Texas MEPD special income limit applies only to an applicant's **countable** income. Therefore, to determine the need for a QIT, it is appropriate to first ask whether the income is countable for purposes of Medicaid eligibility, and to ask whether a prospective applicant's income will stay the same upon getting Medicaid assistance for nursing facility care. For example, certain types of Veterans Affairs (VA) benefits do not count. Also, some types of income — such as VA pensions — are subject to automatic reduction when a person living in a Medicaid-certified nursing facility becomes eligible for MEPD. In addition, when retirement income has been legally divided between spouses through a Qualified Domestic Relations Order and each spouse gets a check in their own name, the income of one spouse is not generally counted with respect to the other spouse. Texas follows a "name on the check" rule in counting the income of applicants for nursing home MEPD assistance.

Characteristics of the Trust

Only pension, Social Security, and other income may be placed in a QIT. No resources can be put into this type of trust. Since the trust has no "corpus" as that term is generally understood in the trust field, the need for much of the standard trust language about management of the trust principal is eliminated, and the language of the written trust instrument may be shortened accordingly. A prospective MEPD applicant may divert all their income into a QIT, or if they have income from multiple sources, only the income from certain sources. However, income from any given source must go entirely into the QIT, or not at all.

VA aid and attendance benefits, housebound allowances, and reimbursements for unusual or continuing medical expenses are exempt from both eligibility and co-payment. **However, if a person deposits these payments into a QIT account, they are countable for co-payment.** If a person receives a VA pension that includes aid and attendance benefits, housebound allowances, or reimbursements for unusual or continuing medical expenses, the person may separate the aid and attendance benefits, housebound allowances, or reimbursements for unusual or continuing medical expenses from the VA pension before depositing the VA pension into the QIT account. Aid and attendance benefits, housebound allowances, or reimbursements for unusual or continuing medical expenses are not income for Medicaid eligibility determinations.

The trust must be irrevocable. CMS has advised that a trust instrument that states the trust is irrevocable, but allows the trust to be revoked through court action, does not meet the irrevocability requirement.

The trust instrument may provide for successor or co-trustees, waive bond, and incorporate the Texas Trust Act provisions regarding the powers of the trustees. The statutory authority for a QIT is silent on who may serve as the trustee, but HHSC recommends that the beneficiary not also serve as the trustee. Among other concerns, HHSC has encountered many instances where a beneficiary did not follow the trust requirements, resulting in the beneficiary losing Medicaid eligibility.

The trust instrument may provide for successor or co-trustees, waive bond, and incorporate the Texas Trust Act provisions regarding the powers of the trustees. The statutory authority for a QIT is silent on who may serve as the trustee, but HHSC recommends not having the beneficiary serve as the trustee. Among other concerns, HHSC has encountered many instances where a beneficiary did not follow the trust requirements, resulting in the beneficiary losing Medicaid eligibility.

The trust instrument must have a reversion clause stating that at the death of the trust beneficiary, the trustee must pay to the state of Texas any funds still in the trust account, up to the full amount of Medicaid assistance

that was given to the beneficiary and not otherwise repaid. Payments made to HHSC, as residuary beneficiary, should be in whole dollar amounts and by cashier's check, money order or personal check. These payments are receipted on Form 4100, Money Receipt.

A QIT instrument must require that the trustee pay:

- a monthly personal needs allowance to the beneficiary;
- court ordered guardianship fees;
- a sum sufficient to give a minimum monthly maintenance needs allowance to the spouse (if any) of the beneficiary; and
- the cost of medical assistance given to the beneficiary, from the funds remaining.

The income must be deposited into the trust account during the month in which it is received, and the trustee must make distributions from the trust account no later than the last day of the following month.

HHSC does not deduct any trust administration costs in determining the amount of the beneficiary's income that must be applied to the cost of the beneficiary's medical assistance. Also, HHSC determines the amount that must be applied to the cost of the beneficiary's medical assistance given based on the beneficiary's total income, including any income that is not diverted to the QIT. If there are funds still in the trust account after the above distributions are made, such funds may be applied to the cost of trust administration.

Income paid from the trust to purchase institutional services, home and community-based waiver services, or other medical services for the beneficiary is not countable income for eligibility purposes. Income paid from the trust directly to the beneficiary, or otherwise spent for their benefit, is countable income for eligibility purposes.

Establishing a Bank or Other Financial Account as the QIT Account

In addition to a completed, signed, and dated trust instrument that meets the QIT requirements as determined by HHSC, there must be a trust account set up. A trust account is a bank (or other financial institution, such as a credit union) account used to deposit the income from the sources listed in the QIT instrument. As noted above, the trust account must contain only income and cannot contain resources. Therefore, the bank account must be used only to deposit the income from the sources listed in the QIT instrument.

A person may use an existing account, if they only use the account to deposit the QIT income. A person may need to open a new account if an existing account includes money from sources other than their QIT income. A person may also need to open a new account if an existing account is a joint account and other account holders make deposits to and withdraw from the joint account using the joint account holders' income and resources. If a joint account holder is on the account for convenience and does not use the account for the joint account holder's personal use, a person can use the account for the QIT.

If a person does need to open another account, some banks may require small deposits (for example, $10 to $20) to open a new account. HHSC allows a small amount of the beneficiary's money or money from another person to be deposited to open a new account. The money that a bank requires, as a deposit to open a new account, is not counted as a resource or income to the beneficiary.

Once the trust account is opened, only the beneficiary's income may be directed to the trust account. If the trustee directs to the trust account different sources of income than those identified in the QIT but directs entire sources and the countable income remains within the special income limit, eligibility is not affected. Any deposits made to the QIT bank account from other resources the beneficiary may own will result in the bank account becoming a countable resource. Any deposits to the QIT bank account from another person may be countable income and result in all deposits to the account being countable income and the bank account becoming a countable resource.

Effective Date

HHSC disregards income for Medicaid eligibility purposes the first month that a valid written trust instrument is signed and properly executed, a trust bank account with the beneficiary's Social Security number is set up, and enough of the beneficiary's income is placed into the account to reduce any remaining income to below the special income limit. The trust may be set up with any or all sources of a beneficiary's income, but an entire income source must be deposited. For the initial month that a QIT is established, a partial deposit of the income for which the trust is established will not invalidate the trust and the entire amount of the income source(s) will be disregarded from countable income for that month. A person may have used some of the monthly income to pay expenses prior to the date the QIT is established so the entire source(s) may not be available to open the QIT account. The entire amount of the income source(s) for which the QIT is established must be deposited into the QIT account in all subsequent months or the QIT is considered invalidated.

These things may be done before the beneficiary applies for MEPD, in which case the effective date of the income disregard may be established as much as three months prior to the application filing date (if all other program requirements are met during the prior period).

Transfer of Assets

The phrase "transfer of assets" refers to the general prohibition against an MEPD applicant or recipient transferring assets without compensation. When a transfer of assets occurs, it may result in a penalty period for Medicaid payment for institutional care or ineligibility for MEPD.

Income that is diverted to a QIT is not a transfer of assets if it is used for payment of institutional services or home and community-based waiver services for the MEPD recipient. Also, any distributions to the recipient's spouse and allowable payments for trust administration as described above are not considered a transfer of assets. However, distributions from the trust that are not made to the MEPD recipient or community-based spouse, or for the benefit of either, are considered a transfer of assets.

In addition, if the trustee fails to make distributions from income deposited into the trust account in the month of receipt by the end of the following month, such failure to timely distribute the income is considered a transfer of assets.

Sample QIT

Appendix XXXVII, Master Pooled Trust and Medicaid Eligibility Information

Body

Revision 16-3; Effective September 1, 2016

This information assists Medicaid applicants and their attorneys in gaining a basic understanding of the Master Pooled Trust. The Texas Health and Human Services Enterprise attorneys are prohibited from providing legal advice to the public. The only circumstances under which legal staff will review trust documents is when HHSC agency staff have questions about a trust that has been submitted along with a Medicaid application.

Background

The Omnibus Budget Reconciliation Act of 1993 (COBRA 93), 42 USC 1396(d)(4)(c), allows nonprofit corporations such as the Arc of Texas to establish and manage a pooled trust for the benefit of individuals with disabilities. Pooled trust provisions are found in 1917(d)(4)(c) of the Social Security Act. A pooled trust:

- contains the assets of individuals with disabilities;
- maintains for each beneficiary a separate subaccount established by the disabled individual, parent/grandparent/guardian, or a court from the disabled individual's funds;
- is managed by a nonprofit association that pools the subaccounts for management/investment purposes; and
- includes a provision that, to the extent that amounts remaining in the individual's account at the individual's death are not retained by the trust, the state is reimbursed in an amount equal to the total amount Medicaid paid on the individual's behalf.

Caution

This information applies only to an individual who meets the definition of disabled according to the Social Security Administration. Based on a medical determination, an individual is considered disabled if they are unable to engage in any substantial, gainful activity because of a medically determinable physical or mental impairment that can be expected to result in death or has continued or can be expected to continue for at least 12 months. A child who is not engaged in substantial, gainful activity is considered disabled if the child suffers from any medically determinable physical or mental impairment of comparable severity to which would preclude an adult from engaging in substantial, gainful activity.

Transfer of Assets

Transfer-of-assets policy does not apply when a pooled trust is established for the benefit of an individual under age 65. Transfer-of-assets policy does apply when a pooled trust is established or when contributions are made to the pooled trust for an individual who is age 65 or older. Transfer-of-assets policy applies to individuals of any age when an individual's assets in the pooled trust are transferred to another party.

Necessity

The principal purpose and objective of this trust is to provide a system for the management, investment, and disbursement of trust assets to promote a beneficiary's comfort and happiness by providing supplemental care. It is not the purpose nor objective of this trust to provide for or to make expenditures for beneficiary's basic maintenance, support, medical, dental, or therapeutic care, or any other appropriate care or service that may be paid for or provided by other sources. It is not the trust's purpose or objective to provide disbursements for the support of any beneficiary.

Characteristics of the Trust

Disbursements for "special needs" or "supplemental needs" or "supplemental care" shall mean nonsupport disbursements and shall not include cash to the beneficiary or payments for food, clothing or shelter. It is not the intention to displace public or private financial assistance that may otherwise be available to any beneficiary. The trustee shall make disbursements only for the supplemental needs as directed by the manager within the manager's sole discretion. The trust is irrevocable upon acceptance of assets by the trustee. A separate trust subaccount shall be maintained for each beneficiary.

Disbursements

The assets in the trust are to be used only for supplemental needs of the beneficiary and shall not include cash to the beneficiary or payments for food, clothing or shelter. Distributions of income or principal from the trust for medical and social purposes are not counted as income. Distributions to the beneficiary of cash or payments for food, clothing and shelter will be treated as income to the beneficiary.

Reporting Procedures

The primary representative of the subaccount is responsible for reporting the establishment of a master pooled trust subaccount. The pooled trust manager maintains records of each disbursement for each subaccount. Medicaid eligibility specialists request records of disbursements made for the beneficiary as part of the eligibility determination process.

Examples of pooled trusts include:

- The ARC of Texas Master Pooled Trust, established in 1997; and
- the Declaration of Trust for the Travis County Master Trust; Founders Trust Company, Trustee, adopted by decree of the District Court of Travis County, Texas, 201st Judicial District, effective Aug. 1, 1993.

Appendix XXXVIII, Pickle Disregard Computation Worksheet

Body

Revision 21-1; Effective March 1, 2021

Note: This information is effective Jan. 1, 2021.

Appendix is available for staff use, here.

Appendix XXXIX, MBI Screening Tool and Worksheets

Body

Revision 21-2; Effective June 1, 2021

Appendix is available for staff use here.

Appendix XL, Medicare and Extra Help Information

Body

Revision 12-3; Effective September 1, 2012

Note: This document is effective Jan. 1, 2010.

Medicare

Medicare is health insurance for people age 65 or older, under age 65 with certain disabilities and any age with permanent kidney failure (called end-stage renal disease). An individual must have entered the U.S. lawfully and have lived here for five years to be eligible for Medicare. Medicare has several parts.

- Medicare Part A (Hospital Insurance) – Helps pay for inpatient care in a hospital, skilled nursing facility or hospice, and for home health care if certain conditions are met. Most people do not have to pay a monthly premium for Medicare Part A because they or a spouse paid Medicare taxes while working in the U.S. If the Part A premium is not automatically free, an individual still may be able to enroll and pay a premium.
- Medicare Part B (Medical Insurance) – Helps pay for medically necessary doctors' services and other outpatient care. It also pays for some preventive services (like flu shots), and some services that keep certain illnesses from getting worse. Most people pay the standard monthly Medicare Part B premium.

  See Appendix XXXI, Budget Reference Chart, for the current Medicare Part B premium amount.
- Medicare Part C, called Medicare Advantage Plans – An individual must have both Part A and Part B to join one of these plans. The plans provide all of the Part A and Part B services, and generally provide additional services as well. An individual usually pays a monthly premium, and co-payments that likely will be less than the coinsurance and deductibles under the original Medicare. In most cases, these plans offer Part D Prescription Drug Coverage as well. These plans are offered by private insurance companies approved by Medicare. Costs and benefits vary by plan.

Prescription Drug Coverage

Medicare Prescription Drug Coverage, called Medicare Part D – An individual can add Part D by joining a Medicare Prescription Drug Plan (PDP). An individual must pay a deductible and usually is charged coinsurance each time services are received. Insurance companies and other private companies approved by Medicare offer PDPs. Costs and benefits vary by plan.

Enrollment is voluntary. Beneficiaries who have other sources of drug coverage (former employer, union, etc.) may stay in that plan. If their coverage is at least as good as the new Medicare drug benefit (creditable coverage), they will avoid higher premium payments if they later sign up for Medicare Rx.

Medicare drug coverage will help by covering brand-name and generic drugs. Like other insurance, after the individual is enrolled, the individual generally will pay a monthly premium, which varies by plan. The

individual also will pay a yearly deductible, which is between $0-$310 in 2010. The individual also will pay a part of the cost of prescriptions, including a co-payment or coinsurance. Costs will vary depending on which drug plan the individual chooses. Some plans may offer more coverage and additional drugs for a higher monthly premium. If the individual has limited income and resources, and the individual qualifies for extra help, the individual may not have to pay a premium or deductible.

For questions about Medicare or the Medicare health and prescription drug plans, visit www.medicare.gov/ online or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Extra Help for Prescription Drug Coverage

Extra help for prescription drug coverage is available for people with Medicare who have limited income and resources. If eligible for extra help, Medicare will pay for almost all prescription drug costs. Extra help provides a subsidy based on the amount of income and resources a person has.

Full Subsidy Benefits from Extra Help:

- Full premium assistance up to the premium subsidy amount
- Nominal cost sharing up to out-of-pocket threshold
- No coverage gap

Other Low Income Subsidy Benefits from Extra Help:

- Sliding scale premium assistance
- Reduced deductible
- Reduced coinsurance
- No coverage gap

An individual who has Medicare and Medicaid does not need to apply for extra help from Social Security. An individual who is eligible for the Medicare Savings Program (MSP) does not need to apply for extra help from Social Security. The MSP-eligible individual's information is sent to CMS automatically for the extra help.

Eligibility specialists ask, "Can I screen you for eligibility for Medicare Savings Program (MSP) since certification would include eligibility for extra help?"

If the caller does not want to be screened for MSP, refer the caller to the Centralized Benefit Services, **1-800-248-1078,** for completion of subsidy application.

If an individual thinks personal information is being misused, call 1-800-MEDICARE (**1-800-633-4227**).

Apply for **extra help** or get more information about **extra help** subsidy by calling Social Security at 1-800-772-1213 (TTY 1-800-325-0778) or visiting www.socialsecurity.gov.

Appendix XLI, Reserved for Future Use

Body

Revision 20-1; Effective March 1, 2020

Appendix XLII, Variable Income Worksheet

Body

Revision 16-4; Effective December 1, 2016

Appendix is available for staff use, here.

Appendix XLIV, Reserved for Future Use

Body

Revision 17-1; Effective March 1, 2017

Appendix XLV, Reserved for Future Use

Body

Revision 21-4; Effective December 1, 2021

Appendix XLVI, Reserved for Future Use

Body

Revision 11-2; Effective June 1, 2011

Appendix XLVII, Simplified Redetermination Process

Body

Revision 16-4; Effective December 1, 2016

Appendix is available for staff use, here.

Appendix XLVIII, Medicaid Buy-In for Children (MBIC) Denial Codes

Body

Revision 16-4; Effective December 1, 2016

Appendix is available for staff use, here.

Appendix XLIX, Medicaid Buy-In for Children Program Forms Chart

Body

Revision 16-4; Effective December 1, 2016

Appendix is available for staff use, here.

Appendix L, 2021 Income and Resources Reference Chart

Body

Revision 21-3; Effective September 1, 2021

This chart lists amounts for the income and resource limits as well as deduction amounts and other pertinent information in a simple, easy-to-read format.

Note: This information is effective Sept. 1, 2021.

Appendix is available for staff use on the LOOP.

Appendix LI, Self-Service Portal (SSP) Information

Body

Revision 12-3; Effective September 1, 2012

Basics of the SSP

The SSP located at www.yourtexasbenefits.com is available to individuals 24 hours a day, seven days a week. They can use this website to:

- Request or print a blank:
  - Form H1200, Medicaid for the Elderly and People with Disabilities Application for Assistance – Your Texas Benefits;
  - Form H1010, Texas Works Application for Assistance – Your Texas Benefits; and
  - Form H1014, Application for Children's Health Insurance Program (CHIP), Children's Medicaid, and CHIP Perinatal Coverage.
- Apply for the following benefits:
  - SNAP food benefits,
  - Medicaid,
  - TANF and TANF-Level Medicaid,
  - Medicare savings programs,
  - Long-term care.
- View Past and future interview date and times.
- View and print submitted applications.
- View case status (approve, denied. and/or terminated).
- View benefit amounts.
- View effective and review date.
- View pending information.
- Report changes:
  - address,
  - phone number,
  - household members,
  - employment income,
  - self-employment income,
  - unearned income,
  - liquid resources,
  - shelter expenses including utility,
  - dependent care expense.
- View Medicaid services and health history.
- Submit redeterminations.

Account Management

SSP provides the user with an option of Application Visibility or Case Visibility. Users with application visibility will be given the option to update to case visibility by going through advanced authentication.

Individuals must set up an SSP Case Visibility account in order to view case information and report changes by going through advanced authentication. If an individual loses their SSP password or is unable to set up a case visibility account because they cannot correctly respond to the authentication security questions via the SSP, they may request assistance from HHSC or the vendor.

If the individual is in the office requesting assistance with alternate account set-up/password reset, staff must verify the individual's identity and use the State Portal SSP account Management tab to grant case visibility access or password reset. See C-2220, In-Person Contact.

If the individual is on the phone, then staff should refer the individual to 2-1-1 for assistance.

For additional information see https://oss.txhhsc.txnet.state.tx.us/sites/tw/SitePages/State%20Processes.aspx, Group: Support Tools. Select Support Tool-SSP Application Registration.

Appendix LII, Reserved for Future Use

Body

Revision 17-1; Effective March 1, 2017

Appendix LIII, Sponsor to Alien Deeming Worksheet

Body

Revision 21-1; Effective March 1, 2021

Note: This information is effective Jan. 1, 2021.

Appendix is available for staff use, here.

Appendix LIV, Description of Alien Resident Cards

Body

Revision 16-4; Effective December 1, 2016

Appendix is available for staff use, here.

Appendix LV, Reserved for Future Use

Body

Revision 20-1; Effective March 1, 2020

Forms

Body

ES = Spanish version available.

Form	Title	
4116	Authorization for Expenditures	
8001	Medicaid Estate Recovery Program Receipt Acknowledgement	ES
H0003	Agreement to Release Your Facts	ES
H0004	Consent for a Person Sponsoring an Immigrant	ES
H0005	Policy Clarification Request	
H0025	HHSC Application for Voter Registration	ES
H0051	Medicaid Buy-In Premium Payment Notice	
H0052	Medicaid Buy-In Refund Notice	
H0053	Medicaid Buy-In Potential Eligibility Notice	ES
H0054	Medicaid Buy-In Eligibility Notice	ES
H0055	Verification of Long Term Care Partnership Insurance Policies	
H0056	Notice of Opportunity to Designate Countable Resources	ES
H0057	Long Term Care Partnership Resource Worksheet	
H0059	Notification of Annuity Remainder Beneficiary	ES
H0062-MBIC	Late Payment Notice	ES
H0065-MBIC	Hardship Form	ES
H0090-I	Notice of Admission, Departure, Readmission or Death of an Applicant/Recipient of Supplemental Security Income and/or Medical Assistance Only in a State Institution	
H0926	Sharing Facts About Me and My Case with a Community Partner	ES
H1003	Appointment of an Authorized Representative	ES
H1004	Cover Letter: Authorized Representative Not Verified	ES
H1016	Supplemental Security Income Referral	
H1019	Report of Change	ES
H1020	Request for Information or Action	ES
H1020-A	Sources of Proof	
H1026	Verification of Railroad Retirement Benefits	
H1026-FTI	Verification of Railroad Retirement Benefits - FTI	
H1027-A	Medicaid Eligibility Verification	
H1027-B	Medicaid Eligibility Verification - MQMB	
H1027-C	Medicaid Eligibility Verification - QMB	
H1028-A	Employment Verification (Aged and Disabled Programs)	
H1028-A-FTI	Employment Verification - FTI	
H1028-MBIC	Employment Verification (Medicaid Buy-In for Children)	
H1035	Pre-Screening Result for Medicaid	
H1038	Medical Facility Referral	

Form	Title	
H1039	Medical Insurance Input	
H1049	Client's Statement of Self-Employment Income	
H1051-IME	Receipt of Durable Medical Equipment	ES
H1052-IME	Notice of Delay in Decision for Incurred Medical Expense	ES
H1053-IME	Provider Notice of Incurred Medical Expense Decision	ES
H1054-IME	Receipt of Dental Services	ES
H1097	Affidavit for Citizenship/Identity	ES
H1131	Individually Identifiable Health Information Fax Transmittal	
H1200	Application for Assistance - Your Texas Benefits	
H1200-A	Medical Assistance Only (MAO) Recertification	
H1200-EZ	Application for Assistance - Aged and Disabled (Large Print)	
H1200-MBI	Application for Benefits - Medicaid Buy-In	
H1200-MBIC	Application for Benefits - Medicaid Buy-In for Children	ES
H1200-MSP-C	Medicare Savings Program Notice	ES
H1200-MSP-D	Medicare Savings Program Denial Notice	ES
H1200-PFS	Medicaid Application for Assistance (for Residents of State Facilities) Property and Financial Statement	
H1201	MAO Worksheet	
H1201-A	Client Declaration or Streamline Review Worksheet	
H1201-EZ	Medicaid Eligibility Client Declaration Worksheet	
H1202-A	MAO Worksheet-Income Changes	
H1202-B	MAO Worksheet-Other Changes	
H1204	Long Term Care Options	
H1207	Notification of Eligibility Special Medicaid Programs	
H1207-A	Notification of Eligibility Special Medicaid Program (State Facilities)	
H1210	Subrogation (Trust/Annuities/Court Settlements)	
H1214	Request for Pension Information	
H1214-FTI	Request for Pension Information - FTI	
H1215	Report of Delay in Certification	
H1217	Quality Assurance Monitoring System	

Form	Title	
H1222	Private Health Insurance Information	
H1223	SMIB Memorandum	
H1224	SSI Monitoring Letter	
H1225	Restitution	
H1226	Transfer of Assets/Undue Hardship Notification	ES
H1228	Application Letter	ES
H1228-A	Medicaid for the Elderly and People with Disabilities -- Application Information	ES
H1230	Notification of Eligibility -- Regular Medicaid Benefits	ES
H1232	Notification of Ineligibility	ES
H1233-MBIC	Redetermination Cover Letter (Medicaid Buy-In for Children)	ES
H1236	Notification of Receipt of Application	
H1238	Verification of Insurance Policies	
H1238-A	Verification of Pre-Need Information	
H1239	Request for Verification of Bank Accounts	
H1239-FTI	Request for Verification of Bank Accounts - FTI	
H1240	Request for Information from Bureau of Veterans Affairs and Client's Authorization	
H1240-FTI	Request for Information from Bureau of Veterans Affairs and Client's Authorization - FTI	
H1242	Verification of Mineral Rights	
H1242-FTI	Verification of Mineral Rights - FTI	
H1243	Verification of Civil Services Benefits	
H1243-FTI	Verification of Civil Services Benefits - FTI	
H1245	Statement of Intent to Return to Home	
H1246	Medicaid Eligibility Interview Guide	
H1247	Notice of Delay in Certification	
H1252	Designation of Burial Funds	
H1253	Verification of Health Insurance Policy	
H1256	Financial Management	
H1259	Correction of Applied Income	
H1260	Parental Status/Inheritances	
H1263	Certification of Medical Necessity	
H1263-A	Certification of Medical Necessity - Durable Medical Equipment or Other IME	
H1263-B	Certification of No Medical Contraindication - Dental	
H1270	Data Integrity SAVERR Notification	
H1272	Declaration of Resources	
H1272-A	Spousal Impoverishment Assessment Letter	

Form	Title	
H1273	Request for Assessment Information	
H1274	Medicaid Eligibility Resource Assessment Notification	
H1275	Request for Expanded Protected Resource Assessment	
H1276	Burial Fund Designation Worksheet	
H1277	Notice of Opportunity to Designate Funds for Burial	
H1278	Request for Patient Trust Fund Information	
H1279	Spousal Impoverishment Notification	
H1280	Statement of Residence Maintenance Needs	
H1281	Trust Notification	
H1296	Notice of SSI Medicaid Ending	
H1297	Request for Information from Teacher Retirement System of Texas	
H1298	SSI Prior Medical Coverage Notice (Certified Clients)	
H1298-A	SSI Prior Medical Coverage Notice (Denied Applicants)	
H1299	Request for Joint Bank Account Information	
H1300	Declaration of Texas Residency	
H1350	Opportunity to Register to Vote	
H1746-A	MEPD Referral Cover Sheet	
H1746-B	Batch Cover Sheet	
H1800	Receipt for Application/Medicaid Report/Verification/Report of Change	
H1826	Case Information Release	ES
H1830	Application/Review/Expiration/Appointment Notice	
H1861	Federal Tax Information Record Keeping and Destruction Log	
H1862	Federal Tax Information Transmittal Memorandum	
H1863	Federal Tax Information Removal Log	
H1864	Federal Tax Information Fax Transmittal	
H1866	Federal Tax Information Visitor Access Log	
H2067	Case Information	
H2076	Authorization to Release Medical Information	
H3033	Report of Physical or Mental Examination	
H3034	Disability Determination Socio-Economic Report	ES
H3035	Medical Information Release/Disability Determination	ES
H3038	Emergency Medical Services Certification	
H3080	Notification of Eligibility - Qualifying Individuals Program	
H3081	QI Transaction Report	
H3618-A	Resident Transaction Notice for Designated Vendor Numbers	
H4100	Money Receipt	
H4800	Fair Hearing Request Summary	
H4800-A	Fair Hearing Request Summary (Addendum)	
H4807	Action Taken on Hearing Decision	

Form	Title	
H4808	Notice of Change in Applied Income/Notice of Denial of Medical Assistance	
H4831	Fraud Referral Log	
H5017-MBIC	Items We Need from You	ES
H5017-MEPD	Items We Need from You	ES
H5018-MBIC	Denial Notice	ES
H5019-MBIC	Hardship Waiver Approved	ES
H5020-MBIC	Hardship Waiver Denied	ES
H5021-MBIC	Initial Certification	ES
H5022-MBIC	Notice of Change in Monthly Payment or Cost Share Limit	ES
H5023-MBIC	Prior Months Eligibility	ES
H5024-MBIC	Termination Notice	ES
HRG-83	SSN Maintenance Memorandum	ES
SS-5	Application for a Social Security Number Card (Original, Replacement, or Correction)	

Revisions

21-4, December Quarterly Revision

Body

Revision Notice 21-4; Effective December 1, 2021

Archived Revision 21-3; Effective September 1, 2021
Archived Revision 21-2; Effective June 1, 2021
Archived Revision 21-1; Effective March 1, 2021
Archived Revision 20-4; Effective December 1, 2020

Revisions

The following sections were revised in the Medicaid for the Elderly and Persons with Disabilities (MEPD) Handbook:

Sections	Section Title	Change
B-3400 B-8400	General Procedures; Procedures for Redetermining Eligibility	Updates related policy cross-references and clarifies policy for returning renewal forms. (All Programs)

Sections	Section Title	Change
B-7450 B-8000 TOC B-8460 (New) Appendix TOC Appendix XLV (Reserved)	Medicaid Certified Person Enters Nursing Facility or Home and Community-Based Services Waiver Program; Changes and Program Transfers; Program Transfer with H1200 Guide	Adds new section with information about processing changes. Incorporates program transfer information from Appendix XLV. Removes Appendix XLV from related policy section. Reserves Appendix XLV for future use. (All Programs)
C-7000 TOC C-7000	National Voter Registration Act of 1993	Removes historical information and outdated terminology. Updates section title to "Voter Registration." (All Programs).
D-3000 TOC D-3800 D-3810 (New) Glossary	Inmates in a Public Institution; Inmates in a County Jail in Texas; Glossary P	Incorporates policy from MEPD and TW Bulletin 18-10, 3. Suspension, Termination and Reinstatement of Health Care Coverage for Persons Confined to a County Jail, released on Dec. 14, 2018. Creates new section and updates existing section title. Adds new terms and removes outdated references from the glossary. (All Programs)
F-7120 Glossary	Application File Date or Program Transfer Request Date; Glossary D, L and S	Removes historical agency references. (MEPD)
M-9000 R-1300	Notices and Forms; Notices	Adds information about notices for certifications and ongoing cases. Clarifies which form to send when denying MBI. (MBI)
N-1310	MBIC and Nursing Facilities	Removes outdated terminology. (All Programs)
C-3000	When and What Information May Be Disclosed	Incorporates policy from MEPD and TW Bulletin 21-21, HIPAA – Notice of Privacy Practices, released on Oct. 18, 2021. New policy reflects that Form H1826, Case Information Release, is the correct form to authorize release of personal information. Updates policy to align with HHS Privacy policy. (MEPD)
C-4100	Privacy Notice	Updates Notice of Privacy Practices processes to reflect automation changes in TIERS. (MEPD)
Appendix VIII Appendix XVII	Summary of Effects of Institutionalization on Supplemental Security Income (SSI) Eligibility; System Generated IEVS Worksheet Legends for IRS Tax Data	Corrects links on Appendix landing pages to direct staff to the LOOP. Updates for standard language. (All Programs)

Forms

The following forms were revised in the MEPD Handbook:

Form	Title	Change
Form H1826	Case Information Release	Adds the ability for the "After this amount of time:" text box to allow both letters and numbers

Form	Title	Change
Form H1046	Inpatient Medical Services Certification	
Form H1020	Request for Information or Action	Updates format of date fields to MM/DD/YYYY and updates format to time fields to HH:MMAM/PM (e.g., 12:40PM).
Form H1020S	Request for Information or Action (Spanish)	Translation
Form H1103	Verification of TANF Eligibility	Changes to the word “child” on second table first line and changes the word “sex” to “gender”

Retired Bulletins

The following bulletins are deleted from the MEPD Handbook. The information has either been incorporated into the handbook or is no longer necessary:

Release Date	Bulletin Number	Title
10-18-21	21-21	HIPAA – Notice of Privacy Practices
08-05-21	21-15	COVID-19 Update: Additional Emergency Allotment Supplement
07-28-21	21-14	COVID-19 Update: Extended Supplemental Nutrition Assistance Program (SNAP) Certification Periods
05-05-21	21-09	COVID-19 Update: Additional Emergency Allotment Supplement
04-22-21	21-08	1. Electronic Benefit Transfer Card Issuance Processing 2. Personal Identification Number (PIN) Packet Issuance Procedures 3. Supplemental Nutrition Assistance Program (SNAP) Benefits Distribution Schedule Update
03-09-21	21-05	1. Healthy Texas Women (HTW) Medicaid 1115 Demonstration Waiver 2. HTW Plus (HTW+)
03-25-21	21-04	1. COVID-19 Update: Additional Emergency Allotment Supplement 2. COVID-19 Update: Extended Supplemental Nutrition Assistance Program (SNAP) Certification Periods 3. COVID-19 Update: SNAP Student Eligibility
01-13-21	21-02	1. COVID-19 Update: Additional Emergency Allotment Supplement 2. COVID-19 Update: Temporary Increase in SNAP Benefits
12-03-20	20-28	COVID-19 Policy Updates #19
10-01-20	20-24	COVID-19 Policy Updates #17
10-31-19	19-10	Discontinuation of The Work Number (TWN)
12-14-18	18-10	1. Removal of Fleeing Felon and Parole/Probation Violator Application Questions 2. Maternal Depression Screening Questions 3. Suspension, Termination and Reinstatement of Health Care Coverage for Persons Confined to a County Jail
12-31-13	14-02	ACA Changes Final

21-3, September Quarterly Revision

Body

Revision Notice 21-3; Effective September 1, 2021

Archived Revision 21-2; Effective June 1, 2021
Archived Revision 21-1; Effective March 1, 2021
Archived Revision 20-4; Effective December 1, 2020
Archived Revision 20-3; Effective September 1, 2020

Revisions

The following sections were revised in the Medicaid for the Elderly and Persons with Disabilities (MEPD) Handbook:

Sections	Section Title	Change
B-9000 C-2000 I-5000 J-7000 R-4000	Denials; Confidential Nature of the Case Record; Calculation of Penalty Period; Income for Eligibility and Co-Payment; Automated Data Exchanges and Tape Matches	Updates sections for plain language and removes duplicate policy listed in other sections. (All Programs)
B-3000 TOC Q TOC	Table of Contents (TOC)	Updates TOC to add new sections and remove retired sections.
B-7440 B-8450	Alternate Care Services; Special Reviews when Facility Contract Closure or Cancellation Occurs	Removes historical agency references and outdated information. (MEPD)
B-8400 B-9000 TOC B-9100 (Reserve)	Procedures for Redetermining Eligibility; Administrative Denials	Removes duplicative policy already listed in B-8400 and reserves section for future use. (All Programs)
C-2300	Custody of Records	Updates contact information for reporting unauthorized inspection or disclosure of Internal Revenue Service (IRS) Federal Tax Information (FTI) or Social Security Administration (SSA) information. (All Programs)
C-2400	Safeguarding Federal Income Data	Adds information about annual training and adds related policy. (All Programs)
C-2500	Disposal of Records	Updates requirements for shredding documents. (All Programs)

Sections	Section Title	Change
D-5000 (TOC) D-5220 D-8320 D-8610	Compact of Free Association States; Qualified Aliens Not Subject to a Waiting Period or Limited Period; Ineligible Aliens	Incorporates policy from MEPD and TW Bulletin 21-10, 1. Compact of Free Association (COFA) Citizens, released on May 20, 2021. (All Programs)
D-8000 TOC D-8210	Terms	Removes glossary terms and updates section title to "United States Citizenship and Immigration Services (USCIS) Documents." (All Programs)
G-7000	Prior Coverage	Clarifies policy and updates section for plain language. (All Programs)
G-7300	Emergency Coverage for Aliens	Clarifies that the Form H3038, Emergency Medical Services Certification, must contain a handwritten signature from the medical practitioner. (MEPD)
H-2710	Using the TX Dental IME Fee Schedule	Corrects the link to the Dental IME Fee Schedule. Updates the examples. (MEPD)
H-2720	Non-Allowable Deductions - Dental	Adds additional non-allowable dental codes. (MEPD)
I-5100	Transfer of Assets Divisor	Incorporates policy from MEPD and TW Bulletin 21-12, 3. Transfer of Assets Divisor, released on July 1, 2021. (MEPD)
J-7200 J-7400	Spousal Co-Payment; Spousal Impoverishment Dependent Allowance	Incorporates policy from MEPD and TW Bulletin 21-11, 2. Spousal Impoverishment Dependent Allowance, released on June 1, 2021. (MEPD)
N-1320 O-1800	MBIC and Home and Community-Based Services Waivers; Texas Home Living (TxHmL)	Revises that TxHmL waiver services are now paid under MBIC. (MBIC)
O-1000	Waiver Programs	Updates sections for plain language. Adds related policy. (MEPD)
R-4300	Income and Eligibility Verification System	Adds that IEVS includes information on unemployment insurance benefits (UIB) and removes historical information. Adds related policy. (All Programs)
R-4600	Public Assistance Reporting Information System (PARIS)	Clarifies the process for PARIS Interstate matches and removes outdated information. (All Programs)
Glossary	A, C, D, F, G, I, L, N, P, R, S, T, U	Adds terms removed from D-8210. Updates terms for plain language. (All Programs)
Appendix XXXI Appendix L	Budget Reference Chart; 2021 Income and Resources Reference Chart	Incorporates policy from MEPD and TW Bulletin 21-11, 2. Spousal Impoverishment Dependent Allowance, released on June 1, 2021, and MEPD and TW Bulletin 21-12, 3. Transfer of Assets Divisor, released on July 1, 2021. (MEPD)

Forms

The following forms were revised in the MEPD Handbook:

Form	Title	Change

Form	Title	Change
Form H3038 Instructions	Emergency Medical Services Certification	Adds instructions clarifying that a “handwritten” signature from the medical practitioner signing the form is required. Removes electronic signature functionality from form.

Retired Bulletins

The following bulletins are deleted from the MEPD Handbook since the information has either been incorporated into the handbook or is no longer necessary:

Release Date	Bulletin Number	Title
06-01-21	21-11	1. COVID-19 Update: Additional Emergency Allotment Supplement 2. Spousal Impoverishment Dependent Allowance
11-02-20	20-26	COVID-19 Policy Updates #18
09-21-20	20-23	COVID-19 Policy Updates #16
09-01-20	20-20	COVID-19 Policy Updates #14
07-29-20	20-18	COVID-19 Policy Updates #12
07-02-20	20-17	COVID-19 Policy Updates #11
05-20-20	20-14	COVID-19 Policy Updates #9
04-08-20	20-07	COVID-19 Policy Updates #4
05-14-15	15-06	Nursing Facility Medicaid to Managed Care and Incurred Medical Expense Changes
03-31-14	14-06	Social Security Administration - Security Awareness
07-12-13	13-09	Vietnamese Interpreter and Translation Information Page
07-03-13	13-08	Data Broker and Alien Status Verification Enhancement
05-06-08	08-11	Afghan and Iraqi Aliens with Special Immigrant Status
04-28-08	08-09	Applications and Restitution for State Schools Cases
01-15-08	08-03	Data Broker and Redeterminations for Medicaid for the Elderly and People with Disabilities
08-13-07	07-12	1. Incurred Medical Expense 2. DME Fee Schedule 3. ADA Survey of Fees

21-2, June Quarterly Revision

Body

Revision Notice 21-2; Effective June 1, 2021

Archived Revision 21-1; Effective March 1, 2021
Archived Revision 20-4; Effective December 1, 2020
Archived Revision 20-3; Effective September 1, 2020
Archived Revision 20-2; Effective June 1, 2020

Revisions

The following sections were revised in the Medicaid for the Elderly and Persons with Disabilities (MEPD) Handbook:

Sections	Section Title	Change
E-6000 M-7000 Q-2000 Q-6000	Self-Employment Income; Premiums; Qualified Medicare Beneficiaries (QMB) – MC – QMB; Qualified Disabled and Working Individuals (QDWI) –MC-QDWI	Updates sections for plain language. (All Programs)
E-6210	Self-Employment Expenses	Incorporates policy from MEPD and TW Bulletin 21-03, 2. Mileage Rate Decrease, released on Feb. 5, 2021. Adds note regarding using the mileage rate instead of tracking actual transportation expenses. (All Programs)
M-5200 M-7100 N-6330 N-6351 Q-2500 Q-3200 Q-5200 Q-6200 Appendix IX Appendix XXII Appendix XXIX Appendix XXXI Appendix XXXIX Appendix L	Medicaid Buy-In (MBI) Income Limits; Post Eligibility – Premium Budgets; Ineligible Sibling Exclusion; Examples of Budgeting Steps; QMB Income Limits; SLMB Income Limits; QI Income Limit; QDWI Income Limit; Medicare Savings Program Information; Home and Community-Based Services Waiver Program Co-Payment Worksheets; Special Deeming Eligibility Test for Spouse to Spouse; Budget Reference Chart; MBI Screening Tool and Worksheets; 2020 Income/Resources Reference Chart	Incorporates policy from MEPD and TW Bulletin 21-03, 4. 2021 Federal Poverty Level, released on Feb. 5, 2021. Updates sections and charts with 2021 FPL income and resource amounts. (All Programs)
Q-3000 Q-5000	Specified Low-Income Medicare Beneficiaries (SLMB) – MC-SLMB; Qualifying Individuals (QIs)	Aligns language regarding dual eligibility for SLMB and QI for certain Medicaid recipients. (MSP)

Retired Bulletins

The following bulletins are deleted from the MEPD Handbook since the information has either been incorporated into the handbook or is no longer necessary:

Release Date	Bulletin Number	Title
02-05-2021	21-03	1. COVID-19: Additional Emergency Allotment Supplement 2. Mileage Rate Decrease 3. Temporary Census Income 4. 2021 Federal Poverty Level
12-04-2020	20-29	Federal Benefits 2021 Cost-of-Living Adjustment (COLA)
11-30-2020	20-27	Electronic Benefit Transfer (EBT) Form Updates
10-22-2020	20-25	Retest Medicaid Eligibility for Persons Certified on Children's Health Insurance Program (CHIP) or CHIP Perinatal (CHIP-P)
09-11-2020	20-22	1. TIERS Updates Related to Pre-Tax Contributions 2. MAGI Updates for Alimony 3. MAGI Updates for Moving Expenses 4. Determining Good Cause for SNAP Employment and Training Noncompliance 5. Revised SNAP Income Limits, Deductions, and Allotments 6. Revised TANF Maximum Grant Amounts 7. Revised SNAP-CAP Allotment Attachment – SNAP Allotment Chart
05-12-2020	20-12	SNAP Online Purchasing Project
06-04-2020	20-11	1. Adult Certified for the Healthy Texas Women Program Leaves the Household 2. Alignment of Medicaid Certification Periods for all Children Living in the Same Household 3. Revised - New SNAP Benefits Distribution Schedule
03-02-2020	20-03	1. Activity Fees as an Allowable Dependent Care Deduction 2. Action on Prisoner Matches 3. Excluding the Full Value of Prepaid Burial Insurance
02-18-2020	20-02	Reasonable Opportunity for Healthy Texas Women (HTW)
10-21-2019	19-09	1. Alimony Paid for MAGI Expenses 2. Data Broker - Predictive Analytics Phase II

21-1, March Quarterly Revision

Body

Revision Notice 21-1; March 1, 2021

Archived Revision 20-4; Effective December 1, 2020
Archived Revision 20-3; Effective September 1, 2020
Archived Revision 20-2; Effective June 1, 2020
Archived Revision 20-1; Effective March 1, 2020

Revisions

The following sections were revised in the Medicaid for the Elderly and Persons with Disabilities (MEPD) Handbook:

Sections	Section Title	Change
B-3300	Authorized Representative	Updates Authorized Representative policy with information from MEPD Bulletin #15-05, 1. Updates to Authorized Representatives, released on April 3, 2015, and MEPD and Texas Works Bulletin #18-08, 3. Authorized Representative Correspondence, released on Sept. 6, 2018. (All Programs)
B-8400	Procedures for Redetermining Eligibility	Adds information about administrative renewals from B-9100. (All Programs)

Sections	Section Title	Change
D-9410 G-1310 G-1320 G-2311.2 G-2312.1 H-6000 J-7200 J-7300 M-7100 Appendix IX Appendix XII Appendix XXII Appendix XXIX Appendix XXXI Appendix XXXIII Appendix XXXVI Appendix XXXVIII Appendix L Appendix LIII	Examples of Sponsor-to-Alien Income Deeming; Community-Based Programs Using SSI Limits; Special Income Limits; Examples of Spouse-to-Spouse Deeming; Examples of Parent-to-Child Deeming; Co-Payment for SSI Cases; Spousal Co-Payment; ICF/IID Spousal Companion Cases; Post Eligibility — Premium Budgets; Medicare Savings Program Information; Nursing Facility and Home and Community-Based Services Waiver Information; Home and Community-Based Services Waiver Program Co-Payment Worksheets; Special Deeming Eligibility Test for Spouse to Spouse; Budget Reference Chart; Medicaid for the Elderly and People with Disabilities Information; Qualified Income Trusts (QITs) and Medicaid for the Elderly and People with Disabilities (MEPD) Information; Pickle Disregard Computation Worksheet; 2021 Income/Resources Reference Chart; Sponsor to Alien Deeming Worksheet	Updates sections and charts based on the 2021 Cost of Living Adjustment (COLA) from MEPD and Texas Works Bulletin #20-29, Federal Benefits 2021 Cost-of-Living Adjustment (COLA), released Dec. 4, 2020. (All Programs)
F-3600 F-3610	Substantial Home Equity; Persons Impacted by Substantial Home Equity Disqualification	Updates substantial home equity limits for 2021 from MEPD and Texas Works Bulletin #20-29, Federal Benefits 2021 Cost-of-Living Adjustment (COLA), released Dec. 4, 2020. (MEPD)
G-4310	Computing Social Security Cost-of-Living Increases	Updates reference chart with the new Pickle multiplier from MEPD and Texas Works Bulletin #20-29, Federal Benefits 2021 Cost-of-Living Adjustment (COLA), released Dec. 4, 2020. (MEPD)

Sections	Section Title	Change
H-1800	Medicare Part B Premium	Updates the standard Medicare Part B premium for 2021 from MEPD and Texas Works Bulletin #20-29, Federal Benefits 2021 Cost-of-Living Adjustment (COLA), released Dec. 4, 2020. (All Programs)
M-8500	Denial Reasons	Adds information about the notice staff use when denying Medicaid Buy-In (MBI). (MBI)
M-9000	Notices and Forms	Adds information about the notice staff use when denying MBI. (MBI)
Q-1300	MSP Resource Limits	Updates resource limits for 2021 multiplier from MEPD and Texas Works Bulletin #20-29, Federal Benefits 2021 Cost-of-Living Adjustment (COLA), released Dec. 4, 2020. (MSP)
Glossary	Glossary Part A	Modifies the definition of Authorized Representative. (All Programs).
Appendix VI	SSA Claim Number Suffixes	Updates SSA Claim Number Suffixes. (All Programs)

Forms

The following forms were revised in the MEPD Handbook:

Form	Title	Change
Form H1861 and Instructions	Federal Tax Information Record Keeping and Destruction Log	Updates form to comply with federal IRS policy.
Form H1862 and Instructions	Federal Tax Information Transmittal Memorandum	Removes obsolete reference to Budget Job Number.

Retired Bulletins

The following bulletins are deleted from the MEPD Handbook since the information has either been incorporated into the handbook or is no longer necessary:

Release Date	Bulletin Number	Title
06-11-20	20-16	Spousal Impoverishment Dependent Allowance
02-05-20	20-01	1. 2020 Federal Poverty Level 2. Incurred Medical Expenses (IME) Forms Automation 3. Mileage Rate Decrease
09-06-18	18-8	1. Modified Adjusted Gross Income (MAGI) Household Composition and Household Income Exception Updates for Tax Dependents Age 19 and Older 2. Healthy Texas Women Auto-Enrollment Expansion 3. Authorized Representative Correspondence 4. Medicaid for the Elderly and People with Disabilities (MEPD) and Medicare Savings Program (MSP) Review Changes
06-13-18	18-5	1. Verifying Fleeing Felons and Parole/Probation Violators for SNAP and TANF 2. Able Bodied Adult Without Dependents (ABAWD) Streamlined Reporting (SR) Requirements 3. Applicant's Right to Copies of Submitted Applications 4. Lawfully Residing Status Codes for Children's Medicaid and Children's Health Insurance Program (CHIP) 5. 2018 Spousal Dependent Allowance 6. Updates to Medicaid After Supplemental Security Income Denial - Children and Qualified Medicare Beneficiary
04-03-15	15-5	1. Updates to Authorized Representatives 2. Electronic Correspondence 3. Preferred Languages for Correspondence

Policy Bulletins

Body

The purpose of this section is to make the most current policy and procedures available within a single resource. Memoranda containing policy or procedural information will be placed on this list at the time of distribution. They will remain on the list until the information contained is either completely incorporated into the handbook or retired as obsolete.

Release Date	Bulletin Number	Title
02-04-22	22-03	2022 Federal Poverty Level

Release Date	Bulletin Number	Title
02-01-22	22-02	1. COVID 19 Update: Additional Emergency Allotment Supplement 2. COVID-19 Update: Processing Denial Actions for Medicaid Programs 3. Medicaid for Inmates of Juvenile Institutions 4. Mileage Rate Increase
01-03-22	22-01	1. Updates to Managed Care Organizations (MCO) Preferred Method of Contact 2. SNAP-CAP Allotment Adjustment 3. COVID-19 Update: Additional Emergency Allotment Supplemental
12-07-21	21-25	Federal Benefits 2022 Cost-of-Living Adjustments (COLA)
12-01-21	21-24	1. Texas Simplified Application Project (TSAP) 2. COVID-19 Update: Additional Emergency Allotment Supplement
11-22-21	21-23	COVID-19 Update: Interview Requirements
11-02-21	21-22	1. Eligibility for Federal Benefits for Afghan Evacuees 2. COVID-19 Update: Additional Emergency Allotment Supplement
10-08-21	21-20	COVID-19 Update: Pending Medicaid Eligibility Determination Groups (EDGs) with Continuous Eligibility
10-01-21	21-19	COVID-19 Update: Additional Emergency Allotment Supplement
10-01-21	21-18	Counting ABAWD Federal Time Limit Months
09-03-21	21-17	1. Revised TANF Maximum Grant Amounts 2. Revised SNAP Income Limits Deductions and Allotments 3. COVID-19 Update: Additional Emergency Allotment Supplement 4. COVID-19 Update: Able-Bodied Adults Without Dependents (ABAWD) Time Limits Attachment: SNAP Allotment Chart
08-27-21	21-16	1. COVID-19 Update: Pandemic Electronic Benefit Transfer (P-EBT) for Summer 2021 2. Afghan Special Immigrant Parolee (SI/SQ) and Lawful Permanent Resident (LPR) Status
07-16-21	21-13	1. COVID-19 Update: Child Tax Credits (CTC) and Earned Income Tax Credits (EITC) 2. COVID-19 Update: Resuming Workforce Orientation for Applicants (WOA) & Choices Participation 3. COVID-19 Update: Temporary Increase in SNAP Benefits
07-01-21	21-12	1. COVID-19 Update: Additional Emergency Allotment Supplement 2. COVID-19 Update: Processing Medicaid Applications for Children Previously in the Conservatorship of the Department of Family and Protective Services (DFPS) 3. Transfer of Assets Divisor
05-21-21	21-10	1. Compact of Free Association (COFA)Citizens 2. COVID-19: Pandemic Electronic Benefit Transfer (P-EBT) for School Year 2020-2021
04-08-21	21-07	1. COVID-19 Update: Processing Denial Actions for Medicaid Programs 2. COVID-19 Update: Additional Emergency Allotment (EA) Supplement
04-02-21	21-06	1. COVID-19 Update: Recovery Rebates 2. COVID-19: Transfer of Assets 3. COVID-19 Update: Federal Pandemic Unemployment (FPUC) 4. COVID-19 Update: Pandemic Unemployment Assistance (PUA) 5. COVID-19 Update: Pandemic Emergency Unemployment Compensation (PEUC)

Release Date	Bulletin Number	Title
01-06-21	21-01	1. COVID-19 Update: Recovery Rebates 2. COVID-19 Update: Federal Pandemic Unemployment (FPUC) 3. COVID-19 Update: Pandemic Unemployment Assistance (PUA) 4. COVID-19 Update: Pandemic Emergency Unemployment Compensation (PEUC)
12-22-20	20-30	COVID Policy Updates #20
09-30-20	20-21	COVID Policy Updates #15
06-15-20	20-15	COVID-19 Policy Updates #10
05-12-20	20-13	COVID-19 Policy Updates #8
04-28-20	20-10	COVID-19 Policy Updates #7
04-07-20	20-06	COVID-19 Policy Updates #3
03-27-20	20-05	COVID-19 Policy Updates #2
03-23-20	20-04	COVID-19 Policy Updates #1
05-30-19	19-06	1. Spousal Impoverishment Dependent Allowance 2. Spousal Impoverishment for Waiver Participants
10-04-17	17-10	1.Counting Social Security Benefits for Modified Adjusted Gross Income Programs 2.Social Security Number Validation 3.Determining Good Cause for SNAP Employment and Training Noncompliance
05-14-15	15-06	Nursing Facility Medicaid to Managed Care and Incurred Medical Expense Changes
01-06-15	15-03	Budgeting of Alien Sponsor's Income and Resources
04-04-13	13-04	American Taxpayer Relief Act of 2012
09-06-11	12-01	Vendor Imaging Forms H1263-A and H1263-B Appendix XLVI – Unsigned Renewal/ 12-2010 Appendix XLVI – Unsigned Renewal/ 12-2010 – Spanish
10-29-10	11-05	New Birth Certificates for Residents of Commonwealth of Puerto Rico

Contact Us

Body

Revision 20-3; Effective September 1, 2020

For technical or accessibility issues with this handbook, please email the HHSC Editorial Services mailbox.

For questions about the Medicaid for the Elderly and People with Disabilities Handbook (MEPDH), email the HHSC MEPD Policy Support mailbox.